HUMAN RESOURCES
COLORADO STATE UNIVERSITY

2024 CSU BENEFIT PLANS

SUMMARY PLAN DESCRIPTION

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

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WELCOME TO CSU

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. Except for 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

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
- 76% of the premium cost of employee + 1 or family coverage under the Green medical
- 75% of the Delta Dental Basic plans

If you upgrade to the 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 for basic group term life and AD&D coverage. You will be asked to select a beneficiary(ies) during the enrollment process

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 from your earnings on a post-tax basis to cover the cost of the STD premium. Your STD and LTD premiums are deducted on a 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.

INSURANCE PREMIUMS

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 insurance 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.

Defined Contribution Plan (DCP) contributions are not affected by pretax deductions. If you are a PERA member, pre-tax deductions (including those to Flexible Spending Accounts) may affect your retirement's 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 any time.

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 and long term disability are provided at no cost. short term disability includes a $4 taxable allowance while the taxable allowance for long term disability varies based on salary.

PLAN	PRE	POST
Medical	X	X
Dental	X	X
Vision	X	X
Basic Life and AD&D		X
Voluntary Life		X
Voluntary AD&D		X
Long Term Disability*		X
Long Term Care		X
Short Term Disability		X
Flexible Spending Accounts (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.

MONTHLY PREMIUMS

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

MEDICAL PLANS

	Green or Ram Plan-HDHP	Gold Plan (closed to new enrollment)	POS Plan
Employee Only			
Total Premium	$674	$813	$925
CSU Pays	$674	$674	$674
You Pay	**$0**	**$139**	**$251**
Employee + 1			
Total Premium	$1,200	$1,491	$1,691
CSU Pays	$912	$912	$912
You Pay	**$288**	**$579**	**$779**
Family			
Total Premium	$1,687	$2,106	$2,399
CSU Pays	$1,282	$1,282	$1,282
You Pay	**$405**	**$824**	**$1,117**
Family-Split*			
Total Premium	$1,687	$2,106	$2,399
CSU Pays	$1,586	$1,586	$1,586
You Pay	**$50.50/each**	**$260/each**	**$406.50**

DENTAL PLANS

	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 faculty/admin pro and have at least one child covered on the plan

VOLUNTARY LIFE 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

MONTHLY PREMIUMS

VOLUNTARY AD&D PREMIUMS

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

Coverage and Benefit Amounts					Monthly Premiums	
Employee	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 Only Coverage	Family Coverage
	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)			
$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	$687.48	$829.26	$943.50	$24.48	$47.94	$5.91	$1.53
2 Persons	$1,224	$1,520.82	$1,724.82	$43.86	$84.66	$11.79	$1.53
Family	$1,720.74	$2,148.12	$2,446.98	$63.24	$144.84	$19.01	$1.53

HOW TO ENROLL

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/2024

ALEX is an interactive online experience designed to help you make confident choices about your benefits during enrollment. Just answer a few questions about your preferences and healthcare needs, and ALEX can narrow it down to only show you plan options that give you the best coverage for the lowest cost.

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 on the HR website
- Designate/change your life insurance beneficiary(ies)

WHEN YOU CAN ENROLL

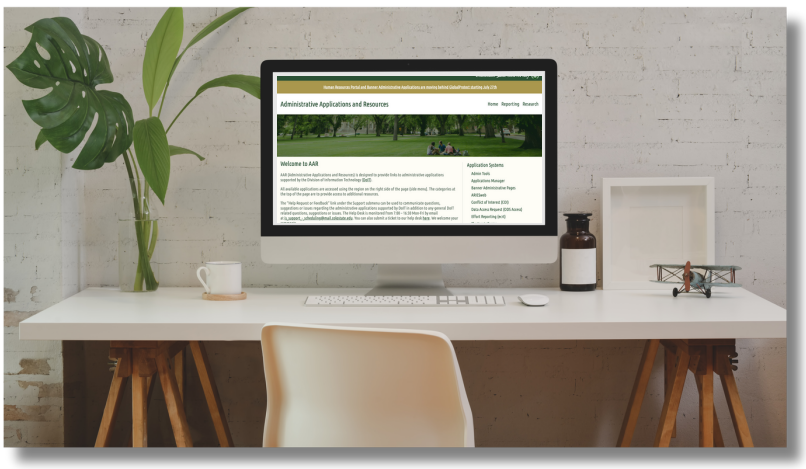
- Within 30 days of being newly hired or newly eligible for benefits
- Within 30 days of a qualifying status change
- During an annual Open Enrollment period

You learn more about dependent eligibility on page 10.

WHAT IS A MID-YEAR EVENT

Under IRS rules, you may only add, drop, or change benefit plans or coverage levels during the plan year if you experience a qualifying status change. Visit page 12 for a list of qualifying status changes and information on how to make changes to your benefits.

This is intended to be an overview. Refer to the specific sections in this booklet for complete information. In the event the information on this page differs from the Plan Document, the Plan Document will govern.



ELIGIBILITY AND 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 Scientists/Scholars 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 each enroll separately in employee-only coverage so they each receive the CSU “employee only” contribution and have the flexibility to enroll in the plans that suit their individual needs. With children: should enroll in the family-split option. This provides a higher premium contribution from CSU while ensuring the whole family is covered under the same policy to maximize 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.

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").

Examples of non-qualified federal tax dependents may be domestic partners, civil union partners, children of 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 before 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.

WHEN DOES COVERAGE BEGIN AND END?

COVERAGE START DATES

Benefits for you and any eligible dependents are generally effective the 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 choose 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 on page 16 for more information regarding the right to continuation of coverage.
Coverage for you 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, a 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.

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 a 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 a post-tax basis ($0 monthly premium). This does not apply to Federal Employees

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 period unless you have a qualifying event as defined by the IRS.

MID-YEAR QUALIFYING EVENTS

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

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. 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.

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

COMMON TYPES OF QUALIFYING EVENTS

- Change in legal marital status, change in domestic partnership or civil union partnership status
- Change in the number of eligible individuals of the employee
- 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, spouse/partner's or child's employment status, e.g. strike, lock-out, unpaid leave, commencement or termination of employment.
- Gain/lose entitlement to Medicare or Medicaid
- Change in residence of the employee, spouse/partner, or eligible individual, which *affects* eligibility for coverage
- Judgment, decree, or Qualified Medical Child Support Order
- A significant change in the health coverage of an eligible child
- Significant change in coverage or cost of spouse/partner's 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

EXAMPLES OF REQUIRED DOCUMENTATION

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

NEWBORNS AND NEWLY ADOPTED CHILDREN UNDER THE AGE OF 18

- If you are currently enrolled in a CSU medical plan, your child or the child of your partner is automatically covered for the first 31 days from the date of birth or placement for adoption.
- 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 by 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 for the entire academic year if 9 months, or the entire calendar year if 12 months, 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 Variable Hour Employees and have their hours tracked during an “Initial Measurement Period”.

