BeneCenter

2026 CHEIBA TRUST

EMPLOYEE BENEFITS GUIDE

Western Colorado University · Fort Lewis College · Metropolitan State University of Denver · Colorado State University Pueblo · Colorado School of Mines · Auraria Campus · Adams State University Colorado Great Stories Begin Here · University of Northern Colorado

Your CHEIBA Trust Benefits

We're committed to you and your health

An annual Open Enrollment period is announced each fall, in which eligible employees can make certain coverage changes. The enrollment window start and end dates vary by institution. The information in this booklet provides an overview of your 2026 benefits package to help you in making the choices that best meet your individual and family's needs – but it is up to you to take action.

In the end, it's your coverage. You have the power – take your health into your own hands through the selections available to you. We encourage you to review the current benefit offerings on BeneCenter before you enroll.

Ensure you elect the best coverage for you and your family:

- Carefully read the benefit summaries and utilize resources before completing your benefit election.
- Review the changes to your medical insurance for the 2026 plan year.
- Add or delete dependents from coverage under the plan.
- If you have questions, phone numbers and website addresses are included throughout this guide for your convenience.
- Make sure your beneficiaries are current on applicable lines of coverage.

"We know your health is important to you, and it is important to us, too. That's why the CHEIBA Trust is committed to providing you and your family a strong benefits package."

Who is CHEIBA?

CHEIBA stands for Colorado Higher Education Insurance Benefits Alliance. Your employer has joined together with seven other educational institutions to create more purchasing power in the insurance market. By creating a purchasing group of over 9,000 lives, your employer is able to deliver better benefits at a lower cost. The Trust meets every other month to monitor your plans, and reevaluates them each year to determine the best benefit offerings.

CHEIBA Trust Member Institutions:

Adams State University, Auraria Campus, Colorado School of Mines, Colorado State University Pueblo, Fort Lewis College, Metropolitan State University of Denver, University of Northern Colorado, and Western Colorado University.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal Law gives you more choices about your prescription drug coverage. Please see page 41 for more details.

Contents

Click on an icon to go to the page:

If you require this information in a different format, or have specific requirements under ADA accessibility, contact your institution's Human Resources/Benefits Office.

Go online to the BeneCenter

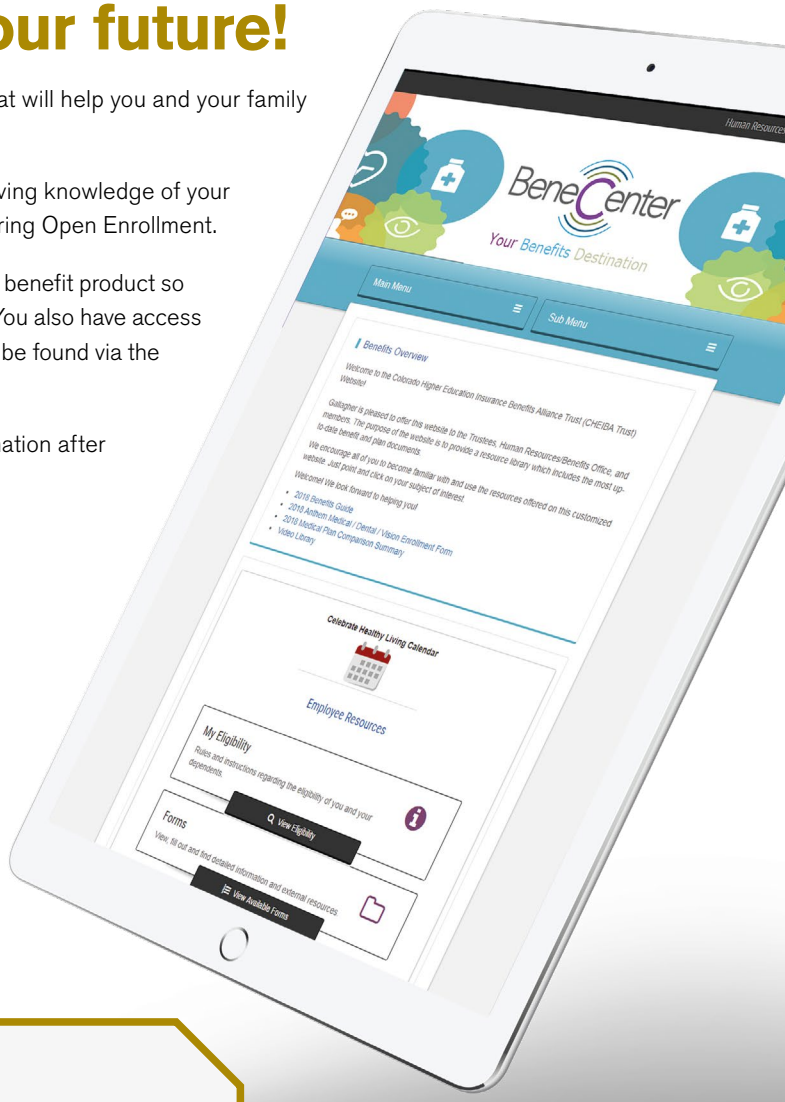
Open Enrollment 2026 – an opportunity to shape your future!

Understanding your benefits is the first step to making a decision that will help you and your family for the next calendar year.

We encourage you to become familiar with the benefits website; having knowledge of your benefit options will guide you to making more informed selections during Open Enrollment.

When you go online, you will find information regarding each employee benefit product so you can choose a benefit package that's right for you and your family. You also have access to various tools and resources loaded with helpful tips, all of which can be found via the BeneCenter home page.

This resource is available year-round should you need benefits information after Open Enrollment ends.



BeneCenter

To learn more about the benefit offerings, levels of coverage, Out-of-Network coverage, and the costs associated, go online to the BeneCenter.

mybensite.com/cheiba

Reference your rate sheet for login information.

What can you find on BeneCenter?

- ✓ BeneBits: Benefits Education Information
- ✓ Plan summaries and comparisons
- ✓ Enrollment and claim forms
- ✓ Health and wellness resources
- ✓ Information on special programs
- ✓ Customer service numbers
- ✓ Direct links to the insurance carriers
- ✓ Premium Information

AND MUCH MORE!

Benefit Advocate Center "BAC"

Need assistance with your benefits?

There comes a time when you'll have a question about your benefits. Your Advocate Team can assist you!

- Could you use help understanding your Explanation of Benefits?
- Is the pharmacy telling you that your medication is not covered or charging you full price?
- Do you need help with an authorization for a medication?
- Are you unsure if the insurance company will pay for a certain procedure?
- Did you receive a bill from a doctor but don't know why?
- Have you had a procedure denied and want to file an appeal?
- Do you need help with your disability or life insurance claim?

Call your Advocate Team!

This service is totally confidential and provided by the CHEIBA Trust at no cost to you. Your licensed healthcare benefit advocate is an independent consultant located at Gallagher, the full-service benefit consulting firm for the CHEIBA Trust.

When you call, have your Member ID number, name of your employer and other relevant information available (e.g. name of insurance company, group number, date of service, physician or hospital name, bills or letters from the insurance company).

Contact the BAC directly

Monday through Friday from
9:00 a.m. to 7:00 p.m. MST

844-931-1174

bac.cheiba@ajg.com

Key Information

You owe it to yourself to decide if the plans you choose fit how you use health care and insurance. Taking some time to analyze you and your family's situation could make a huge difference and save you money.

The following are your benefit offerings for 2026:

- Medical Insurance and Prescription Drugs
- Dental Insurance
- Vision Insurance
- Flexible Spending Accounts (FSA)
- Health Savings Account (HSA)
- Basic Term Life Insurance
- Voluntary Term Life and AD&D Insurance
- Long-Term Disability Insurance
- Employee Assistance Program (EAP)
- Travel Accident Insurance
- Voluntary Critical Illness, Accident and Hospital Indemnity
- Wellness Incentive Program

New hires

Eligible employees must enroll within 31 days of their first day of employment, and authorize payroll deductions. **If an eligible employee does not enroll or waive coverage within 31 days of the first day of employment, the employee will automatically be enrolled in the medical benefits Anthem Prime Blue Priority (PPO) and Anthem Dental Essential Choice PPO plans.**

Eligibility

Who is eligible to be a dependent?

- Legal spouse, including civil union and common law.
- Employee's or spouse's married or unmarried child(ren) until the end of the month in which their 26th birthday occurs or medically certified disabled child(ren) of any age. Children include your natural or legally adopted child, stepchild, or a child who is less than 26 and has been placed under your legal guardianship.

Timeframes

Documentation of dependency must be provided within the following timeframes:

- Within 31 days of benefits eligibility;
- During the annual Open Enrollment period; or
- Within 31 days of all changes related qualifying events.

Documentation

 **Legal Spouse**	Registered copy of marriage certificate, or common-law marriage affidavit, or registered copy of civil union certificate.
 **Child(ren)**	The child's birth or adoption certificate, naming you or your spouse as the child's parent, or appropriate custody or allocation of parental responsibility documents naming you or your spouse as the responsible party to provide insurance for the child.

Qualifying events

Qualifying events are the only opportunities to make changes to your benefit elections outside of annual Open Enrollment, and include, but are not limited to:

A marriage, common-law marriage, civil union, divorce, or legal separation.	The death of a spouse or other dependent.	The birth or adoption of a child.	You or your spouse experiencing a change in work hours that affects benefits eligibility.	Loss or gain of a spouse's coverage through their employer.

