This document is a guide. It only briefly describes the employee benefits available for benefits-eligible employees. The plans and benefits described herein are sponsored by the University of Colorado Hospital Authority for employees who are part of the UCH Health System. If there are any differences between the information contained in this guide and the master plan documents, the plan documents, hospital policies and procedures, and any applicable federal and state laws will govern. The benefits described in this guide may be changed, modified or eliminated at any time and without advance notice.

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Back Cover
We are proud to provide competitive and comprehensive health and welfare benefits as part of our Total Rewards program. We are all part of the UCHealth system, comprised of:

- **UCHealth Central** (formerly UCH and University Hospital)
- **UCHealth South** (formerly Memorial Health System)
- **UCHealth North** (formerly Poudre Valley Health System)

We encourage you to review this guide and ask questions so you’re sure you’re making the right decisions for you and your family. The benefits you choose run through June 30, 2014.

**WHEN CAN I ENROLL?**

- **Current Employees** – Enroll online between May 6 and the May 24, 2013 open enrollment deadline.
- **New or Newly Benefit-Eligible Employees** – Enroll by the deadline provided during your benefits orientation.

Your benefit elections are in effect throughout the plan year. After you enroll, the next open enrollment is the **ONLY TIME** when you can make changes to your health and welfare benefit plans, UNLESS you experience a **qualifying life event** (see **Qualifying Life Events** on page 3 for details).

For open enrollment, you will receive a confirmation statement in the mail at your home address approximately two weeks after the enrollment deadline.

**ENROLL FOR COVERAGE**

If you don’t enroll or waive coverage by the enrollment deadline (see **When Can I Enroll?**), you will automatically be enrolled in these benefits:

- Medical: CU Health Plan – High Deductible, employee-only coverage
- Basic Life: 1 times annual base salary
- Basic Accidental Death & Dismemberment: 1 times annual base salary
- Basic Short Term Disability: 60 percent income replacement
- Basic Long Term Disability: 50 percent income replacement

If you don’t enroll or waive coverage, you **won’t** receive these benefits:

- Personal Accident coverage
- Critical Illness coverage
- Dental coverage
- Vision coverage
- Optional Employee Life Insurance
- Dependent Life Insurance
- Optional Employee AD&D Insurance
- Dependent AD&D Insurance
- Supplemental Short Term Disability coverage
- Supplemental Long Term Disability coverage
- Health Care Spending Account Participation
- Dependent Day Care Spending Account Participation
- Group Legal coverage
ELIGIBILITY FOR BENEFITS

You are eligible for health and welfare benefits if you're a regular employee with a full-time equivalent (FTE) status of .5 or more. This includes:

- Full-time employees regularly scheduled to work .8 FTE or more
- Part-time employees regularly scheduled to work .5 FTE to .79 FTE

Employees with a status of .1 - .49 FTE are:

- Eligible for paid time off (PTO), the Employee Assistance Program (EAP) and Employee Discount Program
- Not eligible for health and welfare benefits

Relief, flex/on-call or per diem employees are:

- Eligible for EAP and Employee Discount Program
- Not eligible for health and welfare or PTO benefits

Ask your Human Resources representative if you’re not sure about your eligibility or employee status.

ELIGIBLE DEPENDENTS

If you cover yourself as an active employee, you may enroll your eligible dependents in certain benefits as described in this guide. Eligible dependents include:

- Your spouse, common-law spouse or Same Gender Domestic Partner (SGDP)¹
- Your, your spouse’s or your SGDP’s children up to age 27², including legally adopted and stepchildren, and children for whom you must provide health plan coverage under the terms of a Qualified Medical Child Support Order (QMCSO), as well as your older children who are mentally or physically unable to support themselves

¹ Contact Human Resources for details on required documentation for covering a common-law spouse or SGDP.
² Reimbursements for dependents age 19-27 or for your SGDP are NOT allowed under the Health Care Spending Account unless they are eligible dependents as defined by IRC regulations.

COVERAGE DATES

WHEN YOUR COVERAGE BEGINS

- If you enroll during open enrollment (May 6-24, 2013), your new benefit coverage begins July 1, 2013.
- If your date of hire as an eligible employee is:
  - The first day of the month, your benefit coverage begins on that date, with the exception of short term and long term disability coverage that requires a 90-day waiting period.
  - Any other date, benefit coverage begins the first day of the following month, with the exception of short term and long term disability coverage that requires a 90-day waiting period.

PREMIUM PAYMENTS

- Premiums cover benefits for the month they are paid. For example, premiums taken from July paychecks pay for July coverage.
- Premium deductions will be made out of the first and second paycheck each month for a total of 24 deductions during the plan year.
- When enrollments are processed after the first paycheck of the month, we will adjust your next check for any missed premium(s). This may require a double or triple deduction from your paycheck to “catch up” on premiums owed.
- Employees who do not receive a paycheck (e.g., employees on leave without pay) will have any premiums owed go into a balance due account. Contact Human Resources to determine how you repay missed premiums.

WHEN YOUR COVERAGE ENDS

- Generally, your coverage ends on your last day of employment. However, health care coverage (medical, dental and vision) ends the last day of the month in which your employment ends or changes to ineligible status. If your employment termination date is the last day of the month, your coverage ends on that date.
- Health care coverage for dependents who no longer meet eligibility requirements ends on the last day of the month in which they lose eligibility. You are responsible for notifying Human Resources of a dependent’s ineligibility within 30 days of the date it occurs. No premium refund will be available for any notice that occurs after 30 days.
QUALIFYING LIFE EVENTS

CHANGING COVERAGE AFTER A QUALIFYING LIFE EVENT

Your benefit elections are in effect throughout the plan year. However, you may adjust your coverage levels within your plans if a qualifying life event occurs. You must make any changes within 30 days of a qualifying life event or your next opportunity to make changes will be the next open enrollment period, unless you experience another qualifying life event during the plan year. If you need to change coverage because your Medicaid or state children’s health insurance plan coverage was terminated, or if you become eligible for premium assistance under Medicaid or a state children’s health insurance program, you have 60 days to make changes.

Contact Human Resources to find out what documentation is required to make coverage changes after a qualifying life event.

Any changes you make must be consistent with and on account of the qualifying life event. For example, if you have a baby you may add the child to your current medical coverage, but you cannot change from the CU Health Plan – High Deductible to the CU Health Plan – Exclusive medical option.

