HUMAN RESOURCES
COLORADO STATE UNIVERSITY

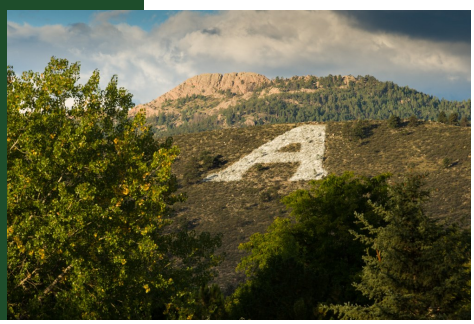
2023 CSU BENEFIT PLANS

updated June 1, 2023

Academic Faculty, Administrative Professionals, Veterinary & Clinical Psychology Interns, Post Doctoral Fellows

Colorado State University

Contents



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Welcome to Colorado State University!

Colorado State University is proud to offer a comprehensive total rewards package that supports your health and well-being.

This Summary Plan Description (SPD) provides an overview of the benefits and privileges available to eligible employees. Every effort was made to ensure the information in this booklet is accurate. In the event of a conflict between the SPD and the official plan or program documents, the plan and program documents will govern.

Benefits and privileges are approved through the Governing Board of Colorado State University and summarized in this booklet. The CSU Benefits Plan (Cost Share), hereafter referred to as CSU Benefits, is made available to eligible Academic Faculty, Administrative Professionals, Post Doctoral Fellows, Veterinary Interns and Clinical Psychology Interns.

It is important for you to familiarize yourself with the benefit plan options available, CSU assumes no responsibility for the loss of any benefits that may otherwise be available to you.

Any employee or covered individual of an employee who knowingly provides false, incomplete, or misleading information in the CSU online benefits enrollment system or related documents may be subject to civil/criminal penalties and/or denial of enrollment in the University benefit plans.

The benefits and privileges described in the SPD are subject to change at any time. With the exception of changes required by law, changes are normally the result of a collaborative and consultative process. Nonetheless, CSU is the final authority and reserves the right to change any or all aspects of the benefits and privileges it provides.

Any benefit plan changes are communicated via Human Resources via online publications, electronic mail, web access or other appropriate means.

Cost Share Model

Long & Short Term Disability

The cost of the disability premiums will be added as a supplemental amount to your monthly salary and listed on your pay advice as "LTD-STD Allowance". $4 will automatically be deducted back out of your earnings on a post tax basis to cover the cost of the STD premium.

Your STD and LTD premiums are deducted post-tax basis. Paying for your premiums on a post-tax basis allows the income replacement benefit to be tax exempt, should you need to utilize it.

Cost Share Model

For Medical and Dental, the University pays:

- 100% of the premium cost of employee only coverage under the Green or Ram Plan-HDHP medical and/or the Delta Dental Basic plans for those eligible employees electing such coverage;
- 76% of the premium cost of employee + 1 or family coverage under the Green medical
- 75% of the Delta Dental Basic plans for those eligible employees electing coverage

If you upgrade to the Gold or POS medical plan and/or to the Delta Dental Plus plan, you will bear the difference in cost of the selected plan(s) and the institutional support for the Green or Delta Dental Basic plan at the comparable coverage level (e.g., employee only, employee + 1, family).

For Basic Group Term Life and AD&D, the University pays:

- The cost of $70,000 basic group term life and AD&D coverage. You will be asked to select a beneficiary(ies) during the enrollment process

Insurance Premium Deductions

9-Month Appointment Insurance Premium Deductions

Employees with 9-month appointments (salary paid over 9 months) have benefit deductions in the spring to ensure benefits coverage through the summer months as follows:

April: two premium deductions for coverage in April and May.

May: two premium deductions for coverage in June and July.

August: premium deduction for coverage in August (return to normal cycle).

Other Salaried Employees

Premiums for insurances are deducted from your monthly pay for the current month's coverage. Enrollment completed after the University monthly payroll deadline will not delay your coverage effective date, but may result in multiple premium deductions on your next paycheck.

Pre and Post-Tax Deductions

You may elect to have eligible insurance premiums taken from your pay by pre-tax or post-tax deductions, when you initially enroll or during the annual benefits Open Enrollment period.

Pre-tax elections are irrevocable, based on Section 125 of the Internal Revenue Code, within the calendar year for which they are made, unless you experience a qualifying event.

Pre-Tax: Insurance premiums deducted from your pay *before* Medicare, Federal, and State taxes are calculated will reduce your taxable gross salary as provided in Section 125 of the Internal Revenue Code.

Plan	Pre	Post
Medical	X	X
Dental	X	X
Vision	X	X
Basic Group Term Life and AD&D		X
Voluntary Group Term Life		X
Voluntary AD&D		X
Long- Term Disability*		X
Long Term Care (no payroll deduction)		X
Short term Disability		X
Flexible Spending Account (FSA)	X	
Health Savings Account (HSA)	X	

*Long term disability premiums are deducted post -tax which means if you become disabled, the disability income benefits will not be subject to income tax.

Defined Contribution Plan (DCP) contributions are not affected by pre-tax deductions.

If you are a PERA member, pre-tax deductions (including those to Flexible Spending Accounts) may affect your retirement highest average salary calculation since they reduce the amount of your monthly salary reported to PERA. For new PERA members as of 1/1/2020, PERA-includable salary will include contributions to pre-tax, cafeteria plans. Please contact PERA for more information.

Post-Tax: Insurance premiums deducted from your pay *after* Medicare, Federal, and State taxes are calculated do not reduce your taxable gross salary. You may *delete* an individual or *cancel* the plan at anytime.

Basic Life Insurance

$70,000 provided at no cost to the employee (employer provided life insurance exceeding $50,000 is subject to imputed income).

Disability Insurance

Short term Disability (STD) is provided at no cost to the employee. There is a $4 taxable allowance.

Long Term Disability (LTD) is provided at no cost to the employee. There is a taxable allowance that varies based upon salary.

Monthly Benefit Plan Premiums

Premiums are subject to change; notification of such changes will typically be during the annual open enrollment period.

	Green Plan or Ram Plan – HDHP	Gold Plan (frozen to new enrollment)	POS Plan
Employee Only			
Total Premium	$648	$782	$889
CSU Pays	$648	$648	$648
You Pay	**$0**	**$134**	**$241**
Employee + 1			
Total Premium	$1,154	$1,434	$1,626
CSU Pays	$877	$877	$877
You Pay	**$277**	**$557**	**$749**
Family			
Total Premium	$1,622	$2,025	$2,307
CSU Pays	$1,233	$1,233	$1,233
You Pay	**$389**	**$792**	**$1,074**
Family-Split*			
Total Premium	$1,622	$2,025	$2,307
CSU Pays	$1,525	$1,525	$1,525
You Pay	**$48.50/each**	**$250/each**	**$391/each**

	Delta Dental Basic	Delta Dental Plus	VSP Vision
Employee Only			
Total Premium	$24	$47	
CSU Pays	$24	$24	
You Pay	**$0**	**$23**	**$5.79**
Employee + 1			
Total Premium	$43	$83	
CSU Pays	$33	$33	
You Pay	**$10**	**$50**	**$11.56**
Family			
Total Premium	$62	$142	
CSU Pays	$46	$46	
You Pay	**$16**	**$96**	**$18.64**
Family-Split*			
Total Premium	$62	$142	
CSU Pays	$57	$57	
You Pay	$2.50/each	$42.50/each	**N/A**

*Available if both spouse/partners are benefits-eligible and have at least one child covered under The Plan(s).

Voluntary Life Insurance Premiums

Voluntary **Employee** Life coverage may be purchased in $10,000 increments up to $500,000. Voluntary Spouse, Domestic Partner or Civil Union Partner Life coverage may be purchased in $10,000 increments up to $300,000.

Premiums are after-tax and based upon age as of January 1st of each calendar year.

The child rate is a flat rate of $1.50 regardless of the number of children you have.

Amount	<29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-70	70+
$10,000	$0.35	$0.50	$0.60	$0.79	$1.23	$1.85	$3.43	$5.00	$8.70	$15.50
$20,000	0.70	1.00	1.20	1.58	2.46	3.70	6.86	10.00	17.40	31.00
$30,000	1.05	1.50	1.80	2.37	3.69	5.55	10.29	15.00	26.10	46.50
$40,000	1.40	2.00	2.40	3.16	4.92	7.40	13.72	20.00	34.80	62.00
$50,000	1.75	2.50	3.00	3.95	6.15	9.25	17.15	25.00	43.50	77.50
$60,000	2.10	3.00	3.60	4.74	7.38	11.10	20.58	30.00	52.20	93.00
$70,000	2.45	3.50	4.20	5.53	8.61	12.95	24.01	35.00	60.90	108.50
$80,000	2.80	4.00	4.80	6.32	9.84	14.80	27.44	40.00	69.60	124.00
$90,000	3.15	4.50	5.40	7.11	11.07	16.65	30.87	45.00	78.30	139.50
$100,000	3.50	5.00	6.00	7.90	12.30	18.50	34.30	50.00	87.00	155.00
$110,000	3.85	5.50	6.60	8.69	13.53	20.35	37.73	55.00	95.70	170.50
$120,000	4.20	6.00	7.20	9.48	14.76	22.20	41.16	60.00	104.40	186.00
$130,000	4.55	6.50	7.80	10.27	15.99	24.05	44.59	65.00	113.10	201.50
$140,000	4.90	7.00	8.40	11.06	17.22	25.90	48.02	70.00	121.80	217.00
$150,000	5.25	7.50	9.00	11.85	18.45	27.75	51.45	75.00	130.50	232.50
$160,000	5.60	8.00	9.60	12.64	19.68	29.60	54.88	80.00	139.20	248.00
$170,000	5.95	8.50	10.20	13.43	20.91	31.45	58.31	85.00	147.90	263.50
$180,000	6.30	9.00	10.80	14.22	22.14	33.30	61.74	90.00	156.60	279.00
$190,000	6.65	9.50	11.40	15.01	23.37	35.15	65.17	95.00	165.30	294.50
$200,000	7.00	10.00	12.00	15.80	24.60	37.00	68.60	100.00	174.00	310.00
$210,000	7.35	10.50	12.60	16.59	25.83	38.85	72.03	105.00	182.70	325.50
$220,000	7.70	11.00	13.20	17.38	27.06	40.70	75.46	110.00	191.40	341.00
$230,000	8.05	11.50	13.80	18.17	28.29	42.55	78.89	115.00	200.10	356.50
$240,000	8.40	12.00	14.40	18.96	29.52	44.40	82.32	120.00	208.80	372.00
$250,000	8.75	12.50	15.00	19.75	30.75	46.25	85.75	125.00	217.50	387.50
$260,000	9.10	13.00	15.60	20.54	31.98	48.10	89.18	130.00	226.20	403.00
$270,000	9.45	13.50	16.20	21.33	33.21	49.95	92.61	135.00	234.90	418.50
$280,000	9.80	14.00	16.80	22.12	34.44	51.80	96.04	140.00	243.60	434.00
$290,000	10.15	14.50	17.40	22.91	35.67	53.65	99.47	145.00	252.30	449.50
$300,000	10.50	15.00	18.00	23.70	36.90	55.50	102.90	150.00	261.00	465.00
$310,000	10.85	15.50	18.60	24.49	38.13	57.35	106.33	155.00	269.70	480.50
$320,000	11.20	16.00	19.20	25.28	39.36	59.20	109.76	160.00	278.40	496.00
$330,000	11.55	16.50	19.80	26.07	40.59	61.05	113.19	165.00	287.10	511.50
$340,000	11.90	17.00	20.40	26.86	41.82	62.90	116.62	170.00	295.80	527.00
$350,000	12.25	17.50	21.00	27.65	43.05	64.75	120.05	175.00	304.50	542.50
$360,000	12.60	18.00	21.60	28.44	44.28	66.60	123.48	180.00	313.20	558.00
$370,000	12.95	18.50	22.20	29.23	45.51	68.45	126.91	185.00	321.90	573.50
$380,000	13.30	19.00	22.80	30.02	46.74	70.30	130.34	190.00	330.60	589.00
$390,000	13.65	19.50	23.40	30.81	47.97	72.15	133.77	195.00	339.30	604.50
$400,000	14.00	20.00	24.00	31.60	49.20	74.00	137.20	200.00	348.00	620.00
$410,000	14.35	20.50	24.60	32.39	50.43	75.85	140.63	205.00	356.70	635.50
$420,000	14.70	21.00	25.20	33.18	51.66	77.70	144.06	210.00	365.40	651.00
$430,000	15.05	21.50	25.80	33.97	52.89	79.55	147.49	215.00	374.10	666.50
$440,000	15.40	22.00	26.40	34.76	54.12	81.40	150.92	220.00	382.80	682.00
$450,000	15.75	22.50	27.00	35.55	55.35	83.25	154.35	225.00	391.50	697.50
$460,000	16.10	23.00	27.60	36.34	56.58	85.10	157.78	230.00	400.20	713.00
$470,000	16.45	23.50	28.20	37.13	57.81	86.95	161.21	235.00	408.90	728.50
$480,000	16.80	24.00	28.80	37.92	59.04	88.80	164.64	240.00	417.60	744.00
$490,000	17.15	24.50	29.40	38.71	60.27	90.65	168.07	245.00	426.30	759.50
$500,000	17.50	25.00	30.00	39.50	61.50	92.50	171.50	250.00	435.00	775.00

Voluntary AD&D Premiums

Detailed plan information can be found in the Voluntary AD&D section.

Coverage and Benefit Amounts					Monthly Premiums	
	Spouse, Domestic Partner or Civil Union Partner			Each Child if no Spouse, Domestic Partner or Civil Union Partner (25% of the Employee coverage level)		
Employee	If no Children (60% of the Employee coverage level)	With Children (50% of the Employee coverage level)	Each Child (15% of the Employee coverage level)		Employee Only Coverage	Family Coverage
$25,000	$15,000	$12,500	$3,750	$6,250	**$0.38**	**$0.95**
$50,000	$30,000	$25,000	$7,500	$12,500	**0.75**	**1.90**
$75,000	$45,000	$37,500	$11,250	$18,750	**1.13**	**2.85**
$100,000	$60,000	$50,000	$15,000	$25,000	**1.50**	**3.80**
$125,000	$75,000	$62,500	$18,750	$31,250	**1.88**	**4.75**
$150,000	$90,000	$75,000	$22,500	$37,500	**2.25**	**5.70**
$175,000	$105,000	$87,500	$26,250	$43,750	**2.63**	**6.65**
$200,000	$120,000	$100,000	$30,000	$50,000	**3.00**	**7.60**
$225,000	$135,000	$112,500	$33,750	$56,250	**3.38**	**8.55**
$250,000	$150,000	$125,000	$37,500	$62,500	**3.75**	**9.50**
$275,000	$165,000	$137,500	$41,250	$68,750	**4.13**	**10.45**
$300,000	$180,000	$150,000	$45,000	$75,000	**4.50**	**11.40**
$325,000	$195,000	$162,500	$48,750	$81,250	**4.88**	**12.35**
$350,000	$210,000	$175,000	$52,500	$87,500	**5.25**	**13.30**
$375,000	$225,000	$187,500	$56,250	$93,750	**5.63**	**14.25**
$400,000	$240,000	$200,000	$60,000	$100,000	**6.00**	**15.20**
$425,000	$255,000	$212,500	$63,750	$106,250	**6.38**	**16.15**
$450,000	$270,000	$225,000	$67,500	$112,500	**6.75**	**17.10**
$475,000	$285,000	$237,500	$71,250	$118,750	**7.13**	**18.05**
$500,000	$300,000	$250,000	$75,000	$125,000	**7.50**	**19.00**

COBRA Premiums

Detailed plan information can be found in the COBRA section.

Coverage Level	Green or Ram Plan-HDHP	Gold	POS	Dental Basic	Dental Plus	Vision	EAP
Single	$660.96	$797.64	$906.78	$24.48	$47.94	$5.91	$1.53
2 Persons	$1,177.08	$1,462.68	$1,658.52	$43.86	$84.66	$11.79	$1.53
Family	$1,654.44	$2,065.50	$2,353.14	$63.24	$144.84	$19.01	$1.53

How to Enroll in Benefits

Employee Self-Service (ESS) is a secure online portal where active employees can manage/view their demographic information, benefits elections (CSU Benefits), leave balances and payroll information. You will have 30 days from your date of eligibility to complete enrollment.

Learn About Available Benefits

- Read this benefits overview
- Visit Alex at myalex.com/csu/2023

What You Can Do in 'CSU Benefits'

- Enroll/review your current benefits enrollment
- Make changes to your benefits elections due to a mid-year life event. Learn more at on the HR website.
- Designate/change your life insurance beneficiary(ies)

Employee Self-Service (ESS)

CSU Benefits for Academic Faculty & Non-Classified Staff

1. Navigate to the AAR portal and select **HR System** from the menu on the right. Then, login with your eID and password. Visit the eID website for password assistance or call (970) 491-6947
2. Expand the ESS menu on the left and click **CSU Benefits**
3. Read the disclaimer and select **Accept** then **Next** to proceed
4. Add dependents and beneficiaries on the following screen
5. Select **CSU Benefits Plan** from the Select Program page and click **Next**
6. Click **Update Benefits** to change your enrollment
7. Remember to click **Finish** to finalize your elections
8. You will not automatically receive an email confirmation so we encourage you to print a confirmation statement for your records

ALEX
Benefits Counselor

ALEX provides personalized, confidential benefits guidance on any computer, tablet, or smartphone! When you talk to ALEX, it will ask you a few questions about your healthcare needs, crunch some numbers and find the plan that fits best.

Before you make your enrollment decisions, let ALEX help you find the plans that make the most sense for you and your family!

Off Campus?

Before you access the HR System, you'll need to login with your eID through the secure website.

Be sure and establish your DUO account which provides an additional layer of security to your account by requiring two-factor authentication. Learn more on the ACNS website.

Eligibility & Appointment Types

Academic Faculty—Regular or Special Appointments

Faculty on regular or special appointments of half-time (50%) or greater are eligible for benefits as of the date of appointment unless otherwise noted. This includes faculty on continuing or contract appointments.

Faculty Transitional Appointments

Faculty transitional appointees have the option of remaining on the active group insurance plans available to full-time academic faculty members.

Administrative Professionals—Regular or Special Appointments

Administrative Professionals on regular or special appointments of half-time (50%) or greater are eligible for benefits as of the date of appointment unless otherwise noted.

Temporary Appointments

Faculty and Administrative Professionals on temporary appointments of half-time (50%) or greater are eligible for benefits. This includes faculty on continuing or contract appointments. Retirement plan participation, in lieu of Social Security, is mandatory and begins as of the date of appointment. Employer contributions to the Defined Contribution Plan for Retirement (DCP) will not begin until a one year waiting period is satisfied. Refer to the Retirement section in this summary booklet for information.

Visiting Faculty, Visiting Scientist/Scholar, Visiting Research Associates, Visiting Senior Scientist/Scholar are not eligible for benefits, except as required as a condition of employment under Colorado law, to contribute to a retirement plan in lieu of Social Security.

Post Doctoral Fellows, Veterinary Interns and Clinical Psychology Interns

Post Doctoral Fellows, Veterinary Interns and Clinical Psychology Interns on appointments of half-time (50%) or greater are eligible for benefits, except for the Defined Contribution Plan (DCP) match, as of the date of appointment.

Federal Employees

Federal employees on appointment of half-time or greater are eligible for benefits (excluding CSU medical and retirement plans) as of the date of appointment unless otherwise noted. Contact Cooperative Extension, (970) 491-6367, for information on Federal medical and retirement option(s).

Benefits-Eligible Spouse, Domestic Partner, Civil Union Partner

Without children: should enroll separately in Employee Only medical and/or dental coverage so they each receive the CSU "employee only" contribution. This also allows greater flexibility to enroll in the plans that suit your individual needs.

With children: should enroll in the Family-Split option. This provides a greater level of institutional support while ensuring the whole family is covered under the same policy for the purposes of maximizing family deductibles and out-of-pocket maximums.

Family-Split Contract Changes

If your spouse, domestic partner or civil union partner loses eligibility, you have 30 days to modify coverage for the remaining employee. If the change is not initiated within the 30 day period, the remaining benefits eligible employee will be automatically responsible for the full premium costs.

Individuals Eligible for University Benefits

You may enroll eligible individuals in certain University benefits plans as outlined in this SPD. Although individuals may be eligible to participate in a University plan as a "dependent" they may not meet the definition of a "qualified" dependent for federal income tax purposes.

If your dependent(s) meet the IRS test as a federal tax dependent, they are considered a "qualified" dependent. If your dependent(s) does not meet the IRS test, they are considered a "non-qualified" dependent. There are tax consequences (imputed income) associated with providing coverage to individuals (domestic partners, civil union partners, children of domestic partners and civil union partners) not meeting the criteria of Section 152 of the Internal Revenue Code which defines a federal tax dependent.

Examples of non-qualified federal tax dependents may be domestic partners, civil union partners, children of domestic partners or children of civil union partners not defined under the Patient Protection and Affordable Care Act (PPACA).

You are encouraged to consult a tax advisor to determine the status of your dependent(s), as this is a complex area of the law.

When enrolling eligible individuals you must first determine if they meet the following eligibility criteria for CSU plans:

- Your spouse or common-law spouse
- Your domestic partner
- Your civil union partner
- You, your spouse's, common-law spouse's, domestic partner's or civil union partner's unmarried or married child(ren) including natural children, legally adopted children, foster children placed with you for adoption, stepchildren, children in which legal guardianship has been designated and children defined under a Qualified Medical Child Support Order (QMCSO).