Changing your benefit elections related to these events must be completed within 31 days of the event.

Waiving coverage

- If employees elect medical coverage, they will automatically be enrolled in dental coverage. However, if employees waive medical coverage, they are still able to enroll in dental and vision coverage.
- If medical and dental coverage is waived, dependent coverage must also be waived.
- If coverage is waived, eligible employees and their dependents may only enroll in coverage during the next open enrollment, or within 31 days of a qualifying event.
- Medical coverage may only be waived with proof of other group medical coverage.

Section 125 pre-/post-tax elections

Complete the Section 125 election form to elect whether or not your insurance premiums will be taxed.

The Defined Contribution Pension Plan retirement benefits are based on the dollars contributed to the plan over your total years of employment. These contributions may be based on your taxable wages which are reduced by your participation in the Section 125 plan. However, you may be able to increase your voluntary retirement plan contributions to compensate for this reduction in contributions and reduction in future retirement benefits.

Public Employee Retirement Association (PERA) contributions are not paid on any dollars re-directed through participation in the Section 125 plan. PERA retirement benefits are based on your highest average salary. If you are within your final three years of employment under PERA, you may want to elect after-tax payments for insurance premiums and decline participation in the spending accounts.

If you joined PERA after July 1, 2019, please check with your benefits office.

Medical Insurance

What's new in 2026?

Changes to the Medical Plans

In response to increased health care costs, it was necessary to revisit the current medical plans offered to you and your family. To keep the amount you pay affordable, you will notice several changes to your plans for 2026.

What you need to know:

- The Blue Advantage HMO/POS
  - Introducing a coinsurance for inpatient hospitalizations, and a modest increase to the annual out-of-pocket maximums
  - Increasing the amount you pay for brand name and specialty medications
- The Prime Blue Priority PPO
  - Applying a modest increase to the current coinsurance percentage and out-of-pocket maximums
  - Increasing the amount you pay for brand name and specialty medications
- The 2500 HDHP PPO
  - Covering Live Health Online telehealth visits at no cost to members
  - Applying a modest increase to out-of-pocket maximums

Please see pages 9 through 12 for additional details.

Increased Dependent Care FSA Limit for 2026!

The annual contribution limit for the Dependent Care Flexible Spending Account (FSA) is increasing to $7,500 per household. This change, part of recent legislation, gives families more flexibility to set aside pre-tax dollars for eligible dependent care expenses.

Please see page 22 for additional details.

Introducing the Benefit Advocate Center (BAC)

The Participant Advocate Liaison "P.A.L." program is moving to the next generation.

The Benefit Advocate Center (BAC) will provide you with the same excellent service as you have today, but with expanded resources to answer your benefit questions, resolve complex billing issues, find network providers and much more.

Please see page 5 for additional details.

Peace of mind when you need it most

Anthem Blue Cross and Blue Shield

We help you protect what's important to you, because it also matters to us. Having coverage when you need it most is as important to us as it is to your family. That's why the CHEIBA Trust offers you three medical insurance plans to choose from.

- Blue Advantage HMO/POS
- Prime Blue Priority PPO
- 2500 HDHP PPO

BeneCenter

To learn more about the benefit offerings, levels of coverage, Out-of-Network coverage, and the costs associated, go online to the BeneCenter.

mybensite.com/cheiba

Reference your rate sheet for login information.

Ensure you carefully review the summaries regarding the various medical insurance plan options to see if it is right for you and your family, before you make your selection.

How do the plans compare?

This is a brief benefit outline of In-Network coverage. For more detail, including Out-of-Network benefits, please see the plan documents in the BeneCenter at mybensite.com/cheiba.

	Blue Advantage HMO/POS	Prime Blue Priority PPO	2500 HDHP PPO
Plan Network Name	HMO Network	Blue Priority PPO Network	Anthem PPO Network
Out-of-Network access?	**Included**	**Included**	**Included**
Deductible Individual/Family	$500/$1,000**	$600/$1,200	$2,500/$5,000
Coinsurance	10% ***	20%	15%
Out-of-Pocket Max Individual/Family	$3,750/$7,500	$3,750/$7,500	$3,750/$7,500
Preventive Care	100% Covered	100% covered	100% covered
Telemedicine Live Health Online	$25 Copay	$10 copayment per visit	100% covered
Primary Office Copay	$25 Copay $0 Copay at a Marathon Health facility*	$10 Copay (Tier 1 - designated provider) 20% after deductible (Tier 2 - participating provider) $0 at a Marathon Health facility*	15% after deductible Significantly lower cost at a Marathon Health facility*
Specialist Office Copay	$50 Copay	$10 Copay (Tier 1 - designated provider) 20% after deductible (Tier 2 - participating provider)	15% after deductible
Inpatient Hospital	10% after deductible	20% after deductible	15% after deductible
Outpatient Surgery	ASC: $125 Copay Hospital: $250 Copay Rural: $175 Copay	10% at a freestanding facility; 20% after deductible at a hospital facility	15% after deductible
Advanced Imaging	Free Standing: $100 Copay Hospital: $250 Copay Rural: $150 Copay	10% at a freestanding facility; 20% at a hospital facility	15% after deductible
Emergency Room	$300 Copay (Deductible waived)	$300 Copay (Deductible waived)	15% after deductible
Urgent Care	$75 Copay (Deductible waived)	$75 Copay (Deductible waived)	15% after deductible

* Must be enrolled in the Marathon Health program to visit an Marathon Health provider. See page 15 for details.
** Deductible applies to facility charges only.
*** Coinsurance applies to Inpatient Hospital only.

How to find an In-Network Doctor/Facility

To find an In-Network provider, visit **anthem.com/find-care**.

If you are a current member, "**Log in for a personalized search**". If you are not yet enrolled, select "**Basic search as a guest**" and follow the steps below.

1. Select "**Medical Plan or Network**" for the type of plan or network.
2. Select "**Colorado**" for the state where the plan or network is offered.
3. Select "**Medical Networks**" for how you get health insurance.
4. For "**Select a plan or network**", choose one of the following based on your CHEIBA plan:
   - Blue Advantage HMO/POS = Select "**POS**" for providers in Colorado, or select "**Anthem PPO**" for providers in other states.
   - PRIME Blue Priority PPO = Select "**Blue Priority PPO**" for providers in Colorado, or select "**Anthem PPO**" for providers in other states.
   - 2500 HDHP PPO = Select "**Anthem PPO**".
5. Enter the remaining search criteria.

What are my options?

Blue Advantage HMO/POS

This plan offers the convenience of an HMO with low deductibles and copays, with the flexibility of using PPO doctors, but with higher out of pocket costs. It's important to understand the coverage options and costs based on where you live and which doctors you visit. There are 3 tiers of coverage. A detailed description of this plan, and helpful resources can be found on the BeneCenter.

Tier 1 – Best Coverage (Lowest Cost)

- For members in Colorado using doctors in the HMO network.
- Lower costs with smaller deductible and copays.
- No surprise bills.

Tier 2 – Medium Coverage

- For members in Colorado using PPO network doctors, or anyone outside Colorado using PPO network doctors.
- Higher costs with bigger deductible and coinsurance.
- No surprise bills.

Tier 3 – Highest Potential Cost

- For anyone seeing a doctor who's not in the Anthem network.
- Possible surprise bills (balance billing).

Tier	Individual Deductible	Family Deductible	Individual Max Cost	Family Max Cost
1	$500	$1,000	$3,750	$7,500
2	$3,000	$6,000	$7,500	$15,000
3	$3,000	$6,000	$7,500	$15,000

How to Find a Doctor

- Use the Sydney app or visit www.Anthem.com
- Log in as a member and click on "Find Care"
- If enrolled in the HMO/POS plan, your experience will be customized to you
  - If you're in Colorado, it will show HMO doctors (Tier 1)
  - If you're outside Colorado, it will show PPO doctors (Tier 2)

Prime Blue Priority PPO

This plan utilizes the broader national PPO network of providers. Members receive the highest level of benefits when seeing PPO providers. Members can also see providers who are not in the Anthem PPO network, but for higher out-of-pocket costs.

Tier 1 (designated) – Best Coverage (Lowest Cost)

- For members in Colorado using doctors in the Preferred network.
- Lower costs with deductible, coinsurance and copays.
- No surprise bills.

Tier 2 (participating) – Medium Coverage

- For members using PPO network providers.
- No copays with same deductible and coinsurance as Tier 1.
- No surprise bills.

Tier 3 – Highest Potential Cost

- For anyone seeing a doctor who's not in the Anthem network.
- Possible surprise bills (balance billing).

2500 HDHP PPO

This plan is an HSA qualified, High Deductible Health Plan (HDHP). With this plan:

- You may pay less out of your paycheck, but more out of pocket at the time of service.
- You can see in and out of network providers but using in-network doctors and facilities provide the greatest cost savings.
- You pay 100% for all services until the deductible is met, even for prescription drugs. The only exceptions are for preventive care and Live Health Online telehealth services which are covered at no cost to you.
- You may be eligible to put pre-tax dollars into an HSA account and use those funds to pay for eligible medical, dental and vision care expenses tax free. An HSA has features similar to a Flexible Spending Account, but with more flexibility.

Prescription Drug Benefits

Save more on regular medications

Your prescription drug coverage has five tiers, with generic medications having the lowest cost. Plans use a drug list called a formulary to help determine your cost for each prescription. Your Essential Formulary can be found on the BeneCenter or on Anthem's website at **anthem.com/pharmacyinformation**.