Qualifying life events include:

- Marriage, legal separation, divorce (a common-law spouse may not be dropped from coverage mid-year without proof of a legal separation or divorce) or dissolution of a partnership with a Same Gender Domestic Partner (Certificate of Termination required)
- Death of the employee’s spouse/SGDP or dependent
- Birth, adoption or legal guardianship of a child by the employee
- Termination or commencement of employment of the employee’s spouse/SGDP, resulting in either loss of coverage or enrollment in new coverage
- Switching from part-time to full-time employment status or from full-time to part-time status of the employee or employee’s spouse/SGDP
- Significant change in the health coverage of the employee or spouse/SGDP attributable to the spouse’s/SGDP’s employment
- Loss of COBRA eligibility under another plan
- Loss of dependent’s eligibility through loss of custody or dependents exceeding the age limit, marrying or entering military service
- Change in cost or hours of dependent care (Dependent Day Care Spending Accounts only)
- Judgment, decree or court order that requires coverage
- Gain of Medicare or Medicaid eligibility by the spouse/SGDP or dependent, where coverage is through the employee
MEDICAL

You have three medical plan options:

- **The CU Health Plan – Exclusive** – in-network coverage only, administered by Anthem Blue Cross and Blue Shield (BCBS)

- **The CU Health Plan – High Deductible** – in-network and out-of-network coverage, administered by Anthem BCBS

- **The CU Health Plan – Kaiser** – in-network coverage only (not available to UCHealth North employees at this time due to Kaiser’s limited network of providers in the area)

**WAIVE COVERAGE OPTION**

You may waive medical coverage if you have medical coverage elsewhere. By selecting “Waive Medical Coverage” on the online enrollment screen, you certify that you have other coverage and are waiving medical coverage for the plan year. Once you waive coverage, you will not be allowed to enroll until the next scheduled open enrollment or within the deadline required for a qualifying life event, according to applicable federal and/or state laws or the master plan documents.

Review this section and all available options carefully before making your selection. Each medical option has a network of doctors, prescription drug benefits and other features. However, each option is different, so you should carefully consider your choices when deciding which option best meets your needs and the needs of your eligible dependents.

For a summary of benefits, limitations, exclusions and formularies, or to find a provider, visit the appropriate website listed in *Important Contacts* at the end of this guide. If you have additional questions, contact your HR representative or your Benefits Service Center.
Here’s a comparison of your medical plan options:

<table>
<thead>
<tr>
<th>Benefit Summary</th>
<th>CU Health Plan – Exclusive</th>
<th>CU Health Plan – High Deductible</th>
<th>CU Health Plan – Kaiser¹</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network only¹</td>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>Annual Deductible</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual/Family</td>
<td>$250/$750</td>
<td>$1,500/$3,000</td>
<td>$3,000/$6,000</td>
</tr>
<tr>
<td>Annual Out-of Pocket Maximum</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual/Family</td>
<td>N/A</td>
<td>$3,000/$6,000 (includes deductible)</td>
<td>$6,000/$12,000 (includes deductible)</td>
</tr>
<tr>
<td>Lifetime Maximum</td>
<td>Unlimited</td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
<tr>
<td>Doctor/Specialist Visit</td>
<td>$30/$40 copay</td>
<td>15% coinsurance after deductible</td>
<td>35% coinsurance after deductible</td>
</tr>
<tr>
<td>Well Visit</td>
<td>100% paid</td>
<td>100% paid</td>
<td>35% coinsurance after deductible</td>
</tr>
</tbody>
</table>

**Hospital Care**

|                                      |                             |                                 |                           |
| Inpatient Services                   | 100% after deductible       | 15% coinsurance after deductible | 35% coinsurance after deductible | $250/day |
| Outpatient Services                  | 100% after deductible       | 15% coinsurance after deductible | 35% coinsurance after deductible | $250/visit |
| Emergency Room                       | 100% after deductible       | 15% coinsurance after deductible | 15% coinsurance after deductible | $150/visit (unless admitted) |
| Urgent Care                          | $30 copay                   | 15% coinsurance after deductible | 35% coinsurance after deductible | $30 copay |
| Lab and X-ray                        | 100% paid after deductible  | 15% coinsurance after deductible | 35% coinsurance after deductible | 100% paid |

¹ This option offers in-network coverage only except in cases of an emergency.
² This option is not available to UCHealth North employees.
## PRESCRIPTION DRUGS

<table>
<thead>
<tr>
<th>Type of Rx</th>
<th>CU Health Plan – Exclusive</th>
<th>CU Health Plan – High Deductible</th>
<th>CU Health Plan – Kaiser¹</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Anthem BCBS Retail</td>
<td>UCH Retail (up to 30-day supply)</td>
<td>UCH Mail Order¹</td>
</tr>
<tr>
<td>Generic</td>
<td>$15 copay</td>
<td>$13 copay</td>
<td>$26 copay</td>
</tr>
<tr>
<td></td>
<td>$35 copay</td>
<td>$30 copay</td>
<td>$60 copay</td>
</tr>
<tr>
<td></td>
<td>$50 copay</td>
<td>$50 copay</td>
<td>$100 copay</td>
</tr>
<tr>
<td>Specialty (30-day supply for retail and mail order)</td>
<td>N/A</td>
<td>N/A</td>
<td>$75 copay</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

¹ For:
- UCHealth Central, after a maximum of three fills, maintenance medications must be filled through the UCH Mail Order Prescription Service or one of the UCH Retail Pharmacies to be covered.
- UCHealth South, after a maximum of three fills, maintenance medications must be filled at the Memorial Hospital Pharmacy or the UCH Mail Order Prescription Service to be covered.
- UCHealth North, after a maximum of three fills, maintenance medications must be filled through the UCH Mail Order Prescription Service or one of the UCH Retail Pharmacies to be covered. You may also request to have your prescriptions available for pick up at either the Poudre Valley Hospital Inpatient Pharmacy window or the Medical Center of the Rockies Inpatient Pharmacy window.

2 This option is not available to UCHealth North employees.
CU HEALTH PLAN – EXCLUSIVE

The Exclusive option is a limited-network plan that offers access to the providers and hospitals affiliated with UCHealth. All members must select an Exclusive primary care physician (PCP) from the Exclusive Provider Directory. (See How to Select a Primary Care Physician for more information.) You can access specialty care only through a PCP referral, and this plan offers in-network coverage only, except in cases of an emergency.