Children must be:

- Under the age of 26 regardless of marital status. Children remain covered through the end of the month in which they turn 26
- Any age and dependent on you because of a permanent physical or mental disability to the end of the month in which they turn 26
    - Once the disabled dependent reaches age 26, the University requires them to be certified as disabled prior to age 23, a "qualified" federal tax dependent and currently enrolled in the plan to maintain coverage

Note: You will be required to submit documentation at the time of enrollment that substantiates dependent status. No spouse, domestic partner, civil union partner or child can be covered on your plan if covered as an employee on this plan or a State Classified plan.

Federal Tax Dependent

When you have confirmed your domestic partner, domestic partner's unmarried or married child(ren), civil union partner or civil union partner's unmarried or married child(ren)'s eligibility and are ready to enroll them in a University plan, you must indicate whether each individual qualifies as YOUR federal tax dependent. If you fail to do so, they will be identified as non-federal tax dependents ("non-qualified").

When Does Coverage Begin and End?

Coverage Start Dates

Benefits for you and any eligible dependents are generally effective first of the month following your eligibility date, the date of your mid-year qualifying event, or January 1 of the following year if changes are made during Open Enrollment.

As a newly eligible employee, you may elect to have insurance become effective on your date of eligibility. If you chose this option, you must pay a full month's contribution regardless of the number of days covered. Premiums are not prorated—contact Human Resources for assistance.

Note: Some plans include an "actively at work" provision that delays the effective date of coverage when the employee is absent from work on the normal effective date. Included plans are: Short term Disability, Long term Disability, Basic Group Term Life and AD&D, Voluntary Group Term Life, Voluntary AD&D and Long Term Care. The Voluntary Group Term Life and the Voluntary AD&D insurance programs delay effective dates for spouses, domestic partners or civil union partners and children under certain circumstances. Consult the Certificates of Insurance for details.

Coverage End Dates

See the *COBRA* section regarding the right to continuation of coverage. Coverage for your and/or your dependents will end at the end of the month in which:

- You no longer meet the eligibility requirements to participate in these plans, or
- You fail to make the required payment, or
- Your employment with the University terminates, or
- A mid-year life event has occurred (e.g. divorce, gain of other coverage)
- A dependent child reaches age 26

Open Enrollment

The Open Enrollment period occurs each year in October/November. During this time, you may enroll, cancel, waive, add, drop or change insurance plans and covered individuals. Any changes made during this time are effective January 1 of the following year. Open Enrollment information

Automatic and Default Enrollment Process

(New Hires / Newly Eligible)

You will be automatically enrolled in these benefits effective on your date of eligibility:

- $70,000 of basic group term life and AD&D insurance
- STD and LTD on an post-tax basis

If you do not complete the enrollment process or "opt-out" of medical coverage within the 30 day enrollment period, you will be defaulted (enrolled) in:

- Employee-only coverage in the Green medical plan on an post-tax basis ($0 monthly premium).
    - Does not apply to Federal Employees

In order to "opt-out" of medical coverage you must certify that you have comparable medical coverage elsewhere. You will not be allowed to make changes again until the next annual Open Enrollment

Mid-Year Qualifying Events

You are permitted to make mid-year election changes within **30 days** of an IRS approved qualifying event. It is necessary to provide documentation to Human Resources to substantiate the qualifying event and to establish the eligibility for, and the effective date of, the requested change within 30 days of the qualifying event.

Note: If you have elected to have your premiums deducted post-tax, you are eligible to delete individual(s) or cancel coverage at any time during the plan year without providing documentation.

Qualifying Events

If you have elected to have your premiums deducted pre-tax, mid-year election changes are regulated by federal law. The Internal Revenue Code Section 125 contains provisions defining "qualifying events" which allow mid-year changes to your insurance and in some cases, health and/or dependent care flexible spending account plan elections.

With the exception of deleting individuals or coverage termination, change in status events use the same eligibility criteria to determine election changes whether premiums are paid on a pre-tax or post-tax basis.

Common Types of Qualifying Events

- Change in your legal marital status, a change in domestic partnership or civil union partnership status
- Change in the number of eligible individuals of the employee, domestic partner, civil union partner or child(ren)
- Gain Dependent—birth, adoption, placement for adoption, stepchildren etc.
- Loss of Dependent—death, attainment of age 26 (unless disabled as defined under the eligibility section). Change in employee's, spouse's, domestic partner's, civil union partner's or child's employment status including strike, lock-out, unpaid leave, commencement or termination of employment, etc.
- Gain / lose entitlement to Medicare or Medicaid
- A change in residence of the employee, spouse, domestic partner, civil union partner or eligible individual, which *affects* eligibility for coverage
- Judgment, decree, or Qualified Medical Child Support order for coverage of an eligible child

- Significant change in health coverage of an eligible child
- Significant change in coverage or cost of spouse, common-law-spouse, domestic partner, civil union partner or domestic partner or civil union child's plan
- Spouse's or dependent's annual enrollment period
- Reduction in Hours of Service
- Enrollment in a Qualified Health Plan through a Health Care Reform Marketplace

Mid-Year Qualifying Events

It is necessary to provide documentation with, or prior to, the election in the CSU Online Benefits Enrollment System to substantiate the qualifying event and to establish the eligibility for, and the effective date of, the requested change.

Examples of Required Documentation

- Court documents for adoption, divorce, marriage, etc.
- Affidavit of Common-Law Marriage or Domestic Partnership
- Certificate of Civil Union Partnership
- Secondary, joint financial document dated within the past 60 days that shows you and your spouse/partners name at a shared address
- Documentation of mid-year qualifying events on company letterhead and which should include:
    - Defined qualifying event type and date
    - Name(s) of individuals who had been covered under other plan
    - Insurance coverage effective date or termination date (for all benefits)

Newborns and Newly Adopted Child(ren) under the age of 18

- If you are currently enrolled in a CSU medical plan, your child or the child of your domestic partner or civil union partner is covered for the first 31 days from the date of birth or placement for adoption. The child is automatically covered for this 31 day time period.
- If you wish to add this child to your insurance(s) beyond the first 31 days of automatic coverage, you must complete enrollment in the CSU Online Benefits Enrollment System within 30 days from the date of birth or placement for adoption. You will be responsible for premiums beginning with the first day of the month following the date of birth or placement for adoption.
- If you do not complete the CSU Online Benefits Enrollment System change adding the child within 30 days from the date of birth or date of placement for adoption, the child will not be covered under your plan beyond the first 31 days. You will not be able to enroll the child until the next Open Enrollment period with coverage effective the first of the following calendar year unless you incur a qualifying event.

The Affordable Care Act

Full-time (30 or more hours) or Variable Hour Employees

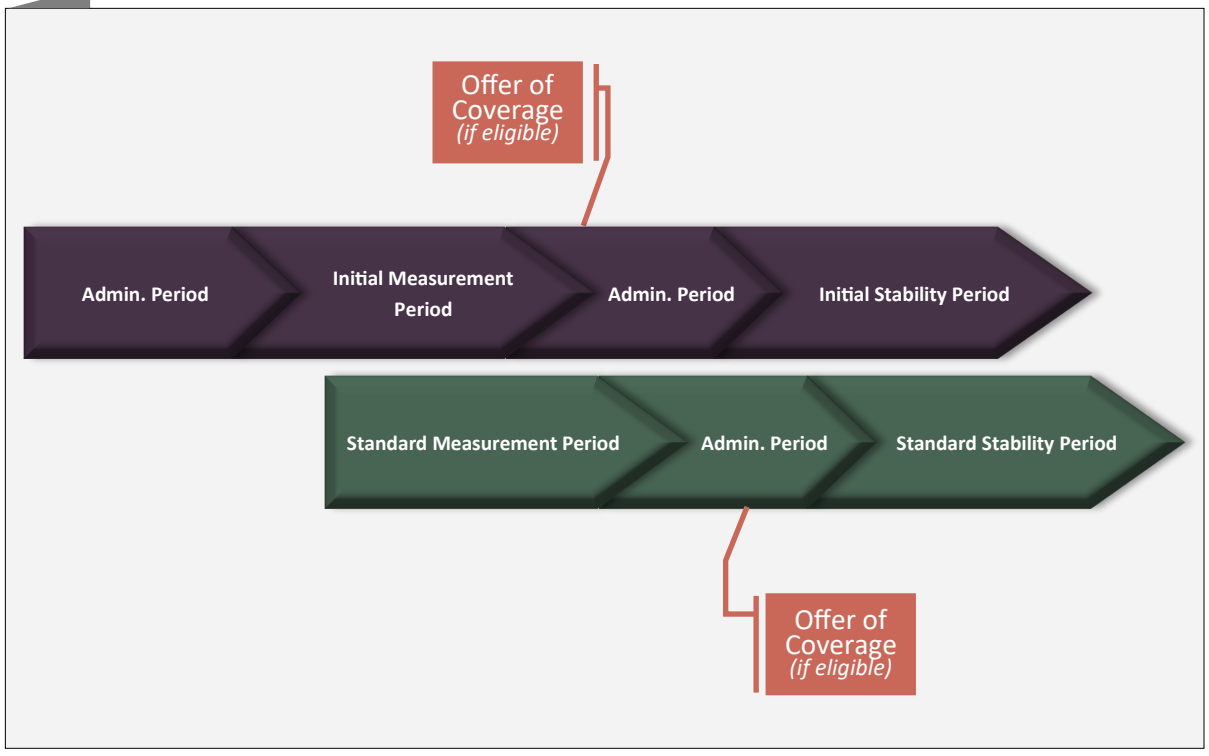
Employees who, at the time of hire, are classified as full-time employees who can reasonably be expected to work 30 hours per week or more[1] for the entire academic year if 9-month, or the entire calendar year if 12-month, will be eligible to enroll in a medical plan as of their date of hire. These employees are not eligible for other benefits.

Employees whose hours cannot be determined to be 30 hours per week or more on an ongoing basis will be classified as a Variable Hour Employee[2] and have their hours tracked during an "Initial Measurement Period[2]". That period will be the first 12 months of employment beginning the 1st of the month following their date of hire. If the employee averages at least 30 hours per week during the 12 month Initial Measurement Period[2], the Variable Hour Employee will be offered medical coverage for a 12 month period beginning the 1st of the month following 30 days after the end of the Initial Measurement Period. The employee must enroll in coverage according to CSU requirements for coverage to become effective.

Employees who have gone through an Initial Measurement Period will also have their hours averaged during the Standard Measurement Period[2]. Hours will be calculated following the Standard Measurement Period and if a employee is determined to have worked 30 or more hours per week on average, they will be offered Medical coverage. Human Resources will notify these employees of their eligibility. Coverage will begin on January 1st following the Standard Measurement Period, providing the employee enrolls in coverage according to CSU requirements. This 12-month period of coverage is referred to as the Standard Stability Period[2].

Coverage will remain in effect for the entire 12-month Stability Period, providing the employee is active and pays their portion of the premium, regardless of the number of hours the employee works during the subsequent Standard Measurement Period. Coverage will remain in effect for each Standard Stability Period providing the employee works a minimum of 30 hours per week on average during each Standard Measurement Period, and pays the appropriate contribution.

[1]Hours worked on a Federal or State work study program do not count towards the 30 hours per week.
[2] Healthcare Reform Variable Hour Employee Terms are defined on the following page.



The Affordable Care Act: Glossary of Terms

Variable Hour Employee: an employee whose Hours of Service an employer cannot determine at the time of hire will average at least 30 hours per week or 130 hours per month.

Administrative Period: a period of time between a Measurement Period and a Stability Period, during which CSU will determine which employees classified as Variable Hour Employees are eligible for coverage, as well as notify and offer medical coverage to those employees. For newly hired employees who are not determined to be Full-Time Employees on the date of hire, the Administrative Period also includes the period between date of hire until the end of the month after the date of hire, unless the date of hire is on the first of the month, and then the Administrative Period will start on the date of hire.

Initial Administrative Period: a period of time between an Initial Measurement Period and an Initial Stability Period, during which CSU will determine which employees classified as Variable Hour Employees are eligible for coverage, as well as notify and offer medical coverage to those employees. The Initial Administrative Period also includes the time period between the date of hire and the beginning of the Initial Measurement Period.

Initial Measurement Period: a period of time that begins the first of the month following your date of hire and is twelve months in length. During an Initial Measurement Period, CSU will calculate an employee's Hours of Service. If that employee averages 30 or more hours of service per week or 130 hours of service per month during that 12-month period, the employee will be considered a Full-Time Employee for purposes of health benefits during an Initial Stability Period.

Initial Stability Period: a period of time during which an employee will either be considered to be a Full-Time Employee or Non-Full-Time Employee for purposes of eligibility for health benefits.

Measurement Period: a period of time during which CSU will "look back" to see how many hours of service per week Variable Hour Employees were credited on average. CSU will use that average to determine the initial eligibility or continued eligibility for health benefits for those employees.

Stability Period: a period of time during which an employee will either be considered to be a Full -Time Employee or Non-Full-Time Employee for purposes of eligibility for health benefits. If an employee is determined to be Full-Time Employee during the immediately prior Measurement Period, that employee will be considered a Full-Time Employee eligible for health benefits for the immediately subsequent Stability Period. However, if the employee is determined not to be a Full-Time Employee during the immediately prior Measurement Period, then that employee will be considered a Non-Full-Time Employee who is not eligible for health benefits for the immediately subsequent Stability Period, unless you have a Change in Employment Status that causes you to become eligible for health benefits.

Standard Administrative Period: a period of time between a Standard Measurement Period and a Standard Stability Period, during which CSU will determine which employees classified as Variable Hour Employees or Seasonal Employees are eligible for coverage, as well as notify and enroll those employees. The Standard Administrative Period will occur annually from October 15 through December 31 of each year.

Standard Measurement Period: a period of time that begins on October 15 each year and is twelve months in length. During a Standard Measurement Period, the employer will calculate an employee's Hours of Service. If that employee averages 30 or more hours of service per week or 130 hours of service per month during that 12-month period, the employee will be considered as a Full-Time Employee for purposes of health benefits during the Standard Stability Period. Hours will be credited for breaks longer than 4 weeks providing the break is not longer than 26 weeks. A maximum of 501 hours can be credited during a calendar year.

Standard Stability Period: a period of time during which an employee will either be considered to be a Full-Time Employee or Non-Full-Time Employee for purposes of eligibility for health benefits. The Standard Stability Period begins on January 1 and ends on December 31 each year.

Leaves

Leave Without Pay

An Academic Faculty member or Administrative Professional on a regular or special appointment, may be granted leave without pay with approval of the Board. Post Doctoral Fellows and temporary Academic Faculty and Administrative Professionals may apply for leave in accordance with the Parental Leave policy, as designated under the Family Medical Leave policy.

First Year: While on leave without pay, you will receive the CSU contribution as applicable during the **first** 12 months of leave without pay, or the amount of LWOP approved by your department.

You must make arrangements with Human Resources to pay your portions, if any, of the cost of your benefit elections. Payments are due no later than the 1st of each month for the current month's coverage.

If two consecutive payments are missed, your benefit coverage will be terminated as of the last day of the month in which premiums were paid. You will not be eligible for COBRA.

If you cancel your CSU medical insurance, you must certify that you have medical coverage elsewhere. Re-enrollment in CSU Benefits cannot take place until the next annual Open Enrollment period with coverage effective the first of the following plan year.

Second Year: During your **second year** of leave without pay, you may continue your insurance elections. However, you will be required to pay the full premium as you will not receive the CSU contribution.

Contact Human Resources to make payment arrangements. Any insurances you continued will terminate at the end of the second consecutive year of leave without pay.

However, you may be eligible for continuation of medical, dental, vision, employee assistance program, and/or health care flexible spending account coverage through COBRA for up to 18 months (see the *COBRA* section).

Sabbatical Leave

Faculty members on sabbatical leave remain eligible for all benefits. Faculty members receive salary during the period of leave as defined in the Academic Faculty and Administrative Professional Manual and continue to receive the CSU contribution during this leave. For further information refer to the Faculty Manual.

A Faculty member who participates in the PERA retirement plan and is on half pay will receive service credit to the extent provided by PERA. Please refer to PERA's website for more information.

A Faculty member who participates in the Defined Contribution Plan (DCP) will receive continued

HealthSmart

(800) 423-4445

healthsmart.com

COBRA — Consolidated Omnibus Budget Reconciliation Act of 1985

Continuation Coverage Rights Under COBRA

Election Notice: Under federal law (COBRA), Colorado State University is required to notify you of your right to continue coverage under "The Plan," which includes group health, dental, vision, employee assistant program and/or a health flexible spending reimbursement account, when the coverage would otherwise end because of specific qualifying events described below. This notice is intended to inform you of your rights and obligations under the continuation provisions of the law.

Federal Regulations do not require employers to offer continuation of coverage to domestic partners, civil union partners or to the children of the domestic partner, civil union partners and children of civil union partners. **Colorado State University has elected to extend COBRA benefits to domestic partners, civil union partners and their children.** You and your spouse or your domestic partner or civil union partner should read the following notice information carefully.

Under certain circumstances (qualifying events), you and/or covered individuals have the right to continue participation in The Plan, beyond the time that coverage would normally end ("Continuation Coverage"). The following is a complete description of your COBRA Continuation Coverage rights.

Continuation Coverage is available to each covered individual, herein referred to as qualified beneficiary(ies), which includes the employee, spouse, domestic partner, civil union partner and any eligible individuals, under The Plan if a qualified beneficiary's enrollment would end due to an eligible qualifying event.

Qualifying Events

You will become a qualified beneficiary if you lose coverage under The Plan due to one of the following qualifying events:

If you are an **employee:**

- Your employment ends for any reason except that of gross misconduct; OR
- Your hours of work are reduced such that you are no longer eligible under The Plan

If you are the **spouse, domestic partner or civil union partner** of an employee:

- The employee dies.
- The employee's work hours are reduced such that they are no longer eligible under The Plan
- The employee's employment ends for any reason except that of gross misconduct
- The employee becomes entitled to Medicare Part A and/or B and cancels coverage under The Plan within 30 days of entitlement
- You become divorced or your domestic partnership or civil union partnership is terminated

COBRA (cont.)

Qualifying Events

If you are an eligible **child(ren):**

- The employee dies
- The employee's work hours are reduced such that they are no longer eligible under The Plan
- The employee's employment ends for any reason except that of gross misconduct
- The employee becomes entitled to Medicare Part A and/or B and cancels coverage under The Plan within 30 days of entitlement (see Medicare entitlement)
- The parents are divorced, the domestic partnership or civil union partner is terminated
- The child is no longer eligible to be covered as described under The Plan

COBRA Period

COBRA Continuation Coverage is a temporary continuation of coverage. When the qualifying event is death of the employee, divorce or termination of a domestic partnership or civil union partnership, or the loss of eligibility for a child under The Plan, COBRA Continuation Coverage may continue for up to 36 months or until they are no longer eligible, whichever comes first.

When the qualifying event is the termination of employment or reduction of work hours to a level such that the employee is no longer eligible for The Plan, COBRA Continuation Coverage may continue up to 18 months.

In the following instances, COBRA Continuation Coverage may end prior to the 18- or 36-month period:

- The date on which a premium payment was due but not paid;
- The date the covered individual becomes covered under another employer's group health plan that does not contain any exclusion or limitation that affects coverage of a covered individual's pre-existing condition
- The date the covered individual becomes entitled to Medicare (see Medicare Entitlement); OR
- The date Colorado State University terminates all of its group health plans

Medicare Entitlement

COBRA (Consolidation Omnibus Budget Reconciliation Act of 1989) clarified that "entitlement to Medicare" means "enrolled" in Medicare. Coverage under The Plan through the University will not end automatically unless you take action to cancel your coverage within 30 days of enrollment.

The Plan reserves the right to retroactively terminate COBRA coverage back to the end of the month prior to Medicare entitlement and seek reimbursement of all benefits paid after Medicare enrollment.

Notification of a Qualifying Event

The Plan will offer COBRA Continuation Coverage to a qualified beneficiary(ies) only after the Plan Administrator has been notified that a qualifying event has occurred.

When the qualifying event is the end of employment, reduction in work hours of employment, or death of an employee, the COBRA Administrator will inform all qualified beneficiaries of the right to obtain Continuation Coverage under The Plan.

If coverage will end because of divorce or termination of a domestic partnership, civil union partnership or a child ceases to be eligible, you or ineligible individuals **MUST** notify the COBRA administrator within 60 days from the qualifying event or ineligibility month.

COBRA (cont.)

COBRA Election

If you or a covered individual wants to continue group health, dental, vision, employee assistance program and/or a health flexible spending account (subject to limitations) plan coverage, the election of coverage must be made within 60 days of the date of the notice or date when your coverage ends, whichever is later. Each qualified beneficiary can individually decide whether or not to continue coverage.

You may have the right to request mid-year enrollment in another group health plan for which you are otherwise eligible (such as a plan offered by your spouse's, your domestic partner's or civil union partner's employer) within 30 days after your group health coverage ends due to a qualifying event listed above.

Information about Healthcare Reform Marketplace

There may be other coverage options for you and your family. You will be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll.

Employees covered by University medical plans may not qualify for the tax credit because the plans offer minimum essential coverage and are affordable. Being eligible for COBRA does not limit your eligibility for coverage or for a tax credit through the Marketplace.

Payments

Continuation Coverage is at your expense and will include a 2% administrative fee. COBRA premiums are 102% of the current premium for active employees.

Initial Payment*:* If you elect Continuation Coverage, you must make your initial payment within 45 days after the date of your election (this is the date the COBRA Election Form is post-marked, if mailed). CSU's Third Party Administrator will mail you a coupon booklet for payment.

The first payment includes premiums for the period from when your active coverage ended up to and including the month you are making the first payment; therefore, the first payment may be for more than one month's premium. If you do not make your initial payment for Continuation Coverage within those 45 days, you will lose all rights for Continuation Coverage under The Plan. While not required, you may include your first payment with your COBRA Election Form to expedite the reinstatement of your coverage.