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, 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. Hours will be calculated following the Standard Measurement Period and if an 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.

These 12 months of coverage are referred to as the Standard Stability Period. 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.

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

FORM 1095-C

The 1095 shows health insurance coverage offered to you (if you meet coverage criteria) and is mailed by CSU to your home address each spring for the year prior.

THE AFFORDABLE CARE ACT, CONT.

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 the date of hire and 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 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 a 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 a Non-Full-Time Employee for purposes of eligibility for health benefits. If an employee is determined to be a 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 notification and enrollment of 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 a 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 insurance you continue 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 contributions during sabbatical leave per the DCP plan description.

COBRA — CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985

HealthSmart

800-423-4445

healthsmart.com

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

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 or the domestic partnership or civil union partner is terminated
- The child is no longer eligible to be covered as described under The Plan

COBRA, CONT.

COBRA PERIOD

COBRA Continuation Coverage is a temporary continuation of coverage. When the qualifying event is the 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 for up to 18 months.

In the following instances, COBRA Continuation Coverage may end before 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 before 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 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, your domestic partner, or your civil union partner’s employer) within 30 days after your group health coverage ends due to a qualifying event listed above.

COBRA, CONT.

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 decide 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 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 postmarked 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.

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 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.

COBRA, CONT.

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 before the end of the initial 18 months of coverage.

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.

COBRA, CONT.

HEALTH CARE FLEXIBLE SPENDING ACCOUNT

If you are enrolled in this plan at the time the coverage ends 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 HealthSmart Benefit Solutions, COBRA Administrator, at (800) 423-4445.

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 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 which you die. They have the option to elect Continuation Coverage through COBRA for up to 36 months.

HIPAA

Following 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

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.

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 reasonably and promptly to provide the information to you. If you have questions, contact Human Resources.

HIPAA, CONT'D

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 the 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 to 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, spouses, 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 as information about how Colorado State University's self-funded plan may use or disclose your medical information, can be found on the HR website.

HIPAA, CONT'D

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.

Genetic Information Nondiscrimination Act (GINA)

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

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), a 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) 491-6947. 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 SBC will be issued in a regulatory-compliant format and will help participants better understand their coverage and allow 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. SBCs can be found on the HR website.

MEDICAL PLANS

Anthem

800-843-5621

anthem.com

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 that 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's maximum benefit allowance. The difference between Anthem Blue Cross and Blue Shields's 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.

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 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, CONT'D

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 at 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 that 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's 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 the 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.

	Point-of-Service POS Plan		Gold Plan	Green Plan	Ram Plan-HDHP
Benefit Component	PPO Participating Providers[1]	Non- Participating Providers	Participating and Non-participating Providers	Participating and Non-participating Providers	Participating and Non-participating Providers
ANNUAL DEDUCTIBLE					
Individual	None	$600	$850, & a separate deductible of $150 for prescription drugs	$1,100, & a separate deductible of $150 for prescription drugs	$1,600
Family	None	$1,200 for all family members No one family member may meet more than $600 of the $1,200 family deductible.	$1,700, & a separate deductible of $300 for prescription drugs No one family member may meet more than $850 of the $1,700 family deductible. No one family member may meet more than $150 of the $300 family Rx deductible.	$2,200, & a separate deductible of $300 for prescription drugs No one family member may meet more than $1,100 of the $2,200 family deductible. No one family member may meet more than $150 of the $300 family Rx deductible.	$3,200 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	• $1,350 in coinsurance, plus • Copayments	• $3,100 in coinsurance, *plus* • ·Deductible, *plus* • Copayments	• $4,600 includes coinsurance and deductible for pharmacy and medical	• $5,100 in coinsurance, *plus* • Deductible, *plus* • $1,000 in coinsurance for prescription drugs	• $6,650 includes deductible and coinsurance
Family	• $2,700 in coinsurance, plus • Copayments. No one family member may meet more than $1,350 of the $2,700 out-of-pocket annual maximum.	• $6,200 in coinsurance, plus • Deductible, plus • Copayments No one family member may meet more than $3,100 of the $6,200 out-of-pocket annual maximum.	• $9,200 includes coinsurance and deductible for pharmacy and medical No one family member may meet more than $4,600 of the $9,200 out-of-pocket annual maximum.	• $10,200 in coinsurance, *plus* • Deductible, *plus* • $2,000 in coinsurance for prescription drugs No one family member may meet more than $5,100 of the $10,200 medical and $1,000 of the $2,000 Rx annual out-of-pocket maximum.	• $13,300 includes deductible and. coinsurance No one family member may meet more than $6,650 of the $13,300 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.

	Point-of-Service POS Plan		Gold Plan	Green Plan	Ram Plan-HDHP
Benefit Component	PPO Participating Providers	Non- 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 $17 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 $17 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 $155 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 $155 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 $155 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 preventive or medical diagnosis.	You pay 20% after deductible. This includes colonoscopies with a preventive or medical diagnosis.	You pay 20% after deductible. This includes colonoscopies with a preventive or 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 $75 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 POS Plan		Gold Plan	Green Plan	Ram Plan-HDHP
	PPO Participating Providers	Non- Participating Providers	Participating and Non-participating Providers	Participating and Non-participating Providers	Participating and Non-participating Providers
AMBULANCE					
Ground	You pay 10% after $75 per trip copayment	You pay 10% after $75 per trip copayment	You pay 20% after deductible	You pay 20% after deductible	You pay 20% after deductible
Air	You pay 10% after $155 per trip copayment	You pay 10% after $155 per trip copayment	You pay 20% after deductible	You pay 20% after deductible	You pay 20% after deductible
URGENT, NON-ROUTINE AFTER HOURS CARE					
Impatient Care	You pay 10% after $155 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 $17 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 - $15 Tier 2 - $30 Tier 3 - $50 **Copayments for mail order service (90-day supply maximum):** Tier 1 - $30 Tier 2 - $60 Tier 3 - $100	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
	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.		**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.		
MENTAL HEALTH CARE					
Impatient Care	You pay 10% after $155 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 $17 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

MEDICAL PLAN COMPARISON, CONT.