The following copays and deductibles may apply:

- No copays for wellness office visits; wellness visits are 100 percent covered
- Prescriptions and wellness visits are not subject to a deductible
- Copays apply for non-wellness office visits, urgent care and prescriptions
- $250 deductible (max. $750 for family) may apply for these services:
  - Inpatient hospital (including for mental health/substance abuse)
  - Outpatient/ambulatory surgery
  - Lab & X-ray
  - Emergency care
  - Ambulance
  - Inpatient therapy
  - Durable medical equipment
  - Home health care
  - Skilled nursing

Other important plan details under the Exclusive option include:

- Coverage is in-network only, except in cases of an emergency.
- Members must choose a primary care physician (PCP) when they enroll to ensure ID cards have PCP information on them when mailed. Be sure to write down the PCP ID number for the doctor you would like to select. You will need this number when enrolling. A provider list is available on Lawson Employee Self Service.
- Anthem BCBS will assign a PCP if you do not choose one.
- Prior authorization from your PCP is not required to obtain care from a network provider who specializes in obstetrics, gynecology or mental health care.
- Each family member may choose his or her own PCP from any Exclusive provider in the state.
- If you have a covered dependent child who lives outside of Colorado, check with Anthem BCBS at the phone number listed in Important Contacts to see if primary care services are available where your dependent lives.

HOW TO SELECT A PRIMARY CARE PHYSICIAN (PCP)

You can choose any PCP 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 PCP.

For assistance and for a list of network providers, contact Anthem BCBS Customer Service at the number listed in Important Contacts or log on to www.anthem.com/cuhealthplan.

It’s important that you do not go to a PCP that you haven’t selected, or one that isn’t assigned to you. You can change PCPs during the plan year. Do not visit a new PCP until you verify the effective date of any change.

It is not necessary to elect a PCP for the CU Health Plan – High Deductible or CU Health Plan – Kaiser medical coverage when you enroll. It is recommended you do so once you become covered under a new plan – a PCP can help you coordinate your health care needs.
CU HEALTH PLAN – HIGH DEDUCTIBLE

The High Deductible option is a Health Savings Account (HSA)-qualified PPO plan that includes:
- National and international coverage
- Benefits for both in- and out-of-network care
- In-network well care covered at 100 percent with no deductible

Select in-network providers from the Anthem BCBS PPO Network. With this option, you’re not required to select a primary care physician (PCP).

With this high deductible option, if you enroll for anything other than Employee Only coverage, the family deductible must be satisfied before benefits are paid for any individual family member. If you go to an out-of-network provider, you’re only covered for allowable benefit charges. The provider may balance bill you for charges above the allowed amount. The in-network deductible and out-of-pocket maximum do not apply toward the out-of-network deductible and out-of-pocket maximum, and vice versa.

Here’s how the CU Health Plan – High Deductible works in three easy steps:

What is a Health Savings Account (HSA)?

An HSA allows you to set aside funds in a bank account to help offset health-related expenses – up to $3,250 for individual coverage and up to $6,450 for family coverage in 2013. Contributions to your HSA are 100% tax deductible as long as the money is used to cover eligible health care expenses. Any remaining HSA balance can be carried forward and used in future years. You must contact a financial institution directly to establish an HSA. If you are interested in establishing an HSA, you should consult with your financial or tax advisor. To establish and contribute to an HSA, you:
- Must be covered by a qualified high deductible health plan – the CU Health Plan – High Deductible is a qualified plan
- Cannot be covered by any other health plan
- Cannot be claimed as a dependent on another person’s tax return
- Cannot contribute to both an HSA and the Health Care Flexible Spending Account
- Cannot be enrolled in Medicare

STEP 1

Meet the annual deductible. You pay 100% of covered expenses, either out-of-pocket or from your HSA, until you meet your deductible – except for in-network well visits paid 100% by the plan.

STEP 2

You and the plan share covered expenses until you meet the out-of-pocket maximum. You pay for your share of the cost for covered expenses – either out-of-pocket or from your HSA.

STEP 3

Once you meet the out-of-pocket maximum, the CU Health Plan – High Deductible option pays 100% of your covered medical and prescription drug costs for the rest of the calendar year.
CU HEALTH PLAN – KAISER
(Not currently available to UCHealth North employees)

You’re not required to select a primary care physician (PCP) at enrollment. However, Kaiser recommends you select and partner with a PCP. See the Kaiser website for a list of available Kaiser PCPs.

- Members pay a copay for covered services provided by the Kaiser in-network doctors
- In-network coverage only, except in cases of an emergency
- Members choose a PCP, but this information is not needed to complete enrollment when first eligible
- You can change PCPs during the plan year
- Kaiser facilities are located only in a limited area
- There is a closed prescription drug formulary, which means physicians can only prescribe drugs from a specific list of medications

MEDICAL PLAN CONTRIBUTIONS

You and your employer share the cost of your medical coverage. Please refer to Employee Premiums (page 23) for specific rates.

DO YOU NEED SUPPLEMENTAL COVERAGE?

Facing unforeseen medical bills and debt associated with a serious accident or illness can be life-changing. Accident Insurance and Critical Illness Insurance, offered through Transamerica Life Insurance Company, can supplement your medical coverage and help with your out-of-pocket costs.

The policies are designed to pay a cash benefit to help you meet financial obligations, such as medical bills, deductibles and uncovered expenses, as well as mortgage payments and other ongoing living expenses. The money can be used for any purpose.

- Coverage is guaranteed-issue – no health questions or physical exams required for you (the employee).
- You can also elect coverage for your eligible family members.
- Coverage is portable – you can take your policy with you if you change jobs or retire.

ACCIDENT INSURANCE

Accident Insurance can help pay out-of-pocket costs if you are injured in a covered accident. The policy pays benefits for injuries and accident-related expenses, including hospitalization, emergency room treatment, physical therapy, transportation, lodging for family and more.

Benefits are paid for accidents that occur on or off the job so you have 24-hour coverage.