Subsequent Payments*:* After you make your initial payment for Continuation Coverage, you will be required to pay for Continuation Coverage for each subsequent month of coverage. Payments are due by the date designated in the coupon booklet. If you make a periodic payment on or before its due date, your coverage under The Plan will continue for that coverage period without any break. The Plan will not send periodic notices of payments due for these coverage periods

Grace Periods for Payments: Although periodic payments are due on the dates shown in the coupon booklet, there is a grace period of 30 days. If you make a payment after the due date, but during the grace period, your coverage under The Plan will be suspended as of the due date and then retroactively reinstated when the payment is received. Any claims submitted while your coverage is suspended may be denied and will have to be resubmitted once your coverage is reinstated. Failure to make a payment before the end of the grace period will result in a loss of all rights to Continuation Coverage under The Plan, and your Continuation Coverage will be terminated.

COBRA (cont.)

SPECIAL RULES FOR COBRA CONTINUATION COVERAGE

Newborns and Adopted Children: If you, your spouse, domestic partner or civil union partner elects COBRA continuation coverage, any child born to or adopted by you, your spouse, domestic partner or civil union partner during the period of continuation coverage will also be entitled to continuation coverage for the remaining period of your entitlement. Such newborns or adopted children must be properly enrolled within 30 days of birth or adoption, and the child's period of COBRA continuation coverage will end at the same time as would the maximum period of coverage for other covered family members. You MUST notify CSU's Third Party Administrator within 30 days after the birth or placement of adoption.

Second Qualifying Event: An extension of coverage for up to an additional 18 months may be available to spouses, domestic partners, civil union partners and children who elect Continuation Coverage if a second qualifying event occurs during the first 18 months of COBRA Coverage. The maximum period of Continuation Coverage available under COBRA is 36 months. Second qualifying events include the death of the covered employee, divorce from or termination of a domestic partnership, civil union partnership with the covered employee, OR the loss of eligibility of a child. You **MUST** notify the Third Party Administrator within 60 days after a second qualifying event occurs.

Effective February 2004, according to IRS Ruling 2004-22, the covered employee's "entitlement to Medicare" is no longer a second qualifying event if an active employee's entitlement to Medicare would not cause the spouse, common-law spouse, domestic partner, civil union partner or domestic partner or civil union partner children to lose coverage under the group health plan.

The 18-month extension rule (36 months total) only applies to the employee's covered spouse, domestic partner, civil union partner and/or children; the COBRA period will remain at 18 months from the date of the qualifying event for the employee.

If the former employee enrolls in Medicare after enrollment in COBRA this extension rule does not apply to the spouse or domestic partner, civil union partner and/or eligible individuals. You **MUST** notify CSU's Third Party Administrator within 30 days of the qualifying event if this extension applies to eligible individuals.

Disability Extension: If a covered individual is disabled at the time they first become eligible for COBRA Continuation Coverage or is disabled within the first 60 days of the Continuation Coverage period, the maximum period of Continuation Coverage is extended to 29 months. In addition, all covered individuals who became qualified beneficiaries due to the same qualifying event as the disabled covered individual are also eligible for the additional 11 months of COBRA Continuation Coverage.

Coverage will still end for any of the other reasons listed above, such as failure to pay premiums when due, etc. In addition, the covered individual must also provide notice within 31 days of the date they are finally determined to no longer be disabled. Coverage will end on the first day of the month beginning 31 days after the covered individual is determined to no longer be disabled.

The cost of Continuation Coverage will increase to 150% of the group rate after the 18th month of Continuation Coverage for all enrolled qualified beneficiaries.

If the covered individual becomes disabled after the first 60 days of the Continuation Coverage period, they must notify the Third Party Administrator within 60 days of the date they are determined to be disabled under any one of the following: the Social Security Act; PERA; or the CSU Long term Disability Plan. This notification must be received PRIOR to the end of the initial 18 months of coverage.

COBRA (cont.)

Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

USERRA gives employees benefit protection to the extent provided by such law. Employees on military leave have a right to COBRA-like health benefit continuation. Contact Human Resources for more information.

Health Care Flexible Spending Account

If you are enrolled in this plan at the time the coverage would end due to a COBRA qualifying event, you have the right to continue coverage if there is a positive account balance at the time of the qualifying event. COBRA Continuation Coverage is only available for the remainder of the plan year in which the qualifying event occurs, and is not subject to the 18- or 36-month period.

Administrative

For more information about your rights under COBRA, the Health Insurance Portability and Accountability Act (HIPAA) and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website.

Questions

If you have any general questions regarding COBRA **or** if you are enrolled in COBRA and your marital , domestic partnership or civil union partnership status or address changes, contact Health*Smart* Benefit Solutions, COBRA Administrator, at (800) 423-4445.

Disclaimer: This COBRA Election Notice is subject to change due to changes in the University's Plan or due to changes in federal law.

Survivor Benefits

If you should die while employed by the University, eligible individual(s) who were enrolled at the time of your death, may be eligible for coverage continuation based on your appointment type.

Medical Coverage

Your enrolled survivor(s) may continue coverage in the group medical insurance at no cost to them for a period of one year from the last day of the calendar month in which you died **OR** until your enrolled survivor(s) becomes eligible for another group medical insurance policy including Medicare/Medicaid, whichever occurs first.

At the end of the one-year period, your survivor(s) may elect to continue enrollment in the University's group medical insurance coverage at their own expense until eligible for another group medical insurance plan (in the case of a surviving spouse, domestic partner or civil union partner) or until no longer eligible according to the terms of the policy (in the case of children).

Dental, Vision, Employee Assistance Program and/or Flexible Spending Accounts (FSA)

Your survivor(s) may have the option to elect Continuation Coverage through COBRA for up to 36 months. *Note:* FSAs may only be extended through the calendar year in which you die.

Temporary Appointments

If you are on a benefits eligible temporary Faculty or Administrative Professional appointment, are a Post Doctoral Fellow, Veterinary Intern, or a Clinical Psychology Intern and surviving eligible individuals were enrolled in active coverage, your survivor(s) are covered through the last day of the calendar month in

Verification of Insurance Coverage

You may contact the Human Resources—Benefits Unit if you need to obtain verification of University insurance enrollment. If you experience a qualifying change in status during the middle of a calendar year and you wish to change your benefits coverage at your spouse, domestic partner or civil union partner's employer, a letter may be required.

Generally, the request will include:

- The name of the individual for whom the verification is requested;
- The last date that the individual was covered under the plan; and
- The name of the participant that enrolled the individual in the plan

After receiving a request that meets these requirements, the Plan will act in a reasonable and prompt fashion to provide the information to you. If you have questions, contact Human

Health Insurance Portability and Accountability Act (HIPAA)

In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) you may have rights to Special Enrollment under this Plan, outside of the initial or annual Open Enrollment period if you or your eligible individuals have declined coverage.

Special Enrollment

A special enrollment period under HIPAA, is offered for three situations:

1. The loss of other health coverage provided that:
    - you and/or your eligible individuals were covered by another group or individual health plan or Medicaid at the time that coverage was initially offered and;
    - the other coverage was the reason for declining enrollment and;
    - you enroll no later than 30 days after the loss of other coverage

In order to qualify for the special enrollment period, Human Resources must receive a **written statement on company letterhead** from the other employer stating coverage and end date, type of coverage and who had been covered or a HIPAA certificate from the former carrier stating coverage end date and covered individuals. The enrollment must also be requested within 30 days of the Special Enrollment right in the CSU Online Benefits Enrollment System.

If the other coverage was COBRA continuation, special enrollment can only be requested after the exhaustion of COBRA continuation coverage. You do not have any special enrollment rights if you lose your coverage as a result of failure to pay premiums.

2. The addition of a new spouse, common-law spouse, domestic partner or civil union partner, domestic partner or civil union partner's unmarried or married children including natural children, legally adopted children, foster children placed with you for adoption, stepchildren, children in which legal guardianship has been designated and children defined under a Qualified Medical Child Support Order (QMCSO).
    - Enrollment must be completed within 30 days after the qualifying event
3. Medicaid Coverage
    - Termination of Medicaid or CHIP coverage—If you and or eligible individual(s) are covered under a Medicaid plan or under a State child health plan (SCHIP) and coverage of the employee or individual under such a plan is terminated as a result of loss of eligibility.
    - Eligibility for employment assistance under Medicaid or CHIP— If the employee or individual becomes eligible for premium assistance under Medicaid or SCHIP, including under any waiver or demonstration project under or in relation to such a plan. This is usually a program where the state assists employed individuals with premium payment assistance for their employer's group health plan rather than direct enrollment in a state Medicaid program.

Required Government and Regulatory Information

Newborns' and Mothers' Health Protection Act of 1996

This Federal Law requires that the Plan may generally not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section.

This law also generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or the newborn earlier than 48 hours (or 96 hours as applicable). In any case, the Plan may not require that a provider obtain prior authorization for prescribing a length of stay not more than 48 hours (or 96 hours).

Women's Health and Cancer Rights Act of 1998

The Women's Health and Cancer Rights Act of 1998 (WHCRA) requires that you be informed of your rights to surgery and prostheses following a covered mastectomy.

The Colorado State University employee medical benefit Plan provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymph edema) for an enrolled employee and/or covered individual. This coverage will be provided in consultation with the patient and patient's attending physician and will be subject to the same deductibles, coinsurance and/or co-payments otherwise applicable under the Plan. Call your chosen medical plan's Member Services line for more information.

This law also requires written notice of the availability of the coverage be delivered to all plan participants upon enrollment and annually thereafter. This notice serves to fulfill that requirement.

Mandatory Reporting Requirement for Group Health Plans

The Centers for Medicare and Medicaid Services (CMS) is the federal agency that oversees the Medicare program. Many Medicare beneficiaries have other private group health plan (GHP) insurance in addition to Medicare. There are federal rules that determine whether Medicare or the other insurance pays first.

Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA), a new federal law that became effective January 1, 2009, requires that group health insurance plans begin to report information about Medicare beneficiaries who have other group coverage. This requirement will assist CMS and other health insurance plans to properly coordinate payment of benefits among plans so that your claims are paid promptly and correctly.

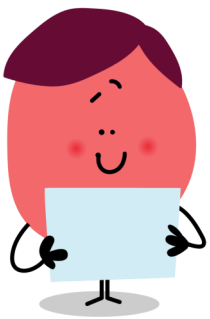
CSU is required to submit Social Security Numbers for ALL employees, spouse's and eligible individuals' covered on insurance plans using a secure transmission protocol. This information is required to be entered during the enrollment process in the CSU Online Benefits Enrollment System. CSU is assessed a daily penalty for each social security number not provided.

Medicare Part D Notice

If you and/or your eligible individuals have Medicare or will become eligible for Medicare in the next 12 months, Federal law gives you more choices about your prescription drug coverage. You may obtain a copy of the annual notice on the HR website.

HIPAA Notice

You have certain rights under the federal Health Insurance Portability and Accountability Act (HIPAA) related to the confidentiality of your personal health information. Information about these rights, as well information about how Colorado State University's self-funded plan may use or disclose your medical information can be found on the HR website.



Required Government and Regulatory Information

Family Medical Leave Act

The Family Medical Leave Act of 1993 entitles all eligible employees up to 12 workweeks of leave during a 12-month period for (a) the birth or placement for adoption or foster care of a child, or (b) the serious health condition of the employee, spouse, child, or parent.

Colorado State University has elected to extend similar coverage to employees with domestic partners and civil union partners.

For further information, refer to the Academic Faculty and Administrative Professional Staff Manual, appendix 3.

Genetic Information Nondiscrimination Act (GINA)

Congress passed the Genetic Information Non discrimination Act (GINA) establishing a national and uniform standard to fully protect workers from genetic discrimination.

This group health plan does not discriminate in premium amounts, contributions charged or eligibility for coverage based on any individual's genetic information. The plan does not use, request or require genetic information about anyone covered by the plan. Genetic information, within the context of GINA, includes the following:

- an individual's genetic tests,
- the genetic tests of an individual's family members (up to fourth-degree relatives by birth, marriage or adoption), manifestation of disease or disorder in family members of an individual, an individual's request for or receipt of genetic services, and
- genetic information of a fetus carried by an individual or their family

Healthcare Reform

Grandfathered Health Plan

CSU Benefits believes the POS and Green medical plans are "grandfathered health plans" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted.

Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator, Human Resources, at (970) 491-MyHR (6947). You may also contact the U.S. Department of Health and Human Services.

Summary of Benefits Coverage (SBC)

Employer sponsored group health plans are required to provide clear, consistent and comparable information about health plan coverage to participants.

This summary of benefits (SBC) will be issued in a regulatory compliant format and will help participants better understand the coverage they have and allow an easy comparison with different insurance options. It will summarize key features of the plan or coverage, such as the covered benefits, cost-sharing provisions, and coverage limitations and exceptions. The Summary of Benefits Coverage (SBC) information is located on the HR website.

Medical Plans

This and the following pages contain a limited description of the benefit coverage available through this group plan. Coverage is governed at all times by the complete terms of the Master Group Insurance Policy issued to Colorado State University (CSU).

Anthem's coverage certificate is also available online on the HR website.

Coinsurance options reflect the amount the Plan will pay. The difference between what the Plan pays and 100% is the amount you pay. All copayments are the amounts you pay.

Point of Service (POS) PPO Plan

With this plan you have two levels of coverage, in-network and out-of-network. Within this coverage you have three levels of providers that you can access. When you choose an in-network provider you receive the highest level of coverage. Some out-of-network services are not covered.

In-Network PPO Contracted Providers:

Within the state of Colorado, you have access to the Anthem Blue Preferred network of PPO contracted providers. In addition, outside of Colorado you will have access to a National Blue Cross and Blue Shield PPO network of contracted providers. Your benefit will be the highest level when you receive covered services from a PPO contracted provider. You are responsible for any applicable copayments and coinsurance. Anthem will pay the PPO contracted provider directly.

Out-Of-Network Non-Contracted Providers:

Non-contracted facilities or providers have not entered into any agreement with Anthem. They may bill Anthem or the patient. By law Anthem is required to reimburse you unless an assignment of benefits which directs payment to the out of network provider has been authorized. Anthem may require a copy of the assignment of benefits for their records. You may be obligated to pay more out-of-pocket expenses when you visit a non-participating provider because non-participating providers are not required to accept Anthem Blue Cross and Blue Shields maximum benefit allowance. The difference between Anthem Blue Cross and Blue Shields maximum benefit allowance and the non-participating provider's billed charge is your responsibility and does not apply toward the deductible or out-of-pocket annual maximum. The determination of a maximum benefit allowance is the maximum amount Anthem approves for a covered service. Deductible and

Anthem

(800) 843-5621

anthem.com

LiveHealth Online

You can get the care you need without the hassle! With LiveHealth Online, you don't have to schedule an appointment, drive to the doctor's office, and then wait for your appointment. Doctors can answer questions, make a diagnosis, and even prescribe basic medications all online.

In addition to medical care, you can receive behavioral health care through LiveHealth Online and schedule appointments with sleep specialists for those impacted by poor sleeping patterns.

Enroll for free at livehealthonline.com or on the mobile app.

Medical Plans

Green, Gold and Ram Plan–HDHP

With these plans you have one level of coverage, and you can access any eligible licensed provider to receive coverage. When you choose Participating Providers, the provider agrees to accept Anthem Blue Cross and Blue Shield's maximum benefit allowance as payment in full and you are responsible for the deductible, coinsurance and non-covered services.

Participating Providers

Within the State of Colorado, you have access to the Anthem Blue Preferred network of PPO Contracted Providers. In addition, outside of Colorado you will have access to a National Blue Cross and Blue Shield PPO network of contracted providers. Your benefit will be the highest level when you receive covered services from a PPO contracted provider. You are responsible for any applicable copayments and coinsurance.

Anthem will pay the PPO contracted provider directly. Your benefit will be the highest level when you receive covered services from a Participating Provider. These Providers (such as a hospital or a physician) have entered into an agreement with Anthem Blue Cross and Blue Shield or the local Blue Cross and Blue Shield to bill directly for covered services, and to accept Anthem Blue Cross and Blue Shield's maximum benefit allowance as payment in full for these services.

You are responsible for any applicable deductible and co-insurance. Anthem Blue Cross and Blue Shield will pay the participating provider directly.

Non-Participating Providers

Non-contracted facilities or providers have not entered into any agreement with Anthem. They may bill Anthem or the patient. By law Anthem is required to reimburse you unless an assignment of benefits which directs payment to the out of network provider has been authorized.

Anthem may require a copy of the assignment of benefits for their records. You may be obligated to pay more out-of-pocket expenses when you visit a non-participating provider because non-participating providers are not required to accept Anthem Blue Cross and Blue Shield's maximum benefit allowance.

The difference between Anthem Blue Cross and Blue Shields maximum benefit allowance and the non-participating provider's billed charge is your responsibility and does not apply toward the deductible or out-of-pocket annual maximum. The determination of a maximum benefit allowance is the maximum amount Anthem approves for a covered service. Deductible and coinsurance amounts are based on this maximum benefit allowance.

Coordination of Benefits

Anthem coordinates benefits when a member has coverage with more than one health benefit plan. Refer to the Anthem Certificate of Insurance Booklet for a complete description of Coordination of Benefits.

Gold Plan Freeze

The Gold Plan is frozen to new enrollment effective January 1, 2018. If you were enrolled in the Gold Plan prior to this date, you may maintain your enrollment in the plan. However, if you switch enrollment to another plan, you will not be allowed to re-elect the Gold Plan at a later date.

Medical Plan Comparison

This chart is a limited description of the benefit coverage available through CSU's group plan. For a complete list of covered services, visit the HR website. Coverage is governed at all times by the complete terms of the Master Group Insurance Policy issued to CSU. In the event of any discrepancies between the information in this guide, Anthem's coverage certificate will govern.

Benefit Component	Point-of-Service PPO Plan		Gold Plan	Green Plan	Ram Plan-HDHP
	PPO Participating Providers[1]	**Non-PPO Participating Providers**	**Participating and Non-participating Providers**	**Participating and Non-participating Providers**	**Participating and Non-participating Providers**
ANNUAL DEDUCTIBLE					
Individual	None	$500	$750, & a separate deductible of $150 for prescription drugs	$1,000, & a separate deductible of $150 for prescription drugs	$1,500
Family	None	$1,000 for all family members No one family member may meet more than $500 of the $1,000 family deductible.	$1,500, & a separate deductible of $300 for prescription drugs No one family member may meet more than $750 of the $1,500 family deductible. No one family member may meet more than $150 of the $300 family Rx deductible.	$2,000, & a separate deductible of $300 for prescription drugs No one family member may meet more than $1,000 of the $2,000 family deductible. No one family member may meet more than $150 of the $300 family Rx deductible.	$3,000 If you select family membership, no individual deductible applies and the family deductible must be met.
COINSURANCE*	Refer to the below benefits for specific details.	You pay 30% or 10% after deductible.	You pay 20% after deductible.	You pay 20% after deductible.	You pay 20% after deductible.
Coinsurance options reflect the amount You will pay. The difference between what you pay and 100% is the amount the Plan pays for PPO (participating) providers. For non-participating providers you also pay the difference between Anthem's Maximum allowed amount and the amount billed by the non-participating provider. *Coinsurance is required up to the out-of-pocket annual maximum. Subject to certain exclusions as identified below.					
OUT-OF POCKET ANNUAL MAXIMUM (OOP)[2]					
Individual	• $1,250 in coinsurance, *plus* • Copayments	• $3,000 in coinsurance, *plus* • Deductible, *plus* • Copayments	• $4,500 includes coinsurance and deductible for pharmacy and medical	• $5,000 in coinsurance, *plus* • Deductible, *plus* • $1,000 in coinsurance for prescription drugs	• $6,550 includes deductible and coinsurance
Family	• $2,500 in coinsurance, *plus* • Copayments. No one family member may meet more than $1,250 of the $2,500 out-of-pocket annual maximum.	• $6,000 in coinsurance, *plus* • Deductible, *plus* • Copayments No one family member may meet more than $3,000 of the $6,000 out-of-pocket annual maximum.	• $9,000 includes coinsurance and deductible for pharmacy and medical No one family member may meet more than $4,500 of the $9,000 out-of-pocket annual maximum.	• $10,000 in coinsurance, *plus* • Deductible, *plus* • $2,000 in coinsurance for prescription drugs No one family member may meet more than $5,000 of the $10,000 medical and $1,000 of the $2,000 Rx annual out-of-pocket maximum.	• $13,100 includes deductible and coinsurance No one family member may meet more than $6,550 of the $13,100 out-of-pocket annual maximum.
Lifetime or benefit maximum paid by the plan for all care	No lifetime maximum	No lifetime maximum	No lifetime maximum	No lifetime maximum	No lifetime maximum

Medical Plan Comparison (cont.)