If you take regular medications for ongoing conditions such as asthma, diabetes, or high blood pressure, you can eliminate monthly trips to the pharmacy and receive a larger supply with fewer copayments with the home delivery service. Typical savings are at least one copayment for each prescription.

Prescription drugs purchased from Out-of-Network pharmacies on the Blue Advantage HMO/POS plan and Prime Blue Priority PPO plan are not covered.

	Blue Advantage HMO/POS	Prime Blue Priority PPO	2500 HDHP PPO
Prescription Drug Deductible	None	None	Medical deductible applies
Retail (30-day supply)			
Preventive Drug*			
Generic/ Preferred Brand/ Non-Preferred Brand	$5/ $25/ $50	$5/ $25/ $50	$5/ $25/ $50
Tier 1: Generic	$10 copayment	$10 copayment	15% after deductible
Tier 2: Preferred Brand	20% coinsurance (max $60)	20% coinsurance (max $60)	15% after deductible
Tier 3: Non-Preferred Brand	30% coinsurance (max $120)	30% coinsurance (max $120)	15% after deductible
Tier 4: Specialty Preferred**	20% coinsurance (max $175)	20% coinsurance (max $175)	15% after deductible
Tier 5: Specialty Non-Preferred**	30% coinsurance (max $300)	30% coinsurance (max $300)	15% after deductible
Mail Order (90-day supply)	2.5x retail cost for Preventive Rx, Tier 1, Tier 2 and Tier 3	2.5x retail cost for Preventive Rx, Tier 1, Tier 2 and Tier 3	Preventive Rx: 2.5x retail cost All Tiers: 15% after deductible

*To see if your prescription is on the PreventiveRx drug list, visit www.mybensite.com/cheiba

**Not all specialty drugs on Tier 4 or Tier 5 are subject to the Tier 4 or Tier 5 coinsurance. Certain specialty drugs may be subject to the Tier 1, 2 or 3 copayment. Specialty drugs by overnight mail or common carrier, up to a 30-day supply, must be ordered through CarelonRx Pharmacy at 1-833-267-2136.

To start home delivery, go to the Pharmacy pages (Anthem/Sydney) or call CarelonRx Mail:

anthem.com

Sydney Health app

833-320-1180

Recommended preventive care routine for adults

100% coverage on all medical plans

	18-29	30-49	50-59	65+
Women	**Pap Smear** (every 3 years from age 21 - 29 and every 5 years from age 30 to 65)	**Mammogram** (every 2 years from age 40 - 74 for women at average risk) **Cholesterol Test** (regularly between 40 and 75)		**Bone Density Scan** (regularly from age 65)
Men		**Cholesterol Test** (every 4-6 years for healthy adults starting from age 20. More frequent testing if risk factors)	**Prostate Cancer Screening** (age 55-69)	**Abdominal Ultrasound** (once between ages 65-75)
Both	**Body Mass Index** (yearly) **Blood Pressure Test** (yearly) **STD Screening** (yearly, depending on sexual activity)	**Blood Sugar Test** (every 3 - 5 years, from age 35)	**Colonoscopy** (every 10 years, after age 45)	

Move to Medicare

Medicare can be a complex topic to navigate. CHEIBA wants to ensure that their members have tools to guide them through this next stage of their healthcare life.

Anthem's Move to Medicare program is a completely free service available to all employees and their families to help you understand your Medicare options and navigate the process.

Contact CHEIBA's Medicare VIP Concierge for guidance.

Jennifer Gerhardt, MPH
Medicare VIP Concierge
818.254.5381
Jennifer.gerhardt@anthem.com

Learn more about Medicare with a webinar at **https://bit.ly/MedicareABCBS**.

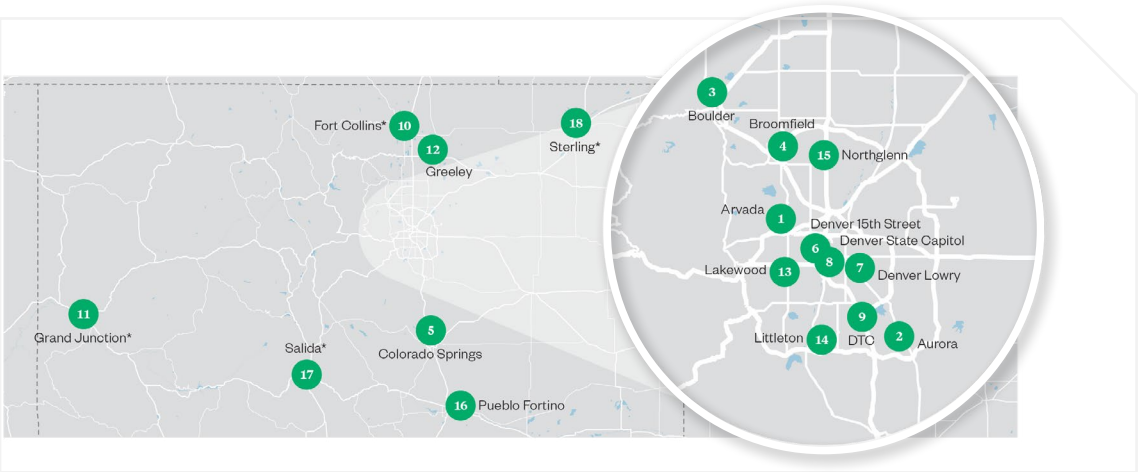
Marathon Health

The healthcare you want and the convenience you need.

Employees and eligible family members who are enrolled in an Anthem plan have access to Marathon Health at no additional cost. Partner with an experienced primary care doctor who delivers a broad scope of care, including primary and preventive care, chronic condition management, same- or next-day appointments for urgent care, and coordination with specialists and hospitals.

- Most services are little to no cost, with no copays or coinsurance,* with a wait time averaging less than 5 minutes.
- Access your doctor 24/7 via phone for urgent needs, email through the health portal or visit your doctor at a convenient location near work or home, including those who live in the Denver Metro area, Boulder, Colorado Springs, Fort Collins, and Pueblo.

Convenient locations:



As part of your benefits through the CHEIBA Trust, you and your eligible family members have access to Marathon Health, formerly Everside Health.

888.830.6538 my.marathon.health

*Members enrolled in the HDHP will pay a significantly lower cost than at a non-Marathon Health facility until they meet their deductible, then will pay $0.

DispatchHealth

Injured or feeling ill?

Get urgent care treatment at home with no membership required. DispatchHealth brings urgent care to you on-demand at your home or workplace.* A medical team arrives equipped with the latest technology and tools to treat common ailments to severe injuries and illnesses. These services will be covered the same as an urgent care visit.

How does it work?

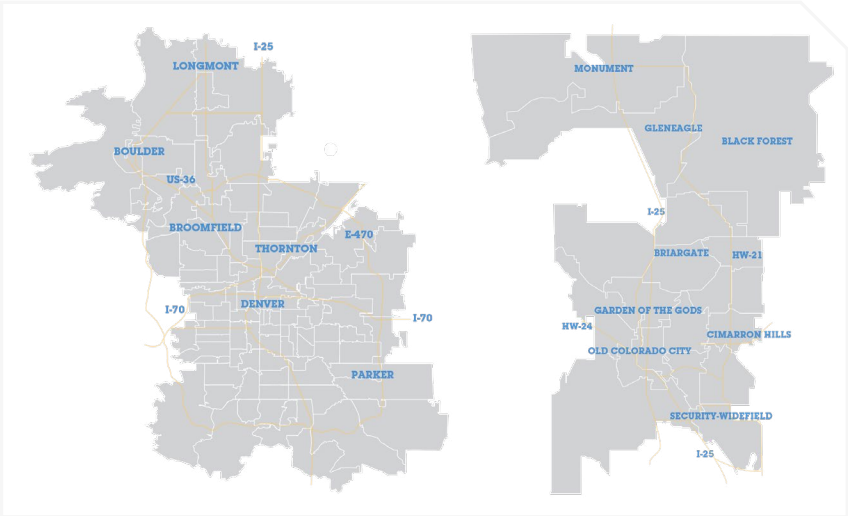
1	2	3	4
Call or go online to request care.	Explain your symptoms to trained medical technicians to ensure correct care.	Stay put at home/work, ER-trained care teams usually arrive within an hour.	Rest up. The mobile team will handle any prescriptions, doctor updates, and billing.

DispatchHealth is available 7 days a week, 365 days a year (from 7a.m.–10p.m.) for those that live in the Denver Metro area, Boulder, and Colorado Springs.

Where we serve:

DispatchHealth is available in the shaded areas as shown below. Check to see if your zip code is in the DispatchHealth service area at **www.dispatchhealth.com/locations/co/denver/map**.

Denver Metro



To get in contact with DispatchHealth, call or go online to request care.

303-500-1518

dispatchhealth.com

*Not currently available in Alamosa, Colorado Springs, Durango, Greeley, Gunnison, or Pueblo.

Sydney

Tired of paperwork and phone calls?

Anthem offers its members a useful website, **anthem.com**, and smartphone app Sydney Health™ takes the hassle out of your health care and allows you to get your information when you need it, help find a doctor, estimate your costs and manage prescription benefits. For a tutorial of the Sydney app, please visit **mybensite.com/cheiba**.