CRITICAL ILLNESS INSURANCE

Critical Illness Insurance pays a lump sum benefit of $10,000 or $15,000 directly to you if you are diagnosed with a covered condition, depending on the amount of coverage you elect. If you elect coverage for your dependents, their benefit amount is 50% of your elected benefit amount. Covered conditions include heart attack, stroke, cancer, major organ transplant, end stage renal failure and coronary artery bypass surgery.

The policy includes a wellness benefit, which pays $50 per insured per calendar year if a covered health screening test is performed (blood test, colonoscopy, mammogram, etc.).

You may enroll for these supplemental plans through Lawson Employee Self Service when you enroll for your other health and welfare benefits. Check your facility’s intranet for detailed coverage information.

This is a brief summary of Accident Insurance and Critical Illness Insurance, both underwritten by Transamerica Life Insurance Company, Cedar Rapids, Iowa, policy form series CPACC100 and CPC0400. Forms and form numbers may vary, and this coverage may not be available in all jurisdictions. Limitations and exclusions apply. Refer to the policy, certificate and riders for complete details.
DENTAL

TYPES OF PLANS

You can choose dental coverage from the Exclusive Panel Option (EPO) or the Dental PPO – both administered by Delta Dental. You can also choose to waive dental coverage.

EXCLUSIVE PANEL OPTION (EPO)

- Members must live in Colorado.
- Benefits are paid ONLY when members use a dentist in the Delta Dental PPO provider network.
- It is extremely important to verify that your dentist is in the network prior to each appointment by calling Delta Dental or your treatment may not be covered.
- Members must pay a copay for most services.
- The provider submits claims.
- Orthodontia benefits are available for both children and adults.
- There’s no international coverage.
- For services exceeding $400, you must have your dentist submit a treatment plan to Delta Dental prior to receiving any services. This will assist you with managing your out-of-pocket costs.

DELTA DENTAL PPO

- In- and out-of-network coverage is available.
- You have lower out-of-pocket costs when using an in-network provider.
- You may change dentists at any time.
- A deductible applies each plan year, per member (except for preventive and diagnostic services).
- Plan pays percentage of covered cost, based on provider used (in-network or out-of-network).
- Plan provides international coverage.
- Members may be required to submit claims.
- Orthodontia benefits are available for children up to age 19 only.

WHICH DENTAL OPTION IS BEST FOR ME?

The chart below provides details on how the two dental options compare.

<table>
<thead>
<tr>
<th>Plan Feature</th>
<th>Delta Dental EPO</th>
<th>Delta Dental PPO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible</td>
<td>Network Only1</td>
<td>PPO Dentist</td>
</tr>
<tr>
<td></td>
<td>None</td>
<td>$50 per person</td>
</tr>
<tr>
<td></td>
<td>$75 per person</td>
<td></td>
</tr>
<tr>
<td>Maximum Benefit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plan Year</td>
<td>$2,000 per person</td>
<td>$2,000 per person</td>
</tr>
<tr>
<td>Orthodontic Lifetime</td>
<td>$4,000 per person</td>
<td>$1,500 per person</td>
</tr>
<tr>
<td>Preventive and Diagnostic Services (oral exam, X-rays, routine cleaning)</td>
<td>$0 copay up to two times per plan year</td>
<td>100% up to two times per year</td>
</tr>
<tr>
<td>Basic Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fillings</td>
<td>Copay based on payment schedule</td>
<td>80% after deductible</td>
</tr>
<tr>
<td></td>
<td></td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Simple Extractions</td>
<td>Copay based on payment schedule</td>
<td>70% after deductible</td>
</tr>
<tr>
<td></td>
<td></td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Major Services (crowns, dentures, bridgework)</td>
<td>Copay based on payment schedule</td>
<td>50% after deductible</td>
</tr>
<tr>
<td></td>
<td></td>
<td>40% after deductible</td>
</tr>
<tr>
<td>Orthodontic</td>
<td>Copay based on payment schedule</td>
<td>50% after deductible</td>
</tr>
<tr>
<td></td>
<td>Covered for adults and children</td>
<td>40% after deductible</td>
</tr>
<tr>
<td></td>
<td>Covered for children up to age 19 only</td>
<td>40% after deductible</td>
</tr>
<tr>
<td></td>
<td>Covered for children up to age 19 only</td>
<td></td>
</tr>
</tbody>
</table>

1 Services must be provided by a Delta Dental of Colorado PPO Dentist; no benefits are payable if services are rendered by a Delta Dental Premier dentist or a non-participating dentist; no benefit outside of Colorado except in emergency

DENTAL PLAN CONTRIBUTIONS

For all dental plan options, you and your employer share the cost of your coverage. Please refer to Employee Premiums (page 23) for specific rates.
VISION

VISION SERVICE PLAN (VSP)

You may enroll in the Vision Service Plan (VSP), which provides coverage for routine eye exams, and eyeglasses and contacts. The CU Health Plan – Exclusive and CU Health Plan – Kaiser options cover an eye exam once a year, but they do not cover materials. The CU Health Plan – High Deductible does not cover a routine eye exam or materials.

When a VSP provider treats you, the provider will file the claim with VSP and you pay either the copay listed below or any amount over the allowance listed below. If you choose to see a non-VSP provider, you will need to file a claim with VSP for reimbursement. The reimbursement level for non-VSP providers will be at a somewhat lower level than for participating VSP providers.

VSP benefits pay for an eye exam, and glasses (or a portion of the cost of contacts) every 12 months. Frames are covered every 24 months. You will be responsible for the copay for these benefits. You are encouraged to verify that the provider you are using is currently participating in the VSP program prior to receiving services.

The following table provides VSP benefit details.

<table>
<thead>
<tr>
<th>Feature</th>
<th>Network</th>
<th>Copay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well Vision Eye Exam</td>
<td>Every 12 months</td>
<td>$15</td>
</tr>
<tr>
<td>Prescription Glasses</td>
<td>See Frame and Lenses benefit below</td>
<td>$15</td>
</tr>
<tr>
<td>Frame</td>
<td>$195 allowance</td>
<td>Included in prescription glasses copay</td>
</tr>
<tr>
<td></td>
<td>$105 allowance at Costco</td>
<td></td>
</tr>
<tr>
<td></td>
<td>20% off amount over allowance, Every 24 months</td>
<td></td>
</tr>
<tr>
<td>Lenses</td>
<td>Single vision, lined bifocal, lined trifocal Polycarbonate for dependent children, Every 12 months</td>
<td>Included in prescription glasses copay</td>
</tr>
<tr>
<td>Lens Options</td>
<td>Standard progressive lenses, Premium progressive lenses, Custom progressive lenses</td>
<td>$50, $80 - $90, $120 - $160</td>
</tr>
<tr>
<td>Contact Lenses</td>
<td>$150 allowance for contacts, Every 12 months</td>
<td>Up to $60 for contact lens exam</td>
</tr>
</tbody>
</table>

CONSIDERING LASIK SURGERY?