Benefit Component	Point-of-Service PPO Plan		Gold Plan	Green Plan	Ram Plan-HDHP
	PPO Participating Providers	**Non-PPO Participating Providers**	**Participating and Non-participating Providers**	**Participating and Non-participating Providers**	**Participating and Non-participating Providers**
PREVENTIVE CARE	Covered in full	**Well baby services,** (0 up to 12 months : You pay 30% after deductible **Children's services** (through age 12): You pay 30% after deductible **Adults' Services** (age 13 and older): Not covered	**Participating Provider:** Covered in full not subject to deductible **Non-Participating Provider:** You pay 20% not subject to deductible	**Participating Provider:** Covered in full not subject to deductible **Non-Participating Provider:** You pay 20% not subject to deductible	**Participating Provider:** Covered in full not subject to deductible **Non-Participating Provider:** You pay 20% not subject to deductible
ROUTINE OFFICE VISITS	Covered in full after you pay $15 per office visit copayment and 10% for laboratory and x-ray services.	You pay 30% after deductible	You pay 20% after deductible	You pay 20% after deductible	You pay 20% after deductible
MATERNITY					
Prenatal care	Covered in full after you pay $15 per office visit copayment and 10% for laboratory and x-ray services	You pay 30% after deductible	You pay 20% after deductible	You pay 20% after deductible	You pay 20% after deductible
Delivery & inpatient well baby care	You pay 10% after $125 per admission copayment	You pay 30% after deductible	You pay 20% after deductible	You pay 20% after deductible	You pay 20% after deductible
INPATIENT HOSPITAL*	You pay 10% after $125 per admission copayment	You pay 30% after deductible	You pay 20% after deductible	You pay 20% after deductible	You pay 20% after deductible
	* Pre-certification from Anthem BCBS must be received **before a hospital admission or within 5 days** after an emergency admission for full benefits to be payable. Consultation for a second opinion (and third if necessary) is paid at 100%. If you use a non-participating provider, you are responsible for making sure this pre-certification has been obtained.				
OUTPATIENT/ AMBULATORY SURGERY	You pay 10% after you pay $125 per admission copayment. This includes colonoscopies with a medical diagnosis.	You pay 30% after deductible. This includes colonoscopies with a preventive or medical diagnosis.	You pay 20% after deductible. This includes colonoscopies with a medical diagnosis.	You pay 20% after deductible. This includes colonoscopies with a medical diagnosis.	You pay 20% after deductible. This includes colonoscopies with a medical diagnosis.
LABORATORY AND X-RAY	You pay 10%	You pay 30% after deductible	You pay 20% after deductible	You pay 20% after deductible	You pay 20% after deductible
EMERGENCY CARE[3]	You pay 10% after $60 copayment per emergency room visit, applied to inpatient hospital copayment if admitted.	You pay 30% after deductible	You pay 20% after deductible	You pay 20% after deductible	You pay 20% after deductible

Medical Plan Comparison (Cont.)

Benefit Component	Point-of-Service PPO Plan		Gold Plan	Green Plan	Ram Plan-HDHP
	PPO Participating Providers	**Non-PPO Participating Providers**	**Participating and Non-participating Providers**	**Participating and Non-participating Providers**	**Participating and Non-participating Providers**
AMBULANCE					
Ground	You pay 10% after $60 per trip copayment	You pay 10% after $60 per trip copayment	You pay 20% after deductible	You pay 20% after deductible	You pay 20% after deductible
Air	You pay 10% after $125 per trip copayment	You pay 10% after $125 per trip copayment	You pay 20% after deductible	You pay 20% after deductible	You pay 20% after deductible
URGENT, NON-ROUTINE AFTER HOURS CARE					
Inpatient Care	You pay 10% after $125 per admission copayment	You pay 30% after deductible	You pay 20% after deductible	You pay 20% after deductible	You pay 20% after deductible
Outpatient Care	Covered in full after you pay $15 per office visit copayment and 10% for laboratory and x-ray services.	You pay 30% after deductible	You pay 20% after deductible	You pay 20% after deductible	You pay 20% after deductible
PRESCRIPTION DRUGS*	**Copayments for retail & specialty pharmacy for each 34-day supply:** Tier 1 - $10 Tier 2 - $20 Tier 3 - $40 **Copayments for mail order service (90-day supply maximum):** Tier 1 - $20 Tier 2 - $40 Tier 3 - $80 *Note:* Prescription Drugs will always be dispensed as ordered by your provider and by applicable State Pharmacy Regulations, however you may have higher out-of-pocket expenses. You may request, or your provider may order, the brand-name drug. However, if a generic drug is available, you will be responsible for the cost difference between the generic and the brand-name drug, in addition to your tier 1 copayment. By law, generic and brand-name drugs must meet the same standards for safety, strength and effectiveness. Anthem reserves the right, at our discretion, to remove certain higher cost generic drugs from this policy. For drugs on our approved list, contact Anthem.	Not covered	You pay 20% after separate deductible for retail or specialty prescription drugs of $150 per member or $300 per family.	You pay 20% after separate deductible for retail or specialty prescription drugs of $150 per member or $300 per family up to separate OOP annual max for retail or specialty prescription drugs of $1,000 per member or $2,000 per family.	You pay 20% after deductible

Applicable to all plans (including POS):

Specialty Pharmacy: Participating pharmacy (34-day supply). Specialty pharmacy drugs often require special handling such as temperature controlled packaging and overnight delivery and are often unavailable at a retail pharmacy or through the mail order service. Benefits are only provided when you receive services from a specialty pharmacy as determined by Anthem for those specialty pharmacy drugs included on Anthem's specialty drug list.

Smoking Cessation Prescription Drugs: Includes coverage for smoking cessation prescription legend drugs when enrolled in a smoking cessation counseling program approved by Anthem.

Birth Control: Certain oral, injection and contraceptive devices obtained by a physician's prescription are covered at 100%.

Prescription drugs are covered only when received from a participating pharmacy (34 day supply), participating specialty pharmacy (34 day supply) or participating mail order service.

Medical Plan Comparison (cont.)

Benefit Component	Point-of-Service PPO Plan		Gold Plan	Green Plan	Ram Plan-HDHP
	PPO Participating Providers	**Non-PPO Participating Providers**	**Participating and Non-participating Providers**	**Participating and Non-participating Providers**	**Participating and Non-participating Providers**
MENTAL HEALTH CARE					
Inpatient care	You pay 10% after $125 per admission copayment	You pay 30% after deductible	You pay 20% after deductible	You pay 20% after deductible	You pay 20% after deductible
Outpatient care	You pay 10% after $15 per office visit copayment *Copayments for other mental health care do not count towards the out-of-pocket annual maximum.*	You pay 30% after deductible	You pay 20% after deductible	You pay 20% after deductible	You pay 20% after deductible
ALCOHOL & SUBSTANCE ABUSE					
Inpatient care	You pay 10% after $125 per admission copayment	You pay 30% after deductible	You pay 20% after deductible	You pay 20% after deductible	You pay 20% after deductible
Outpatient care	You pay 10% after $15 per office visit copayment *Copayments for other alcohol & substance abuse care do not count towards the out-of-pocket annual maximum.*	You pay 30% after deductible	You pay 20% after deductible	You pay 20% after deductible	You pay 20% after deductible
PHYSICAL, OCCUPATIONAL, & SPEECH THERAPY					
Inpatient care	You pay 10% after $125 per admission copayment	You pay 30% after deductible	You pay 20% after deductible	You pay 20% after deductible	You pay 20% after deductible
Outpatient care	You pay 10% after $15 per office visit copayment	You pay 30% after deductible	You pay 20% after deductible	You pay 20% after deductible	You pay 20% after deductible
See Benefit Booklet for definitions, limitations, and exclusions.					
DURABLE MEDICAL EQUIPMENT	You pay 10%	Not covered	You pay 20% after deductible	You pay 20% after deductible	You pay 20% after deductible
OXYGEN	You pay 10%	Not covered	You pay 20% after deductible	You pay 20% after deductible	You pay 20% after deductible
ORGAN TRANSPLANTS[4]	You pay 10% after $125 per admission copayment	Not covered	You pay 20% after deductible	You pay 20% after deductible	You pay 20% after deductible
Pre-certification required. Includes liver, heart, heart-lung, pancreas, cornea, kidney, bone marrow and peripheral stem cell.					
HOME HEALTH CARE	Covered in full after you pay $15 per visit copayment (up to 100 visits per calendar year)	Not covered	Covered in full (up to 100 visits per calendar year combined in and out-of-network)	Covered in full (up to 100 visits per calendar year combined in and out-of-network)	You pay 20% after deductible (up to 100 visits per calendar year combined in and out -of-network)
HOSPICE CARE	Covered in full	You pay 30% after deductible	Covered in full	Covered in full	You pay 20% after deductible
HEARING AIDS	Covered in full after you pay $15 copayment	Not covered	You pay 20% after deductible	You pay 20% after deductible	You pay 20% after deductible
Up to $2,000 hearing aid benefit every three years.					

Medical Plan Comparison (cont.)

Benefit Component	Point-of-Service PPO Plan		Gold Plan	Green Plan	Ram Plan-HDHP
	PPO Participating Providers	**Non-PPO Participating Providers**	**Participating and Non-participating Providers**	**Participating and Non-participating Providers**	**Participating and Non-participating Providers**
SKILLED NURSING FACILITY CARE	You pay 10% after $125 per admission copayment *(copayment waived if admitted directly to skilled nursing facility from an inpatient acute facility)*	You pay 30% after deductible	You pay 20% after deductible	You pay 20% after deductible	You pay 20% after deductible
	Up to 100 days per calendar year in and out-of-network combined				
VISION CARE	Covered in full after you pay $15 per office visit copayment	Not covered	You pay 20% after deductible	You pay 20% after deductible	You pay 20% after deductible
	Limited to one exam per calendar year, eyeglass hardware not covered				
RETAIL HEALTH CLINIC VISITS	Covered in full after you pay $15 per office visit copayment and 10% for laboratory and x-ray services	Not covered	You pay 20% after deductible for participating providers; not covered for non-participating providers	You pay 20% after deductible for participating providers; not covered for non-participating providers	You pay 20% after deductible for participating providers; not covered for non-participating providers
CHIROPRACTIC CARE	Covered in full after you pay $15 per visit copayment (up to 20 visits per calendar year) and 10% for laboratory and x-ray services. Copayment does not apply if an office visit if not billed	Not covered	You pay 20% after deductible (up to 20 visits per calendar year combined in and out-of-network)	You pay 20% after deductible (up to 20 visits per calendar year combined in and out-of-network)	You pay 20% after deductible (up to 20 visits per calendar year combined in and out -of-network)
SIGNIFICANT ADDITIONAL COVERED SERVICES	**Treatment of Autism Spectrum Disorders:** benefit level determined by type of service provided				

Excluded expenses: charges not covered include (partial list) Glasses & other vision hardware, cometic surgery except for injury or birth defects, purely custodial care, dental work except if done within 1 year of an accidental injury to sound natural teeth if an accident occurred while insured, surgery or treatment of Temporomandibular Joint Disorders, charges in excess of reasonable and customary, services considered experimental in nature, charges in connection with impregnation or fertilization, treatment of weak, strained, flat, unstable or unbalanced feet. Sexual Dysfunction: this plan does not pay for prescription drugs for treatment of sexual dysfunction, including but not limited to Viagra.

[1] "Network" refers to a specified group of physicians, hospital, medical clinics and other medical care providers that your Plan may require you to use in order to get any coverage at all under the Plan, or that the Plan may encourage you to use because it pays more of your bill if you use their network providers (i.e., go in-network) than if you don't (i.e., go out-of-network).

[2] "Out-of-pocket maximum" is the maximum amount you will have to pay for allowable covered expenses under a medical Plan, which may or may not include the deductible or copayments, depending on the contract for that Plan. It includes charges for non-participating providers that are above Anthem's maximum allowed amount. No one family member may meet more than the individual OOPM when enrolled in Family coverage.

[3] "Emergency care" means services delivered by 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.

[4] "Transplants" will be covered only if they are medically necessary and the facility meets clinical standards for the procedure.

Medical Plans — Appeal Process

Medical Plan Complaints, Appeals and Grievances

If you disagree with Anthem's denial, in whole or in part, of a medical claim, requested service or supply, you are advised to follow their instructions below which detail the process for initiating a complaint, filing an appeal or filing a grievance.

Complaints**:** If a member has a complaint about any aspect of Anthem's service or claims processing, the member should contact Anthem's customer service department. A trained representative will work to clear up any confusion and resolve the member's concerns. A member may submit a written complaint to the address listed below. If the member is not satisfied with the resolution of their concerns by the Anthem customer service associate, the member may file an appeal.

Appeals**:** While Anthem encourages members to file appeals within 60 days of the adverse benefit determination, the member's written appeal must be received by Anthem within 180 days of the adverse benefit determination. Anthem will assign a Customer Advocate to assist the member in the appeal process. Members may send written appeals to the following address:

Anthem — Appeals Department
700 Broadway CAT CO105-0540
Denver, CO 80273-0001

An appeal may be filed with or without first submitting a complaint. In the appeal, the member must state plainly the reason(s) why the claim or requested service or supply should not have been denied. The member should include any documents not originally submitted with the claim or request for the service or supply and any information that may have a bearing on Anthem's decision.

For a thorough, unbiased review, the member may access two internal levels of appeal. In the case of a benefit denial based on utilization review, an independent external review appeal is also available to the member.

Members may designate a representative (e.g., the member's physician or anyone else of the member's choosing) to file any level of appeal review with Anthem on the member's behalf. The member must give this designation to Anthem in writing.

Level 1 Appeal: — This is an appeal in which Anthem appoints an internal person(s) not involved in the initial determination to review the denial of the claim, requested service or supply. A person that was previously involved with the denial may answer questions. The person(s) appointed to review a Level 1 Appeal involving utilization review shall consult with an appropriate clinical person(s) in the same specialty as would typically manage the case being reviewed. For utilization review issues, the member will receive a response to the member's Level 1 Appeal within 20 workdays of receipt of the appeal request. Non-utilization review appeals will typically be resolved within 30 workdays.

Level 2 Appeal: This is an appeal of an adverse benefit determination that has not been resolved to the member's satisfaction under the Level 1 Appeal process. The Level 2 Appeal must be requested within 60 calendar days after the Anthem adverse determination from the Level 1 Appeal. The member may appear or be teleconferenced in to present testimony, introduce documentation the member believes supports their appeal and provide documentation requested by Anthem at a hearing concerning the appeal.

The panel of reviewers shall include a minimum of three people and may be composed of Anthem associates who have appropriate professional expertise. A majority of the panel shall be comprised of persons who were not previously involved in the dispute; however, a person who was previously involved with the dispute may be a member of the panel or appear before the panel to present information or answer questions.

Medical Plans — Appeal Process (cont.)

In the case of utilization review appeals, the majority of the persons reviewing the appeal shall be health care professionals who have appropriate expertise. Such reviewing health care professionals shall meet the following criteria:

- Have not been involved in the care previously
- Is not a member of the board of directors of the health plan
- Have not been involved in the review process for the covered person previously
- Do not have a direct financial interest in the case or in the outcome of the review

Anthem will issue a copy of the written decision to the member and to the provider who submits an appeal on the member's behalf, if any, within 50 workdays of Anthem's receipt of the Level 2 Appeal request. A member or member's representative has the right to request an expedited appeal of a utilization review decision when the timeframes for a standard review would: seriously jeopardize the life or health of the covered person; jeopardize the covered person's ability to regain maximum function; or for persons with a disability, create an imminent and substantial limitation on their existing ability to live independently. Typically the decision will be made within 72 hours. Expedited appeals will be evaluated by an appropriate clinical peer or peers who were not involved in the initial denial. Anthem will not provide an expedited review for retrospective denials.

Level 3 Appeal: These are conducted by an independent third party and are available only in those circumstances where benefits were denied due to medical necessity and which have gone through the Anthem Level 2 Appeal process. To request a Level 3 Appeal, contact the Colorado State University's Human Resources Department at the following address:

Colorado State University
c/o Human Resources
6004 Campus Delivery
Fort Collins, CO 80523-6004

The request for a Level 3 appeal must be made within 60 calendar days after the Anthem Level 2 denial. *Note*: Appeals due to other, non-medical necessity reasons such as a procedure the plan does not cover are not eligible for a Level 3 Appeal. In the case of a non-medical necessity appeal, Anthems 2nd level appeal decision is final.

Anthem Engage

As part of our ongoing commitment to provide CSU employees and their families with best-in-class health benefits, we have partnered with Anthem to help you experience benefits in a whole new way.

Use Engage to take charge of your benefits! Engage will help you take charge of your health plan and benefits so you can be confident you're making the best choices for your health and well-being. With Engage, you can:

- See what's covered by your health plan and access your digital insurance card.
- Find in-network providers.
- Track sleep, steps and food to create healthy habits and redeem points to win prizes.
- Save time and money by discovering additional benefits and programs.

Learn more about what Engage has to offer and get started now!

(800) 343-0860

nb.fidelity.com/csu

Health Savings Account (HSA) Ram Plan—HDHP

Ram Plan— High Deductible health Plan

The Ram Plan-HDHP + HSA—is it right for you? This plan allows you to enroll in an HSA.

An HSA helps you save for healthcare expenses such as deductibles or co-insurance, for medical, dental, and vision. You may not enroll in the HSA if you are in the Gold, Green or POS plans as they do not meet specified regulatory requirements for a high deductible health plan. You also may not enroll in the HSA if you are eligible for or enrolled in Medicare.

The HSA also helps you to pay for those expenses on a pre-tax basis, saving you federal and often state taxes. An HSA offers triple tax savings to save as much as you can now up to IRS maximums and reap the rewards of a nice nest egg at retirement, if you do not spend the money on healthcare. The 2023 maximum annual amount that can be contributed to an HSA is $3,850 for an individual or $7,750 for family HDHP coverage, which is employee + 1 or family coverage. To help build your account quickly, **CSU will deposit $500 in your HSA account each year**; IRS contribution maximums are reduced the employer deposit. If you wish to contribute, you may do so pre-tax through payroll deduction.

You never lose funds in an HSA as they roll over from year to year. While CSU is required to report HSA contributions on your W-2, it is your responsibility as the individual account owner to not exceed the IRS allowed maximum.

FSA and HSA Comparison

Regulatory Summary	FSA	HSA
Funds can be used to pay for out-of-pocket medical expenses including deductibles	Yes	Yes
Employees over age 55 can make catch-up contributions up to an additional $1,000 per year	No	Yes
Maximum annual contribution in 2023 is $2,750	Yes	No
Combined employee / employer 2023 maximum contributions of $3,850 for individuals, $7,750 for families	No	Yes
Available with Green, Gold, and POS Plans	Yes	No
Automatic enrollment with the Ram Plan — HDHP	No	Yes
Enrollment allowed even if covered elsewhere in a non-HDHP medical plan	Yes	No
Eligible if enrolled in for Medicare	Yes	No
Eligible if spouse has an FSA	Yes	No
Access 100% of annual election as of January 1, regardless of what has been contributed	Yes	No
You can spend only what you have contributed	No	Yes
Unused balance rolls over from year to year	No	Yes
Contributions are made on a pre-tax basis	Yes	Yes
You can take it with you if you change jobs or retire	No	Yes
CSU contributes $500 to the account each year	No	Yes
You cannot be covered by a non-HDHP at the same time you are covered by the Ram Plan-HDHP	No	Yes
Can be claimed as a dependent on another person's tax return	Yes	No
Requires a valid US address	No	Yes
Allows you to invest your funds in a mutual funds as long as the account balance is at least $500	No	Yes

Discovery Benefits®
a WEX company

(866) 451-3399

discoverybenefits.com

Flexible Spending Accounts (FSA)

Plan Description

You have access to a Flexible Spending Account (FSA) which allows you to pay for certain health care and child care expenses with pre-tax dollars. FSA's may allow you to save money as contributions to the accounts are deducted from your wages before Federal, State and retirement deductions are calculated.

The FSA funds can be accessed in two ways. You can pay your providers out of pocket and submit for a reimbursement or you also have access to a Benefits Debit Card. This card can be presented to participating merchants and the transaction is completed at the point of sale. You should save debit card receipts in the event you need to substantiate the expenditure with Discovery Benefits, Inc. The amount of savings you may derive from participating in a Flexible Spending Account will depend on your income, your tax bracket and the amount of money that is withheld from your pay on a pre-tax basis.

Note: Health Care Reform extends medical FSA reimbursement to your adult children up to age 26. Only your "qualified" federal tax dependents are eligible for reimbursement of expenses under a FSA dependent care account.

Your pre-tax contributions are deducted in equal amounts from your pay either on a 9-month or 12-month basis. If you are on a Faculty transitional appointment, deductions will occur on a 4-month or 5-month basis.

Consult your tax advisor if you have questions about participation in the Flexible Spending Accounts.

General IRS Guidelines

FSA's are governed by the IRS and certain rules apply in order for you to enjoy the potential tax savings.

Elections must be made prior to the beginning of each plan year and/or your effective date. The FSA plan year is a calendar year and begins each January 1 and ends December 31. Eligible expenses must be incurred during this time frame to be eligible for reimbursement. The IRS definition of "incurred" refers to the date the service is provided regardless of when you are billed or when you pay for it. **You are required to re-enroll in an FSA each Open Enrollment period to continue participation in the next plan year.**

If you do not use all of the money in your Health Care or Dependent Care Spending Account for eligible expenses incurred in the same plan year, you will lose any unused dollars at the end of the year.

IRS guidelines do not allow you to transfer money from one spending account to another. They consider these separate accounts. Carefully consider how much money you need in each account and set aside only the money you need for incurred expenses during the calendar year.

You are not permitted to make lump-sum contributions to your spending accounts. Your contributions must be made through payroll deduction.

There is a deduction limit for FSA's which restrict taxable income from being taken below minimum wage as a result of salary reduction.

It is important to note that you cannot take the federal tax credit or tax deduction for dependent care or health care expenses reimbursed by your FSA.

Please consult your tax advisor before determining if participation will benefit you or if taking the tax deduction or tax credit on your tax return is more effective.

FSA (cont.)

Reimbursement Process

Benefits Debit Card: You can use your Benefits Debit Card to pay for eligible items/services at the point of sale with participating merchants. Present your card to the cashier and the amount is deducted directly from your FSA balance. Make sure to retain a copy of an itemized receipt or EOB for substantiation purposes.

Claim Submission: You can make an out of pocket purchase and file a claim using the Reimbursement Request Form or submitting electronically online through a secure portal. Complete this form and submit to Discovery Benefits along with a copy of your itemized receipt or EOB.

All documentation to be submitted to Discovery Benefits can be sent via mail, fax or email or uploaded via your mobile device or computer. See contact information below:

Discovery Benefits
3216 13th Avenue South
Fargo, ND 58103

Fax: (866) 451-3245

Email: customerservice@discoverybenefits.com

Year End Claim Filing Due Date

Active employees will have **90 days** following the end of the plan year to submit claims incurred during the plan year.