Click through Medical & Prescription > Sydney Mobile App > Video: Sydney Health (anthem.com)

Register at anthem.com

Helpful extras – included in your Anthem Plan at no additional cost

24/7 NurseLine – confidential, one-on-one conversations

With 24/7 NurseLine, you can talk to a nurse about hundreds of health issues from colds, coughs, and headaches to food and diet, smoking, and women's health.

800-337-4770

ConditionCare – make a real difference

ConditionCare offers 24-hour, toll-free access to registered nurses to answer questions and provide support as well as educational tools to help mange conditions, such as diabetes, coronary artery disease, heart failure, chronic obstructive pulmonary disease or asthma.

866-962-0953

Building Healthy Families – nurses available around the clock

Benefit from useful maternity care materials and tools to help you. Your Building Healthy Families nurse tracks your pregnancy, identifies possible risks, and provides extra pre- and post-natal confidential support and education.

800-828-5891

Colorado QuitLine – if you would like to quit smoking, join the QuitLine

Join the Colorado QuitLine free and receive your personally tailored quit program, nicotine replacement therapy, support network, telephone coaching, and tools and tips based on the latest research.

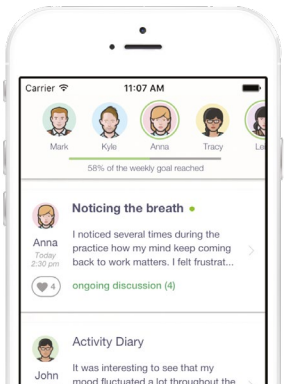
800-784-8669

Meru Health

Wellbeing and healthy lifestyle support

Meru Health* is here to help improve your mental health through a 12-week program proven to reduce anxiety, depression, and burnout. Over the course of three months, you will learn and practice the skills needed to create long-lasting healthy lifestyle habits —all with the daily support of your personal therapist and peer group.

1-833-940-1385 **meruhealth.com/cheiba**



*Meru Health is presently only available to Colorado residents.

Dental Insurance

Smile, you're covered

Anthem Blue Cross and Blue Shield

Strong teeth and healthy gums are a big part of your overall health. We give you coverage when it comes to your teeth and gums for a reason. Aside from routine check-ups and cleanings, knowing that you're covered should you need to see a dentist or a specialist for a big-ticket procedure, such as fillings, root canals, and crowns, is added peace of mind.

The Anthem Dental Essential Choice PPO network offers you a broad provider network and comprehensive dental benefits.

The Anthem Dental Essential Choice PPO also allows access to powerful member tools, including Ask a Hygienist, risk assessments, cost estimators, as well as network information and on-the-go claims info via Anthem Anywhere. **Look for a provider listing in the Anthem "Dental Complete" Network on anthem**.com.

BeneCenter

To learn more about your dental plan, Out-of-Network coverage, and the costs associated, go online to the BeneCenter.

mybensite.com/cheiba

Anthem Dental Essential Choice PPO Prices

Benefit	Description	In-Network	Out-of-Network
Deductible	Individual/Family	$0/$0	$50/$150
Preventive/Diagnostic	▪ Oral Exam ▪ X-rays ▪ Cleanings (2x annual for adults)	100% Deductible waived	80%
Basic	▪ General anesthesia ▪ Endodontics ▪ Periodontal ▪ Tooth extractions ▪ Root canals ▪ Specified space maintainers	80%	60%
Major (Prosthodontic/ Repairs)	▪ Crowns/onlays ▪ Removable/fixed partials or dentures ▪ Implants ▪ Oral surgery	50%	40%
Orthodontics	Realignment of teeth (adults and children)	50%	40%
Orthodontics Maximum	Per eligible person	$1,500	$1,500
Annual Maximum per person	Per insured person. Preventive/ diagnostic costs do not apply.	$2,000	$2,000

Vision Insurance

Your vision, our coverage

Anthem Blue View Vision

We understand how important vision is in everyday life, and how expensive it can be if you aren't insured. That's why we give you coverage that will help your eye health and your wallet at the same time. Employees can elect the voluntary full-service vision coverage, comprising of a yearly vision exam, eyewear materials, and lens treatments (LASIK discounts are also included in this plan) all through the Blue View Vision network.

BeneCenter

To learn more about your vision benefit, levels of coverage, Out-of-Network coverage, and the costs associated, go online to the BeneCenter.

mybensite.com/cheiba

Plan Prices

Benefit	Description	Copay	Frequency
Vision Exam		$15 copay, then 100% covered	12 months (from last day of service)
Materials		$15 copay	12 months (from last day of service)
Frames		$130 allowance, then 20% off remaining balance	12 months (from last day of service)
Lenses	▪ Plastic Single Vision ▪ Plastic lined Bifocals ▪ Plastic lined Trifocals	$15 copay, then 100% covered	12 months (from last day of service)
Lens Enhancements materials copay applies	▪ Transitions Lenses (Adult) ▪ Polycarbonate (Adult) ▪ UV Coating **Progressive Lenses** ▪ Standard ▪ Premium Tier 1 ▪ Premium Tier 2 ▪ Premium Tier 3 **Anti-Reflective Coating** ▪ Standard ▪ Premium Tier 1 ▪ Premium Tier 2 ▪ Other Add-ons and Services	$75 $40 $15 $65 $85 $95 $110 $45 $57 $68 20% off retail price	Included as part of the Lenses Benefits
Contacts	▪ Medical Necessary ▪ Elective Conventional ▪ Elective Disposable ▪ Exam & Fitting	Covered in full $130 allowance, 15% off balance $130 allowance Up to $55	12 months (from last day of service)
Low Vision Benefit Those with severe visual problems that are not correctable with regular lenses	Maximum Supplementary Testing Supplementary Care Aids	$1,000 Covered in full 25% copay	24 months
Additional Glasses Benefit	Additional sets of glasses can be obtained on the same day as an exam by the same provider	40% discount	

Lasik VisionCare Program
Anthem BVV partners with TruVision & Premier Lasik to offer multiple discount options for Lasik surgery candidates. Log in at anthem.com, select discounts, then Vision, Hearing & Dental.

Remote Health Options

Virtual healthcare where and when you need it.

Often virtual healthcare visits are a safe and efficient way to receive care from a provider, wherever you are. By using online video, you can access consultations, get answers to medical questions, diagnose illnesses, evaluate injuries and access at home dentistry. Anthem's virtual care offering helps redirect unnecessary emergency room visits and is often the same cost or less than a regular office visit.

What are the benefits of virtual healthcare?

- ✓ **Affordable –** Typically costs the same or less than a regular office visit.
- ✓ **Convenient –** Available at home or on the go, 7 days a week.
- ✓ **No waiting –** Be seen in minutes or schedule a time to suit you.

LiveHealth Online

Administered through Anthem, LiveHealth Online offers at home or on the go private video visits with board-certified doctors, mental health professionals, psychiatrists or licensed therapists from your smartphone, tablet or computer.

To sign up for LiveHealth Online or for more information, visit **livehealthonline.com** or download the app and register on your phone or tablet.

855-603-7985
livehealthonline.com

Ortho@Home

At home orthodontia is now covered as part of select Anthem Dental plans. By partnering with several popular providers, such as Byte and Candid, Anthem is now able to offer clear orthodontic aligners at home, overseen remotely by licensed dentists.
On average, at home orthodontia costs up to 60% less than traditional orthodontics.

To find a participating provider please visit **anthem.com** or contact your Anthem representative.

TheTeleDentists

TheTeleDentists® is an in-network provider with Anthem, offering virtual dental consults via laptop, tablet or smart phone – all from board-licensed dentists.

Providing a valuable solution if primary care dental offices are closed, lack teledentistry capabilities, or for those members who do not have a primary care dentist, Anthem covers all teledentistry care the same as if provided in a dentist office.

For more information visit **www.anthem.com/find-care** or contact your Anthem representative or the number on the back of your ID card.

Online vision tools

If you're a Blue View Vision member, you can use in-network benefits when ordering glasses and contacts online, saving you money, time and effort.

Glasses.com – offering a wide range of styles and 24/7 phone and online access, Glasses.com works with your eye doctor to make sure you get the right lenses for your vision.

ContactsDirect – Use your contact lens allowance to order lenses from the convenience of your home.

1-800 CONTACTS – get access to the largest variety of brand-name specialty lenses in stock and ready to ship.

Flexible Spending Accounts

Making your money go further

You have the option to take advantage of tax-efficient accounts if you so choose

When you choose to participate in a Flexible Spending Account, your monthly taxable income is reduced. Dollars elected in the Healthcare Spending Account are available to you at any time during the plan year. You can claim reimbursement for eligible expenses incurred while you are active in the account, up to your maximum elected amount. This plan is offered on a voluntary basis and participation may require an administration fee. See your institution's rate sheet for fee information.

Use the comparisons and descriptions below to carefully consider you and your family's health and child/dependent care needs, and estimate predictable expenses you will incur during the plan year. Any contributions to these accounts that are not used for eligible expenses incurred during the plan year will be forfeited unless your employer offers a roll-over option.

What is a Flexible Spending Account?

Pay some of your out-of-pocket medical, dental, vision, and other eligible family expenses with pre-tax dollars. Alerus tax-efficient accounts make your money go further. All you have to do is sign up to reap the reward.

