BENEFIT HIGHLIGHTS

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Benefit Eligibility

Benefits under the CHEIBA Trust Plan are available to Eligible Employees and Dependents of the State colleges, universities and institutions of higher education who participate in the CHEIBA Trust.

Employee

“Employee” means all exempt faculty and administrative personnel of an Employer that are regularly scheduled to work at least .5 FTE and that are included on the payroll records of the Employer. Leased Employees, independent contractors and part-time Employees who work less than .5 FTE are not eligible. Eligible Employees on an authorized leave of absence not to exceed a 24 consecutive month period, including Employees on sabbatical and summer break, are included as Eligible Employees until the Employer notifies the Insurance Company of termination of eligibility.

Dependent

A. "Dependent" means an Employee's (a) legal spouse; and (b) an Employee's unmarried child(ren) who are primarily dependent upon the Employee for support and maintenance (i) until the end of the month of their 25th birthday, or (ii) of any age who are medically certified by a physician as disabled. Dependents must also satisfy the requirements of the Internal Revenue Code to qualify as tax dependents of the Employee for, as applicable, medical and dental plan purposes or life insurance purposes, and satisfy the eligibility requirements for coverage under a Benefit Plan. A Dependent may also include a child for whom the Employee is required to provide health benefits pursuant to a court order or qualified medical child support order. A Dependent shall also include any dependent which is required by State insurance law to be covered or offered coverage under any insurance contract issued to the Trust for a Benefit Plan.

B. For purposes of medical, dental, voluntary vision, voluntary life, and voluntary accidental death and dismemberment benefits (hereinafter collectively referred to as "Benefits"), including any COBRA rights related to such Benefits, a Dependent shall also include an Employee's Domestic Partner as described in paragraph 1 and the child of an Employee's Domestic Partner as described in paragraph 2.

1. An Employee's Domestic Partner is an adult of the same or opposite gender as the Employee, whose personal relationship with the Employee meets the criteria established by the Trust Committee for domestic partnership. The Employee must follow the procedures established by the Trust Committee with regard to the enrollment and termination of a Domestic Partner, including the completion of an Affidavit for Domestic Partnership. A Domestic Partner is not a legal spouse of an Employee under Colorado law pursuant to C.R.S. 14-2-104.

2. The natural or adopted child of a Domestic Partner who is not related by blood, adoption or court order to the Employee, is a child who satisfies the following: (i) is a member of the Employee's household or a full-time student; and (ii) otherwise meets the definition of
a dependent child under paragraph A(b)(i) or (ii) above. Dependents must also satisfy the requirements of the Internal Revenue Code to qualify as tax dependent of either the Domestic Partner or the Employee for medical and dental plan purposes and satisfy the eligibility requirements for coverage under a Benefit Plan. A Dependent shall also include any dependent which is required by State insurance law to be covered or offered coverage under any insurance contract issued to the Trust for a Benefit Plan. The Employee must follow the procedures established by the Trust Committee with regard to enrollment and termination of coverage for the child(ren) of a Domestic Partner.

C. For the purposes of an Anthem certificate of insurance evidencing medical, dental and voluntary life coverage, any reference to the term "spouse" shall also include a Domestic Partner.

**Participant**

“Participant” means an Eligible Employee, Dependent or Beneficiary who satisfies the requirements for participating in any Benefit Plan offered under the Trust, and includes any former Employee, former Dependent, qualified Beneficiary or Retiree whose coverage under any Benefits Plan is continued or extended in accordance with the provisions of the Benefit Plan and Trust.

**Retiree**

“Retiree” means a Participant in the CHEIBA Trust Health Benefit Plan who satisfies all of the following requirements: (1) on or after January 1, 1999, terminates employment with a College on or after age 50 and prior to age 65, due to retirement; (2) who is immediately eligible to commence receiving retirement benefits under a qualified retirement plan sponsored by an Employer; (3) was covered by the CHEIBA Trust Health Benefit Plan immediately prior to retirement; (4) upon termination of employment elects to continue coverage under the CHEIBA Trust Health Benefit Plan pursuant to the Consolidated Omnibus Budget Reconciliation Act (COBRA) and, (5) exhausts such COBRA coverage and timely elects to continue coverage under the CHEIBA Trust Health Benefit Plan as a Retiree.

The CHEIBA Trust Benefit Plans are fully insured and benefits are provided under fully insured master contracts with several insurance companies. Entitlement and eligibility for benefits is governed by the terms of each insurance contract and certificate of insurance issued to you by an insurance company. In the event of a conflict between the provisions of this summary and the insurance contract or certificate, the terms of the certificate and insurance contract will control. Each certificate of insurance coverage contains a separate definition of Eligible Dependent. Your Eligible Dependents must also satisfy any requirements contained in a certificate of insurance coverage from the insurance companies providing benefits under the Benefit Plan.