You have access to nationally recognized surgeons at University of Colorado Hospital Eye Center. All are cornea fellowship trained, meaning they have additional education and surgical experience in all aspects of vision correction.

Employees receive Custom LASIK/PRK for $1,650 per eye (regularly $1,950 per eye). This includes pre-operative exam, surgery and post-operative visits.

The UCH Eye Center is not a VSP provider, but you can use your Health Care Spending Account or Health Savings Account (HSA) for this procedure. Call the UCH Eye Center at 720-848-2020 for more information.

In northern Colorado, employees receive Lasik for $1,795 per eye (regularly $2,295 per eye) through the Eye Center of Northern Colorado. For more information on this discount, please call 970-221-2222.

VISION SERVICE PLAN CONTRIBUTIONS

Please refer to Employee Premiums (page 23) for specific vision contribution rates.
LIFE AND DISABILITY INSURANCE

LIFE INSURANCE

All benefits-eligible employees receive employer-provided Basic Employee Term Life Insurance of 1x annual base pay up to $2,000,000. In addition to the basic coverage provided by your employer, you may choose to purchase Optional Employee Term Life Insurance. This voluntary benefit increases your coverage in $10,000 increments up to the lesser of 5x annual base pay or $1,000,000.

You may also choose to purchase Optional Term Life Insurance for your eligible dependents. You may purchase spouse coverage in $10,000 increments up to the lesser of 100 percent of your employee coverage amount or $500,000, and $10,000 per child. The cost of child coverage is the same, no matter how many children are insured.

ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE

If your death is the result of an accident, your designated beneficiary will be paid the amount of any Accidental Death & Dismemberment (AD&D) coverage you have elected. You will also receive a partial payment if you sustain certain accidental dismembering injuries. All benefits-eligible employees receive employer-provided Basic Employee AD&D Insurance of 1x annual base pay up to $2,000,000.

In addition to the basic coverage, you may choose to purchase Optional Employee AD&D Insurance. This voluntary benefit increases your coverage in $10,000 increments up to the lesser of 5x annual base pay or $1,000,000.

You may also choose to purchase Optional Spouse AD&D coverage in $10,000 increments up to the lesser of 100 percent of your employee coverage amount or $500,000.

SPECIAL SERVICES

The following services are available, at no cost, as part of your employer-paid Life and AD&D Insurance coverage:

- Travel Assistance – Available when you are more than 100 miles from home for 90 days or less. You can also take advantage of pre-trip planning, emergency medical assistance and emergency personal services.

- Estate Guidance Will Preparation Services – Create a simple, legally binding will quickly and conveniently online with assistance from licensed attorneys.

- Funeral Planning and Concierge Services – Advisors can help you understand your funeral pre-planning options.

SHORT-TERM DISABILITY (STD) INSURANCE

STD insurance provides income protection in the case of a short-term illness. Benefits are generally payable after a seven-day elimination period for up to 173 calendar days, except in the instance of overnight hospital admission, in which case the seven-day elimination period is waived. During the elimination period, you will use the PTO that you have accrued. PTO will also supplement the STD coverage you elect.

SUPPLEMENTAL DISABILITY COVERAGE

If you do not enroll for Supplemental STD and/or Supplemental LTD when you are first eligible, you will be required to provide evidence of insurability if you enroll for coverage at a later date.

You are eligible for STD coverage on the first of the month coincident with or next following 90 days of employment. Once you meet this eligibility waiting period, you will be automatically enrolled in employer-provided Basic STD coverage. This basic coverage replaces 60 percent of weekly base pay, up to $5,000 per week.

You may purchase Supplemental STD coverage to increase your benefits from 60 percent to 70 percent of your weekly base pay. You pay the entire cost for this additional coverage.

Be aware that STD benefits are reduced by income you may receive from other sources, such as PERA benefits. If you are receiving Worker’s Compensation benefits, you will be ineligible to receive STD benefits.
LONG-TERM DISABILITY (LTD)

LTD provides income protection in case of a long-term illness or injury. Benefits are payable after a 180-day elimination period. During the 180-day elimination period, you can use your PTO and STD benefits (if applicable).

You are eligible for LTD coverage on the first of the month coincident with or next following 90 days of employment. Once you meet this eligibility waiting period, you will be automatically enrolled in employer-provided Basic LTD coverage. This basic coverage replaces 50 percent of monthly base salary up to a monthly maximum of $17,500.

You may purchase Supplemental LTD coverage to increase your benefits from 50 percent to either 60 percent or 66-2/3 percent of your monthly base salary. You pay the entire cost for this additional coverage.

Be aware that LTD benefits are reduced by income you may receive from other sources, such as PERA retirement benefits, auto insurance, Workers’ Compensation, etc.

SPENDING ACCOUNTS

HEALTH CARE SPENDING ACCOUNT (HCSA)

With the HCSA, you can use tax-free dollars to pay for eligible health care expenses not covered by health care plans, such as copays, deductibles and other health-related expenses. You must re-enroll each year for HCSA participation. Here’s how it works:

- Estimate the amount of money you and your federal tax dependents expect to spend on eligible out-of-pocket health care expenses from the beginning of your participation to the end of the plan year. For new hires, this is from the first of the month when your benefits started to the next June 30. For open enrollment, this is from July 1 - June 30 each plan year.
- Set aside up to $2,500 for the plan year (up to $104.16 per pay period) in your HCSA to pay for those expenses. This money will be deducted in equal amounts from your paychecks and is not subject to federal or state income tax.
- When you incur an eligible health care expense during the plan year, submit documentation with a claim form to receive reimbursement from your HCSA up to the total amount of your election for the plan year. Expenses qualify for reimbursement when they are incurred, not when they are paid.
- You may not use this account to reimburse insurance premiums.
- You cannot make contributions to both the HCSA and a Health Savings Account.
- Reimbursements for dependents who are age 19 - 27 and Same Gender Domestic Partners are NOT allowed under the Health Care Spending Account UNLESS they are qualified federal tax dependents as defined by Internal Revenue Code (IRC) regulations.