Benefit Component	Point-of-Service POS Plan		Gold Plan	Green Plan	Ram Plan-HDHP
	PPO Participating Providers	Non- Participating Providers	Participating and Non-participating Providers	Participating and Non-participating Providers	Participating and Non-participating Providers
ALCOHOL & SUBSTANCE ABUSE					
Inpatient Care	You pay 10% after $155 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 $17 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					
Impatient Care	You pay 10% after $155 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 $17 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 $155 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 $17 per visit copayment (up to 100 visits per calendar year)	Not covered	You pay 20% after deductible	You pay 20% after deductible	You pay 20% after deductible
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 $17 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.				
Skilled Nursing Facility Care	You pay 10% after $155 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
Retail Health Clinic Visits	Covered in full after you pay $17 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

MEDICAL PLAN COMPARISON, CONT.

	Point-of-Service POS Plan		Gold Plan	Green Plan	Ram Plan-HDHP
Benefit Component	PPO Participating Providers	Non- Participating Providers	Participating and Non-participating Providers	Participating and Non-participating Providers	Participating and Non-participating Providers
Vision Care	Covered in full after you pay $17 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				
Chiropractic Care	Covered in full after you pay $17 per visit copayment (up to 20 visits per year) and 10% for laboratory and x-ray services. Copayment does not apply if an office visit is 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 PLAN - GUAM PARTICIPANTS

BlueCross BlueShield Global GeoBlue

800-810-2583

bcbsglobalcore.com

GEOBLUE

Employees who are located in Guam are eligible to enroll in any of the Anthem medical plans, and GeoBlue is contracted to administer Anthem’s healthcare services outside of the United States, including Guam. While the claims processing may be different, the same services are available to all employees.

GeoBlue has established relationships with many preferred providers to make it easier to obtain services and ensure claims payments from Anthem. After enrollment, each employee receives a personalized guide for thier provider indicating how to submit claims for guaranteed payment, how to obtain authorizations, if needed, GeoBlue contact information. Preferred and network providers can be located on the GeoBlue/GlobalCore website.

It is important to understand that for most medical services, no benefits are payable until the deductible is satisfied. (Does not apply to covered preventive services, which are not subject to the annual deductible and are covered in full for any provider in Guam.) Contact Human Resources for more information.

MEDICAL PLANS- APPEALS 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 the 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 who 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.

APPEALS PROCESS, CONT'D

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

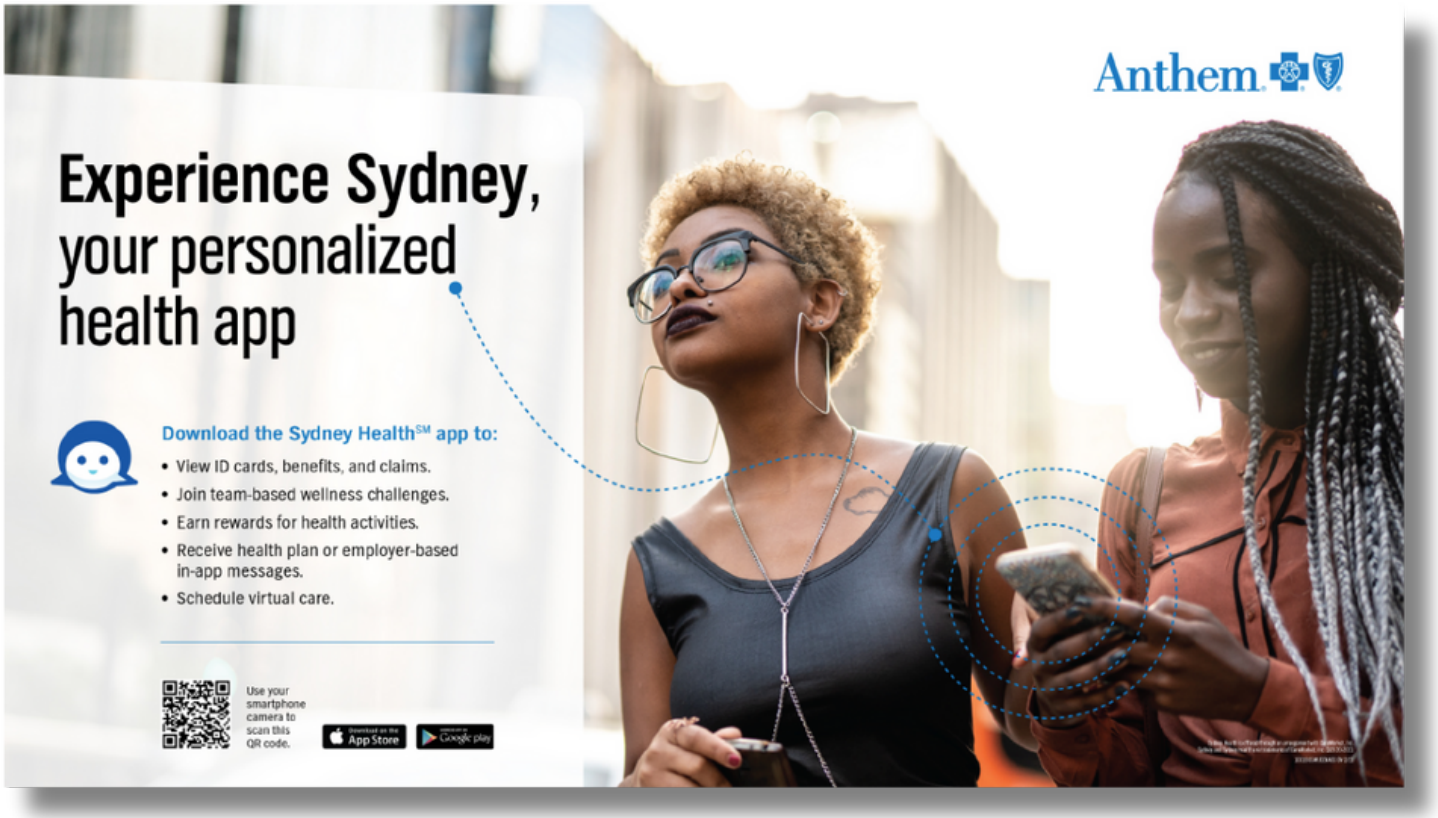
- Have not been involved in the care previously
- Is not a member of the board of directors of the health plan
- Have not been involved in the review process for the covered person previously
- Do not have a direct financial interest in the case or in the outcome of the review

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 work days 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.