**Enrollment**

Eligible Employees must complete and file an enrollment application within thirty-one (31) days of their first day of employment and authorize payroll deductions for the coverage elected. Coverage under the Trust is effective on an Employee’s date of hire unless coverage is waived. Eligible Employees may waive health and dental coverage if they submit evidence of coverage under another group health plan and submit a signed waiver form during initial or annual enrollment. If coverage under the Health and Dental Benefits Plans is waived, Dependent coverage must also be waived. If coverage is waived, Eligible Employees and their Dependents may enroll in coverage under a Benefits Plan only during the next annual open enrollment or within thirty-one (31) days of a qualifying event under IRC section 9801.

**NOTE ON HEALTH AND DENTAL:** Employees must enroll in both Health and Dental insurance. If Employees waive Health insurance, Dental insurance must also be waived.
Coverage may also be waived due to religious affiliation. All waiver and enrollment requests must be approved by your Human Resources/Benefits Office.

NOTE ON BASIC TERM LIFE & AD&D (provided by Anthem Life) AND LONG TERM DISABILITY (provided by Standard Insurance): Employees must enroll in basic term life and accidental death and dismemberment insurance provided by Anthem Life and long term disability insurance provided by Standard Insurance. Such insurance coverages may not be waived.

Default Health and Dental Coverage
If an Eligible Employee does not complete and file an enrollment application or waiver form within thirty-one (31) days of the first day of employment, the Employee will automatically be enrolled in the Health Benefits PRIME PPO plan option and Anthem Blue Dental PPO Plus plan. Contributions will be deducted from the Employee’s payroll on an after-tax basis as a condition of employment if the Employer requires Employee contributions. Changes to default coverage are only permitted during the annual open enrollment and within thirty-one (31) days of a qualifying status change.

Annual Open Enrollment
Each fall the CHEIBA Trust announces an annual open enrollment period, during which time Eligible Employees may make certain coverage changes. During open enrollment, Employees may add or delete Eligible Dependents from coverage under the Plan. Employees and qualified beneficiaries may add dependents only during open enrollment or during “special enrollment and qualifying status changes” described later in this summary.

Termination of Eligibility
Eligibility to participate in the Benefit Plans under the Trust shall terminate on the earliest of the following dates:
- The last day of the month following the month in which an Employee terminates employment for any reason including death and retirement,
- The last day of the month in which an Employee ceases to satisfy the definition of an Eligible Employee either because of a change in status or a reduction in the scheduled work hours per week falls below the minimum number of hours required for coverage under the Trust,
- The last day of the month for which contributions are paid in a timely manner,
- The date the Trust or any Benefit Plan under the Trust is terminated or amended to terminate benefits for any class of Participants,
- The effective date an Employee elects to waive coverage under any Benefit Plan,
- The date a Participant enters the armed forces of any country on active full-time duty,
- The date any certificate of insurance coverage issued under any Benefit Plan is terminated or amended to terminate coverage for any Participant, or
- The date a Participant falsifies or misuses documents or information relating to coverage or services under any Benefit Plan or any certificate.

Dependent coverage terminates on the earliest of the date coverage would otherwise terminate above, and the following:
- The date a Dependent enters the armed forces of any country on active full-time duty,
- The last day of the month in which the Dependent ceases to satisfy the definition of a Dependent under the Trust, any Benefit Plan under the Trust or any certificate of insurance coverage,
- The last day of the month a Dependent child marries.
- The last day of the month a Dependent child turns age 25.
Leaves of Absence

Coverage under the Plan may continue for certain Employees on an Approved Leave of Absence, including but not limited to:

- STD/LTD
- Workers Compensation Leave
- Family and Medical Leave Act
- Military Leave under the “Uniformed Services Employment and Reemployment Rights Act”

Domestic Partner Benefits

Effective January 1, 2009, the Colorado Higher Education Insurance Benefits Alliance Trust (the "CHEIBA Trust") modified the definition of "Dependent" to include Domestic Partners of covered Employees. This means that Domestic Partners are eligible for group medical, dental, voluntary vision, voluntary life, and voluntary accidental death and dismemberment benefits offered by member schools.

A Domestic Partner is an adult who shares a committed relationship with a member school’s eligible Employee of the same or opposite gender, evidenced by an Affidavit of Domestic Partnership filed by the Employee with their respective employer.

Affidavit of Domestic Partnership: The Affidavit of Domestic Partnership contains an affirmation by the Employee and the Domestic Partner of the following:

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

The affidavit must be signed by both partners and witnessed by a notary public.
Legal Concerns
The Affidavit of Domestic Partnership required to register a Domestic Partner includes an attestation of the relationship. Due to the legal obligations that may be created between the Employee and the Domestic Partner by submitting such an affidavit, both parties are advised to consult an attorney for advice.

Eligibility for Coverage
Domestic Partners and their eligible dependents will be eligible for medical, dental, voluntary vision, voluntary life, and voluntary accidental death and dismemberment insurance in the same manner as for an Employee's spouse and other dependent children. In order to be eligible for coverage, "eligible dependent children" of Domestic Partners must:

- be the natural or adopted children of the Domestic Partner;
- be members of the Employee's household or a full-time student; and
- otherwise meet the definition of eligible dependent children under the CHEIBA Trust and its Group Medical, Dental, Vision, Life, and Accidental Death and Dismemberment Plans.