Employment End Filing Date

Any money left in your accounts when you terminate or lose benefits eligibility can only be used to reimburse you for eligible expenses incurred prior to the date your eligibility ends.

You have 90 days from this date to submit for reimbursement from your account.

Unsubstantiated Debt Implications

The IRS requires you to submit documentation for expenses reimbursed with your FSA debit card.

If you do not submit this documentation before the end of the grace period, the unsubstantiated FSA claim amount(s) will be subtracted from your pay advice and returned to the University to offset plan expenses.

Itemized Receipts

When submitting a health care reimbursement claim or substantiation documentation on a card charge, attach a fully itemized receipt that includes the date of service, type of service, and provider's name and/or a copy of the explanation of benefits (EOB) statement provided by the insurance company.

Over the Counter (OTC) Drugs

Claims for over-the-counter drugs must include the itemized cash register receipt attached to the claim form and a copy of the written prescription obtained from a medical practitioner.

Dependent Care Reimbursement Process

You can submit a Recurring Dependent Care Reimbursement Form to Discovery Benefits to be set up for automatic reimbursements throughout the plan year. This is a great feature because you will not need to continually submit claims for reimbursement.

You can submit dependent care reimbursement claims as needed by completing a claim form or submitting the receipts electronically through Discovery Benefits secure portal.

If you are unable to provide an itemized receipt with the claim, please have your Dependent Care provider sign Section 2b of the Reimbursement Request Form. Claims cannot be submitted until after the dependent care services have been provided.

You will be reimbursed if there are sufficient funds in your account. Otherwise, you will receive reimbursement for the amount in your account and the remainder will be paid when your account balance permits.

Be sure to keep copies of your mailed claims and supporting documentation. No documentation will be returned to you.

Direct Deposit

All reimbursements will be made to you either by check or direct deposit. You will be responsible for paying the health or dependent care provider.

Health Care FSA

The Health Care Flexible Spending Account is designed to help you pay for expenses that are not covered by your health plans, including deductibles, co-pays, and co-insurance.

Reimbursable expenses may also include expenses that are not covered by your basic plans, for example, prescription eyeglasses and some over-the-counter drugs as long as you obtain a written prescription from a medical practitioner.

If you decide to enroll in a Health Care Flexible Spending Account, you may deposit up to **$2,750** into the account each year.

If you and your spouse or domestic partner both work at CSU and are eligible for CSU Benefits, each of you may contribute up to **$2,750** per year.

Note: Expenses that are reimbursed through your Health Care FSA are not tax deductible at the end of the year.

Administrative Fee—paid by CSU

Colorado State University will fund the monthly administrative fee on your behalf.

Examples of Eligible Health Care Expenses

- Acne medicine (as prescribed by a medical practitioner)
- Acupuncture
- Band aids
- Birth control pills
- Braille books and magazines
- Breast pump rental or purchase (with letter of medical necessity)
- Chiropractic care
- Contact lenses and solutions
- Cosmetic surgery (as medically necessary)
- Crutches
- Dental & orthodontic fees
- Dental implants
- Diagnostic tests
- Enemas
- Equipment for the disabled
- Hearing aids and batteries
- Hearing treatment
- Insulin
- In vitro fertilization
- Lab fees
- Medical nursing home services
- Massage therapy (with prescription and letter of medical necessity and treatment plan)
- Muscle or joint pain ointments
- Nicotine gum or patches (for stop-smoking programs)
- Nursing services
- Optometrist fees
- Organ transplants
- Orthotics
- Oxygen
- Pedialyte for dehydration
- Periodontal fees
- Physical therapy
- Pregnancy test—over the counter
- Prenatal care
- Radial Keratotomy, PRK, Lasik
- Saline solution
- Services for diagnosed severe learning disabilities
- Special schools for the disabled
- Sterilization
- Substance abuse treatment
- Sunburn ointment
- Surgery
- Telephone for the deaf or hearing impaired
- Therapy for mental/nervous disorders
- Vaccinations
- Vitamins (as prescribed by a medical practitioner)
- Wart remover treatments
- Weight loss program/drugs (must be prescribed by a doctor with a specific IRS-approved diagnosis)
- Wheelchairs
- X-ray fees

For a complete list of eligible and ineligible expenses, refer to IRS Publication 502.

Dependent Care FSA

The Dependent Care Flexible Spending Account is similar to the Health Care Flexible Spending Account, except it allows you to pay for eligible dependent day care expenses with pre-tax dollars. To decide whether a Dependent Care FSA is right for you, determine if you will incur eligible expenses. If you are paid 12 months out of the year you may not elect to have dependent care deducted for nine (9) months only. Generally, child and elder care companion services are eligible expenses. For the expense to be eligible, all of the following must be true:

Your dependent(s) must be:

- Under age 13 (stops on 13th birthday) or mentally or physically unable to care for him/herself
- Spending at least eight hours a day in your home
- Eligible to be claimed as a dependent on the employee's federal income tax return. Special rules may apply in divorced or separated situations
- Receiving care when you are at work and your spouse is at work, searching for work, in school full-time, or is mentally or physically disabled and unable to provide the care
- Receiving care provided in your home or outside your home by a licensed day or elder care center or by babysitters or companions; this includes relatives, but excludes your dependent children under age 19

Note: The caregiver must claim the wages you pay him/her on his/her income tax return for the year and you must be able to provide the tax identification number or Social Security Number of the provider when submitting a claim. When you file your personal income tax return, this same information will need to be reported on Form 2441.

If you decide to participate in a Dependent Care FSA, you may contribute up to **$5,000** into the account each year. However, if you and your spouse both work, the IRS currently limits your maximum contribution to a Dependent Care FSA as follows:

- If you file separate personal income tax returns, the annual contribution amount is limited to $2,500 for you and your spouse
- If you file a joint income tax return and your spouse also contributes to a Dependent Care Flexible Spending Account, your combined limit is $5,000
- If your spouse is disabled or a full-time student, special limits apply. Limits are defined in IRS Publication 503
- If you and or your spouse earn less than $5,000 combined, the maximum is limited to your combined earnings

Ineligible Dependent Care Expenses

- Transportation to and from the dependent care location
- Amounts you pay for child and dependent care while you or your spouse are off work because of illness (including maternity leave), injury, vacation, or leave of absence
- Summer sleep-over camps
- Full or half day kindergarten programs
- Fees for extracurricular classes, e.g., gymnastics, swimming, dance
- Boarding schools
- Nursing homes

Dental Plans

CSU offers two dental plans for employees to choose from: Delta Dental Basic and Delta Dental Plus. Both plans are self-insured and administered, including claims processing, by Delta Dental of Colorado.

For both dental plans, claims must be submitted within 12 months from the date of service. If submitted after 12 months, the plan will not make payment.

Dental Providers

You may obtain care from any licensed dentist. Neither dental plan requires the use of network dental providers. The Delta Dental Basic plan does not have an associated network. The Delta Dental Plus Plan has two networks (PPO and Premier). You will receive the best benefits by choosing a PPO dentist.

Coordination of Benefits

Delta Dental Basic: This dental reimbursement plan is always considered the secondary payer when a covered employee or dependent is also covered by another dental insurance plan.

Payments will only be processed after a determination has been made by the other dental plan. This Plan will provide Benefits, which together with the other Plan will not exceed 100% of the allowable expenses.

Delta Dental Plus: When employees and/or dependents are covered by this plan and another dental plan, coordination of benefits will be administered in the following manner. For children covered as dependents on this plan and as dependents on a spouse, domestic partner or a civil union partner's plan, the plan of the individual whose birthday falls first in the calendar year will be the primary payer. In the case of spouses, domestic partners or civil union partner's plan where coverage is other than as a dependent will be the primary payer.

If this plan is secondary, this plan will provide Benefits which together with the other plan will not exceed 100% of the allowable expense of this plan's maximum benefit. Please refer to the official plan document for Coordination of Benefit rules for custody arrangements.

Pre-Determination of Benefits

Pre-determination of benefits is recommended for any expensive dental services. The typical guideline for obtaining a predetermination of benefits is approximately $400. This will allow you to determine in advance whether a proposed service is covered under the plan and, if covered, the extent of any deductibles and other out of pocket expenses.

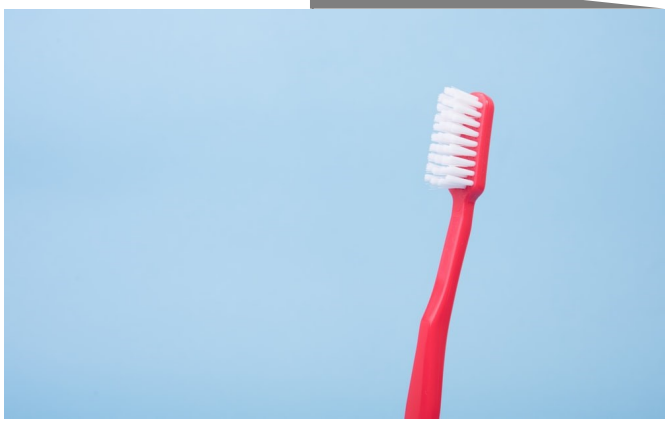
FSA & HSA Expenses

Many unreimbursed dental expenses are considered eligible expenses for a Flexible Spending Account (FSA) or a Health Savings Account (HSA). Refer to the FSA and HSA sections for details.

DELTA DENTAL®

(800) 610-0201

deltadental.com



Plan Coverage

The Delta Dental Basic Plan reimburses covered expenses at the following levels:

- 100% for the first $100; plus
- 50% of the next $1,800 for **each covered member** per calendar year
- Maximum benefit is **$1,000** for each covered member per calendar year

This plan reimburses for covered services regardless of the frequency of service and without applying Maximum Plan Allowance guidelines, up to the plan's maximum benefit.

Delta Dental Basic Plan

Group Number: **9709**

The following is a summary of the coverage available through the CSU dental plans and is not to be construed as the official plan document which covers claims administration. Please contact Delta Dental of Colorado for dental coverage inquiries.

Plan Description

This is a Direct Reimbursement Plan rather than dental insurance in which benefits are payable according to the dentist's billed charges. There is no provider network associated with this plan. There is no deductible on this plan.

Exclusions

Any expense other than those specifically excluded below, which is incurred by you and/or your enrolled dependents for services, supplies, medication, or appliances provided by or at the direction of a dentist is covered. If you and/or your covered dependents are enrolled under any other dental insurance plan, this plan will only pay after a determination has been made by your other dental insurance plan.

Exclusions (what this plan does not cover)

- Orthodontia
- Jaw joint problems (generally known as TMJ)
- Any expenses payable by other dental plans under which you or your dependents are covered

Providers

Freedom of choice – as long as the provider is a licensed dentist. Dental benefits under the Delta Dental Basic Plan (a dental reimbursement plan) are not subject to any contractual arrangements between Delta Dental and the dental providers limiting the amount charged. Dental providers will charge their usual fees to members. There is no dental network associated with this plan.

Claims Payments

Claim payments for the Delta Dental Basic Plan will be made direct to the member even if the dentist accepts assignment of benefits. You will be responsible for payment to the dentist.

If your dentist will not submit the claim for you, you will need to complete a claim form and submit it to Delta Dental of Colorado. Claim forms are available on the HR website and the Delta Dental website.

A separate claim form must be submitted for each member.

Claims must be submitted within 12 months from the date of service or no payment will be made from the plan.

Claims Address: P.O. Box 173803
Denver, CO 80217-3803

Delta Dental Plus Plan

Group Number: **9684**

Plan Description

This is a dental insurance plan which allows for varying levels of benefit payments depending upon the type of service provided by your dentist. If you or enrolled dependents are also covered under another dental plan, the Plan's coordination of benefits rules will apply.

Providers

Freedom of choice – You may use any licensed dentist. Maximum savings will be received when accessing care from a Delta Dental PPO Dentist.

Claim Payments

Claims under the Delta Dental Plus plan will be processed according to Delta Dental's processing standards and contractual arrangement with the dentist. Maximum savings are received when using a PPO Dentist.

PPO Dentist: Payment is based upon the PPO dentist's allowable fee, or the fee actually charged, whichever is less.

Premier Dentist: Payment is based upon the Premier Maximum Plan Allowance, or the fee actually charged, whichever is less.

Non-Participating Dentist: Payment is based upon the Premier Maximum Plan Allowance, or the fee actually charged, whichever is less.

Submission of Claims: Delta Dental PPO and Premier dentists will submit claims direct to Delta Dental of Colorado and will only charge you the deductible and/or coinsurance you are responsible for (if any).

Non-participating dentists may require that you pay the full fee at time of service and submit your own claim. If your dentist will not submit the claim for you, you will need to complete a claim form and submit it to Delta Dental. Claim forms are available on the HR website and the Delta Dental website. A separate claim form must be submitted for each member.

Delta Dental Provider Comparison *(Illustrative Purposes Only)*
You will receive the highest level of coverage by choosing a PPO dentist.

	PPO Dentists In-Network	Premier Dentists In-Network	Non-Participating Dentists Out-of-Network
Charged Fee (Filling)	$100.00	$100.00	$100.00
Maximum allowed*	$56.00	$80.00	$80.00
Benefit Percentage	80%	80%	80%
Benefit	$44.80	$64.00	$64.00
Member not Responsible	$44.00	$20.00	$0.00
Member Pays	**$11.20**	**$16.00**	**$36.00**

PPO Dentist: Payment based upon the PPO dentist's allowable fee, or the fee charged, whichever is less.

Premier Dentist: Payment based upon the Premier maximum plan allowance, or the fee charged, whichever is less.

Non-Participating Dentist: Payment based upon the Premier maximum plan allowance, or the fee charged, whichever is less.

*Allowable fee for a PPO dentist is the fee schedule which the dentist has agreed to charge. Allowable fee for a Premier dentist is the maximum amount per procedure that a Premier dentist can charge based on their contractual agreement with Delta Dental. Allowable fee for a non-participating dentist is equal to the Premier maximum allowable fee, however the dentist may charge the additional balance to the patient as they are not under contract with Delta Dental.

Delta Dental Plus Plan (cont.)

Annual Deductible

Expenses will be covered at the applicable levels after the deductible is met, does not apply to Preventive or Orthodontic services.

- $50 per person or a maximum of 2 deductibles per family—$100

Delta Dental Plus Percent of Covered Expenses	
Preventive & Diagnostic Services	**100%**
Basic Dental Services	**80%**
Major Dental Services	**60%**
Orthodontia	**50%**

Plan Maximums

Preventive and Diagnostic services do not apply to the annual maximum.

- **Basic and Major services**
  - $2,000—Annual maximum; per member per calendar year (excludes any orthodontic services)
- **Orthodontic Treatment and Appliances**
  - $1,800—Lifetime maximum (excludes preventive and diagnostic, basic and major services)

Preventive and Diagnostic Dental Services—100% of Plan Allowable (no deductible)

- Routine oral examinations *(2 times per calendar year)*
- Routine cleanings (excludes periodontal*, 2 times per calendar year)*
- Sealants on the occlusal surface of a permanent posterior tooth for children *(every 3 years until age 16)*
- Fluoride treatments for children *(2 times per calendar year through age 13)*
- X-rays (in relation to preventive or diagnostic services only)
  - *Bitewing x-ray series (2 times per calendar year); full mouth/complete set (every 2 years)*
- Emergency palliative treatment for pain
- Space maintainers for covered children until age 16 to replace primary teeth

Basic Dental Services—80% of Plan Allowable (after deductible)

- Fillings, other than gold
- Root canals (including non-surgical endodontic treatment)
- Oral Surgery (limitations apply)
- Administration of injectable antibiotic drugs
- Recementing bridges, crowns or inlays
- Periodontics (gum treatments), including scaling and root planning *(4 quadrants in any 24 month period)*
- Periodontal Cleanings. (2 in 12 months)
- Non surgical services
- General or intravenous anesthesia for oral surgery procedures or upon demonstration of dental necessity

Major Dental Services—60% of Plan Allowable (after Deductible)

- Crown, Inlays and Onlays
- Periodontic services (surgical)
- Bridges (installation and repairs)
- Dentures (relining, rebasing and attachment points)
- Implants (non cosmetic)

For an Orthodontic treatment plan started prior to the eligibility date of the patient, Delta Dental will begin periodic payments with the first payment due following the patient eligibility date. The maximum benefit will be determined based upon the prior payment records.

Orthodontia—50% of Plan Allowance (no deductible)

- 50% of eligible charges up to a $1,800 lifetime maximum

Covered orthodontic procedures include:

- Moving teeth into proper alignment, position and occlusion
- Preliminary study, including x-rays, diagnostic casts, treatment plan and active treatment
- Post-treatment appliances (retainers); doesn't include lost or broken appliances

Dental Plans — Exclusions

The following Services are not Benefits:

- Services for injuries or conditions which are compensable under Worker's Compensation or employer's liability laws, or Services which are provided to the Covered Person by any federal or state government agency or are provided without cost to the Covered Person by any municipality, county or other political subdivision, or any Services for which the Covered Person would have no obligation to pay in absence of this coverage, except as such exclusion may be prohibited by law
- Any Covered Service Started when the person was not eligible for such Service under this Contract
- Services for cosmetic reasons
- Services related to protecting, altering, correcting, stabilizing, rebuilding or maintaining teeth due to improper alignment, occlusion or contour
- Services related to periodontal stabilization of teeth
- Habit appliances, night guards, occlusal guards, athletic mouth guards and gnathological (jaw function) Services, bite registration or analysis, or any related Services.
- Charges for prescription drugs
- Dental treatment which is experimental or investigational in nature and not yet approved by the American Dental Association
- Any procedures done in anticipation of future need (except Covered Preventive Services)
- Hospital costs and any additional fees charged by the Dentist or hospital for hospital services or visits, or charges for use of any facility
- Orthodontic Services including any related diagnostic, preventive or interceptive Services (surgical and other treatment of malalignment of teeth and/or jaws), unless shown as covered on the Summary of Dental Plan Benefits
- Myofunctional therapy or speech therapy
- Services for the treatment of any disturbances of the temporomandibular joint (TMJ), facial pain, or any related conditions, including any related diagnostic, preventive or interceptive Services
- Services not performed in accordance with the laws of the State in which Services are rendered, Services performed by any person other than a person authorized by license to perform such Services, or Services performed to treat any condition, other than an oral or dental disease, malformation, abnormality or condition
- Oral hygiene instructions or dietary instructions
- Completion of forms, providing diagnostic information or records, or duplication of x-rays or other records
- Replacement of lost, stolen or damaged appliances
- Repair of appliances altered by someone other than a Dentist
- Any Services including any associated Services or procedures not specifically included in Covered Services
- Services for which charges would not have been made if this coverage had not existed, except for Services as provided under Medicaid
- Missed appointment charges
- Preventive control programs, including home care items
- Plaque control programs

Healthy Smile, Happy Life

Make sure to schedule regular dental exams, and in between visits, take advantage of numerous free resources for improving your oral health on the Delta Dental website.

Dental Plans — Appeal Process

Adverse Benefit Determination

An adverse Benefit Determination shall mean a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit. An inquiry regarding eligibility or benefits without a Claim for benefits is not a Claim and therefore, cannot be appealed.

The Plan shall provide written or electronic notice of the determination on a Claim in a manner meant to be understood by the Claimant.

If the Claimant does not understand the reason for the Adverse Benefit Determination, the Claimant should contact the Claims Administrator at the address or telephone number printed on the Notice of Determination.

Appeal Process

A Covered Person has the right to appeal any adverse determination made on a claim, whether in whole or in part. An appeal request may be submitted in writing within 180 days of the date of the original Explanation of Benefits to:

Delta Dental of Colorado
Appeals Analyst
PO BOX 172528
Denver, CO 80217-2528

A Covered Person may submit additional documentation in support of the appeal.

Second Level Appeal

If the Claimant does not agree with the Claims Administrator's determination from the first level review, the Claimant may submit a second level appeal in writing within 60 days of the Claimant's receipt of the Notice of Determination from the first level of review, along with any additional supporting information. Failure to appeal the determination from the first level of review within the 60 day period will render that determination final.

The second level of review will be done by the Claims Administrator. The Claims Administrator will review the information initially received and any additional information provided by the Claimant, and make a determination on the appeal based upon the terms and conditions of the Plan and other relevant information. The Claims Administrator will send a written or electronic Notice of Determination for the second level of review to the Claimant within 30 days of receipt of the appeal.

Third Level Appeal

These are conducted by an independent third party and are available only in those circumstances where benefits were denied and which have gone through the Level 2 Appeal process. To request a Level 3 appeal, contact:

Colorado State University
c/o Human Resources
6004 Campus Delivery
Fort Collins, CO 80523-6004

The request for a Level 3 appeal must be made within 60 calendar days after the Level 2 denial.

Vision Plans

Anthem Medical Plans

The Green, Gold, Ram Plan-HDHP and POS medical plans allow participants one eye exam per calendar year subject to normal copays or deductibles and coinsurance.

Vision Exam — one routine exam per year, per member

POS Plan: **$15 copay** every calendar year *(in-network providers only)*

Gold Plan: **80%** after the deductible has been met

Green Plan: **80%** after the deductible has been met

Ram Plan-HDHP: **80%** after the $1,500 deductible has been met

(participating and non-participating providers for Green, Gold, Ram Plan-HDHP)

EyeMed Vision Care — discounts on exams and materials

In-Network Coverage Only

EyeMed is a no-cost discount plan available through Delta Dental. Discounts on exams and materials are through a discount card. Dental coverage enrollment is not necessary. EyeMed provides the following features:

- Discounts on eye exams, frames and conventional contact lenses
- Scheduled pricing for lenses and lens options
- Choice of any available frame
- Unlimited frequency
- Discounts on LASIK and PRK
- Replacement Contact Lens by mail program

EyeMed Provider Network: includes private practice optometrists, ophthalmologists, opticians, and optical retailers including LensCrafters, Target, Sears Optical and most Pearle Vision locations.