Making changes to elections

You may change elections during the plan year only when a qualifying status change occurs as described earlier in this summary and in accordance with IRS rules governing tax qualified flexible benefit plans. Changes in a daycare provider would allow for a change in the election of the participant. You would be allowed to stop, increase or decrease your election for this reason. **Changes must be requested within 31 days of the status change and must be approved by your Human Resources/Benefits Office.**

You must enroll for the Healthcare Spending Account and the Dependent Care Spending Account on an annual basis. Please contact your Human Resources/Benefits Office.

"Use it or Lose it"

You must incur eligible expenses during the plan year while you are an active participant in the plan. All claims must be received no later than April 15 of the year following the plan year.

Dollars not claimed by April 15 will be forfeited. The 'Use it or Lose it' provisions may have some exceptions. Please check with your Human Resources/Benefits Office for more information. If employment is terminated, remaining FSA dollars can not be "cashed in". You may file claims for eligible expenses incurred prior to termination, or elect FSA COBRA to spend down the remaining FSA dollars.

What do these accounts mean to me?

Healthcare Spending Account

Through the Healthcare Spending Account, eligible out-of-pocket expenses incurred by you, your spouse and dependents during the plan year include the following items: deductibles, copayments, (non-cosmetic) dental work, orthodontics, prescriptions, eye care, glasses, LASIK, and PRK procedures, contact lenses, and more.

Generally, if a medical expense is considered eligible as a medical deduction on your federal tax return it may be eligible for pre-tax payments within your Flexible Benefit Plan. Expenses for your eligible dependents may be reimbursed through this account even if they are not enrolled in the CHEIBA Trust medical, dental, or vision plans. If you wish to continue to participate in this benefit you must re-enroll in the plan each year.

Dependent Care Spending Account

If you are single, married filing jointly, or filing head of household, you may contribute up to $7,500. The number of children or dependents does not impact the $7,500 limit. If you are married and filing separate tax returns, you are limited to $3,750 per spouse, per calendar year.

Eligible expenses must be for children under the age of 13, or for older dependents with a physical or mental disability requiring supervision so you and your spouse can work or attend college full-time. All care expenses must be necessary to employment or the pursuit of a college education on a full-time basis. Ineligible expenses include payments for referral services, parenting seminars, tuition expenses including kindergarten, child support payments, and payments to a spouse or other dependent for the care of the child or dependent. Overnight camp is not an eligible expense.

Note: You cannot take advantage of both the Dependent Care FSA and the ChildCare tax credit; however, you may be able to use a combination of the tax credit and the pre-tax program. When a combination is used you are limited to the tax credit limits for the total dollars allowed. Expenses paid through a Dependent Care Spending Account cannot be claimed as a tax credit on your income tax return or submitted to any other source for reimbursement. Be sure to consult a tax professional for information as to which tactic is best for your specific situation.

For a complete list of qualified medical expenses, see IRS Publication 502 at **www.irs.gov/forms-pubs/about-publication-502**.

Alerus – account types

	Healthcare Spending Account	Dependent Care Spending Account
	Re-enroll during open enrollment each year, or enroll as a new benefit-eligible employee.	Re-enroll during open enrollment each year, or enroll as a new benefit-eligible employee.
Maximum amount of reimbursement	Up to the IRS annual maximum limit. The 2026 limit is $3,400.	$7,500 if you are married filing jointly, or filing as single or head of household. $3,750 if you are married filing separately.
Minimum contribution	Check with your institution.	N/A
Payments not covered	Health-related insurance premiums.	N/A
Funds availability	Full election is available as of January 1.	Funds are available once they are deposited in the account (on a per period basis).

Health Savings Account

Why should I choose a health savings account (HSA)?

An HSA is a benefit that allows you to choose how much of your paycheck you'd like to set aside, before taxes are taken out, for healthcare expenses or use as a retirement savings tool. This plan offers tax savings that a 401(k) and IRA don't, making it a powerful option for diversifying your retirement portfolio. For 2026, you can contribute up to $4,400 annually for single coverage and up to $8,750 for family coverage. Individuals aged 55 or older can make an additional "catch-up" contribution of $1,000.

It's yours

Think of your HSA as a personal savings account. Any unspent money in your HSA remains yours, allowing you to grow your balance over time. When you reach age 65, you can withdraw money (without penalty) and use it for anything, including non-healthcare expenses.

Flexibility

Save for a rainy day. Invest for your future retirement. Or spend your funds on qualified expenses, penalty free.

Easy to use

Swipe your HSA benefits debit card at the point of purchase. There is no requirement to verify any of your purchases. We recommend keeping any receipts in case of an IRS audit.

Smart savings

The HSA's unique, triple-tax savings means the money you contribute, earnings from investments and withdrawals for eligible expenses are all tax-free, making it a savvy savings and retirement tool.

Investment options

You can invest your HSA funds in an interest-bearing account or our standard mutual fund lineup. Savvy investors may opt for a Health Savings Brokerage Account powered by Charles Schwab, giving you access to more than 8,500 mutual funds, stocks and bonds.

What does it cover?

There are thousands of eligible items. The list includes but is not limited to:

- ✓ Copays, coinsurance, insurance premiums
- ✓ Doctor visits and surgeries
- ✓ Over-the-counter medications (first aid, allergy, asthma, cold/flu, heartburn, etc.)
- ✓ Prescription drugs
- ✓ Birthing and lamaze classes
- ✓ Dental and orthodontia
- ✓ Vision expenses, such as frames, contacts, prescription sunglasses, etc.

View our searchable list of eligible expenses at **www.wexinc.com/insights/benefits-toolkit/eligible-expenses**

Can I enroll?

You must be enrolled in a high-deductible health plan (HDHP) in order to enroll in the HSA.

You're not eligible for an HSA if:

- You're claimed as a dependent on someone else's taxes.
- You're covered by another plan that conflicts with the HDHP, such as Medicare, a medical flexible spending account (FSA) or select health reimbursement arrangements (HRAs).
- You or your spouse are contributing to a medical FSA.

Wellness Program

Anthem's Wellness Reward Program

Get rewarded for reaching your goals

We want you to be as healthy as you can because we care about you and your family. To encourage you to live a healthier life, we are offering Anthem's incentive wellness program again this year.

Because your health is so important, we want to reward you for it. Anthem's wellness program offers many types of wellness activities you can earn incentives through. Below is a list of activities available to you:

Incentives*	
Complete Online Health Assessment	$25
Enroll in and complete ConditionCare	$100
Complete Online Digital Health Rewards	Up to $100**
Enroll and Complete Wellbeing Coach	$100
Complete Annual Wellness Exam	$50
Mammogram	$75
Colorectal Cancer Screening	$75
Prostate Cancer Screening	$75
Meru Program Completion	$50
Maximum Incentive Amount Per Person	**$225**

*Covered spouses are eligible to earn wellness program incentives.
**Visit mybensite.com/cheiba for a list of Digital Health Rewards.

BeneCenter

To learn more about Anthem's Wellness Reward Program and levels of coverage, go online to the BeneCenter.

mybensite.com/cheiba

How it works

As you complete your healthy activities, you will begin earning dollars towards a digital gift card. As you complete activities throughout the year and earn additional rewards, your rewards account is automatically updated with the funds.

Once you have completed your first Health Reward activity, you will have an online balance in your anthem.com account. You will be able to redeem those dollars at any point, or save them up through the course of the year. When you are ready, you can redeem your dollars by selecting a digital gift card on anthem.com or the Sydney mobile app.

How to access Anthem Health Rewards

To access Anthem Health Rewards through the member portal:

1. Register at **anthem.com**.
2. Go to the My Health Dashboard. Select Program.
3. Select Anthem Health Rewards.

To access it through the Sydney app:

1. Launch the Sydney App.
2. Go to the More Menu.
3. Select My Health Dashboard.
4. Scroll down and select My Rewards to view or Redeem
5. Rewards to select a gift card.

If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. **See the Wellness Program Disclosures on page 42** for more information.

Basic Term Life Insurance

A helping hand when you need it most

The Standard

It's unpleasant to think about, but you can take comfort in knowing your family is covered in the event of death or accident with Basic Term Life Insurance, which includes Term Life and Accidental Death and Dismemberment (AD&D). There's also dependent coverage, so you know you've got your entire family covered.

BeneCenter

To learn more about your Basic Term Life Insurance and levels of coverage, go online to the BeneCenter.

mybensite.com/cheiba

Maximum Benefits

The amount of life insurance benefit for active employees is calculated on your annual base salary. This plan provides the following coverage:

Age 66 and under	Age 67-69	Age 70 and over
Two times annual base salary to a maximum of $500,000	Two times annual base salary to a maximum of $50,000	$10,000
Coverage is rounded up to the nearest $1,000. If an employee takes a sabbatical and receives a lower salary during the time of the sabbatical, the life insurance benefit will be calculated at the lower salary level.		

Dependent Coverage	Beneficiary Changes	AD&D Benefits
Eligible dependents have a maximum benefit of $2,000 per person. Eligible dependent children aged 14 days to six months are insured for $200. Coverage excludes any person who is an employee and any person residing outside the United States or Canada.	You must submit any changes to your beneficiary designation through the Human Resources/Benefits Office.	Should you experience an unexpected loss due to accidental death or dismemberment, Anthem Life will pay the amount of insurance specified in the loss Schedule of Indemnities as explained in the Anthem Life brochure.

Voluntary Term Life & AD&D Insurance

Need more coverage?