Enrollment Procedure
Enrolling a Domestic Partner is subject to the same limitations that apply to a spouse or child. Enrollment is limited to:

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

To enroll, the Employee must file an Affidavit of Domestic Partnership to enroll a Domestic Partner and the Domestic Partner's children.

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

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

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

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

Flex Plans

If the Domestic Partner and his/her children are the Employee's tax dependents for health and dental plan purposes and the Employee has completed a Certification of Tax-Qualified Dependents, then the Employee may receive reimbursements of their expenses from the Employee's flexible spending account. If the Domestic Partner and his/her children are not the Employee's tax dependents, however, then their expenses are not eligible for reimbursement from the Employee's flexible spending account.

Benefits relating to the Domestic Partner and his/her children under dependent care assistance flexible spending accounts will depend on how the Domestic Partner and/or his or her children fit within the guidelines established by the tax code for these benefits.

COBRA

While continuation of medical, dental and voluntary vision coverage is not required under federal COBRA laws, such coverage is allowed under the same terms that would apply to an Employee's spouse and children. A registered Domestic Partner and/or children of the Domestic Partner enrolled in medical, dental and voluntary vision plans have 60 days from the date that eligibility for coverage ends to enroll in COBRA coverage.

Tax Effect

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

Benefit Availability

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

Contact your Human Resources office for more information.

Retiree Continuation of Coverage

Retirees and their dependents shall be eligible to continue health insurance coverage only under the Anthem Blue Cross and Blue Shield fully insured Health Benefit Plan coverage. Retirees are not eligible to participate in any other Benefit Plans offered under the Trust. An Eligible Retiree must enroll in the Health Benefit Plan immediately after continuation of coverage under COBRA is exhausted with no lapse in coverage under the Health Benefit Plan (electing and exhausting COBRA coverage is the only way a retiree is eligible for CHEIBA retiree health coverage). Once Retiree coverage under the Health Benefit Plan terminates for any reason set forth above, coverage
may not be reinstated. In addition to the termination provisions above, Retiree coverage terminates on the last day of the month in which a Retiree becomes covered under any other group health plan, Medicare, or the Colorado Public Employees Retirement Association retiree health plan. Retirees and their Dependents may make enrollment changes during the Health Benefit Plan open enrollment period each year and due to Qualifying Events. If the CHEIBA Trust terminates the Anthem Blue Cross and Blue Shield fully insured Health Benefit Plan coverage, a Retiree’s coverage shall also terminate with no guarantee of coverage under a new Health Benefit Plan coverage option, nor any conversion or continuation rights.

Retirees must pay the entire contribution applicable to Retirees, including any Contribution rate increases, for Health Benefit Plan coverage in a timely manner. Contributions are due on the first calendar day of the month of coverage and are considered timely paid if received by the Plan Administrator by the last calendar day of the month. If payment is not received by the last calendar day of the month, then coverage will terminate effective the last day for which a premium was paid.

Authority of the CHEIBA Trust Committee
The CHEIBA Trust Committee has the sole and absolute discretion to interpret the terms of the Plan and determine the right of any Participant to receive benefits under the CHEIBA Trust Plan. The right of any Participant to receive benefits under a fully insured benefit plan shall be determined by the insurance company pursuant to the terms of its insurance contract and certificate of insurance. The CHEIBA Trust Committee’s decision is final, conclusive and binding upon all parties.

Assignment and Payment of Benefits
No benefit payable under the Plan can be assigned, transferred or subject to any lien, garnishment, pledge or bankruptcy. However, a Participant may assign benefits payable under this Plan to a provider or hospital pursuant to the term of the certificate. Ultimately, it is the Participant’s responsibility to pay any hospital or provider. If the benefit payment is made directly to a Participant, for whatever reason, such payment shall completely discharge all liability of the Plan, the CHEIBA Trust Committee and the Employer.

If any benefit under this Plan is erroneously paid to a Participant, the Participant must refund any overpayment back to the Plan. The refund may be payment, reduction of future benefits otherwise payable under the Plan, or any other method as the CHEIBA Trust Committee in its sole discretion, may require.

Right to Information and Fraudulent Claims
The CHEIBA Trust Committee has the right to request information from any Participant to verify his/her eligibility and entitlement to benefits under the Plan. If a Participant falsifies any document in support of a claim or coverage under the Plan, the CHEIBA Trust Committee may, without the consent of any person, terminate coverage and refuse to honor any claims under the Plan for the Participant and Dependent and the Participant may be liable to the CHEIBA Trust or his or her employer for all resulting monetary damages, costs and attorneys' fees which result from such actions. In addition, the Employee may be subject to disciplinary action, up to and including termination of employment.