REIMBURSEMENT FOR ELIGIBLE SPENDING ACCOUNT EXPENSES

Your Spending Accounts are administered through United Medical Alliance (UMA).

You will be issued a debit card for your HCSA, which will allow you to pay for your out-of-pocket expenses at time of service. Save your receipts – UMA may require proof that the purchase was for an eligible expense.

For the DCSA, you pay the provider and then submit a claim for reimbursement.

For your convenience, you can select a direct deposit option for HCSA and DCSA reimbursements.

For a full list of eligible expenses, call the IRS at 1-800-829-3676 and ask for publication 502 (for eligible health care expenses) or 503 (for eligible dependent day care expenses), or log on to www.irs.gov/publications.
**DEPENDENT DAY CARE SPENDING ACCOUNT (DCSA)**

The DCSA lets you pay for eligible day care expenses with tax-free dollars. You can use your Dependent Day Care Spending Account to pay child care or dependent care expenses so you and your spouse (if married) can work outside your home, or so that your spouse can attend school full time. The DCSA is similar to the Health Care Spending Account. You must re-enroll each year for DCSA participation.

- **EXPENSES MAY NOT BE PAID TO YOUR SPOUSE, TO ANY OF YOUR CHILDREN WHO ARE UNDER AGE 19 AT THE END OF THE YEAR IN WHICH THE EXPENSES ARE INCURRED, OR TO ANY OTHER INDIVIDUALS FOR WHOM YOU OR YOUR SPOUSE ARE ENTITLED TO A PERSONAL TAX EXEMPTION AS A DEPENDENT.**

- **YOU HAVE THE CHOICE OF USING EITHER THE DCSA OR THE FEDERAL CHILD CARE TAX CREDIT. THE TAX CREDIT REDUCES THE AMOUNT OF TAX YOU PAY BASED ON PERCENTAGE OF YOUR DEPENDENT CARE EXPENSES. YOU SHOULD CONSULT YOUR OWN TAX ADVISOR TO DETERMINE WHICH OPTION IS BETTER FOR YOU. YOU CANNOT CLAIM A FEDERAL TAX CREDIT FOR EXPENSES REIMBURSED THROUGH THE SPENDING ACCOUNT. IF YOU USE THE SPENDING ACCOUNT AND THE TAX CREDIT, THE MONEY YOU USE FROM THE SPENDING ACCOUNT IS SUBTRACTED FROM YOUR QUALIFYING EXPENSE LIMIT.**

**Plan Carefully**

Be sure you plan your contribution carefully. IRS rules require that any balance remaining in your account after the deadline for submitting claims incurred during the plan year will be forfeited. You have until September 30 after the plan year ends (on June 30) to submit eligible expenses incurred in the plan year.

- **EXPENSES MAY NOT BE PAID TO YOUR SPOUSE, TO ANY OF YOUR CHILDREN WHO ARE UNDER AGE 19 AT THE END OF THE YEAR IN WHICH THE EXPENSES ARE INCURRED, OR TO ANY OTHER INDIVIDUALS FOR WHOM YOU OR YOUR SPOUSE ARE ENTITLED TO A PERSONAL TAX EXEMPTION AS A DEPENDENT.**

- **YOU HAVE THE CHOICE OF USING EITHER THE DCSA OR THE FEDERAL CHILD CARE TAX CREDIT. THE TAX CREDIT REDUCES THE AMOUNT OF TAX YOU PAY BASED ON PERCENTAGE OF YOUR DEPENDENT CARE EXPENSES. YOU SHOULD CONSULT YOUR OWN TAX ADVISOR TO DETERMINE WHICH OPTION IS BETTER FOR YOU. YOU CANNOT CLAIM A FEDERAL TAX CREDIT FOR EXPENSES REIMBURSED THROUGH THE SPENDING ACCOUNT. IF YOU USE THE SPENDING ACCOUNT AND THE TAX CREDIT, THE MONEY YOU USE FROM THE SPENDING ACCOUNT IS SUBTRACTED FROM YOUR QUALIFYING EXPENSE LIMIT.**
GROUP LEGAL PLAN: ULTIMATEADVISOR®

UltimateAdvisor, the Group Legal Plan administered by ARAG®, offers you a wide range of legal services to help you prevent and resolve everyday legal issues. Whether you’re looking for online resources, telephone advice or in-office services, UltimateAdvisor offers you comprehensive coverage to take control of your situation. Most importantly, it gives you a place to turn for answers and protects you from high-cost attorney fees.

ATTORNEY SERVICES

UltimateAdvisor gives you access to a network of participating attorneys, who can review or prepare documents, make follow-up calls or write letters on your behalf, provide legal advice and consultation, and represent you in court. When you use a network attorney, fees for most covered services are 100% paid in full and you don’t need to submit a claim form. Covered legal matters include:
- Civil damage claims
- Consumer protection issues
- Criminal matters
- Debt-related matters
- Family law
- General matters
- Government benefits
- Landlord/tenant matters
- Real estate matters
- Small claims court
- Tax issues
- Traffic matters
- Wills and estate planning

For complete plan details, visit www.ARAGLegalCenter.com and enter Access Code 17931uch.

ADDITIONAL SERVICES

UltimateAdvisor also offers you the following services:
- Unlimited telephone advice from a network attorney
- Identity theft services from a certified identity theft case manager
- A variety of online resources, including the Education Center with information to help you understand everyday legal issues, DIY Docs® to guide you in creating your own state-specific, legally-valid documents, and Online Financial Tools to help you map out a solid financial strategy
- Reduced fee benefits apply for any legal matters not already covered and not excluded (this includes immigration assistance)

Business matters or matters related to your employment are not covered.

AFTER ENROLLING

You will receive a welcome kit and ID cards from ARAG.
OTHER BENEFITS

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Personal issues, planning for life events or simply managing daily life can affect your work, health and family. ComPsych Guidance Resources provides support, resources and information for personal and work-life issues. UCHealth sponsors this benefit, and you and your dependents can receive confidential assistance at no charge. Just call or log on for help.