Voluntary VSP Vision Care Plan

Vision Exam, materials, and discounts: VSP is a voluntary vision insurance plan — see next page for details.

Note: Vision exam expenses may only be submitted under one plan.

Eye exams can improve more than your vision

Even if you can see well, regular eye exams are important to help keep you healthy. Eye exams can diagnose diseases such as: glaucoma, macular degeneration, and cataracts. They can also help spot health problems such as diabetes, high blood pressure, and certain cancers.

Finding out about these problems early means you can get treatment early. This can help you get better and lower your healthcare costs!

Vision Service Plan (VSP)

Group Number: **30021702**

The following is a summary of the coverage available through the voluntary Vision Service Plan (VSP) and is not to be construed as the official plan document which governs claims administration. Please contact VSP for vision coverage related inquiries.

(800) 877-7195

vsp.com

Plan Description

The Vision Care Plan is a voluntary vision insurance plan provided by VSP. Employee premiums are located in the Summary Monthly Premium section of this booklet. This plan provides exams and materials based on a co-pay and annual benefit allowance.

Discounts provided by VSP doctors are not a negotiated benefit. VSP Doctors provide the discounts to the participant as a courtesy. To qualify for the extra discounts and savings, services and materials must be received within 12 months of the last covered eye exam from any VSP network doctor. If a participant utilizes Anthem or EyeMed for the eye exam, the VSP discount may be provided subject to the discretion of the VSP provider.

Coverage

Vision enrollment is voluntary and requires employee monthly contributions. Please review the following VSP Summary of Benefits to determine if this plan is beneficial for you and your family.

Premiums

Employee monthly premiums are located in the premium section of this booklet. The VSP Vision Care Plan is a voluntary option in which the employee pays the full monthly premium.

How to Use Your Vision Plan

- To obtain vision care services, call your VSP doctor. To locate a VSP network doctor, call VSP at (800) 877-7195 or visit their website
- When making an appointment, **identify yourself as a VSP member**, provide your member identification number and the CSU group name/ number, the network doctor will contact VSP to verify eligibility and plan coverage and obtain authorization for eye exam services and eyewear

Summary of Benefits		
Description	**Level of Coverage from a VSP doctor**	**Non-VSP Doctor or Provider Reimbursement**
Exam *(once every calendar year)*	Covered in full after $40 copay	Reimbursed up to $45
Basic Lenses *(once every calendar year)*	$25 copayment for lenses, frames or both lenses and frames	
Single Vision	Covered in full after copayment	Reimbursed up to $30
Lined Bifocal	Covered in full after copayment	Reimbursed up to $50
Lined Trifocal	Covered in full after copayment	Reimbursed up to $65
Frames (*once every other calendar year)*	Covered up to $175 allowance	Reimbursed up to $70
Contact lenses *(once every calendar year)*	Covered up to $175 allowance	Reimbursed up to $105

VSP (cont.)

Note: You will not receive a VSP membership card when enrolling in this voluntary benefit option.

As a VSP member, there are so many ways to save!

Visit VSP Special Offers to view exclusive member extras!

Eyeglasses

VSP covers in full single vision, lined bifocal, lined trifocal lenses. Polycarbonate lenses are covered for children (up to age 18). In addition to the coverage provided, VSP network doctors extend cost controls on lens options, which average 20-25% off the network doctor's usual fees.

Cost controlled options include but are not limited to, tints, scratch coating, UV protection, anti-reflective coating, photochromic lenses and progressive lenses (blended/no line).

Frames are covered in full up to $150 allowance. If a frame is selected over the VSP provided allowance, the patient is responsible for the additional amount. VSP doctors provide a 20% discount on amounts over the plan allowance. Typically if a patient selects a frame that is not in the VSP doctor's inventory, the doctor can order the frame for you.

Contact Lenses

Contact lens services and materials are covered instead of frames and lenses. If a patient chooses to purchase contacts instead of glasses, the plan will cover up to $150 towards the doctor's professional services and materials. Any costs exceeding this allowance are the patient's responsibility.

You cannot receive both glasses and contacts in the same service period. VSP doctors provide a 15% discount off their professional services for contact lenses (fitting and evaluation).

(800) 523-2233

thehartford.com

Basic Group Term Life

Group Life Policy Number: 677984

Basic AD&D Policy Number: S07449

The following is a brief description of the coverage provided through this group plan. Coverage is governed at all times by the complete terms of the Master Group Insurance policy issued to Colorado State University. The basic group term life and AD&D Insurance Plan is provided by The Hartford Life and Accident Insurance Company. (Referred to as The Hartford or Hartford).

General information about the plans is provided in this Summary Plan Booklet. Additional information is contained in the Certificate of Coverage, available on the HR website.

Plan Description

You are automatically enrolled in $70,000 of University provided Basic Group Term Life and AD&D (employer provided life insurance exceeding $50,000 is subject to imputed income).

- For non-accidental deaths, the basic group term life and AD&D Insurance benefit will be $70,000 less any age reduction (see Benefit Reduction) or Accelerated Death Benefit previously paid under this plan
- For deaths resulting from an accident, the benefit will be equal to $140,000 ($70,000 basic group term life PLUS $70,000 Accidental Death), less any age reductions (see Benefit Reduction) or Accelerated Death Benefit previously paid under this plan
- For injuries resulting from an accident, you may be eligible to receive a Dismemberment benefit equal to a full or prorated basic group term life and AD&D benefit based on the loss. Full details are contained in the Certificate of Coverage
- There are many AD&D benefit enhancements included in your plan. Please refer to Hartford's Certificate for details

The following AD&D Exclusions apply to losses from:

1) Intentionally self-inflicted Injury;
2) Suicide or attempted suicide, whether sane or insane;
3) War or act of war, whether declared or not;
4) Injury sustained while on full-time active duty as a member of the armed forces (land, water, air) of any country or international authority;
5) Injury sustained while On any aircraft except a Civil or Public Aircraft, or Military Transport Aircraft;
6) Injury sustained while On any aircraft:
    a) as a flight instructor or examiner;
    b) being used for tests, experimental purposes, stunt flying, racing or endurance tests;
    c) if it is owned, operated or leased by or on behalf of the Policyholder, or any Employer or organization whose eligible persons are covered under The Policy; or
    d) as a pilot, crewmember or student pilot;
7) Injury sustained while riding or driving in a scheduled race or testing any Motor Vehicle on tracks, speedways or proving grounds;
8) Injury sustained while driving while Intoxicated.

Basic Group Term Life (cont.)

Benefit Reduction

Basic group term life and AD&D Insurance Benefits reduce to 65% of the Plan coverage amount in January of the year following your 70th birthday and further reduce to 50% of the Plan coverage amount in January of the year following your 75th birthday.

Living Benefits Option (Accelerated Death Benefit)

Accelerated Death Benefits are available if you are diagnosed with a terminal illness, which is expected to result in your death within 12 months and from which there is no reasonable prospect of recovery.

You may be eligible to receive up to 80% of your life insurance benefits up to a maximum of $56,000.

Continuation of Life Insurance Benefits Due to Total Disability

If You are Totally Disabled, your Life Insurance Benefits may continue if:

a) the Total Disability began while you were insured under this Policy;

b) the Total Disability began before you reached age 60;

c) You have completed your Disability Elimination Period; and

d) Proof of the Total Disability is given to The Hartford as described.

You must notify The Hartford of your Total Disability during the Disability Application Period which is the nine consecutive months of Total Disability beginning on the date you first become Totally Disabled.

Actively At Work Provision

You must be actively at work for the coverage to begin.

Conversion / Portability

Subsequent to coverage termination, you will be contacted by The Hartford regarding your Conversion and/or Portability options.

If you wish to convert (no age limit) or port (limited to age 70) your coverage, you must do so within 31 days of your notification date.

Portability rates match the voluntary life rates; you must request a quote for Conversion rates from The Hartford. If you have questions, please contact The Hartford.

Life Conversations

As a part of your coverage under The Hartford, you have access to Life Conversations. This tool provides support and the answers related to:

- Selecting the appropriate amount of life insurance
- Creating a will / Estate Planning
- Funeral Planning
- Grief Counseling

Life Conversations is a single source to help families prepare for the future and navigate difficult end-of-life decisions.

Life Conversations includes access to tools and services, including Everest, the first nationwide funeral planning and concierge service.

Call **(866) 854-5429** or visit hartfordlifeconversations.com for more information.

Basic Group Term Life (cont.)

Travel Assistance with ID Theft Resolution Services

Toll-free emergency assistance is available to you, your spouse, domestic partner, civil union partner or your children 24 hours a day, seven days a week when traveling 100 miles or more away from your primary home for 90 days or less. The Travel Assistance program provides three kinds of services for your business or vacation travels:

- Emergency medical assistance
- Emergency personal services
- Pre-trip planning

Sometimes travel emergencies can be complicated by a lost or stolen wallet or medical information compromised by identity theft. For this reason the travel assistance program is enhanced to include services for Identity Theft Protection & Assistance.

Identity theft is one of the fastest growing crimes in the United States today. And while you may take precautions to protect yourself, anyone can be the victim of ID theft. The identity theft program provides education to prevent or avoid ID theft and resolution services if you suffer the unfortunate experience of having your identity stolen.

Identity Theft Protection and Assistance service relieves the time burden and personal stress caused by identity theft. Caseworkers are available 24/7 to act as your advocate, advising and handling certain administrative tasks on your behalf to rectify any issues you may encounter as a result of identity theft.

The Hartford's Travel Assistance and Identity Theft Resolution programs are provided by Europ Assistance USA, a leader in the assistance industry. Europ Assist has been helping customers in times of crisis for more than 46 years. They have the expertise to handle the complex issues involved with travel emergencies and identity theft.

Note: Some restrictions and exclusions apply. Visit The Hartford website for full details.

Contact Europ Assistance Services

Toll Free from U.S. or Canada — (800) 243-6108

Collect from other locations — (202) 828-5885

Fax — (202) 331-1528

Travel Assistance with ID Theft Services Include:

- Medical Referrals
- Medical monitoring
- Medical evacuation
- Repatriation
- Traveling companion assistance
- Dependent children assistance
- Visit by a family member or friend
- Emergency medical payments
- Return of mortal remains
- Medication and eyeglass assistance
- Sending and receiving emergency messages
- Emergency travel arrangements
- Emergency cash
- Locating lost items (i.e. wallet)
- Legal assistance
- Bail advancement
- Translation services
- Identity theft awareness and education
- Identity theft victim solutions

Voluntary Group Term Life

Group Life Policy Number: 677984

Plan Description

This voluntary group term life insurance plan is an optional plan, which allows you to choose levels of coverage, in increments of $10,000, up to $500,000 for the employee and up to $300,000 for the spouse, domestic partner or civil union partner of the employee. You can also elect coverage for your eligible children who are at least 14 days old, up to age 26. Premiums are after–tax and based on your age and the level of coverage you elect.

If you are enrolling your spouse, domestic partner or civil union partner, the premiums will be based on your spouse, domestic partner or civil union partner's age and the level of coverage you are electing. If your spouse, domestic partner or civil union partner is also a benefits eligible CSU employee, you may not carry duplicate life coverage (spouse, domestic partner or civil union partner and children).

If life insurance coverage is desired, each employee must enroll separately and may not cover the spouse, domestic partner or civil union partner as a dependent for life insurance purposes. Dependent children can be insured under only one parent. Complete details of this benefit are available in the Certificates of Coverage online HR website.

Benefit Reduction

Life insurance benefits reduce to 65% of the prior coverage in January of the year following the 70th birthday and further reduce to 50% of the amount of prior coverage in January of the year following the 75th birthday. Premiums will be based on the reduced coverage.

Living Benefits Option (Accelerated Death Benefit)

Accelerated Death Benefits are available if you are diagnosed with a terminal illness, which is expected to result in your death within 12 months and from which there is no reasonable prospect of recovery. You may be eligible to receive up to 80% of your life insurance benefits up to a maximum of $400,000.

The following **Voluntary Group Term Life Exclusions** apply: results from suicide, while sane or insane within one year from the date insurance begins. Results from suicide, while sane or insane, within one year from the effective date of any increase in the amount of coverage, the amount of the increase will not be paid.

Continuation of Life Insurance Benefits Due to Total Disability

If You are Totally Disabled, Your Voluntary group term life insurance benefits may be eligible to continue without payment of premium provided:

a) the Total Disability began while you were insured under this Policy;

b) the Total Disability began before You reached age 60;

c) You have completed your Disability Elimination Period; and

d) Proof of the Total Disability is given to The Hartford as described.

You must notify The Hartford of Your Total Disability during the Disability Application Period which is the nine consecutive months of Total Disability beginning on the date you first become Totally Disabled. If you exercise your portability privilege, you will not be eligible for waiver of premium due to total disability.

Voluntary Group Term Life (cont.)

New Hire/Newly Eligible Initial Enrollment

Coverage up to Guarantee Issue Amounts: you may enroll within 30 days of your eligibility date. "Initial" enrollments up to $250,000 in coverage will be guaranteed for the employee, $50,000 guaranteed for the spouse, domestic partner or civil union partner and child life may be added automatically without requiring evidence of insurability.

Coverage above Guarantee Issue Amounts: initial enrollments in excess of $250,000 for the employee or $50,000 for the spouse, domestic partner or civil union partner will require completion/approval of a Personal Health Application (Evidence of Insurability).

Effective Date: coverage for guaranteed issue amounts is generally effective the first of the month following your hire/change date providing you meet any applicable actively at work provisions. For coverage over the guaranteed issue amount, coverage will be effective upon approval from The Hartford.

Actively At Work Provision

You must be actively at work for initial coverage or policy increases to begin.

Benefits Open Enrollment

Employee: you may apply for voluntary group term life insurance coverage from $10,000 to $500,000 in $10,000 increments. During the Benefits Open Enrollment period, you can enroll, apply for an increase, decrease, or cancel your employee voluntary group term life insurance coverage.

Open Enrollment allows you to commence or increase your employee voluntary group term life coverage in increments of $10,000 up to $30,000 automatically, unless the total policy amount exceeds $250,000 which requires completion/approval of a Personal Health Application.

You must enter any change in the CSU Online Benefits Enrollment System. Changes made during the Open Enrollment Period will become effective January 1st following the Open Enrollment Period, unless evidence of insurability is required, which may delay the effective date.

Spouse, Domestic Partner or Civil Union Partner Life: you may purchase spouse, domestic partner or civil union partner voluntary group term life insurance coverage from $10,000 to $300,000 in $10,000 increments. During the open enrollment period, you can enroll, apply for an increase, decrease, or cancel your spouse, domestic partner or civil union partner voluntary group term life insurance coverage.

Open Enrollment allows you to commence or increase your spouse, domestic partner or civil union partner voluntary group term life coverage in increments of $10,000 up to $30,000 automatically, unless the total policy amount exceeds $50,000, which requires completion/approval of a Personal Health Application.

You must enter any change in the CSU Online Benefits Enrollment System. Changes made during the Open Enrollment Period will become effective January 1st following the Open Enrollment Period, unless evidence of insurability is required, which may delay the effective date.

Children's Life Insurance

$20,000

Child(ren) rates are per **unit**. A unit consists of all eligible child (ren) per family. If your spouse, domestic partner or civil union partner also works at CSU and is eligible for CSU Benefit Plans, only one of you may choose children's life insurance coverage. Duplicate coverage is not allowed.

Any request to add or enroll child(ren) children in life insurance during open enrollment must be entered in the CSU Online Benefits Enrollment System. Changes made during open enrollment become effective the first of the following plan year.

Voluntary Group Term Life (cont.)

Qualifying Events Outside of the Open Enrollment Period

Decreases in coverage: you can *decrease* or cancel your coverage at any time by making the change in the CSU online enrollment system.

Increases in coverage: applications for *increases* in coverage outside of the Open Enrollment period are only approved if you have incurred a qualifying event, subject to restrictions, and as defined in the "Change in Coverage" section of the Certificate of Insurance from The Hartford. Application must be made within 30 days from the qualifying event.

The employee and spouse, domestic partner or civil union partner may enroll in coverage up to the guaranteed issue amounts without evidence of insurability when they experience a qualifying event. Guarantee issue amounts are $250,000 employee, $50,000 spouse, domestic partner or civil union partner and $20,000 child(ren).

If you request coverage in excess of guaranteed issue amounts, approval amounts, completion of a Personal Health Application (Evidence of Insurability) and approval by The Hartford is required. Qualifying events are the determining factor in what may be changed mid-year to allow employees flexibility in modifying coverage mid-year.

Effective Date: coverage will be effective the first of month following the specific life event date or the first of the month following the date of the approval notice from The Hartford if the amount applied for requires approval of an Evidence of Insurability Form.

You must be actively at work for the coverage to begin. Please refer to the Certificate of Insurance from The Hartford for official plan details.

Beneficiary Information

Beneficiary designations for life insurance are made in CSU's Online Benefits Enrollment System. The employee may change beneficiary designations at any time; the change will take effect as of the date entered in the online system or signed.

Court Orders: Beneficiary designations may be governed by court orders involving participants. These orders may mandate that the life insurance beneficiary named be a spouse, former spouse, or child (ren). For these court orders to be honored by the life insurance carrier, it is imperative that Human Resources receives copies of any court orders addressing life insurance. Also, the employee must take appropriate steps to change beneficiaries on file to reflect the court order.

The employee is the beneficiary for any eligible Spouse, Domestic Partner, Civil Union Partner or Children enrolled in the plan.

Types of Beneficiaries

- **Primary beneficiary**: the person(s) or entity who will receive the life insurance money when you pass away.

- **Contingent beneficiary**: the person(s) or entity who will receive the life insurance money if your primary beneficiary is deceased or unable to collect on the policy.

Voluntary Accidental Death & Dismemberment (AD&D)

Group Number: S07449

Plan Description

Eligible enrolled participants will be protected 24-hours a day, 365 days a year, for covered accidents (subject to the Exclusions and Limitations of the Contract). These program benefits are paid in a lump sum.

Amount of Insurance

You may elect any multiple of $25,000 up to a maximum of $500,000.

The amount of insurance on each of your eligible dependents is a percent of your employee coverage. The percent that applies on any date is shown below. It is based on the persons who are then your eligible dependents.

- Your spouse, domestic partner or civil union partner: **60%**
- Your child(ren): **25%** on each child
- Your spouse, domestic partner or civil union partner and child(ren): **50%** on your spouse, domestic partner or civil union partner, and **15%** on each child.

Dependent Coverage

Your dependents are covered as long as they remain eligible. See the 'Individuals Eligible for University Benefits' page.

Exceptions: Your spouse, domestic partner, civil union partner, or child is not eligible for enrollment while on active duty in the armed forces of any country or when insured under the Group Contract as an employee.

It is your responsibility to remove any ineligible individuals within 30 days of a qualifying event.

Benefits Open Enrollment

Enrollment: you may enroll, cancel, or change your coverage level during the open enrollment period each year.

Effective Date: coverage will be effective January 1st of the following calendar year providing you meet any applicable actively at work provisions.

Beneficiary Designation

You may name any beneficiary(ies) you wish. If you purchase coverage for your family under the Family Plan, you are automatically your dependents' beneficiary for loss of life. You may change your beneficiary at any time.

Outside of Open Enrollment

Mid-Year Qualifying Events: at the time of an IRS approved qualifying event, you can increase, decrease or cancel your coverage within 30 days of the qualifying event. It is necessary to provide documentation to Human Resources to substantiate the qualifying event and to establish the eligibility for, and the effective date of, the requested change.

At any time of the year, you can cancel or decrease your coverage.

Actively At Work Provision

You must be actively at work for the coverage to begin.

Conversion

Subsequent to coverage termination, you will be contacted by the Hartford regarding your Conversion options. If you wish to convert your coverage, you must do so within 31 days of your notification date. You must request a quote for Conversion rates from The Hartford. There is no Portability Policy available for this plan.

Voluntary AD&D (cont.)

Benefit Information

Full Amount:

- Loss of life or
- Loss of one hand & one foot, or
- Loss of both hands or both feet, or
- Loss of either hand or foot and sight of one eye, or
- Loss of speech & hearing of both ears

One-half the Full Amount:

- Loss of either hand or foot, or
- Loss of sight of one eye, or
- Loss of speech or hearing of both ears

One-quarter the Full Amount: Loss of thumb and index finger of either hand.

Paralysis Benefit

Full Amount: Quadriplegia (loss of movement of both upper and lower limbs)

Three-Quarters the Full Amount:

- Paraplegia (loss of movement of both upper and lower limbs)
- Triplegia (loss of movement of three limbs)

One-Half the Full Amount: Hemiplegia (loss of movement of both upper and lower limbs on one side of the body)

One-Quarter the Full Amount: Uniplegia (loss of movement of one limb)

Monthly COMA Benefit

If a covered insured is injured in a covered accident, which results in a coma for at least **31** consecutive days, the Program will begin payment of a Monthly Coma Benefit. Payment of this benefit will continue each month as long as the insured person remains in a comatose condition, up to a maximum of **100** months. This benefit will be paid at a rate of **1%** of the Amount of Insurance less any benefits paid as a result of the same covered accident. "Coma" means complete and continuous unconsciousness; and inability to respond to external or internal stimuli, as verified by a physician.

Exposure & Disappearance

A loss will be covered if an Insured is exposed to the elements because of a covered accident due to forced landing, stranding, sinking or wrecking of a conveyance in which the insured was an occupant at the time of the accident. We will presume an insured suffered a loss of life if their body has not been found within one year after a covered accident involving the disappearance of a conveyance in which the insured was an occupant at the time due to accidental forced landing, stranding, sinking or wrecking.

Extended Dependents Coverage

If you elect Family coverage and die in a covered accident, your family's coverage may be continued, at no cost to your family, for a specified period, from the date of your death, provided your spouse, domestic partner, civil union partner and/or dependent children remain eligible under the Plan.