Third Party Reimbursement and Subrogation
If you or a covered Dependent receive benefits under a CHEIBA Trust Plan for injury, sickness or disability that was caused by a third party, and you have a right to receive a payment from the third party, then the CHEIBA Trust has the right to recover payments for the benefits paid by the CHEIBA Trust Plans. If you recover any amount for covered expenses from a third party, the amount of benefits paid by the CHEIBA Trust Plans will be reduced by the amount you recover.

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

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THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT
(USERRA)

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

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

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

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

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

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

If you are a covered Employee called to a period of active service in the Uniformed Service, you should check with the Plan Administrator for a more complete explanation of your rights and obligations under USERRA. In the event of a conflict between this provision and USERRA, the provisions of USERRA, as interpreted by us or your former employer, will apply.

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BENEFIT PLAN CHOICES

Employees must enroll in both Health and Dental insurance. If Employees waive Health insurance, Dental insurance must also be waived. Coverage may also be waived due to religious affiliation. All waiver and enrollment requests must be approved by your Human Resources/ Benefits Office.

Health Insurance

Anthem Blue Cross and Blue Shield
You select your health plan coverage during open enrollment or when you become a new benefit-eligible Employee. Three options are available:

- BlueAdvantage Point-of-Service Plan (HMO/POS)
- PRIME Health Plan (PPO)
- Custom Plus Health Plan (closed to new enrollment January 1, 2010)

NEW:
The following benefit changes are effective January 1, 2010:

- **HMO/POS Plan**
  - Increased maximum for durable medical equipment to $3,000 combined in and out-of-network and combined with oxygen.
  - Chiropractic benefits include acupuncture and massage therapy for a combined maximum of 20 visits per calendar year.

- **PPO Plan**
  - Chiropractic maximum of 20 visits per calendar year combined with acupuncture and massage therapy treatments. No lifetime maximum.
  - Dental inpatient/outpatient services are based on medical necessity.
  - Hospice benefit is unlimited.
  - Unlimited bereavement support services for the family.
  - Transplants include: heart, lung, heart-lung, pancreas, pancreas-kidney, peripheral stem cell (i.e. bone marrow), small bowel and multivisceral.
Custom Plus Plan
- Close all future enrollment in the Custom Plus plan. Coverage for current members who are covered in the Custom Plus plan will be grandfathered.

HMO/POS and PPO Plans
- All transplants must be received through an Anthem approved facility. The $1 million maximum is removed. The amount Anthem will now pay for covered benefits will be equal to the health plan maximum covered benefit. The $25,000 donor health limit has been removed and a $30,000 donor search benefit for bone marrow and stem cells has been added.
- Prescription Drug – diabetic supplies and prescriptions will be covered under Tier 1.
- Prescription Drug – asthma inhalers and prescriptions will be covered under Tier 1.

HMO/POS, PPO and Custom Plus Plans
- Smoking Cessation Program – prescription drugs for smoking cessation are covered up to the $250 maximum benefit per year. Anthem's lifetime payment maximum is limited to $500 per member. No coverage for over-the-counter medications, counseling or programs.

Reminders:
- The contracted lab provider for Anthem is LabCorp.
- There is no coverage for anesthesia when administered by a separate anesthesiologist for colonoscopies, unless medically necessary and pre-authorized by Anthem.
- Flu Shots received at other locations (other than an in-network provider’s office) are reimbursable up to approximately $25 using the Flu Shot claim form at www.anthem.com, Colorado, Answers@Anthem, Download Commonly Requested Forms, Large Group Forms, Flu Shot Clinic Form.

Dental Insurance
Anthem Blue Cross and Blue Shield
You select your dental plan coverage during open enrollment or when you become a new benefit-eligible Employee. Two options are available:
- Anthem Blue Dental PPO Plus
- Anthem Blue Dental PPO

NOTE: Out-of-network services may be subject to balance billing. Out-of-network provider payments are based on a maximum allowable charge. If a provider's charge exceeds the maximum allowable charge, you, the member, pay the excess as an out-of-pocket.

Remember: Always verify in-network provider participation via the Anthem.com Website prior to receiving services.

Vision Insurance
VSP
This is a voluntary Employee-paid option selected during open enrollment each year. LASIK discounts are included in this plan.

NEW:
The following benefit changes are effective January 1, 2010:
- Retail frame allowance for VSP doctor is increased from $105 to $120.00.
Elective contact lenses allowance is increased from $110 to $120 for VSP and non-VSP doctors.

Basic Term Life Insurance

Anthem Life Insurance Company
Term Life and Accidental Death and Dismemberment coverage is provided as a basic plan. The basic coverage is two times your annual base salary (until age 65) to a maximum of $500,000 in death benefits for all benefit-eligible Employees. Review page 42 for details regarding basic coverage for Employees 65 and older. There is Dependent life coverage included in the group life insurance premium (see Basic Term Life Insurance section for details).

Voluntary Employee-Paid Term Life Insurance

Anthem Life Insurance Company
This plan is available for all benefit-eligible Employees, their spouses, Domestic Partners and children. An Employee can purchase coverage in $10,000 increments to a maximum of $300,000 in death benefits for yourself, your spouse and your Domestic Partner. Eligible Dependent children can be covered to a maximum of $5,000 per child. (Restrictions apply. See Voluntary Term Life Insurance chapter for details).