The EAP provides the following services:

- **In-person emotional counseling** – UCHealth pays for the first five visits to a counselor to address stress/anxiety, depression, family/marital relationships, substance abuse, difficulties at work, etc.

- **FamilySource®** – Work-Life specialists will do the research for you, providing qualified referrals and customized resources for child and elder care, moving and relocating, making major purchases, college planning, pet care and home repair

- **LegalConnect®** – Telephone access to licensed attorneys for information on legal concerns, including divorce and family law, debt and bankruptcy, landlord/tenant issues, real estate transactions, civil and criminal actions and contracts. Receive a free in-person, 30-minute consultation with an in-network attorney, plus a 25% reduction in customary legal fees thereafter

- **FinancialConnect®** – Telephone consultation with a Certified Public Accountant or Certified Financial Planner who can help you with issues including getting out of debt, credit card or loan problems, tax questions, retirement planning, estate planning and saving for college

<table>
<thead>
<tr>
<th>Location</th>
<th>EAP Toll-Free Number</th>
<th>Web ID for <a href="http://www.GuidanceResources.com">www.GuidanceResources.com</a></th>
</tr>
</thead>
<tbody>
<tr>
<td>UCHealth Central</td>
<td>1-877-862-6423</td>
<td>QC9163U</td>
</tr>
<tr>
<td>UCHealth South</td>
<td>1-855-419-9533</td>
<td>MHS</td>
</tr>
<tr>
<td>UCHealth North</td>
<td>1-855-408-8372</td>
<td>CP912</td>
</tr>
</tbody>
</table>
PAID TIME OFF

The Paid Time Off (PTO) program includes vacation, sick time and holiday hours. You receive PTO based on the following schedule:

<table>
<thead>
<tr>
<th>Length of Service</th>
<th>PTO Hours/Hour Worked</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 – 12 months</td>
<td>.0731 hours</td>
</tr>
<tr>
<td>13 – 36 months</td>
<td>.1059 hours</td>
</tr>
<tr>
<td>37 – 60 months</td>
<td>.1135 hours</td>
</tr>
<tr>
<td>61 – 120 months</td>
<td>.1256 hours</td>
</tr>
<tr>
<td>121+ months</td>
<td>.1504 hours</td>
</tr>
</tbody>
</table>

If you are a new hire, you will receive initial PTO with your first paycheck: 24 hours for FTE status of .5 or more, and 12 hours for FTE status of .1 - .49.

Then after completing 12 months of employment, you’ll receive additional PTO: 24 hours for FTE status of .5 or more, and 12 hours for FTE status of .1 - .49.

PTO has a cap of 420 hours. Once you reach 420 hours of accumulated PTO time, accruals stop until some time is used and the accumulated amount falls below 420.

EDUCATIONAL ASSISTANCE

For information on educational assistance benefits, refer to the policy on your location’s intranet.

AUTO AND HOME INSURANCE

MetLife Auto & Home® is a voluntary group auto and home benefit program that provides you with access to insurance coverage for your personal insurance needs. A variety of policies are available, including:

- Auto
- Home
- Landlord’s Rental Dwelling
- Condo
- Mobile Home
- Renters
- Recreational Vehicle
- Boat
- Personal Excess Liability

The program gives you access to special group discounts not available through many other group insurance programs. Payroll or bank account deductions are available. Contact MetLife Auto & Home for a personal quote (see Important Contacts section).

You may elect this coverage at any time during the year.

EMPLOYEE DISCOUNT PROGRAM

The BenefitHub discount marketplace, available through Motivano, allows you access to over 100,000 name brands at hundreds of your favorite retailers. You’ll also find restaurants, gyms, Groupon deals and thousands of other local offers too, as well as tickets to sporting events, concerts, theatres, movies and theme parks. Experience great discounts and earn cash back points for simply shopping in your own customized BenefitHub site. See Important Contacts section.
LEGAL NOTICES

MEDICARE PART D CREDITABLE COVERAGE NOTICE

This notice is required by the Centers for Medicare and Medicaid Services (CMS) regarding Medicare Part D prescription coverage.

IMPORTANT NOTICE FROM UCHA REGARDING 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 UCHA 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. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

NOTE: UCHA provides medical coverage through an affiliation agreement with the University of Colorado.

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. UCHA has determined that the prescription drug coverage offered by the CU Health Plan – Exclusive option, the CU Health Plan – High Deductible option and the CU Health Plan – Kaiser are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered “Creditable Coverage.”

Because your existing UCHA coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 through December 7. For some individuals this means you may have to wait until the following November to join.

You may be required to pay a higher premium (a penalty) as long as you have Medicare prescription drug coverage. However, if you lose creditable prescription drug coverage through no fault of your own, you will be eligible for a 60-day Special Enrollment Period (SEP) because you lost creditable coverage to join a Part D plan. In addition, if you lose, or decide to leave, employer sponsored coverage, you will be eligible to join a Part D plan at that time using an Employer Group Special Enrollment Period. 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.

If you decide to join a Medicare drug plan, your UCHA medical coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

If you do decide to join a Medicare drug plan and drop your UCHA medical plan, which includes prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back. You should also know that if you drop or lose your coverage with UCHA and do not 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 prescription drug coverage that’s at least as good as Medicare’s prescription drug coverage, your monthly premium may go up by at least one percent of the base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without coverage, your premium may consistently be at least 19 percent higher than the base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For more information about this notice or your current prescription drug coverage:

Contact Payroll & Benefit Services at 303-860-4200.

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 UCHA changes. You also may request a copy.

For more information about your options under Medicare prescription drug coverage:

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

For more information about Medicare prescription drug coverage:

Visit www.medicare.gov.

Call your State Health Insurance Assistance Program for personalized help (see your Medicare & You handbook for their telephone number).

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 whether or not you are required to pay a higher premium (a penalty).