HEALTH SAVINGS ACCOUNT (HSA)

Fidelity INVESTMENTS

800-343-0860

nb.fidelity.com

Ram Plan— High Deductible Health Plan
Choosing the Ram Plan-HDHP allows you to enroll in an HSA.

An HSA helps you save for healthcare expenses such as deductibles or coinsurance, 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 2024 maximum annual amount that can be contributed to an HSA is $4,150 for an individual or $8,300 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**
Can be used to pay for out-of-pocket medical expenses, including deductibles	✓	✓
Employees over age 55 can make catch-up contributions up to an additional $1,000 per year		✓
Maximum annual contribution in 2024 is $2,750	✓	
Combined employee/employer 2024 maximum contributions ($4,150 individual, $8,300 family)		✓
Available with Green, Gold, and POS Plans	✓	
Automatic enrollment with the Ram Plan — HDHP		✓
Enrollment allowed even if covered elsewhere in a non-HDHP medical plan	✓	
Eligible if enrolled in Medicare	✓	
Eligible if spouse has an FSA	✓	
Access 100% of annual election as of January 1, regardless of what has been contributed	✓	
You can spend only what you have contributed		✓
Unused balance rolls over from year to year		✓
Contributions are made on a pre-tax basis	✓	✓
You can take it with you if you change jobs or retire		✓
CSU contributes $500 to the account each year		✓
You cannot be covered by a non-HDHP and the Ram Plan-HDHP at the same time	✓	
Can be claimed as a dependent on another person's tax return	✓	
Requires a valid US address		✓
Allows you to invest funds beyond $500 in mutual funds		✓

FLEXIBLE SPENDING ACCOUNTS (FSA)

866-451-3399

customer.wexinc.com

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 providers out of pocket and submit for reimbursement or you have access to a benefits debit card, which can be used at participating merchants and the transaction is completed at the point of sale. You should save receipts in the event you need to substantiate the expenditure with WEX. The amount of savings from participating in a FSA will depend on your income, tax bracket and any amounts withheld from your pay on a pre-tax basis.

Note: Health Care Reform extends medical FSA reimbursement to your children up to age 26. Only your "qualified" federal tax dependents are eligible for reimbursement of expenses under an FSA 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. **You are required to re-enroll in an FSA each Open Enrollment period to continue participation in the next plan year.** Eligible expenses must be incurred during this time to be eligible for reimbursement. The IRS definition of "incurred" is the date the service is provided regardless of when you are billed or when you pay for it.

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.

FLEXIBLE SPENDING ACCOUNTS, CONT'D

PLAN DESCRIPTION

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 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 submit it electronically online through a secure portal.

YEAR END CLAIM FILING DUE DATE

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

EMPLOYMENT END FILING DUE DATE

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

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 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.

Complete and submit a claim form to WEX with a copy of your itemized receipt or EOB. All documentation can be uploaded via your mobile device/computer, sent via fax at 866-451-3245 or by email at customerservice@wexhealth.com or by mail:

WEX
3216 13th Avenue
South Fargo, ND 58103

ITEMIZED RECEIPTS

When submitting a health care claim or substantiation documentation on a card charge, attach a fully itemized receipt that includes:

- date of service
- type of service
- provider's name and;
- 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 WEX for automatic reimbursements throughout the plan year and you will not need to continually submit claims.

You can submit dependent care reimbursement claims as needed by completing a claim form or submitting the receipts electronically through the WEX secure portal. If you are unable to provide an itemized receipt 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. Keep copies copies of your mailed claims and supporting documentation, as no documentation will be returned to you.

FLEXIBLE SPENDING ACCOUNTS, CONT'D

DIRECT DEPOSIT

All reimbursements will be made 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 include those not covered by your basic plans, such as prescription glasses 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 $3,050 into the account each year. If you and your spouse or partner both work at CSU and are eligible for CSU Benefits, each of you may contribute up to $3,050 per year.

Note: Expenses 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.

FLEXIBLE SPENDING ACCOUNTS, CONT'D

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 themselves
- 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 them on their 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.

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

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.

DENTAL PLANS

DELTA DENTAL®

800-610-0201

deltadentalco.com

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 DeltaDental 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 plans where coverage is other than as a dependent will be the primary payer.

If this plan is secondary, this plan will provide Benefits that 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 the Coordination of Benefits 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). Please take a look at the FSA and HSA sections for details.

DENTAL, CONT'D

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 directly to the member even if the dentist accepts the 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

PO Box 173803
Denver, CO 80217-3803

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.

DENTAL, CONT'D

DELTA DENTAL PLUS PLAN
GROUP NUMBER: 9684

Plan Description
This is a dental insurance plan that 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 charged, whichever is less.

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

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

Submission of Claims: Delta Dental PPO and Premier Dentists will submit claims directly 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 the time of service and submit your 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	$100	$100
Maximum allowed*	$56	$80	$80
Benefit percentage	80%	80%	80%
Benefit	$44.80	$64	$64
Member not responsible	$44	$20	$0
Member pays	**$11.20**	**$16**	**$36**

*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.

DENTAL, CONT'D

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 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 EXCLUSIONS

DENTAL PLANS — EXCLUSIONS

The following Services are not covered benefits:

- Services for injuries or conditions that are compensable under Worker's Compensation or employer's liability laws, or Services that 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 are done in anticipation of future needs (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 following 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 APPEAL

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 of 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 60 days 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 on 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 SERVICE PLAN

800-877-7195

vsp.com

GROUP NUMBER: 30021702

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

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

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 discount may be provided at 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. Contact VSP to locate a VSP network doctor.
- 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	**VSP Provider Coverage**	**Non-VSP Provider**
Exam *(once every calendar year)*	Full after $40 copay	Reimbursed up to $45
Basic Lenses *(once every calendar year)*	$25 copay for basic lenses	
Single Vision *Lined Bifocal* *Lined Trifocal*	Full after copayment	Reimbursed up to $30 Reimbursed up to $50 Reimbursed up to $65
Frames *(once every other calendar year)*	Up to $175 allowance	Reimbursed up to $70
Contact lenses *(once every calendar year)*	Up to $175 allowance	Reimbursed up to $105

VISION SERVICE PLAN, CONT'D

EYEGLASSES

VSP covers full single-vision, lined bifocal, and 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 a $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.