Voluntary Employee-Paid Accidental Death & Dismemberment Insurance

Mutual of Omaha Insurance Company
Accidental Death and Dismemberment Insurance can be purchased as an Employee Only Plan or an Employee and Family Plan. Coverage for you is available to a maximum of $500,000. Under the Family Plan, the benefit amount to your spouse or Domestic Partner will be 50% of yours and each eligible child’s benefit amount will be 10% of yours.

Flexible Benefit Plan

PayFlex Systems USA, Inc. (Except for Fort Lewis College)
The colleges, universities and institutions of higher education participating in the CHEIBA Trust offer a Flexible Benefit Plan under Section 125 of the Internal Revenue Code. There are three separate and optional components under the Plan: Pre-Tax Insurance Premium Payments, Health Care Spending Account, and Dependent Care Spending Account. These options provide you with the opportunity to pay some of your insurance premiums and other eligible family expenses with pre-tax dollars. Once selected, the Pre-Tax Insurance Premium Payment option will continue until a waiver is signed during open enrollment or as the result of a qualifying status change. Employees must re-enroll in the Health Care Spending Account and the Dependent Care Spending Account during open enrollment each year, or enroll as a new benefit-eligible Employee. The Spending Accounts are administered by the PayFlex Systems, USA, Inc. (except for Fort Lewis College).

Long-Term Disability Insurance

Standard Insurance
Should you experience a long-term disability, the plan will pay 66 2/3% of your salary to a maximum benefit of $7,000 per month, reduced by other income you receive or are eligible to receive because of your disability. You are eligible for benefits after you have been disabled for 90 days.
PERA Disability Program

(Requires 5 years of earned service credit to be vested in PERA)

PERA Disability Program
PERA provides vested members with a two-tier Disability Program. One tier is short-term disability (STD) insurance provided by an insurance company, and the other tier is a PERA disability retirement benefit. Since the Disability Program is part of the PERA benefits structure, members are not charged a premium for this program.

Travel Accident Insurance

The Hartford
This employer-paid insurance provides protection should you be seriously injured or die during employer-approved work-related travel (i.e. conferences, seminars and workshops etc).

Retirement Plans

Choices are available based on your location.
Various types of retirement plans are funded on your behalf by your employer. Choices vary based on your specific educational facility options. You also have voluntary Employee-funded options available to help you save for your future retirement needs. These tax-deferred voluntary plans may vary based on your employer and may include: 401(k), 457 or 403(b) plan choices.

CHANGING ELECTIONS DURING THE PLAN YEAR

After your institution’s annual open enrollment period is closed, you may change your benefits election during the Plan Year only after a qualifying status change. Within thirty-one (31) days of a qualifying status change, you must submit a written request to your Human Resources/Benefits Office specifying the change you are seeking. Upon approval of the change by your Human Resources/ Benefits Office, the election change is then completed by you on a new Employee Election Form. This approved election change will continue until another eligible event occurs or until you change your election during the next annual open enrollment period.

Eligible Events that May Allow Election Changes

All changes requested after open enrollment must be approved by the Human Resources/Benefits Office. Requested changes must be on account of and corresponding with a qualifying status change that affects eligibility for coverage under an employer’s plan.

Election changes must be requested within thirty-one (31) days of the qualifying status change event. Changes allowed under federal regulations must fit within one of these categories: HIPAA, FMLA, COBRA or Qualifying Status Change (see the following definitions).

Health Insurance Portability and Accountability Act (HIPAA)
Special enrollment provisions may allow you to enroll or add Dependents during the Plan Year and waive pre-existing condition exclusion waiting periods. This option applies only to insurance coverage changes. Special enrollment is only permitted if you properly waive coverage because you have other coverage and your other coverage involuntarily terminates. Special enrollment is also permitted when an Employee who was previously not enrolled marries or has a new child. You must request special enrollment in writing within
thirty-one (31) days of the event. See your Human Resources/Benefits Office for more details if you believe this applies to you.

When you or a covered Dependent terminates coverage under the health plan, the plan will send you a certificate of coverage that identifies the length of coverage under the plan. The HIPAA Certificate of Coverage may be needed if you enroll in another health plan that imposes a pre-existing condition waiting period. If you are eligible for Medicare and did not enroll in the Medicare drug card program, Medicare Part D, during the initial open enrollment in November 2005, you are also entitled to a notice of creditable prescription drug coverage. You will need this notice to later enroll in Medicare Part D without penalty.

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

Qualifying Status Changes
You are only allowed to change your election during a Plan Year, if certain life changes occur. Any approved election change must be on account of and corresponding with a qualifying change in status that affects eligibility for coverage under an employer’s plan.