Sun Life Financial

Voluntary Term Life & AD&D provides added security if you need more than the Basic Life Insurance included in your benefits. We understand you may want to provide more coverage for your family – the voluntary employee-paid term life insurance and AD&D insurance plans add protection beyond the basic plan. You'll have high-limit protection in case the unthinkable happens. Our voluntary employee-paid term life insurance plan can be designed to meet the needs of each individual or family.

BeneCenter

To learn more about your Voluntary Term Life & AD&D Insurance, levels of coverage, and the costs associated, go online to the BeneCenter.

mybensite.com/cheiba

	Voluntary Term Life	AD&D
Employee	Choose from $10,000 to $500,000 (without exceeding 5x annual salary) in $10,000 increments. The benefit amount is reduced to 50% at age 70 and to 35% at age 75.	Choose from $10,000 to $500,000 (without exceeding 5x annual salary) in $10,000 increments. The benefit amount is reduced to 67% at age 70 and to 50% at age 75.
Spousal	Additional coverage for your spouse is available from $10,000 to $300,000 in $10,000 increments. Starting with new plans issued in 2021, employees must have coverage for themselves in order to elect spouse coverage. Coverage ends when your spouse turns age 70.	Choose from $5,000 to $250,000 (without exceeding 100% of employees elected amount) in $5,000 increments. Coverage ends when your spouse turns age 70.
Dependent Children	Coverage for children age 14 days to 6 months is $500, in 6 months to age 26 choose from $5,000 to $25,000 in increments of $5,000 with no health questions asked. You must be accepted for coverage in order to elect child coverage.	Choose from $1,000 to $10,000 (without exceeding 100% of employees elected amount) in $1,000 increments.
Notes	This is a general summary of your Voluntary Term Life Insurance Plan. Final interpretations and a complete listing and description of any and all benefits, limitations and exclusions are found in, and governed by the Sun Life Master Contracts.	This is only an overview of your AD&D Plan, for more information, explanations and for a complete description of loss payment schedules, see the Sun Life Financial brochure.

Employees may elect up to $200,000 of coverage upon benefits eligibility without providing Evidence of Insurability when you are first eligible. Any employee who wishes to add or increase coverage after their initial eligibility may do so, but must be approved through medical underwriting.

Long-Term Disability Insurance

Let your benefits do the work

Sun Life Financial

If you're sick or hurt and can't work, you are covered with Long-Term Disability (LTD) Insurance. You are eligible to receive two-thirds of your salary, up to $7,000 a month, after you have been disabled for 90 days, so even during one of the hardest times of your life, you'll be able to support those you love.

Schedule of Coverage

LTD Benefit is the lesser of the following:

- 66.66% of your pre-disability earnings to a maximum benefit of $7,000 per month; or
- 70% of your pre-disability earnings, reduced by deductible income (i.e., Social Security or PERA disability).

The benefit waiting period is 90 days. The minimum monthly payment is $100. Cost-of-living adjustment (COLA) is included.

Some limitations may apply.

Any questions

Contact Sun Life Financial Customer Service.

800-247-6875

sunlife.com/us

Employee Assistance Program

Everybody needs support sometimes

We provide counseling and referrals through the Colorado State Employee Assistance Program (C-SEAP).

It's completely confidential, cost-free, and there are offices state-wide, or phone counseling, so you can talk to someone in your time of need.

C-SEAP is offered to State employees with work-related or personal concerns, and is a resource for supervisors and managers seeking individual managerial consultation, work-group organizational development, assistance with conflict resolution, or help with resolution of work-place traumatic events such as:

- Grief
- Domestic Violence
- Anger
- Stress
- Depression
- Anxiety
- Couples/Family Problems
- Health Concerns
- Substance Abuse
- Workplace Conflict
- Job Performance Concerns
- Personal/Professional Growth

> **Sometimes balancing work and personal responsibilities creates stress that is hard to handle on your own. We'll help you find the answers.**

C-SEAP offices are located in Downtown Denver, Loveland, Sterling, Grand Junction, Colorado Springs, Pueblo, Canon City, Alamosa, Golden and Durango. Phone counseling is available in all areas.

Want to schedule an appointment?

Call C-SEAP anytime Monday through Friday between 8 a.m. and 5 p.m.

303-866-4314
800-821-8154
colorado.gov/c-seap

Travel Accident Insurance

The coverage you're used to, anywhere on the planet

Unexpected medical emergency while you're traveling? No worries. That's already "packed" into your group life insurance. We want to make sure you can get the help you need — whenever you need it and no matter where you are in the world.

CHEIBA offers two options for travel insurance depending on which benefits meet your needs.

BeneCenter

To learn more about your Travel Accident Insurance go to:

mybensite.com/cheiba

Chubb – all employees

CHUBB provides all employees free access to Europ Assistance to give you 24/7 access to medical and travel assistance services around the world, while on business. That way, you never have to worry where you're covered and just have to worry about the situation at hand.

If the accidental injuries to the insured person result in death or dismemberment within 365 days of the date of the accident, a percentage of the maximum benefit "Principal Sum" ($100,000) of Accidental Death and Dismemberment will be paid depending on the injury sustained.

Traveling for work?

Go to the web link below for more information. Once registered follow the link in the automated email to complete your registration.

acetravelassistance.com

Group ID: aceah

Activation Code: security

For medical referrals, evacuation, repatriation or other services please call:

Chubb Travel Assistance Program
800-243-6124 (Inside the USA)
202-659-7803 (Outside the USA Call Collect)
OPS@europassistance-usa.com

Visit **www.acetravelassistance.com** for access to global threat assessments and location based intelligence.

Register to access the site using the Group ID and Activation Code:

Group ID: aceah
Activation Code: security

Travel Assistance Program

Plan Number: 01AH585
Organization: COLORADO HIGHER EDUCATION INSURANCE BENEFITS ALLIANCE TRUST
Policy Number: 9906-91-71
Assistance Provider: Europ Assistance USA

Europ Assistance provides emergency medical and travel services and pre-trip information services. Please call when:

- You require a referral to a hospital or doctor
- You are hospitalized
- You need to be evacuated or repatriated
- You need to guarantee payment for medical expenses
- You experience local communication problems
- Your safety is threatened by the sudden occurrence of a political or military event.

The Standard – Travel Assistance for benefits eligible employees

The Standard provides all benefits-eligible employees free access to Generali Global Assistance, Inc. (GGA) to give you and your dependents 24/7 access to medical and travel assistance services around the world. Whether you are traveling for personal or business, you can get medical travel assistance when you're more than 100 miles away from home for 90 days or less. You have access to medical expertise and coordination, emergency medical and travel assistance, and more.

If you have a medical emergency while traveling, call the local emergency authorities right away. Then, as soon as possible, call GGA using the travel assistance wallet card below. **All services, including medical transport, must be arranged in advance by GGA.**

Traveling for pleasure?

For travel emergency assistance services, first call the appropriate number below, depending on your location:

U.S. and Canada:
1-866-295-4890

Other locations (call collect):
+1-202-296-7482, Opt 2

Travel Assistance

Provided by Generali Global Assistance, Inc. (GGA) for The Standard

Valid only for eligible members with group life insurance coverage. Retirees are not eligible for travel assistance services.

For travel emergency assistance services, first call the appropriate number, depending on your location:

For more details, go to **www.standard.com**.

U.S. and Canada: **1-866-295-4890**
Other locations (call collect): **+1-202-296-7482**

For help, call the number above based on your location. All services must be arranged in advance by GGA to be cover.

When you call, you will hear the following prompts. Select Option 2:

1. For information regarding Beneficiary Companion Assistance.
2. If you have questions about Travel assistance or need assistance due to a medical emergency.
3. Unsure or have additional questions.

Travel Assistance Plans

	CHUBB – BTA	The Standard – Basic Life
Covered Population	All employees covered by the BTA policy	All employees covered by the Basic Life policy
Services Provided	Pre-Travel Risk Intelligence; Medical Assistance; Medical Evacuation and Repatriation	Pre-Trip Travel Tips; Emergency Travel Support; Medical Assistance; ID Theft Recovery & Monitoring, Legal Services (through Resource Advisor Benefits)
Covered Travel	Business travel, and personal excursions while on business travel – away from residence or regular place of employment. Limited to any consecutive 7 day period surrounding business or relocation travel	Any business or personal travel 100+ miles from home for 90 days or less
Covered Dependents	Employee only	Employee, spouse, and dependent children
Contracted Carrier and Contact Info	Europ Assistance 800-243-6124	Generali Global Assistance, Inc. US/Canada: 866-295-4890
International Coverage	Yes; call collect 202-659-7803	Yes; call collect 202-296-7482

Voluntary Accident Insurance

Accident Insurance

Sun Life Financial

Accidents can happen to anyone, and, if tragedy strikes, the costs associated with treatment can add up quickly.

Sun Life's Accident Insurance helps you manage such costs by paying a cash benefit if you or a covered family member require medical care as a result of a covered accident. You can spend it any way you choose and it is payable regardless of other coverage you may have.

Examples of covered injuries and services include:

- Broken bones
- Cuts
- Stitches
- Burns
- Hospital admission
- Physical therapy

BeneCenter

To learn more about Sun Life's Accident and Critical Illness Insurance, go online to the BeneCenter.

mybensite.com/cheiba

An example of how this benefit can help you:

Covered event: Inpatient – compound leg fracture	Benefit payment
Fracture (open)	$1,000
Ground ambulance	$100
Hospital admission	$500
Hospital confinement (15 days per accident) – 3 days	$450
Physical therapy – 8 times	$200
Physician follow-up visits – 2 times	$50
Total benefits	**$2,300**

Voluntary Critical Illness Insurance

Critical Illness Insurance

Sun Life Financial

Critical illnesses can have devastating physical and financial consequences. Health plans cover many of the direct costs associated with a critical illness, but related expenses like child care, travel, high deductibles and copays can also be worrying.