Exclusions and Limitations

A Loss is not covered if it results from any of these:

- Intentionally self-inflicted Injury;
- Suicide or attempted suicide, whether sane or insane;
- War or act of war, whether declared or not;
- Injury sustained while on full-time active duty as a member of the armed forces (land, water, air) of any country or international authority;
- Injury sustained while On any aircraft except a Civil or Public Aircraft, or Military Transport Aircraft;
    - Injury sustained while On any aircraft:
    - as a flight instructor or examiner;
    - being used for tests, experimental purposes, stunt flying, racing or endurance tests;
    - if it is owned, operated or leased by or on behalf of the Policyholder, or any Employer or organization whose eligible persons are covered under The Policy; or
    - as a pilot, crewmember or student pilot;
- Injury sustained while riding or driving in a scheduled race or testing any Motor Vehicle on tracks, speedways or proving grounds;
- Injury sustained while driving while Intoxicated.

Only one benefit, the largest to which the owner is entitled, is payable for all losses resulting from one accident. No loss sustained prior to such covered accident shall be included in determining the amount payable.

Voluntary AD&D (cont.)

Child Care Expenses Benefit

If you elect the Family Plan coverage and die in a covered accident, the Plan will provide child care assistance to each eligible dependent child who is enrolled in a licensed child care center, or who enrolls in a licensed child care center within 90 days from the date of the covered accident. This important benefit pays **5%** of your Amount of Insurance up to **$5,000** annually for up to 4 consecutive years, paid annually. If you have no eligible children who qualify, the Plan will pay a lump sum of **$500** to your beneficiary.

Spouse, Domestic Partner or Civil Union Partner Education Benefit

If you elect the Family Plan coverage and you die in a covered accident, the Plan will provide a Occupational Training Benefit to your eligible spouse, domestic partner or civil union partner. The expense must be incurred within 2 years of the employee's date of death. This Training Benefit is a lump-sum payment of the lesser of 5% of your Amount of Insurance or $5,000.

Child Education Benefit

If you elect the Family Plan coverage and die in a covered accident, the Plan will provide an Child Education Benefit to each eligible dependent child who is a full-time student at a college, University, vocational school, or trade school over the 12th grade level at the time of (or enrolls within 365 days of) your death.

This Child Education Benefit is an annual payment of the lesser of 5% of your Amount of Insurance or $5,000. Payments will be made each year for up to 4 consecutive years for each child who qualifies. Benefit payments will cease when the child ceases to be a full-time student or reaches the age of 26. If there are no dependent children who qualify for this benefit, a single lump sum of $500 will be paid to your beneficiary.

Seat Belt/Air Bag Benefit

Because of the added protection seat belts and air bags bring to drivers and passengers every day, this special benefit is provided for you and your family members. If, while insured for this benefit, you or your covered dependent suffer accidental death due to a covered accident in which you or your covered dependent was seated in an automobile with a seat belt properly fastened, the Plan will pay an additional 10% of the Principal Sum, to a maximum of $25,000.

An additional Air bag benefit may be payable if the injured person was positioned in a seat equipped with a factory-installed Air Bag and properly strapped in the seat belt when the Air Bag inflated. The Air Bag Benefit pays 5% of the Principal Sum to a maximum of $5,000.

Critical Burn Benefit

If an Insured Employee is accidentally critically burned and requires reconstructive surgery, as determined by a physician, a Critical Burn Benefit may be payable. This Benefit will be equal to the lesser of 25% of the Employee's Principal Sum or $25,000.
(Critically Burned means burns are certified by a Physician as more severe than second degree burns and result in scarring over at least 25% of the body which will last indefinitely and can only be corrected through reconstructive surgery.)

War Risk Benefit

The benefit covers Worldwide territories, excluding geographical limits, territorial waters, or the airspace above certain countries as defined within the Group Master Policy. Contact the Hartford to determine which countries this applies to.

HUMAN RESOURCES
COLORADO STATE UNIVERSITY

(970) 491-6947

hr.colostate.edu

Short Term Disability (STD)

The group plan summarized below is subject to the terms and conditions of the Plan Document for CSU's self-insured STD Income Replacement Plan.

Plan Description

1) STD benefits commence after an "elimination period" of 10 continuous **working** days of absence or when all sick and annual leave is exhausted, whichever is later.
2) The STD benefits period of 60 work days runs concurrently with the elimination period, sick leave, and annual leave. Benefits are payable for the duration of the disability based on supporting medical documentation, but no longer than 60 continuous workdays from the commencement date of the disability. The date of disability is determined by the physician, not necessarily when all sick and annual leave is exhausted. Benefits will cease upon the effective date of long term disability benefits, retirement, the return to work date, or separation from service. Except in the two instances described below, benefits will not be paid during the summer term for participants with 9-month appointments:
    - Benefits will continue into the upcoming summer term for 9-month appointees who have *no summer term* appointment for that summer term if they had received summer term appointments for two of the past three summer terms and who either:
        - are already receiving benefits on the end date of their current spring semester appointment, or
        - have completed the "elimination period" described in #2 above and who exhaust their accumulated sick leave on the end date of their current spring semester appointment.
        - benefits for the summer term will be equal to the average appointment level and duration of the highest two appointments in the past three summer terms or until the disability ends, whichever is the shorter period.
    - Benefits will be payable on the basis of the level and duration of the *approved summer term* appointment upon satisfaction of the conditions detailed in #2 above for 9-month appointees who are:
        - already working on a summer term appointment,
        - who have a summer term appointment, for the upcoming summer approved by the President or their designee at the time of the commencement of disability.
        - Benefits will continue until the end of the approved summer term appointment or until the disability ends, whichever is the shorter period.
5) Required medical documentation specifying the length of an illness, injury, pregnancy, or surgery that will prevent the performance of essential job functions for 10 or more continuous working days.
6) The date of disability is determined by medical documentation from the employee's health care provider.
7) STD benefits are payable once per condition or related condition.
8) STD benefits are paid once the application and supporting medical documentation is received, reviewed and approved by Human Resources.
9) An employee who is eligible to receive STD benefits and is able to work part-time can receive partial benefits. Note that the Short term Disability period of 60 continuous workdays would not be extended. Hours worked would be paid by the employee's department.
10) STD benefits are not subject to retirement deductions and taxes.

Short term Disability insurance is provided at no cost to you (taxable $4 allowance). The plan provides a continuation of income in the event of illness, injury, surgery, or pregnancy for employees who exhaust their sick and annual leave balances.

This plan provides for continuation of the monthly base salary beyond the exhaustion of accrued paid sick and annual leave up to the 60th continuous work day of absence caused by an eligible disability (illness, injury, surgery, or pregnancy).

Replacement of covered monthly base salary earnings at **100%**.

STD (cont.)

Actively at Work Provision

Coverage for employees absent from work on the effective date of coverage will be deferred until the employee commences or resumes active work.

Income Replacement Offset

The monthly Short Term Disability income replacement benefit may be offset by any disability income benefits (Worker's Compensation payable elsewhere.

Newborn Birth

Routine Delivery: allows for replacement income up to a maximum of 4 weeks (20 work days) after satisfying the 2 week (10 work days) STD elimination period.

Caesarean Delivery: allows for replacement income up to a maximum of 6 weeks (30 work days) after satisfying the 2 week (10 work days) elimination period.

Note: STD is not payable until all sick and annual leave has been exhausted. Leave balances in excess of the maximum recuperation period may eliminate STD benefits. The maximum recuperation period is generally 6 weeks (30 work days) or 8 weeks (40 work days) for pregnancy recovery, unless medical complications are documented by your health care provider.

Parental Leave details can be found on the HR website.

Sun Life Financial

(800) 451-4531

sunlife.com

Long Term Disability (LTD)

The group plan summarized below applies to total disabilities and is subject to the terms and conditions of the Plan Document for CSU's LTD Income Replacement Plan.

Plan Description

LTD is provided at no cost to you (taxable allowance based on salary). The plan provides a monthly income replacement benefit, which begins on the 91st consecutive calendar day of total disability and continues to be payable each month during the term of continuous disability. The last monthly income replacement benefit payment will be made as of the first day of the month in which the earlier of these events occur:

Termination of disability (recovery or death); or

Attainment of these age or time limits.

Age When Disability Starts	Maximum Duration of Benefits
Less than 60	to age 65
60 but less than 65	4 ¾ years
65 but less than 68 ¾	to age 70

Actively at Work Provision

Coverage for employees absent from work on the effective date of coverage will be deferred until the employee commences or resumes active work.

Retirement Plan Enrolled	Monthly Premium—**The cost of coverage is provided by the University** (taxable allowance based on salary)
Defined Contribution Plan	Cost: 0.45% of your covered monthly salary. Maximum premium is $168.75
PERA or Federal	Cost: 0.15% of your covered monthly salary. Maximum premium is $56.25

Income Replacement

Your "Covered Monthly Salary" used to determine benefits is one-twelfth of your base salary (exclusive of any overtime and other forms of additional compensation, except that, for an employee who has taught two out of the last three summer sessions or has taught one out of the last two summer sessions and has signed a contract to teach the next summer session, basic annual salary will include compensation for the most recent summer session taught). Premiums are deducted post-tax basis which allows the income replacement benefit to be tax exempt, should you need to utilize it.

DCP participants: the monthly income replacement benefit is up to 69% of your "Covered Monthly Salary" as of the date the disability begins, but not to exceed $25,875 per month.

PERA and Federal Retirement Plan participants: the monthly income replacement benefit is up to 60% of your "Covered Monthly Salary" as of the date the disability begins, but not to exceed $22,500 per month.

The monthly income replacement benefit payable by the Plan during continuous total disability will increase each year by 3% compounded annually, beginning with the first calendar month following 13 full months of such continuous disability.

LTD (cont.)

Income Replacement Offset

The monthly income replacement benefit is offset by any income benefits payable from Social Security for yourself and/or your dependent children, Workers' Compensation, disability benefits payable under any employer group insurance, disability or retirement benefits payable under a public pension plan (e.g. PERA), federal retirement plan and/or the University's Defined Contribution retirement plan, or benefits payable under the University's sick leave or salary continuation program. In no event will the monthly income replacement benefit be less than $50 per month, even though this amount may bring your total disability income to more than 60% or 69%, respectively, of your "Covered Monthly Salary."

Definition of Total Disability

Total disability under this program is, "during the first 27 months of such total disability the inability of the employee, by reason of sickness, bodily injury or pregnancy, to engage in their regular own occupation. Thereafter, it will mean the inability of the employee, by reason of sickness, bodily injury or pregnancy, to engage in any occupation for which the employee is reasonably fitted by education, training or experience." Disability recertification may be requested at any time by the administrator, but is generally recertified every six to twelve months to determine continued eligibility for plan benefits.

Filing Claims

An employee applying for LTD must complete an LTD Claim Statement (available in Human Resources), which shall be furnished to Assurant Insurance Company within 12 months after the commencement of disability. Assurant Insurance Company is the University's third party administrator on the LTD Plan, meaning they review claims and make determinations on behalf of the University's LTD plan provisions. The LTD Claim Statement shall include any and all supporting medical or other information to support your disability that may be requested by Assurant Insurance Company. The burden of proof for establishing the existence of a qualifying disability rests with the claimant.

Exclusions

Benefits are not payable if total disability results from any of the following causes:

- Injury or sickness resulting from war, declared or undeclared
- Intentional self-inflicted injury or sickness
- Disabilities caused by any condition for which treatment was rendered within the twelve month period preceding enrollment in the plan, will not be covered until twelve consecutive months have elapsed after enrollment in the plan

Genworth

(800) 416-3624

genworth.com

Long Term Care (LTC)

Group Number: **14120**

Plan Description

You have access to a voluntary Group Long Term Care (LTC) Insurance policy of which the benefits, limitations and exclusions are summarized below. In the event of a conflict between this information and the official governing program policy, the policy will govern. Certificates of insurance are issued to each insured person and contain details of the coverage under the Plan.

CSU is pleased to sponsor the Long Term Care Insurance Program through Genworth Life Insurance Company (Genworth). Genworth is the underwriting company for the Plan and will serve as Benefits and Claims Administrator under the Plan.

The LTC program provides eligible employees, retirees and certain family members with affordable coverage that can help protect them from the high costs of long term care services, including care at home, in the community, in assisted living facilities (including Alzheimer's facilities), and in nursing homes.

If you are approved for coverage under this Plan, premiums are paid directly to Genworth Financial on an after-tax basis by the employee.

Eligibility

An employee is eligible to apply for coverage on their first day of work. Upon initial benefits eligibility, the underwriting criteria utilized during the application process includes the following:

- Employees age 18-65 will be subject to a reduced underwriting process
- Employees age 66-69 will be subject to a short form underwriting process
- Employees age 70+ will be subject to the full (long form) underwriting

Employees must submit a completed application within 45 days of their benefits eligibility date to take advantage of the less restrictive underwriting criteria listed above (age 18-69). Subsequent to initial benefits eligibility, enrollment applications will be accepted on an ongoing basis whereas comprehensive (full) underwriting will apply in all circumstances.

Actively at work means any employee who is performing the usual duties of their job at the usual place of work as required by CSU in an eligible position. An employee is considered actively at work while on approved vacations, holidays, and regularly scheduled days off, or during temporary business closures. An employee is not considered to be actively at work if they are unable to perform their usual duties due to a sickness, accident or injury; or if they are on a leave of absence, sabbatical or retired.

Retirees under the age of 76 may also apply for long term care insurance under the plan.

An eligible employee's or a retiree's family members (spouse, domestic partner, civil union partner, adult children, siblings, siblings-in-law, parents, grandparents, parents-in-law and grandparents-in-law), between the ages of 18 and 75, may also apply for long term care insurance under the Plan. A person cannot be eligible in more than one class under the Plan.

LTC (cont.)

Actively at Work Provision

What are the Benefits?

Benefits are payable for expenses incurred for:

Care and services during confinement in a nursing facility or assisted living facility, up to the Nursing Facility Maximum based on the option selected

Home and community care which includes adult day care, and nurse or therapist services, home health or personal care services, and incidental homemaker and chore care provided in the insured's home, up to 100% of the Nursing Facility Maximum

Bed Reservation is available for temporary absences of up to 60 days per calendar year when room charges are covered in the facility.

Home Assistance Benefit covers: home modifications; assistive devices; supportive equipment; emergency medical response systems; and caregiver training. It pays up to a lifetime limit equal to 3 months of full Nursing Facility Benefits.

Hospice Care Benefit covers services designed to provide palliative care and alleviate discomforts if the insured person is chronically and terminally ill. Benefits are payable up to the Nursing Facility Maximum for care received in a covered facility and the limit for the Home and Community Care Benefit when care is received while the insured person is living at home.

Informal care for maintenance or personal care services provided in the insured's home, by someone who does not normally reside there, a daily benefit up to 1% of the Nursing Facility Maximum per day for up to 30 days per calendar year.

Respite Care Benefit provides short term coverage to relieve the person who normally and primarily provides the insured person with care in their home on a regular, unpaid basis.

Alternate Care Benefit may, subject to approval and mutual agreement, pay for covered expenses incurred for services, devices or treatments that are Qualified Long Term Care Services not specifically covered under another benefit.

Other Plan benefits include:

Care coordination services are available. Professional care coordinators review the insured's specific situation and develop an appropriate Plan of Care to meet those needs. The cost of this service is not deducted from the Coverage Maximum.

International Nursing Facility Benefit:
This benefit will pay for Covered Expenses received while the insured person is outside the United States. Subject to the Coverage Maximum, it pays up to 75% of the Nursing Facility Maximum for confinement in an out-of-country nursing facility. This benefit terminates four years after the date for which it first makes payment.

Waiver of Premiums while the insured is receiving benefits for facility care or home and community care.

Note: In the event of a conflict among this coverage summary and the official certificate of insurance, the certificate issued as part of your policy will govern.

LTC (cont.)

What does the Plan Cost?

Premium rates are available online at Genworth Life's website (use Group ID: **CSU** and Access Code: **groupltc**).

The insured pays for LTC insurance through bank account reduction. CSU does not provide payroll deduction for Long Term Care Insurance. The cost of coverage depends on the options selected and the age of the applicant.

Benefit Increase Options

The plan provides ways for an insured person to help keep up with the increasing costs of Covered Care over time.

Future Purchase Options: This benefit will apply if neither of the Automatic options are selected. Every three years the insured is offered the opportunity to increase their benefit amounts by 5% compounded annually. The premium for the additional coverage is based on the insured's attained age as of the effective date of the increase. The offer is not made if the insured is in claim, is benefit eligible, is receiving benefits, or is satisfying the certificate of insurance's stated Elimination Period.

Automatic 5% Compound Benefit Increases: With this optional benefit, the benefit amounts increase automatically each year by 5% compounded annually while the insurance is in effect and premiums are paid. There is an additional premium for this optional inflation protection.

Automatic 3% Compound Benefit Increases: With this optional benefit, the benefit amounts increase automatically each year by 3% compounded annually while the insurance is in effect and premiums are paid. There is an additional premium for this optional inflation protection.

Available Coverage

Two Optional Levels of Coverage:

Primary Plan

24 months approximate benefit duration
100% of the Nursing Facility Maximum (NFM) for Home & Community Care
Informal Care Included

Preferred Plan

60 Months approximate benefit duration
100% NFM Home & Community Care
Informal Care included

Five levels of the Nursing Facility Maximum

$3,000 per month $4,500 per month $6,000 per month
$7,500 per month $9,000 per month

Three Inflation Protection Options

Future Purchase Option Benefit
Automatic 3% Compound for Life
Automatic 5% Compound for Life

Optional Non-forfeiture Benefit Rider

Available to Residents of Alaska, Connecticut, Delaware, Montana and Oklahoma only, for additional premium. This rider allows the insured to retain partial coverage if they decides to cancel coverage after it has been in force for more than three years.

LTC (cont.)

What Long Term Care Expenses are Covered?

The Plan pays benefits as reimbursement for covered expenses for Covered Care.

Covered Care must:

- Constitute Qualified Long Term Care Services; and
- Be provided pursuant to a written Plan of Care prescribed by a Licensed Health Care Practitioner; and
- Occur while coverage is in force and prior to the exhaustion of any benefit limits, and the Coverage Maximum

Conditions for Receiving Benefits

For an insured to be eligible for benefits:

- The insured person must be Chronically Ill
- Genworth Life must receive a current eligibility certification for the insured person from a licensed health care professional, and;
- Genworth Life must receive ongoing proof which verifies that the Covered Care the insured person receives is needed due to continually being Chronically Ill

Before benefits are payable, the Elimination Period must be satisfied. Elimination Period means 90 calendar days, beginning with the first day on which a Covered Expense is incurred, before the insured is entitled to Benefits. Days used to satisfy the Elimination Period do not need to be consecutive; and can be accumulated over time. Once satisfied, the insured person will never have to satisfy a new Elimination Period for this coverage.

What are Important Policy Definitions?

Other definitions for this coverage can be found in your Certificate of Insurance.

A **Chronically Ill Individual** is a person who has been certified by a Licensed Health Care Practitioner as being unable to perform, without Substantial Assistance from another individual, at least two (2) Activities of Daily Living due to a loss of functional capacity. In addition, this loss of functional capacity must be expected to exist for a period of at least 90 days; or a person requiring substantial supervision to protect the person from threats to health and safety due to a Severe Cognitive Impairment.

Activities of Daily Living are bathing, continence, dressing, eating, toileting, and transferring (getting into and out of a bed, chair or wheelchair).

Covered Care means only those Qualified Long Term Care Services for which the insurance pays benefits or would pay benefits in the absence of an Elimination Period.

Covered Expenses means costs incurred for Covered Care. Each benefit defines the Covered Expenses under that benefit. An expense is considered to be incurred on the day on which the care, service or other item forming the basis for it is received by the insured individual.

Nursing Facility Maximum is the maximum amount that will be paid for confinement in a nursing facility, assisted living facility or hospice care facility. This amount is also used to determine other benefit maximums.

Licensed Health Care Practitioner means any of the following who is not a member of the insured person's immediate family:

A Physician (as defined in Sec. 1861(r)(1) of the Social Security Act);

LTC (cont.)

Licensed Health Care Practitioner means any of the following who is not a member of the insured person's immediate family:

- A Physician (as defined in Sec. 1861(r)(1) of the Social Security Act);
- A registered professional nurse;
- A licensed social worker; or
- Any other individual who meets such requirements as may be prescribed by the Secretary of the Treasury of the United States

A **Plan of Care** is a written, individualized plan for care and support services for the insured that specifies:

- The type, frequency and duration of all services required to meet those needs;
- The kinds of providers appropriate to furnish those services; and
- An estimate of the appropriate cost of such services

Coverage Maximum is the maximum amount of benefits payable to the insured, and is reduced by the amount of claims paid. The Policy Lifetime Maximum is determined by multiplying the Facility Care Maximum by the benefit duration.

Qualified Long Term Care Services are necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services, and maintenance or personal care services which are required

Severe Cognitive Impairment is a loss or deterioration in intellectual capacity that: is comparable to (and includes) Alzheimer's disease and similar forms of irreversible dementia; and is measured by clinical evidence and standardized tests that reliably measure impairment in the person's: short term or long term memory; orientation as to people, places or time; deductive or abstract reasoning; and judgment as it relates to safety awareness.

When Does Long Term Care Insurance Take Effect?

The coverage effective date is subject to underwriting approval by Genworth Life, and will take effect upon approval. Your coverage will become effective on the Certificate Effective Date show in your policy, subject to the timely payment of the first premium due.

A Deferred Effective Date will apply if you have not been actively at work for the prior 30 calendar day period prior to your Certificate Effective Date. If you cannot satisfy this requirement, your Certificate Effective Date will be deferred until the first day of your regular pay cycle, following the time you have been Actively at Work, after you have been Actively at Work for the prior 30 day calendar day period.