Eligible changes listed under IRS regulations include the following status changes:
- change in Employee’s marital status; marriage, divorce, annulment, legal separation or death of a spouse;
- change in number of tax-eligible Dependents; birth, adoption, placement for adoption, court ordered change in legal custody status or Qualified Medical Child Support Order (QMCSO) or death of a Dependent;
- change in employment status: transition from full-time to part-time, part-time to full-time, strike or lockout, affecting an Employee, Employee’s spouse or Eligible Dependent;
- commencement of/or return from an unpaid leave of absence Family Medical Leave Act (FMLA) or other approved unpaid leave of absence by an Employee, Employee’s spouse or Eligible Dependent;
- commencement or termination of employment by an Employee, Employee’s spouse or Eligible Dependent;
- attainment or loss of Dependent eligibility as defined by the Plan, i.e., exceeding the Plan’s established age limitations, marriage or eligibility for coverage under another health plan would all qualify as an eligible change in status events;
- entitlement to/or loss of Medicaid or Medicare coverage by an Employee, Employee’s spouse or Eligible Dependent;
- residence and/or worksite change: a required change in place of residence and/or work site of an Employee, Employee’s spouse or Eligible Dependent, i.e., a move outside a health plan’s service area would qualify as a change in status event;
- an Employee may revoke his/her election or make a prospective election change during the Plan Year if the change corresponds with an open enrollment period change made by the Employee’s spouse or Eligible Dependent, provided that the election change is consistent with the changes under the group plan; or
- significant change in available benefits and/or their costs, i.e., if a fully insured health plan imposed a change in benefit coverage levels or increases premiums substantially, this would qualify as a change in status event. NOTE: This does not allow election changes in the Health Care Spending Account.
- Other eligible changes include the establishment of a domestic partnership.
NOTE: See your Human Resources/Benefits Office to request a change during the Plan Year and to help you determine if an election change is allowed based on your individual situation.

Required Government and Regulatory Section

- Medicare Secondary Payer Reporting Requirement

The Medicare Secondary Payer rules make Medicare the secondary payer to most employer-sponsored group health plans. Effective January 1, 2009, a new Mandatory Insurer Reporting Law will require insurers and third party administrators (TPAs) for group health plans to obtain certain information from plan sponsors and participants for the purpose of identifying situations where the group health plan is or has been a primary plan to Medicare. Social Security numbers are required for all members including dependents.

- Mental Health Parity Expansion

On October 3, 2008, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (Wellstone Act) was signed into law as part of the emergency economic recovery bill. The mental health parity legislation requires employer-sponsored group health plans to provide the same level of benefits for mental health coverage as for other physical illnesses and diseases. The act adds protection for substance abuse disorder benefits on the same basis as the protections for mental health benefits. These benefits include deductibles, copayments, out-of-pocket expenses, coinsurance, covered hospital days and covered out-patient visits. The effective date of the Mental Health Parity Expansion for the CHEIBA Trust is January 1, 2010.

- Children’s Health Insurance Program Reauthorization Act of 2009

The CHEIBA Trust group health plan will allow an employee or dependent who is eligible, but not enrolled for coverage, to enroll for coverage if either of the following events occur:

- Termination of Medicaid or CHIP Coverage - if the employee or dependent is covered under a Medicaid plan or under a State child health plan (SCHIP) and coverage of the employee or dependent under such a plan is terminated as a result of loss of eligibility;
- or

- Eligibility for Employment Assistance Under Medicaid or CHIP - if the employee or dependent becomes eligible for premium assistance under Medicaid or SCHIP, including under any waiver or demonstration project conducted under or in relation to such a plan (usually a program where the state assists employed individuals with premium payment assistance for their employer’s group medical, dental and vision plans rather than direct enrollment in a state Medicaid program).

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


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

- Genetic Information Nondiscrimination Act (GINA)
  Congress passed the Genetic Information Nondiscrimination Act (GINA) establishing a national and uniform standard to fully protect workers from genetic discrimination. In addition to prohibitions on discrimination in employment practices, GINA prohibits group health insurers and group health plans from adjusting premiums or contributions based on genetic information. Also, GINA amended the HIPAA privacy rules to include genetic information in the definition of protected health information. The effective date of GINA for the CHEIBA Trust is January 1, 2010.

- Michelle's Law
  Michelle's Law allows seriously ill or injured college students to take up to one year of medical leave without losing their health insurance. Pursuant to the bill, group health plans cannot terminate coverage of a dependent child due to a medically necessary leave of absence before the date that is the earlier of:
  - The date that is one year after the first day of the medically necessary leave of absence;
  - The date on which such coverage would otherwise terminate under the terms of the plan or health insurance coverage.

  The effective date of Michelle’s Law for the CHEIBA Trust is January 1, 2010.

- Autism
  Effective January 1, 2010, Colorado will require health benefit plans to cover the assessment, diagnosis and treatment of autism spectrum disorders for a child. Treatment, to be prescribed by a licensed physician or licensed psychologist, shall include: (1) evaluation and assessment services; (2) behavior training, behavior management and applied behavior analysis; (3) habilitative or rehabilitative care including occupational therapy, physical therapy or speech therapy; (4) pharmacy care and medication if covered by the health benefit plan; (5) psychiatric care; (6) psychological care including family counseling; and (7) therapeutic care. The annual maximum benefit for mandated applied behavior therapy shall not exceed $34,000 for a child under nine years of age, and $12,000 for a child at least nine but under 19. Otherwise, autism coverage may not be subject to dollar limit, deductibles or coinsurance provisions that are less favorable to an insured than those applicable to physical illness under the plan.