Sun Life's Critical Illness Insurance offers the financial help to pay the costs associated with life-altering illnesses. The plan pays a fixed benefit if you are diagnosed with a critical illness such as a heart attack, stroke, kidney failure, cancer, advanced Alzheimer's or Parkinson's, or if you require treatment like coronary artery bypass surgery or a major organ transplant. Benefits are paid directly to you so you decide how to spend the money.

Premiums for Critical Illness Insurance are age-based and correlate to your tobacco status. As part of the plan you can choose from $5,000 to $30,000 of coverage for yourself, $2,500 to $15,000 of coverage for a spouse, and $2,500 or $5,000 of coverage for children. The benefit amount is reduced to 50% at age 70.

BeneCenter

To learn more about Sun Life's Accident and Critical Illness Insurance, go online to the BeneCenter.

mybensite.com/cheiba

An example of how this benefit can help you:

Covered condition	Benefit payment
Wellness benefit: blood test for cholesterol	$50
Heart attack (100%)	$30,000
Recurrent heart attack (100%)	$30,000
Coronary artery bypass graft (25%)	$7,500
Total benefits	**$67,550**

Hospital Indemnity

Hospital Indemnity Insurance

Sun Life Financial

If you have to stay in the hospital, Hospital Indemnity insurance provides cash payments directly to you, to help protect your finances from the costs you may incur from a hospital stay.

- Supplement your health insurance with a lump sum benefit for hospital stays due to a covered accident or sickness.
- Pays benefits for each day that you're in the hospital.
  - $1,000 is payable the first day
  - $100 each day for up to 30 days while in the hospital
  - $100 per day for up to 10 days if you are in ICU
- Receive $50 for your annual wellness screening.
- Use the benefit however you see fit – to help pay for out-of-pocket medical costs like, co-pays or deductibles, or for everyday expenses like childcare or groceries.
- For more information on the benefits you could receive, refer to your plan details.

BeneCenter

To learn more about Sun Life's Hospital Indemnity Insurance, go online to the BeneCenter.

mybensite.com/cheiba

An example of how this benefit can help you:

Hospitalization for Heart Attack – 5 days/2 days ICU	Benefit payment
Wellness benefit: blood test for cholesterol	$50
First Day Hospital benefit	$1,000
Hospital Confinement	$500
ICU Confinement	$200
Total benefits	**$1,750**

FAQs

Key Contacts

Legal Notices

Frequently Asked Questions

What is the CHEIBA Trust?

The Colorado Higher Education Insurance Benefits Alliance Trust is a benefit purchasing consortium and trust. Each participating college shall designate one of its Employees to serve as a Trustee and member of the Trust Committee.

What is a copayment?

A copayment is a charge that must be paid at the time of service e.g. a visit to your doctor's office.

What is a coinsurance?

The portion of covered health care costs for which the covered person has a financial responsibility (usually a fixed percentage). Often coinsurance applies after first meeting a deductible requirement.

What is a deductible?

The amount of eligible expenses a covered person must pay each year from his/her own pocket before the plan will make payment for eligible benefits.

What is an Out-of-Pocket cost?

The portion of payments for health services required to be paid by the enrollee (includes copayments, coinsurance and deductibles).

What is an Out-of-Pocket limit?

This is the pre-determined amount of medical expenses you are responsible for before a plan pays 100% of remaining "reasonable and customary" charges. Certain charges like penalties for non-pre-certification and balance billing are not eligible for out-of-pocket limits.

What is a drug formulary?

This is a listing of prescription medications which are preferred for use by the health plan and which will be dispensed through participating pharmacies to covered persons. A plan that has adopted an "open or voluntary" formulary allows coverage for both formulary and non-formulary medications. A plan that has adopted a "closed, select or mandatory" formulary limits coverage to those drugs in the formulary.

What is 'balance billing'?

Out-of-network reimbursements are based on a maximum allowable fee schedule. If the provider's charge exceeds the maximum allowable fee schedule amount, you may be required to pay the excess amount as out-of-pocket expenses.

What is a Point-of-Service (POS) Plan?

A POS health plan allows the covered person to choose to receive a service from a participating or non-participating provider, with different benefit levels associated with the use of participating providers. POS can be provided in several ways:

- a HMO may allow members to obtain limited services from non-participating providers;
- a HMO may provide non-participating benefits through a supplemental major medical policy;
- a PPO may be used to provide both participating and non-participating levels of coverage and access; or
- various combinations of the previous options may be used.

What is a Health Maintenance Organization (HMO)?

An HMO is an entity that provides, offers or arranges coverage of health services needed by Plan members for a fixed, prepaid premium.

What is a High Deductible Health Plan (HDHP)?

An HDHP is a health insurance plan that has a high minimum deductible which does not cover the initial costs or all of the costs of medical expenses. The deductible must be met by the insurance holder before the insurance coverage kicks in. Compared to other plans, the HDHP has lower monthly premiums and you pay a portion of the expenses when you use the services.

What is a Health Savings Account (HSA)?

An HSA is a tax-favored savings account that, when paired with a qualified High Deductible Health Plan (HDHP), allows you to pay for qualified medical expenses, or leave funds invested in the account for future medical expenses, tax-free. An HSA account is a personal, portable account and remains in your control regardless of your employment. An HSA can be established through WEX. You will be responsible for monthly fees associated with the account.

What is a Flexible Spending Account (FSA)?

An FSA is a tax-free account which allows employees to set aside pre-tax dollars from their gross wages to later be reimbursed tax free for eligible expenses incurred during the plan year. Unclaimed dollars are forfeited to the employer. Accounts include a Health Care Spending Account for out-of-pocket health care expenses for the family and a Dependent Care Spending Account for dependent care expenses necessary to employment. There is also a pre-tax insurance payments process which allows Employees to use their pre-tax dollars to pay their share of all the CHEIBA Trust sponsored health-related insurance premiums.

If I terminate employment, when do my benefits end?

Eligibility will terminate at the end of the month of the termination of employment for any reason including death and retirement. Contact Human Resources/Benefits Office for other situations.

If I have a leave of absence, is my coverage affected?

Coverage under the Plan may continue for certain Employees on an Approved Leave of Absence, including but not limited to: Short/Long Term Disability, Workers Compensation Leave, Family and Medical Leave Act, Sabbatical or Military Leave under the "Uniformed Services Employment and Reemployment Rights Act". Contact your HR Department for information related to your specific leave.

What is the Section 125 Premium Only Plan?

A pre-tax insurance payments process which allows employees to use their pre-tax dollars to pay their share of all the CHEIBA Trust sponsored health-related insurance premiums.

Key Contacts

Here are some frequently used telephone numbers and websites if you need more information about any of the benefits we offer.

Health Insurance

Anthem Blue Cross and Blue Shield

- Blue Advantage Point of Service Plan (HMO/POS)
- Prime Blue Priority Plan (PPO)
- High Deductible Health Plan

Phone: 1-800-542-9402
Web: www.anthem.com

Building Healthy Families

Phone: 1-800-828-5891

24/7 NurseLine

Phone: 1-800-337-4770

LiveHealth Online

Phone: 1-888-548-3432
Web: www.livehealthonline.com

Meru Health

Phone: 1-833-940-1385
Web: www.meruhealth.com/cheiba

Prescription Drug Benefit

Home Delivery Pharmacy

Phone: 1-833-203-1739

Marathon Health

Phone: 888-830-6538
Web: my.marathon.health.com

DispatchHealth

Phone: 1-888-908-0553
Web: www.dispatchhealth.com

Health Savings Account (HSA)

WEX

Phone: 1-866-451-3399
Web: benefitslogin.wexhealth.com

Dental Insurance

Anthem Blue Cross and Blue Shield

- Anthem Dental Essential Choice PPO

Phone: 1-844-729-1565
Web: www.anthem.com

Vision Insurance

Anthem Blue Cross and Blue Shield

Phone: 1-866-723-0515
Web: www.anthem.com

Basic Term Life Insurance

The Standard

Phone: 1-800-552-2137
Web: www.standard.com

Voluntary Life and Accidental Death and Dismemberment Insurance

Sun Life Financial

Phone: 1-800-247-6875
Web: www.sunlife.com/us

Flexible Spending Accounts

Alerus

Phone: 1-877-661-4727
Web: www.alerusrb.com/Contact
Email: info@alerus.com
Participant Web: alerusrb.com

COBRA Coverage

Alerus

Phone: 1-800-761-1934
Email: cobra2@alerus.com
Participant Web: cobra.alerus.com

Voluntary Critical Illness Insurance

Sun Life Financial

Phone: 1-800-247-6875
Web: www.sunlife.com/us

Voluntary Accident Insurance

Sun Life Financial

Phone: 1-800-247-6875
Web: www.sunlife.com/us

Hospital Indemnity

Sun Life Financial

Phone: 1-800-247-6875
Web: www.sunlife.com/us

Long-Term Disability Insurance

Sun Life Financial

Phone: 1-800-247-6875
Web: www.sunlife.com/us

Colorado State Employee Assistance Program

C-SEAP

Phone: 303-866-4314
Toll Free: 1-800-821-8154
Web: www.colorado.gov/c-seap

Travel Accident Insurance

Chubb

Phone: 1-800-247-6875
Email: medservices@assistamerica.com
Web: www.assistamerica.com

Benefit Advocate Center (BAC)

Gallagher

Phone: 1-844-931-1174
Email: bac.cheiba@ajg.com

Legal Notices

Patient Protections Disclosure

The CHEIBA Trust Medical Plans generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Anthem Blue Cross and Blue Shield or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Anthem Blue Cross and Blue Shield at **anthem.com/find-doctor**.