When Does the Long Term Care Insurance End?

Coverage ends on the first to occur of:

- The date the insured dies;
- The date coverage is cancelled by the insured;
- The date the policy lifetime maximum is exhausted; or
- The end of the grace period if the amount of any overdue premium is not received

If a person ceases to be eligible, they can continue coverage under the Plan by paying premiums directly to Genworth Life.

LTC (cont.)

Can an Insured Change Coverage Options?

Long Term Care coverage selections can be changed at any time, as follows:

To increase the coverage level to a higher option at any time a request must be sent with satisfactory proof of good health. Upon approval, premiums for the additional coverage will be based on the age of the insured on the date the change is effective.

To decrease the coverage level, proof of good health is not required. The premium for the reduced coverage will be based on the original issue age.

What if the Insured's Employment Status Changes?

If the status of employment changes, for example, if the insured employee takes an unpaid leave of absence, goes out on long term disability, terminates employment or is no longer benefits eligible, coverage will continue as long as premiums are paid when due. Employees must ensure continued payment is made directly to Genworth Life through a direct billing process. CSU does not offer payroll deduction for Long Term Care insurance.

What if the Insured Dies?

Coverage ends at the death of the insured. If the surviving spouse also has coverage, that coverage will remain in place, as long as they continue to pay the premiums. If premiums were paid through payroll deductions for the spouse's coverage, upon the employee's death, those deductions will end upon the employee's death, and the billing will be sent to the surviving spouse.

30 Day Refund

If the insured is not completely satisfied with the Long Term Care Insurance coverage, they may return the certificate within 30 days of receipt of the Certificate of Insurance for a full refund of any premiums paid.

Coordination of Benefits

Benefits will be reduced for Covered Care when the total amount payable under this and all other Long Term Care Coverage is greater than the actual expense incurred.

State variations may apply to coverage options and exclusions and limitations. Read the Outline of Coverage in the Information Kit carefully. It will reflect any required state variations and other details of the Plan. All state variations are included in the Certificate of Insurance that is part of the Group Policy.

LTC (cont.)

What are the Exclusions and Other Limitations for the Plan?

Exclusions: Benefits are not paid for any expenses incurred for any Covered Care:

1. For which no charge is normally made in the absence of insurance;
2. Provided outside the United States of America, its territories and possessions; except as described in the International Nursing Facility Benefit;
3. Provided by the insured's immediate family, unless a benefit specifically states that a member of the immediate family can provide Covered Care. We will not consider care to have been provided by a member of the immediate family when:
   a) They are a regular employee of the organization that is providing the services; and
   b) Such organization receives payment for the services; and
   c) They receive no compensation other than the normal compensation for employees in their job category;
4. They are a regular employee of the organization that is providing the services; and
5. Such organization receives payment for the services; and
6. They receive no compensation other than the normal compensation for employees in their job category;
7. Provided by or in a Veteran's Administration or Federal government facility, unless a valid charge is made to the insured's estate;
5. Resulting from war or any act of war, whether declared or not;
6. Resulting from attempted suicide or an intentionally self-inflicted injury while sane;
7. Resulting from participation in a felony, riot, or insurrection;
8. Resulting from the insured's alcoholism or addiction to drugs or narcotics (except for an addiction to a prescription medication when administered in accordance with the advice of a Physician);
9. For which the insured receives, or is eligible to receive, workers' compensation benefits, occupational disease act benefits, or similar benefits.

Benefits are payable for Alzheimer's disease, subject to the same exclusions, limitations and provisions otherwise applicable to other Covered Care.

Non-Duplication of benefits: Benefits will be paid only for Covered Expenses that are in excess of the amount paid or payable under:

- Medicare (including amounts that would be reimbursable but for the application of a deductible or coinsurance amount); and
- Any State or Federal workers' compensation, employer's liability or occupational disease law; and
- Any other Federal, State or other governmental health or long term care program or law except Medicaid

However, this Non-Duplication provision will not disqualify a Covered Expense from being used to satisfy any Elimination Period requirement.

Pre-Existing Conditions Limitation: We will not pay for Covered Expenses incurred for any care or confinement that is a result of a Pre-Existing Condition when the care or confinement begins within twelve (12) months following the initial certificate effective date..

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(800) 759-7372

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Mandatory Retirement Plans

Plan Description

All Academic Faculty, Administrative Professionals, Post Doctoral Fellows, Veterinary Interns and Clinical Psychology interns appointed on or after April 1, 1993, are required as a condition of employment under Colorado law to participate in either the University's Defined Contribution Plan (DCP) for Retirement or, in very limited cases, in the Public Employees' Retirement Plan (PERA) of Colorado, a defined benefit plan.

Only those newly appointed employees with qualifying prior service in Colorado's PERA retirement system may be eligible to elect to continue membership in that retirement plan. All other new appointees must enroll in the DCP with Fidelity.

Please refer to the Defined Contribution Plan for Retirement Summary Plan Description for further information. PERA participants should contact PERA directly for PERA eligibility criteria and plan benefits.

Enrollment

New Hire/ Newly Eligible: to enroll, you must complete your enrollment in the CSU Online Benefits Enrollment System and in addition return the Retirement Election form within 30 days of your eligibility date. If you meet PERA's eligibility requirements as determined by PERA, you must elect to participate in PERA no later than 30 days from your date of appointment or you will be enrolled in the DCP. Refer to the PERA Eligibility information section referenced on the following page.

Your election in the retirement Plan (DCP or PERA) is irrevocable for the duration of any employment in which participation in the University's retirement plan is required.

Default Procedures: failure to complete enrollment within 30 days of your date of eligibility will eliminate any option you might otherwise have had to select PERA in lieu of the DCP. If you have not enrolled within 30 days of eligibility, you will be placed in the DCP in accordance with a default procedure established by the University.

Further, all retirement plan contributions are placed in a non-interest bearing account until you either make an investment company selection or are defaulted to a vendor. If you terminate employment prior to electing a retirement plan, you will be enrolled in a DCP retirement plan in accordance with default procedures established by the University upon termination.

Mandatory Retirement Plans (cont.)

Contributions

Employee Contributions: You are required to contribute 8% of your Covered Monthly Salary on a tax-deferred basis to either the DCP or 11% to PERA. Tax-deferred means that your W-2 income from the University will not include your retirement plan contribution.

"Covered Monthly Salary" includes all salary, incorporating summer salary and supplemental pay, as defined in the Academic Faculty and Administrative Professional Staff Manual.

For PERA participants, "Covered Monthly Salary" does not include pre-tax medical, dental, vision, flexible spending account, or parking permit deductions.

Employer Contributions

DCP: The University contributes 12% of your covered monthly salary (for regular or special appointments of half-time or greater, from the date of appointment).

Temporary Academic Faculty and Administrative Professionals, Post Doctoral Fellows, Veterinary Interns, and Clinical Psychology Interns of half-time or greater will receive the University DCP contribution after one (1) year of continuous service at the required appointment level. To complete one year of service, a 9-month employee must complete 2 consecutive semesters of continuous 1/2 time or greater employment (excluding summer term) and a 12-month employee must complete 12 months of 1/2 time or greater employment. Any interruption in continuous appointment requires the eligible employee to complete one year of service again before CSU will provide the employer match to the DCP.

For any DCP participant who is a PERA "retiree" (as defined by Article 51 of Title 24 of the Colorado Revised statutes) as of the date of employment or reemployment or becomes a PERA "retiree" at any time thereafter, the employer contribution will be reduced by any amount CSU is required to contribute to PERA with respect to the employee, except that the reduction shall not apply to: tenured/tenure track faculty members hired prior to July 1, 2005, or to tenured faculty members on a transitional appointment that commenced prior to January 2, 2006.

PERA: Enrollment in PERA is restricted to those who meet PERA's eligibility criteria which includes, but is not limited to being an active PERA participant with at least 12 months of service credit, an in-active member with that amount of service credit or a current PERA retiree. However, unless you are a PERA retiree, you may not elect PERA as your retirement plan if you have previously been employed by a public college or university in Colorado and made an election to participate in that institution's ORP. In addition, if your election at that time was to participate in PERA, you may not now elect the ORP. Such elections are, by law, irrevocable.

Effective January 1, 2011, present PERA retirees may elect either PERA or the ORP as their retirement plan each time they are reappointed. Any election to participate in PERA will require you to make the required employee or working retiree contribution to that Plan and complete the Retirement Election form each time you are reappointed.

It is important for you to disclose to PERA if you are receiving or have ever received a PERA annuity.

The University's contributions to PERA are never vested; instead, you acquire a vested right to future benefits after five (5) years of PERA credited service if you do not request a refund of your contributions upon termination of employment with the University. Please refer to PERA publication and rules for specific details on eligibility and retirement plan features.

For information about receiving your DCP money and retirement eligibility, please visit the HR website.

PERA is a separate and independent entity and has the authority to make determinations regarding eligibility for membership.

CSU cannot mandate, nor is it responsible for, PERA's determinations regarding eligibility.

If PERA determines that you are not eligible for membership, the University must enroll you in the DCP.

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Voluntary Retirement Savings Plans

Tax-Deferred Investments

CSU offers employees the opportunity to contribute to tax-deferred investment accounts. These accounts can supplement the mandatory retirement plans.

Available Options:

- 403(b) Tax-Deferred Annuities and Custodial Accounts
- PERA 457 Deferred Compensation Plan
- PERA 401(k) Plan

403(b) Tax-Deferred Annuities and Custodial Accounts

CSU has established a relationship with Fidelity Investments to provide 403(b) arrangements for both "Traditional" and "Roth" accounts. A "Traditional" account is funded with pre-tax contributions and a Roth is funded with post-tax contributions.

To enroll in the Plan, an eligible employee must initiate contributions through Fidelity's online system or by calling 800-343-0860. Contributions apply for any payroll in which salary is paid including summer session pay for nine-month employees.

The authorized vendor is Fidelity Investments.

Fidelity agrees to strictly adhere to rules set forth under the final 403(b) regulations published by the Department of Treasury in the July 26, 2007 Federal Register.

Fidelity must ensure that requests for exchanges or transfers from a current or past participant in CSU's 403(b) plan are processed only to current employees and former employees with an established CSU 403(b) contracts or custodial accounts.

Purchases of permissive service credit by contract-to-plan transfers to a qualified defined benefit plan that is a governmental plan [as defined in section 414(d)], such as Colorado PERA.

PERA 457 Deferred Compensation Plan

This plan is offered to all CSU employees and the initial enrollment form must be submitted to PERA. You will then be sent a secure PIN by PERA which allows you to complete the enrollment process online and to make future changes to contribution amounts or fund selections. Payroll deductions are initiated the month following completion of the online enrollment process.

PERA's 401(k) Plan

You may begin participation by completing a salary deferral election form and the necessary PERA application available in Human Resources. New enrollments/changes are due by the 10th day of the month for the change to be effective for that monthly payroll cycle.

Voluntary Retirement Savings Plans (cont.)

This table identifies and compares the University's tax-deferred investment options (TDI). You can enroll in these plans any time throughout the year. This is a general summary and is not intended to replace IRS regulations on vendor products, sales literature or a product prospectus.

	403(b) Plan Fidelity (Traditional and Roth)	**PERA 457** Colorado PERA (Traditional and Roth)	**401(k) Plan** Colorado PERA (Traditional and Roth)
Maximum Contribution for 2023*	$**22,500** Combined 403(b) & 401(k) limit	$**22,500** Separate from 403(b) & 401(k) limit	$**22,500** Combined 403(b) & 401(k) limit
To Enroll or Make Changes	To enroll in the Plan, an eligible employee must initiate contributions through Fidelity's online system or by calling 800-343-0860	Contact PERA for general information and to enroll. Contribution changes must be made online through PERA by the **25th of the month prior** of the month in which the deduction would begin.	The 401(k) enrollment/ change form can be found on the HR website. Submit the completed form to **no later than the 10th** of the month in which the deduction would begin.
Loan Provisions	Yes, if contract permits	Yes	Yes
Active Service Withdrawal	Disability, age 59 ½ or financial hardship	Disability, age 59 ½ or financial hardship	Disability, age 59 ½ or financial hardship
Penalty on Early Withdrawals	**Traditional 403(b)** Yes, unless rolled over or separated from service after January 1st in the year you turn age 55 **Roth 403(b)** Yes, must separate from service, be at least age 59 ½ and have had the account for at least 5 years	**Traditional 457** No, must separate from service or be over age 59 ½ **Roth 457** No, must separate from service, be at least age 59 ½ and have had the account for at least 5 years	**Traditional 401(k)** Yes, unless rolled over or separated from service after January 1st in the year you turn age 55 **Roth 401(k)** Yes, must separate from service, be at least age 59 ½ and have had the account for at least 5 years
Fees	Variable — please check with the plan vendor		
Catch-up for Participants Age 50 +	**$7,500** 2023 annual catch-up contribution**		

The above sections of the Internal Revenue Code permit certain employees (eligibility criteria vary by plan, contact Human Resources for details) of the University to exclude from current taxable income that portion of their salaries invested in a tax-deferred investment with pre-tax contributions. State and federal income taxes are deferred on the excluded portion until it is withdrawn and actually received by the employee. Income taxes can be postponed on the "deferred" amount until retirement or some other later time chosen by the employee.

* The Internal Revenue Service code may further limit the maximum contributions you may make if you participate in more than one kind of tax-deferred plan. Check with plan vendor.

** This additional contribution is a combined limit between 401(k) and 403(b) plans. This catch-up contribution provision can be used at the same time as the traditional 457 catch-up contribution provision.

Academic Privileges

Employee Study Privilege and Reciprocal Study Privilege

Under the following conditions, Academic Faculty, Administrative Professionals, Post Doctoral Fellows, Veterinary Interns, and Clinical Psychology Interns with appointments of half-time or greater may register for credit courses at Colorado State University, Colorado State University-Global Campus, Colorado State University-Pueblo, and; subject to the terms of agreement between specific institutions, the University of Northern Colorado, on a space-available-basis without the assessment of the student portion of total tuition or general fees to the employee.

Ideally, courses taken as an employee under the Employee Study Privilege shall contribute to the employee's success at the university. This is one of several factors taken into account in determining whether or not the value of this benefit is taxable to the employee. Such determinations are made by Human Resources and Business and Financial Services, with reference to the Internal Revenue code (26 U.S.C. sections 127, 132(d) and 117). However, supervisors may approve an employee's use of study privilege even if the subject matter is not directly related to current job duties.

The employee must obtain the written consent from the head of their administrative unit to register for specific courses. Time off to attend courses taught during an employee's scheduled work hours require advance supervisor approval, which should be granted unless there is no reasonable way for the employee to perform their duties at other times. Time off that is granted to attend courses in which an employee enrolls at the request of the department in order to improve job skills should be treated as administrative leave with pay. Eligible employees may register for courses without being regularly admitted to CSU. Eligible employees include:

- Academic Faculty and Administrative Professionals with Regular, Special, or Temporary appointments of half-time or greater. This includes faculty on continuing or contact appointments.
- Faculty Transitional appointees are eligible for the same benefit available to full-time academic faculty;
- Post-Doctoral Fellows, Veterinary Interns, and Clinical Psychology Interns with appointments of half-time or greater;
- Non-temporary State Classified employees with appointments of half-time or greater;

Note: Effective July 1, 2014, the one year continuous eligibility waiting period of half-time or greater service has been eliminated for Temporary Academic Faculty and Administrative Professional employees.

Contact Human Resources at 970-491-6947 for eligibility provisions for Military Science (ROTC).

Credits are prorated based on appointment percentage:

- 100% appt. 9 credits
- 75-99% appt. 7 credits
- 50-74% appt. 5 credits
- Under 50% appt. 0 credits

These credit maximums include courses which are audited by the employee rather than taken for credit. Tuition will be assessed as soon as credits are taken in excess of the program maximum for the employee.

Academic Privileges (cont.)

Employee Study Privilege — Eligible Courses

The Employee Study Privilege includes credit courses which are a part of the university curriculum, as defined by the CSU General Catalog. These courses are identified with a departmental course number. In particular, the study privilege does not cover the cost of continuous registration.

CSU Online offerings are included under this benefit if they are credit bearing at the institution; however, tuition for these courses may be higher than "Resident Instruction" tuition, in which case, the difference must be paid by the employee or by some other source. Courses that provide only continuing education units (CEUs) are not eligible.

Eligible expenses:

- Base Tuition – up to 9 credits per year (credits are prorated based on your appointment percentage)
- Differential Tuition – up to 9 credits per year (credits are prorated based on your appointment percentage)
- Program Charges – at least one study privilege credit must be utilized each semester to allow eligibility for program charges
- University Technology Fee and General Fees – credited (fee waiver) to your student account. This waiver of General Fees removes your free access to the Recreation Center, athletic events, and other campus services
- University Facility Fee – prorated according to the number of study privilege credits utilized
- College Charges for Technology – prorated according to the number of study privilege credits utilized each semester

Note: The University Technology Fee and General Fees will be credited (fee waiver) to your student account even if study privilege credits have been exhausted provided the Employee Study Privilege form is submitted.

Ineligible expenses:

- Undergraduate tuition normally covered by the College Opportunity Fund (COF) – if you take a COF eligible course in a manner that COF cannot be applied (i.e., you do not apply for and authorize COF, or you audit a course), the Employee Study Privilege will not cover the portion of tuition that would have been covered by COF
- Special Course fees – a list of associated courses with applicable fees is available on the Provost website.
- After the exhaustion of available Employee Study Privilege credits, any remaining tuition, charges or fees are not eligible for coverage or the College Opportunity Fund (if applicable)

The employee study privilege application form can be found on the HR website.

Reciprocal Study Privilege

The Employee Study Privilege Program includes reciprocal provisions that allow employees to take courses at CSU-Global, CSU-Pueblo, and the University of Northern Colorado.

Enrollment requires the agreement to fulfill financial obligations and abide by the policies of the reciprocal educational institution in which student status is obtained. Program eligibility shall be defined and determined by the Employee Study Privilege of Colorado State University.

Additional forms are required to gain pre-approval under the reciprocal provisions of the Employee Study Privilege.

Other Benefits & Privileges

CSU is committed to creating a healthy workplace, which includes several benefit offerings to help balance your work and personal needs. From tuition assistance to generous leave policies, you'll find the University offers a best-in-class total rewards package.

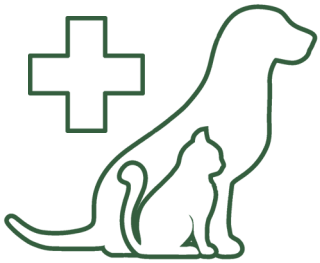
The benefits outlined below are based upon an employee with a 100% FTE (full-time). Some benefits, such as leave and Employee Study Privilege credits, are prorated based upon the number of hours you work.

In the event there is a discrepancy between the information below and the governing plan or program documents, the plan or program documents will govern. Visit the HR website for a complete list of available benefits and eligibility information.

50%

TUITION DISCOUNT

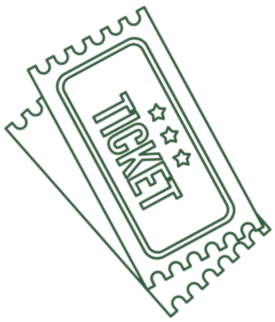
FOR ELIGIBLE FAMILY MEMBERS TO ATTEND CSU, CSU-GLOBAL, AND CSU-PUEBLO



DISCOUNTS ON WORLD-CLASS VETERINARY CARE THROUGH OUR VETERINARY TEACHING HOPSITAL

IT'S FREE TO RIDE THE CITY'S BUS RAPID TRANSPORT SYSTEM WITH YOUR CSU ID

YOU RECEIVE 9 FREE CREDITS PER ACADEMIC YEAR



FREE TICKETS TO SELECT MUSIC, THEATRE, AND DANCE DEPARTMENT PERFORMANCES

5

HOURS OF ADMIN LEAVE PER MONTH TO VOLUNTEER IN ANY PUBLIC SCHOOL

50% OFF THE COST OF MEMBERSHIP AT OUR STATE-OF-THE-ART RECREATION CENTER

10

HOURS OF SICK TIME YOU EARN EACH MONTH

YOU EARN 16 HOURS OF PAID VACATION TIME EACH MONTH

Vendor	Plans	Group Number	Phone	Website
Dental				
Delta Dental	Delta Dental Basic Delta Dental Plus	9709 9684	800-610-0201	deltadental.com
Employee Assistance Program (EAP)				
ComPsych	EAP	CSUEAP	800-497-9133	eap.colostate.edu
Flexible Spending Accounts (FSA)				
Discovery Benefits	Health Care FSA Dependent Care FSA		866-451-3399	discoverybenefits.com
Health Savings Account (HSA)				
Fidelity Investments	HSA		800-343-0860	fidelity.com
Life Insurance, AD&D				
The Hartford	Basic & Voluntary Life Travel Assistance	677984 SO7449	800-523-2233	thehartford.com
Medical				
Anthem	Green Plan Gold Plan POS Plan Ram Plan – HDHDP	C10223M002 C10223M001 C102230007 C10223M014	800-843-5621	anthem.com
Vision				
Vision Service Plan	VSP	30021702	800-877-7195	vsp.com
Retirement Plans				
Colorado PERA	Mandatory, 401(k), 457		800-759-7372	copera.org
Fidelity Investments	DCP & 403(b)		800-343-0860	fidelity.com
Previous Vendors (options ended May 31, 2023)				
TIAA	DCP & 403(b)		800-842-2776	tiaa.org
Corebridge (formerly AIG)	DCP & 403(b)		800-448-2542	aig.com

HUMAN RESOURCES
COLORADO STATE UNIVERSITY

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6004 Campus Delivery
Fort Collins, CO 80523

Phone: 970-491-6947
Fax: 970-491-6302
Email: MyHR@colostate.edu