EXTRA SAVINGS

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

Visit VSP Special Offers to view exclusive member extras!

CONTACT LENSES

Contact lens services and materials are covered instead of frames and lenses. If a patient chooses to purchase contacts instead of glasses. 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).

BASIC GROUP TERM LIFE

800-523-2233

thehartford.com

GROUP LIFE POLICY NUMBER: 677984
BASIC AD&D POLICY NUMBER: S07449

This is an overview of the coverage provided through this group plan. Coverage is governed at all times by the 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.

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.

BASIC GROUP TERM LIFE, CONT'D

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.

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.

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'D

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

- 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.

VOLUNTARY LIFE, CONT'D

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:

1. the Total Disability began while you were insured under this Policy;
2. the Total Disability began before You reached age 60;
3. you have completed your Disability Elimination Period; and
4. proof of the Total Disability is given to The Hartford as described.

WAIVER OF PREMIUMS

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 a waiver of premium due to total disability.

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 and approval of a Personal Health Application.

VOLUNTARY GROUP TERM LIFE, CONT'D

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.

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 outside of Open Enrollment 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/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 for employees, $50,000 for spouse/partner, and $20,000 child(ren).

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

Effective Date: coverage will be effective the first of the month following the 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.

VOLUNTARY GROUP TERM LIFE, CONT'D

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, Human Resources must receive 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.

VOLUNTARY AD&D, CONT'D

DEPENDENT COVERAGE

Your dependents are covered as long as they remain eligible. See the 'Individuals Eligible for University Benefits' page. It is your responsibility to remove any ineligible individuals within 30 days of a qualifying event.

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.

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.

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.

BENEFICIARY DESIGNATION

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

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.

VOLUNTARY AD&D, CONT'D

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 an 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 a body has not been found within one year after an 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 before such covered accident shall be included in determining the amount payable.

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.

VOLUNTARY AD&D, CONT'D

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 an 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 a 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 airbags 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 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

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

STD benefits begin after a "waiting period" of 10 continuous work days of absence or when all sick and annual leave is exhausted, whichever is later. The STD benefits period of 60 work days runs concurrently with the waiting 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 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 end upon reaching the maximum, the start of long term disability benefits, retirement, return to work, 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 appointment for that term, if they have had summer term appointments for two of the past three summers and who either:
  - are already receiving benefits on the end date of their current spring semester appointment,
  - or have completed the "elimination period" described 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 and duration of the highest two appointments in the past three summer terms or until the disability ends, whichever is the shorter period.

Short term Disability 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 the continuation of the monthly base salary beyond the exhaustion of accrued paid sick and annual leave up to 60 continuous work days of absence caused by an eligible disability (illness, injury, surgery, or pregnancy).

Replacement of covered monthly base salary earnings at 100%.

- 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.

1. 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.
2. Date of disability is determined by medical documentation from the employee's healthcare provider.
3. STD benefits are payable once per condition or related condition.
4. STD benefits are paid once the application and supporting medical documentation are received, reviewed, and approved by Human Resources.
5. An employee who is receiving STD and is able to work part-time may receive partial benefits, and then hours worked would be paid by the employee's department. The STD max period of 60 continuous workdays would not be extended.
6. STD benefits are not subject to retirement deductions and taxes.

SHORT TERM DISABILITY, CONT'D

ACTIVELY AT WORK PROVISION

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

INCOME REPLACEMENT OFFSET

The monthly STD income replacement benefit may be offset by any disability income benefits (e.g. worker's compensation) payable elsewhere.

NEWBORN BIRTH

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.

The 6 or 8-week period noted is not in addition to an employee's leave accruals. This duration is from the date of the baby's birth.

Routine Delivery (6 weeks): income replacement up to a maximum of 4 weeks (20 work days), after the minimum two-week (10 work days) STD waiting period.

Cesarean Delivery (8 weeks): up to a maximum of 6 weeks (30 work days) replacement of income, after the minimum two-week (10 work days) STD waiting period.

PARENTAL LEAVE

CSU is committed to helping employees achieve a positive work life balance. Part of this effort includes the parental leave benefit which provides paid time off for parents to bond and care for their new child. Additional unpaid leave is permitted under FMLA

Eligibility: Faculty, administrative professional and post doctoral fellows with 50% or greater appointments and eligible for benefits.

Who is a Parent: Birth, non-birth parents and adoptive parents (both primary* and non-primary caregivers).

Parental Leave Entitlement: Three work weeks of paid time off, in addition to the employee's accrued sick and annual leave (and any STD benefits to which the birth parent is entitled) to be used for care and bonding with the child.

When Can Leave be Taken: Parental leave may be taken within the first year after delivery or placement for adoption and runs concurrently with Family Medical Leave.

How to Apply: An eligible employee should meet with their department's HR Partner to notify them of the need and duration of leave. The HR Partner will enter the leave, complete the Parental Leave application, and submit to HR for reimbursement. More information on Parental Leave can be found on the CSU website.

*A primary caregiver is the parent who has primary responsibility for the care of a child immediately following the birth or adoption of the child.

FAMILY AND MEDICAL LEAVE INSURANCE (FAMLI)

HUMAN RESOURCES
COLORADO STATE UNIVERSITY
970-491-6947
hr.colostate.edu

The plan summarized below is subject to the terms and conditions of the Plan Document for CSU's private FAMLI plan.

WHAT IS FAMLI?

Colorado voters approved Proposition 118 in November 2020, paving the way for a state-run paid leave program. FAMLI supports both employees and businesses by supporting them when certain life events happen.

Starting in January 2024, all eligible employees will be able to apply for FAMLI benefits program to receive a portion of their weekly salary for up to 12 weeks of leave per year to care for themselves or a family member, with an additional four weeks leave for complications during pregnancy or childbirth.

WHO IS ELIGIBLE?

All CSU employees who reside in Colorado, are eligible to apply for FAMLI benefits. Employees are eligible for FAMLI payments on day one of employment and employees receive job-protection through FAMLI after 180 days of employment.

FAMLI leave only applies to in-state employees. Out-of-state employees do not pay the premium deduction and must use their state's family medical leave policies.

FOR WHAT REASONS CAN IT BE USED?

12 weeks of FAMLI can be used for the following reasons:

- Care and bonding with a new child after birth, adoption, or foster care placement
- Serious health condition of the employee
- Serious health condition of the employee's family member
- Making arrangements for a family member's military deployment
- Address immediate safety needs and impact of domestic violence or sexual assault.