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- REMINDERS
  - Women’s Health and Cancer Rights Act
    All health plans offered through the CHEIBA Trust provide coverage for certain reconstructive services under the Women’s Health and Cancer Rights Act. These services include:
    - reconstruction of the breast upon which a mastectomy has been performed
    - surgery/reconstruction of the other breast to produce a symmetrical appearance
    - prostheses
    - treatment related to physical complications during all stages of mastectomy, including lymphedemas
Refer to your certificate of coverage for specific information on coverage. The plans may apply deductibles and copays consistent with other coverage provided.

○ **Participant Advocate Link “P.A.L.”**

You have a P.A.L.! This service is provided by the CHEIBA Trust (at no cost to you) to assist you in resolving benefit issues that you have been unable to resolve on your own. Your P.A.L. is an independent consultant located at Gallagher Benefit Services, Inc., the full-service benefit consulting firm for the CHEIBA Trust. If you have billing problems with your doctor or hospital, a claim or service denied in error, reimbursement problems, trouble seeing a specialist, disability insurance or life insurance problems, call your P.A.L. directly at 303-889-2790 or 1-800-943-0650; Monday through Friday from 8:00 a.m. to 5:00 p.m. When you call, have your Member ID number, name of the college or agency and other relevant information available (i.e. name of insurance company, group number, date of service, physician or hospital name, bills or letters from the insurance company).

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[ CONTINUATION COVERAGE RIGHTS UNDER COBRA ]

This information is being provided to you to fulfill the notice requirements of the COBRA regulations. The right to COBRA continuation coverage was created by a federal law, Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage may become available to you and your dependents that are covered under the Plan when you would otherwise lose your group health coverage. This notice gives only a summary of your COBRA continuation coverage rights. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan’s Summary Plan Description or get a copy of the Plan Document from the HealthSmart COBRA Administrator listed below.

COBRA continuation coverage for the Plan is administered by:

HealthSmart
10303 E. Dry Creek Road, Suite 200
Englewood, CO  80112
(800) 423-4445

○ **What is COBRA Continuation Coverage?**

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed later in this section. COBRA continuation coverage must be offered to each person who is a “qualified beneficiary”. A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, Employees, spouses of Employees, Domestic Partners and dependent children of Employees/Domestic Partners may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an Employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because either one of the following qualifying events occurs:

1. Your hours of employment are reduced, or
2. Your employment ends for any reason other than gross misconduct.

If you are the spouse or Domestic Partner of an Employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because any one of the following qualifying events occurs:

1. The Employee dies;
2. The Employee’s hours of employment are reduced;
3. The Employee’s employment ends for any reason other than gross misconduct;
4. The Employee becomes enrolled in Medicare (Part A, Part B, or both);
5. You become divorced or legally separated from your spouse; or
6. The domestic partnership is terminated.

Your dependent children and the dependent children of a Domestic Partner will become qualified beneficiaries if they will lose coverage under the Plan because any one of the following qualifying events occurs:
1. The parent/Employee dies;
2. The parent/Employee's hours of employment are reduced;
3. The parent/Employee's employment ends for any reason other than his or her gross misconduct;
4. The parent/Employee becomes enrolled in Medicare (Part A, Part B, or both);
5. The parents become divorced or legally separated;
6. The domestic partnership is terminated; or
7. The child stops being eligible for coverage under the plan as a “dependent child”.

When is COBRA Coverage Available?
The Plan will offer COBRA continuation to qualified beneficiaries only after the Plan Administrator has been notified in a timely manner that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the Employee, or enrollment of the Employee in Medicare (Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

Employees Must Give Notice of Some Qualifying Events
For the other qualifying events (divorce or legal separation of the Employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator. The Plan requires you to notify the Plan Administrator in writing within 60 days after the later of the qualifying event or the loss of coverage.

IF YOU, YOUR SPOUSE, DOMESTIC PARTNER OR DEPENDENT CHILDREN DO NOT ELECT CONTINUATION COVERAGE WITHIN THIS 60-DAY ELECTION PERIOD, YOU WILL LOSE YOUR RIGHT TO ELECT CONTINUATION COVERAGE.

How is COBRA Coverage Provided?
Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage on behalf of their spouses and Domestic Partners, and parents may elect COBRA continuation coverage on behalf of their children. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin either (1) on the date of the qualifying event or (2) on the date that Plan coverage would otherwise have been lost, depending on the nature of the Plan.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the Employee, your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the Employee’s hours of employment, and the Employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the Employee lasts until 36 months after the date of Medicare entitlement. For
example, if a covered Employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

Otherwise, when the qualifying event is the end of employment or reduction of the Employee’s hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability Extension of 18-month Period of Continuation Coverage
If you or anyone in your family covered under the Plan is determined by the Social Security Administration or PERA to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. This notice should be sent to the HealthSmart COBRA Administrator.