Women's Health & Cancer Rights Act

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the plan.

If you would like more information on WHCRA benefits, please call your Human Resources Department.

Newborn's and Mother's Health Protection Act

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

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2025. Contact your State for more information on eligibility.

Alabama – Medicaid

Website: http://myalhipp.com Phone: 1-855-692-5447

Alaska – Medicaid

The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/ Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx

Arkansas – Medicaid

Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

California – Medicaid

Website: Health Insurance Premium Payment (HIPP) Program
http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

Colorado – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)

Health First Colorado Website: www.healthfirstcolorado.com
Health First Colorado Member Contact Center:
1-800-221-3943/State Relay 711
CHP+: https://hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service:
1-800-359-1991/State Relay 711
Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com
HIBI Customer Service: 1-855-692-6442

Florida – Medicaid

Website: https://www.flmedicaidtplrecovery.com
Phone: 1-877-357-3268

Georgia – Medicaid

GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1

GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: 678-564-1162, Press 2

Indiana – Medicaid

Health Insurance Premium Payment Program
All other Medicaid
Website: https://www.in.gov/medicaid
http://www.in.gov/fssa/dfr

Family and Social Services Administration
Phone: 1-800-403-0864
Member Services Phone: 1-800-457-4584

Iowa – Medicaid

Medicaid Website: Iowa Medicaid | Health & Human Services
Medicaid Phone: 1-800-338-8366
Hawki Website:
Hawki - Healthy and Well Kids in Iowa | Health & Human Services
Hawki Phone: 1-800-257-8563
HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov)
HIPP Phone: 1-888-346-9562

Kansas – Medicaid

Website: https://www.kancare.ks.gov
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

Kentucky – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP)
Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kynect.ky.gov
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms

Louisiana – Medicaid

Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

Maine – Medicaid

Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003
TTY: Maine relay 711
Private Health Insurance Premium Webpage:
https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740
TTY: Maine relay 711

Massachusetts – Medicaid & CHIP

Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: (617) 886-8102
Email: masspremassistance@accenture.com

Minnesota – Medicaid

Website: https://mn.gov/dhs/health-care-coverage
Phone: 1-800-657-3672

Missouri – Medicaid

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

Montana – Medicaid

Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

Nebraska – Medicaid

Website: www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

Nevada – Medicaid

Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

New Hampshire – Medicaid

Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext. 15218

Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

New Jersey – Medicaid & CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid
Phone: 1-800-356-1561
CHIP Premium Assistance Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710 (TTY: 711)

New York – Medicaid

Website: https://www.health.ny.gov/health_care/medicaid
Phone: 1-800-541-2831

North Carolina – Medicaid

Website: https://medicaid.ncdhhs.gov
Phone: 919-855-4100

North Dakota – Medicaid

Website: https://www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825

Oklahoma – Medicaid & CHIP

Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

Oregon – Medicaid & CHIP

Website: http://oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

Pennsylvania – Medicaid & CHIP

Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html
Phone: 1-800-692-7462
CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov)
CHIP Phone: 1-800-986-KIDS (5437)

Rhode Island – Medicaid & CHIP

Website: http://www.eohhs.ri.gov
Phone: 855-697-4347, or 401-462-0311 (Direct RIte Share Line)

South Carolina – Medicaid

Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

South Dakota – Medicaid

Website: http://dss.sd.gov
Phone: 1-888-828-0059

Texas – Medicaid

Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services
Phone: 1-800-440-0493

Utah – Medicaid & CHIP

Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp
Email: upp@utah.gov
Phone: 1-888-222-2542
Adult Expansion Website: https://medicaid.utah.gov/expansion
Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program
CHIP Website: https://chip.utah.gov/

Vermont – Medicaid

Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access
Phone: 1-800-250-8427

Virginia – Medicaid & CHIP

Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select

https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid/CHIP Phone: 1-800-432-5924

Washington – Medicaid

Website: http://www.hca.wa.gov
Phone: 1-800-562-3022

West Virginia – Medicaid & CHIP

Website: https://dhhr.wv.gov/bms
http://mywvhipp.com
Medicaid Phone: 304-558-1700
CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

Wisconsin – Medicaid & CHIP

Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

Wyoming – Medicaid

Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility
Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2025, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

HIPAA Notice of Privacy Practices Reminder

Protecting Your Health Information Privacy Rights

CHEIBA Trust is committed to the privacy of your health information. The administrators of the CHEIBA Trust (the "Plan") use strict privacy standards to protect your health information from unauthorized use or disclosure.

The Plan's policies protecting your privacy rights and your rights under the law are described in the Plan's Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting Human Resources department.

HIPAA Special Enrollment Rights

Notice of Your HIPAA Special Enrollment Rights

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

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

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

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

Important Warning

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

Notice of Creditable Coverage

Important Notice from CHEIBA Trust About Your Prescription Drug Coverage and Medicare

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. CHEIBA Trust has determined that the prescription drug coverage offered by the Blue Advantage HMO/POS, Prime Blue Priority PPO and HDHP medical plans are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

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

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current CHEIBA Trust coverage may be affected.

If you do decide to join a Medicare drug plan and drop your current CHEIBA Trust coverage, be aware that you and your dependents may be able to get this coverage back.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with 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 by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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

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

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

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

For more information about Medicare prescription drug coverage:

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

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1 800-772-1213 (TTY 1-800-325-0778).

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

Wellness Program Disclosures

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact your Human Resources department and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

NOTICE REGARDING WELLNESS PROGRAM

The Anthem wellness program is a voluntary wellness program available to all employees enrolled in one of the Anthem medical plans. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You are not required to complete the HRA.

However, employees who choose to participate in the wellness program will receive incentives as indicated on page 24 of this guide. Although you are not required to complete the HRA or participate in certain health related activities, only employees who do so will receive digital gift cards through Anthem.

If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting your Human Resources department.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and CHEIBA may use aggregate information it collects to design a program based on identified health risks in the workplace, the CHEIBA Wellness Program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information are Anthem health coaches in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained by Anthem and are separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Human Resources department.

COBRA General Notice

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

Introduction

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

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

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

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

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

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

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

When is COBRA continuation coverage available?

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

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

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

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

Alerus

Phone: 1-800-761-1934

Email: cobra2@alerus.com

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.healthcare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

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

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

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

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care – like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You are protected from balance billing for:

Emergency services

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

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

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

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

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

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

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you believe you've been wrongly billed, contact https://www.cms.gov/nosurprise/consumers or call 1-800-985-3059 to obtain more information and complaints.

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

Visit State Balance-Billing Protections | Commonwealth Fund for more information about your rights under applicable state laws.

Human Resources & Benefits Office contact information

Name of Entity/Sender	Contact Position/ Office	Address	Phone Number
Adams State University	Human Resources/ Benefits Office	208 Edgemont Blvd. Alamosa, CO 81101	719-587-7990
Auraria Campus	Human Resources/ Benefits Office	Campus Box C, PO Box 173361 1201 5th Street, #370 Denver, CO 80217-3361	303-556-3384
Colorado School of Mines	Human Resources/ Benefits Office	1500 Illinois Street Golden, CO 80401	303-273-3052
Colorado State University Pueblo	Human Resources/ Benefits Office	2200 Bonforte Boulevard Pueblo, CO 81001	719-549-2441
Fort Lewis College	Human Resources/ Benefits Office	1000 Rim Drive Durango, CO 81301-3999	970-247-7428
Metropolitan State University of Denver	Human Resources/ Benefits Office	Campus Box 47, PO Box 173362 Student Success Building 890 Auraria Parkway, Suite 310 Denver, CO 80217-3362	303-615-0999
University of Northern Colorado	Human Resources/ Benefits Office	Carter Hall, Rm. 2002 Campus Box 54 Greeley, CO 80639	970-351-2718
Western Colorado University	Human Resources/ Benefits Office	1 Western Way Taylor Hall, Room 321 Gunnison, CO 81231	970-943-3140

Authority of the CHEIBA Trust Committee

The CHEIBA Trust Committee has the sole and absolute discretion to interpret the terms of a Plan and determine the right of any Participant to receive benefits under a 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.

Disclaimer: These benefits are designed to meet your individual needs and preferences. While we expect to offer these benefits in future years, the CHEIBA Trust retains the right to discontinue or change the benefits at any time. Changes will be communicated, in writing, to all benefit-eligible Employees. In preparing these written materials, every attempt has been made to convey accurate information. The materials provide a summary of your benefits to be used as reference throughout the plan year. In the event of a discrepancy between the information contained herein and the Trust Agreement, a plan document or certificate of insurance under which a specific benefit or insurance is provided, the terms of the plan document or certificate of insurance shall take precedence over this booklet and shall prevail in settling any disputes or claims that may arise. If errors or discrepancies are found, contact your Human Resources/Benefits Office for the official plan document.