HOW MUCH WILL MY BENEFIT BE?

The weekly benefit is 90% of an employee's average weekly wage if the employee's average weekly wage is equal to or less than 50% of the state average weekly wage (SAWW).

Then, for any portion of an employee's average weekly wage that is greater than 50% of the SAWW, you would calculate 50% of the your remaining average weekly wage and add it to the calculation above.

The maximum benefit is $1,100 per week for 2024.

Use the online calculator to determine what you'll receive while on leave.

HOW WILL FAMLI BENEFITS BE PAID

Payments are made via direct deposit, bi-weekly throughout the duration of the leave. Benefit premium will not be deducted from FAMLI benefits, but will be deducted if other leaves are used in coordination.

FAMLI, CONT'D

HOW DO I APPLY FOR BENEFITS?

To apply for FAMLI leave, eligible employees should fill out an application form and provide all necessary documents to Human Resources. If you submit your application in the fall of 2023, you may start receiving the leave benefits starting from Jan. 1, 2024.

Do not apply for benefits through the State of Colorado. CSU has established a private FAMLI plan and benefits will be processed and paid through CSU.

WHY DOES CSU HAVE A PRIVATE PLAN?

According to state law, employers can present their own self-funded family leave program that matches or goes beyond the state's FAMLI program, instead of joining the state insurance program.

CSU has submitted a private plan proposal, which has been evaluated and accepted by the State of Colorado.

The self-funded and self-administered plan implemented by CSU will allow the university to consolidate FAMLI leave with all of CSU's leave programs. Since FAMLI coverage only partially replaces an employee's wages, staff will have the option to use paid sick or annual leave and other types of leave or insurance coverage to bridge the gap.

HOW DOES FAMLI WORK WITH OTHER CSU LEAVE PROGRAMS?

FAMLI may either run concurrently or in conjunction with other leave programs:

- **Family and Medical Leave Act (FMLA)**: This federal program provides job protection for 12 weeks per rolling 12 months. FMLA will run concurrently with FAMLI when the need for leave meets the FMLA requirements.
- **Parental Leave**: Runs concurrently with FAMLI and FMLA.
- **Short Term Disability**: There is a coordination of compensation for employees on a short term disability leave. It will also run concurrently with FAMLI and FMLA.
- **Sick and Annual Leave**: Accruals of leave through CSU employment can be used in conjunction with FAMLI, as the employee desires. The use of sick and annual leave prior to or in coordination with FAMLI is not required. It will also run concurrently with FAMLI and FMLA.

HOW OFTEN CAN I USE FAMLI?

Employees are allowed 12 weeks of partial wage replacement through FAMLI every rolling 12-month period.

HOW IS FAMLI FUNDED?

State employers, including CSU, are required to implement a payroll tax of 0.45% on each employee's wages to fund the new paid leave for employees. The university is also required to pay half of the cost of the leave program (an additional 0.45% of each employee's wages, as defined by FAMLI).

This tax is only paid by employees residing in the state of Colorado.

LONG TERM DISABILITY

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 ages or time limits:

Sun Life Financial

800-451-4531

sunlife.com

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

Monthly Premium

The cost of coverage is provided by the University (taxable allowance based on salary and retirement plan)

Retirement Plan Enrolled

Defined Contribution Plan: 0.45% of your covered monthly salary. Maximum premium is $168.75

PERA or Federal: 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, the 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.

LONG TERM DISABILITY, CONT'D

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 from Human Resources), which shall be furnished to SunLife Financial within 12 months after the commencement of disability. SunLife Financial 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 SunLife Financial. 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 months preceding enrollment in the plan, will not be covered until twelve consecutive months have elapsed after enrollment in the plan
- Eligibility for LTD benefits does not continue beyond age 70.

LONG TERM CARE

Genworth

(800) 416-3624

genworth.com

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.

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 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 include 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 PROVISION

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.

WHAT ARE THE BENEFITS?

Benefits are payable for expenses incurred for:

- Care and services during confinement in a nursing facility or the assisted living facility, up to the Nursing Facility Maximum based on the option selected
- Home and community care which includes adult day care, 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

LONG TERM CARE, CONT'D

- 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 between this coverage summary and the official certificate of insurance, the certificate issued as part of your policy will govern.

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.

LONG TERM CARE, CONT'D

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 an additional premium. This rider allows the insured to retain partial coverage if they decide to cancel coverage after it has been in force for more than three years.

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.

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

LONG TERM CARE, CONT'D

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 mean 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); 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.

LONG TERM CARE, CONT'D

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 canceled 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.

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 that 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.

LONG TERM CARE, CONT'D

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:
    - They are a regular employee of the organization that is providing the services; and
    - Such organization receives payment for the services; and
    - 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;
8. Resulting from war or any act of war, whether declared or not;
9. Resulting from attempted suicide or an intentionally self-inflicted injury while sane;
10. Resulting from participation in a felony, riot, or insurrection;
11. 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);
12. 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.

MANDATORY RETIREMENT PLANS

Fidelity INVESTMENTS

(800) 343-0860

netbenefits.com/csu

COLORADO PERA

(800) 759-7372

copera.org

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 for eligibility criteria and plan benefits.

ENROLLMENT

Newly Eligible: Complete your enrollment in the CSU Online Benefits Enrollment System and return the Retirement Election form within 30 days of your eligibility. If you meet PERA's eligibility requirements as determined by PERA, you must elect PERA no later than 30 days from your date of eligibility or you will be enrolled in the DCP. Refer to PERA Eligibility 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 have had to select PERA in lieu of the DCP. If you did not enroll within 30 days of eligibility, you will be placed in the DCP in accordance with a default procedure established by the University.

All retirement plan contributions are placed in a non-interest-bearing account until you are defaulted to Fidelity. If you terminate employment before electing a retirement plan, you will be enrolled in the DCP in accordance with default procedures established by the University upon termination.

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 W2 income from the University will not include retirement plan contributions.

Covered monthly salary includes all salary, summer salary, and supplemental pay, as defined in the Academic Faculty and Administrative Professional Manual.

For PERA participants, covered monthly salary does not include pre-tax medical, dental, vision, flexible spending account, or parking permit deductions.

MANDATORY RETIREMENT PLANS, CONT'D

EMPLOYER CONTRIBUTIONS

DCP: For regular or special appointments of half-time or greater, the University provides a contribution of 12% of your covered monthly salary.