Second Qualifying Event Extension of 18-month Period of Continuation Coverage
If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse and dependent children if the former Employee dies, or gets divorced or legally separated. The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the HealthSmart COBRA Administrator.

If You Have Questions
If you have questions about your COBRA continuation coverage, you should contact the HealthSmart COBRA Administrator at 1-800-423-4445.

COBRA Premium Payment Guidelines
COBRA Premium Payment guidelines will be provided at the time of COBRA enrollment.

The monthly premium for continuation of the Health Care Flexible Spending Account is based on the annual amount you choose to contribute to the account and the number of months remaining under COBRA coverage during the period for which the employee made the election. The Plan may charge additional administrative fees for continued participation.

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

Keep Your Plan Administrator Informed of Address Changes
In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

**Important HIPAA Information:**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) includes some provisions that may affect decisions you make about your participation in the Group Health Plan under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). These provisions are as follows:

1. Under HIPAA, if a qualified beneficiary is determined by the Social Security Administration to be disabled under the Social Security Act at any time during the first 60 days of COBRA coverage, the 11-month extension is available to all individuals who are qualified beneficiaries due to the termination or reduction in hours of employment. The disabled individual can be a covered Employee or any other qualified beneficiary. However, to be eligible for the 11-month extension, affected individuals must still comply with the notification requirements.

2. A child that is born to or placed for adoption with the covered Employee during a period of COBRA coverage will be eligible to become a qualified beneficiary. In accordance with the terms of the employer's group health plan(s) and the requirements of Federal law, these qualified beneficiaries can be added to COBRA coverage upon proper notification to the Plan Administrator of the birth or adoption.

3. HIPAA restricts the extent to which group health plans may impose pre-existing condition limitations.

4. If you were covered by a group health plan(s) prior to your employment with an employer in the CHEIBA Trust, your previous employer or their insurance carrier should have provided you with a Certificate of Creditable Coverage, a form required by the HIPAA law that describes the health coverage you and your dependents, if any, have or had, and the dates you were covered. IF YOU HAVE NOT RECEIVED A CERTIFICATE OF CREDITABLE COVERAGE AND ARE ENTITLED TO ONE, PLEASE CONTACT YOUR FORMER EMPLOYER. Once you deliver the Certificate of Creditable Coverage to your Human Resources/Benefits Office, you are exempt from any pre-existing condition exclusions in our group health plan(s), provided you had twelve months of creditable coverage (eighteen months if a late enrollment) and have not had more than a sixty-three day gap in coverage.

Under COBRA, your right to continuation coverage terminates if you become covered by another employer's group health plan that does not limit or exclude coverage for your pre-existing conditions. If you become covered by another group health plan and that plan contains a pre-existing condition limitation that affects you, your COBRA continuation coverage cannot be immediately terminated. However, if the other plan's pre-existing condition rule does not apply to you by reason of HIPAA's restrictions on pre-existing condition clauses, the employer's group health plan(s) may terminate your COBRA coverage.

If you have any questions about COBRA, or if you have changed marital status, or you or your spouse have changed addresses, please contact the HealthSmart COBRA Administrator.

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IMPORTANT NOTICE FROM THE CHEIBA TRUST ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE (CREDITABLE COVERAGE NOTICE)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the CHEIBA Trust and prescription drug coverage available for people with Medicare. It also explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage. Please share this information with any other family member who is covered under the plan and who may be eligible for Medicare Part D.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. The CHEIBA Trust has determined that the prescription drug coverage offered by the CHEIBA Trust for the HMO/POS, Prime PPO and Custom Plus plans is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage pays and is considered Creditable Coverage.

Because your existing coverage is Creditable Coverage you can keep this coverage and not pay a higher premium (a penalty) if you later decide to enroll in Medicare prescription drug coverage.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from November 15th through December 31st. However, if you lose creditable prescription drug coverage, through no fault of your own, you will be eligible for a sixty (60) day Special Enrollment Period (SEP) because you lost creditable coverage to join a Part D plan.

If you decide to join a Medicare drug plan, your CHEIBA Trust coverage will be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

If you do decide to join a Medicare drug plan and drop your CHEIBA Trust prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

You should also know that if you drop or lose your coverage with the CHEIBA Trust and don’t join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up at least 1% of the base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium may consistently be at least 19% higher than the base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.
For more information about this notice or your current prescription drug coverage, please reference the Colorado Health Plan Description Form included in the back pocket of the Benefit Booklet or contact your Human Resources/Benefits Office for further information. NOTE: You will receive this notice annually and at other times in the future such as before the next period you can join a Medicare drug plan, and if this coverage through the CHEIBA Trust changes. You also may request a copy.

For more information about your options under Medicare prescription drug coverage:
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. For more information about Medicare prescription drug coverage:
- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the Medicare & You handbook for their telephone number) for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

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