After completing one year of continuous service, temporary faculty, administrative professionals, post-doctoral fellows, veterinary interns, and clinical psychology interns working half-time or more are eligible for the University DCP contribution. 9-month employees must complete two consecutive, continuous semesters at half-time or more (not including summer session) while 12-month employees must complete 12 months of half-time or more employment. If there is a break in the continuous appointment, another year of service is required before CSU can provide the employer match to the DCP.

If a DCP participant is a PERA retiree at the time of employment or becomes one later, CSU's employer contribution will be reduced by the amount required to contribute to PERA for that employee, except for tenured or tenure-track faculty members hired before July 1, 2005, or tenured faculty members on a transitional appointment that began before January 2, 2006 (as defined by Article 51 of Title 24 of the Colorado Revised statutes).

PERA: Enrollment in PERA is restricted to those who meet PERA's eligibility criteria which includes, but not limited to being an active PERA participant with at least 12 months of service, an inactive member with 12 month of service or a current PERA retiree.

Unless you are a PERA retiree, you may not elect PERA for retirement if you were previously employed by a public college or university in Colorado and made an election to participate in that institution's optional retirement plan (ORP). Also, if your election then was to participate in PERA, you may not elect the ORP now. Such elections are, by law, irrevocable.

Effective January 1, 2011, PERA retirees may elect either PERA or the ORP as their retirement plan each time they are reappointed. Any PERA election will require you to make the employee or working retiree contribution to that Plan and complete the Retirement Election form when you are reappointed. It is important to disclose to PERA if you are receiving or have ever received a PERA annuity.

It's important to note that the University's contributions to PERA are never vested. However, you can obtain vested rights to future benefits after five years of PERA credited service if you choose not to request a refund of your contributions once your employment with the University ends. For more information about eligibility and retirement plan features, please refer to PERA publication and rules. If you're looking to receive your DCP funds or are curious about retirement eligibility, please visit the HR website.

PERA ELIGIBILITY

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

CSU cannot mandate, or is 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.

VOLUNTARY RETIREMENT SAVINGS PLANS

Fidelity INVESTMENTS

(800) 343-0860

nb.fidelity.com/csu

COLORADO PERA

(800) 759-7372

copera.org

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 Account
- 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 for nine month employees.

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 participate 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 that month's payroll cycle.

VOLUNTARY RETIREMENT SAVINGS PLANS

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

	403(b) Plan Fidelity	**PERA 457** Colorado PERA	**401(k) Plan** Colorado PERA
	Tradtional and Roth options		
2024 Maximum Contributions*	**$23,000** Combined 403(b) & 401(k) limit	**$23,000** Separate from 403(b) & 401(k) limit	**$23,000** 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.
Loans Allowed	Yes		
Active Service Withdrawal	Disability, age 59 ½ or financial hardship		
Penalty on Early Withdrawals	**Traditional 403(b)** Yes, unless rolled over or separated from service after January 1 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 1 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	Fees Variable — please check with the plan vendor		
Catch-up Contributions	**$7,500** 2024 annual catch-up contribution for participants age 50+**		

The above sections of the Internal Revenue Code (IRC) permit certain employees (eligibility varies 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 IRC 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 (ESP) AND RECIPROCAL STUDY PRIVILEGE

Eligible employees may register for courses at CSU Fort Collins, CSU Pueblo, CSU Global, and the University of Northern Colorado (on a space-available-basis) without the assessment of tuition or general fees as defined below. To apply, use the ESP application on the HR website.

Tax Implications of IRC 127 for Higher Education Programs

IRC 127 outlines the taxability of education programs offered by higher education institutions. According to this code, taxation applies to graduate-level tuition benefits that exceed $5,250 per calendar year, regardless of whether or not the program is job-related. The IRS classifies a graduate-level student as someone who has earned an undergraduate degree and is pursuing a new degree at either the undergraduate or graduate level or taking graduate-level courses without being degree-seeking. Also taxable are courses related to games, hobbies, or sports that aren't directly related to obtaining a degree. As a result, this tax will reduce your net pay at the end of the year.

Employees who wish to take courses under the ESP must obtain authorization from their department head and ideally, that the courses contribute to their success at the university. Advance supervisor approval is necessary for time off during scheduled work hours, although time off for courses to improve job skills should be administrative leave with pay. Eligible employees may register for courses without being regularly admitted to CSU.

Eligible employees include appointments of:

- Faculty and administrative professionals that are regular, special, or temporary at 50% or greater (including continuing or contract)
- Faculty Transitional
- Post doctoral fellows, veterinary interns, and clinical psychology interns at 50% or greater
- State classified employees at 50% or greater.
- Contact Human Resources at 970-491-6947 for eligibility for Military Studies (ROTC)

Credit eligibility is prorated based on appointment percentage:

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

Credits apply to either audited courses or those taken for credit.

EMPLOYEE STUDY PRIVILEGE — ELIGIBLE COURSES

The Employee Study Privilege covers credit courses identified with a departmental course number in the university curriculum under the CSU General Catalog. CSU Online courses are eligible if they are credit-bearing, while courses providing only continuing education units (CEUs) are not covered. The privilege does not include the cost of continuous registration.

Eligible expenses:

- Base Tuition – up to 9 credits per year*
- Undergraduate Differential Tuition – up to 9 credits per year*
- Graduate Differential Tuition – at least one credit must be used each term (not an additional credit)
- University Facility Fee and College Charges for Technology – prorated based on credits used
- University Technology Fee – credited to your student account (fee waiver)
- General Fees – credited to your student account (fee waiver). Waiver removes your free access to services under General Fees including, but not limited to, the Student Recreation Center, CSU Health Network, University Counseling Center other campus services

ACADEMIC PRIVILEGES, CONT'D

As long as an ESP application is submitted, University Technology Fee and General Fees are credited to your student account even if study privilege credits have been exhausted.

Ineligible expenses:

- Undergraduate tuition covered by the College Opportunity Fund (COF) – if you take a COF eligible courses and it is not applied (e.g. you do not apply or audit a course), ESP will not cover tuition that would have been covered by COF.
- Special Course Fees – associated courses and fees available at provost.colostate.edu/students/

If you exhaust ESP credits, any remaining tuition, charges or fees are your responsibility.

RECIPROCAL STUDY PRIVILEGE

The Employee Study Privilege Program offers reciprocal study opportunities for employees to enroll in courses at CSU Pueblo, CSU Global, and the University of Northern Colorado. To be eligible, employees must agree to meet all financial obligations and adhere to the policies of the institution where they will be enrolled as students. Program eligibility is determined by the Employee Study Privilege of Colorado State University. To gain pre-approval under the reciprocal provisions of the program, additional forms are required.

TUITION SCHOLARSHIP PROGRAM FOR SPOUSES, DOMESTIC PARTNERS AND ELIGIBLE CHILDREN

Spouses, domestic partners and eligible children of CSU employees can receive a scholarship for 50% of resident tuition for regular, on-campus credits. The amount may vary depending on degree program.

Employee Eligibility

- Faculty members with regular, special, senior teaching appointments of half-time (0.5) or greater. Faculty transitional appointments are eligible for the same benefit available to full-time academic faculty.
- Administrative Professionals with regular or special appointments of half-time (0.5) or greater, and;
- Non-temporary state classified appointments of half-time (0.5) or greater.

Spouse, Domestic Partner or Civil Union Partner, or Eligible Child Criteria

- The eligible employee's legal spouse, including common-law spouse.
- The eligible employee's domestic partner or civil union partner. A domestic partner or civil union partner is eligible if an Affidavit of Domestic Partnership or Certificate of Civil Union Partnership and the Certification of Dependency for University Benefits forms are submitted and approved, in conjunction with this application.
- The eligible employee's biological children, adopted children, foster children, stepchildren, and legal wards of either the eligible employee or the eligible employee's spouse, common-law spouse, domestic partner, or civil union partner as well as any person for whom either the eligible employee or the eligible employee's spouse, common-law spouse, domestic partner, or civil union partner is standing in loco parentis, provided that the eligible child is under twenty-six (26) years of age. The Certification of Dependency for University Benefits form must be submitted to determine tax consequences (imputed income), if applicable.

The student must be a Spouse, Domestic Partner or Civil Union Partner or Eligible Child of an Eligible CSU Administrative Professional, Academic Faculty, or State Classified staff member.

There are certain eligibility criteria that both the student and the employee must meet in order to be eligible for this scholarship. These criteria are described in detail on the application form.

ACADEMIC PRIVILEGES, CONT.

Scholarship Amounts
The amount of the scholarship is rounded to the nearest dollar and is determined after the add/drop date.

- **Undergraduate:**
  - Equal to 50% of student's base tuition, minus the College Opportunity Fund stipend, for in-state, regular, on-campus credits*.
  - It includes 50% of Differential Tuition, but does not include 50% of other fees, charges, or program fees.
- **Graduate:**
  - Equal to 50% of student's base graduate tuition for in-state, regular, on-campus credits*.
  - It **does not** include 50% of Graduate Differential Tuition, fees, charges, or program fees.
- **Doctor of Veterinary Medicine:**
  - Equal to 50% of student's base graduate tuition* (not Doctor of Veterinary Medicine tuition)
  - It does not include 50% of Graduate Differential Tuition, fees, charges, or program fees.

*Even if the student is classified as a non-resident/out-of-state for tuition purposes.

Course Eligibility and Restrictions

- The student must be enrolled in regular on-campus credits.
  - **Test-Out, Advanced Placement, CSU Online, and Education Abroad credits are not considered regular on-campus credits.**
- The student must be admitted to a degree-seeking program at CSU, CSU-Pueblo or CSU-Global. Students seeking Teacher Certification or Principal Licensure may do so at CSU in Fort Collins.

The total financial aid awards received (through scholarships, grants, work-study, or loans) may not exceed individual costs for attending Colorado State University. The Office of Financial Aid will notify the student if this tuition scholarship causes a refund or reduction in other aid.

Taxation
This is a summary of the tax implications for the tuition scholarship program. The University does not provide tax advice, you are encouraged to contact a personal tax advisor for more detail. Additional information can be found in IRS Publication 970.

- **Undergraduate Tuition**
  - Undergraduate tuition benefits for an eligible employee's legal spouse are not subject to taxation.
  - Undergraduate tuition benefits for an eligible employee's child are not subject to taxation if the child is claimed as a tax dependent on the employee's income tax return for the calendar year the benefits applies.
  - If the employee's child is a non-qualified federal tax dependent, then the undergraduate tuition benefits **are** subject to taxation.
- **Graduate and Professional-Level Tuition**
  - All graduate level courses taken by any eligible family members **are** subject to federal taxation.

Application Deadlines
The scholarship will be processed after the add/drop date each semester because individual enrollment can fluctuate until then. The student will not be assessed a late payment penalty (Payment Deferral Charge) for not making the payment due date, meaning you can wait until the tuition scholarship amount pays and then remit any remaining balance due, even if it is after the payment due date.

This scholarship is not automatically renewed; it must be applied for each year. An application must be submitted for summer if the student is enrolled for the summer semester.

Additional information and the online application is available on CSU's Financial Aid website.

OTHER BENEFITS & PRIVILEGES

CSU is committed to creating a healthy workplace, which includes benefit offerings to help balance your work and personal needs such as tuition assistance and generous leave policies. Benefits are based on full-time employment but may be prorated for part-time employees. For complete information on available benefits and eligibility, visit the HR website. Plan or program documents will govern in case of any discrepancies.

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

PROVIDER QUICK REFERENCE GUIDE

VENDOR	PLANS	GROUP NUMBER	PHONE	WEBSITE
Medical				
Anthem	Green Plan Gold Plan POS Plan Ram Plan-HDHP	C10223M002 C10223M001 C102230007 C10223M014	800-843-5621	anthem.com
Health Savings Account				
Fidelity Investments	HSA		800-343-0860	fidelity.com
Dental				
Delta Dental	Dental Basic Dental Plus	9709 9684	800-610-0201	deltadental.com
Vision				
Vision Service Plan	VSP Plan	30021702	800-877-7195	vsp.com
Flexible Spending Account				
WEX	Health Care FSA Dependent Care FSA		866-451-3399	wexinc.com
Life Insurance, AD&D				
The Hartford	Basic & Voluntary Life Travel Assistance	677984 SO7449	800-523-2233	thehartford.com
Employee Assistance Program				
ComPsych	EAP	*CSUEAP*	800-497-9133	eap.colostate.edu
Retirement Plans				
Colorado PERA	Mandatory, 401(k), 457		800-759-7372	copera.org
Fidelity Investments	DCP & 403(b)		800-343-0860	fidelity.com