Date: July 1, 2013

Name of Entity/Sender: UCHA

Contact: Office of Payroll & Benefit Services

Address: 1800 Grant Street, Suite 400

Denver, CO 80203-1187

Phone Number: 303-860-4200
MEDICARE PART D PLAN SUMMARY AND COMPARISON

<table>
<thead>
<tr>
<th>Insurance Carrier</th>
<th>Member Pays</th>
<th>Member Pays (30-day supply for retail; 90-day supply for mail order)</th>
<th>Carrier Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>CU Health Plan – Exclusive</td>
<td>No deductible</td>
<td>$15 copay (30-day generic)/$35 copay (30-day brand)/$50 copay (30-day non preferred brand)</td>
<td>100% after co-pay</td>
</tr>
<tr>
<td>Anthem BCBS Retail</td>
<td>No deductible</td>
<td>$13 copay (30-day generic)/$30 copay (30-day brand)/$50 copay (30-day non preferred brand)</td>
<td>100% after copay</td>
</tr>
<tr>
<td>UCH Retail</td>
<td>No deductible</td>
<td>$26 copay (90-day generic)/$60 copay (90-day brand)/$100 copay (90-day non preferred brand)/$75 copay (30-day specialty oral and injectable)</td>
<td>100% after copay</td>
</tr>
<tr>
<td>CU Health Plan – High Deductible</td>
<td>$1,500/$3,000 deductible (in network)</td>
<td>20% up to $3,000/$6,000, then member pays 0% for balance of the plan year – retail</td>
<td>80% up to $3,000/$6,000, then plan pays 100% for balance of the plan year</td>
</tr>
<tr>
<td>Anthem BCBS Mail Order – Specialty Only</td>
<td>$1,500/$3,000 deductible (in network)</td>
<td>20% up to $3,000/$6,000, then member pays 0% for balance of the plan year – retail</td>
<td>80% up to $3,000/$6,000, then plan pays 100% for balance of the plan year</td>
</tr>
<tr>
<td>UCH Mail Order 90-day</td>
<td>$1,500/$3,000 deductible (in network)</td>
<td>20% up to $3,000/$6,000, then member pays 0% for balance of the plan year – retail</td>
<td>80% up to $3,000/$6,000, then plan pays 100% for balance of the plan year</td>
</tr>
<tr>
<td>CU Health Plan – Kaiser</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kaiser Retail</td>
<td>No deductible</td>
<td>$15 copay (30-day generic)/$35 copay (30-day brand)/20% up to $75 max (30-day specialty)</td>
<td>100% after copay</td>
</tr>
<tr>
<td>Kaiser Mail Order</td>
<td>No deductible</td>
<td>$30 copay (90-day generic)/$70 copay (90-day brand)</td>
<td>100% after copay</td>
</tr>
</tbody>
</table>

COBRA OVERVIEW

What is COBRA?

Under a federal law known as the Consolidated Omnibus Reconciliation Act of 1985 (COBRA), most employers sponsoring group health plans are required to offer qualified beneficiaries (employees and their eligible dependents for federal tax purposes) the opportunity for temporary extension of health coverage (called “continuation coverage”) at group rates in certain instances where coverage under the plan would otherwise end.

Qualified beneficiaries have certain rights and obligations under the continuation coverage provisions of the law. Both you and your dependents should take the time to read this section carefully. It explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

For additional 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 UCHA COBRA administrator (see Important Contacts at the back of this guide).

If you or anyone in your family covered under the plan is determined by the Social Security Administration or by another disability insurer to be disabled at any time during the first 60 days of COBRA continuation coverage, and you notify the plan administrator in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must notify the plan administrator of the disability determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage.

How long can coverage continue?

EMPLOYEE

Covered employees enrolled in a UCHA medical, dental, vision and/or health care flexible spending account plan have a right to choose COBRA continuation coverage if they are losing coverage for any of the following reasons:

- Termination of employment (for reasons other than gross misconduct): 18 months
- Reduction of work hours 18 months
- Qualified Beneficiary becomes disabled (within 60 days of termination) 29 months

DEPENDENT OF A COVERED EMPLOYEE

A dependent of a covered employee enrolled in a UCHA medical, dental, vision and/or health care flexible spending account plan has the right to choose COBRA continuation coverage after a loss of coverage for any of the following reasons:

- Termination of covered employee 18 months
- Reduction of covered employee’s work hours 18 months
- Death of employee 36 months
- Divorce, legal separation or termination of relationship 36 months
- Employee becomes Medicare-eligible (dependent only) 36 months
- Child loses eligibility 36 months

However, in any case involving the health care flexible spending account plan, continuation coverage may not extend past the end of the current plan year.
When should you notify the plan administrator of a qualifying life event?

INITIAL QUALIFYING LIFE EVENT
The plan will offer COBRA continuation coverage to qualified beneficiaries only after the plan administrator has been notified that a qualifying life event has occurred.

When the qualifying life event is the end of employment or a reduction of work hours, death of the employee, or enrollment of the employee in Medicare (Part A, Part B, or both), UCHA will notify the plan administrator of the qualifying life event within 30 days of the date that coverage ends. For other qualifying life events (divorce or legal separation of you and your spouse, or a dependent child losing eligibility for coverage as a dependent child), you must notify the plan administrator in writing within 60 days after the qualifying event occurs, and provide any information UCHA may request to verify that the event has occurred.

Once the plan administrator receives notice that a qualifying life event has occurred, COBRA continuation coverage will be offered to all of your 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. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the first of the month following the date that plan coverage would otherwise have been lost.

Disability Extension of the 18-month period of continuation coverage
SECOND QUALIFYING LIFE EVENT
If your family experiences a second qualifying event while receiving COBRA continuation coverage, your spouse and dependent children may get an additional 18 months of COBRA continuation coverage – up to a maximum of 36 months. This extension is available to the spouse and dependent children if a former employee dies, enrolls in Medicare (Part A, Part B, or both), or gets divorced or legally separated. The extension is also available to a dependent child when that child loses eligibility as a dependent child. In each of these cases, you must notify the plan administrator in writing within 60 days of the second qualifying life event, and provide any information UCHA may request to verify that the event has occurred.

When must continuation coverage be elected?
The qualified beneficiary has 60 days from either the date of the election notice or the date plan coverage terminates, whichever comes later, to elect COBRA continuation coverage. Coverage must be elected in writing. If COBRA continuation coverage is not elected within this period, the right to COBRA continuation coverage will be lost at the end of the 60-day election period.

What is the cost of COBRA?
Under the plan, qualified beneficiaries who elect COBRA continuation coverage must pay for it. COBRA continuation coverage premiums are 102 percent of the total premium. This includes the qualified beneficiary’s share, UCHA’s contribution (if any), and an administrative fee. COBRA continuation coverage premiums for the 11-month disability extension are 150 percent of the total premium.

When and how must payment for continuation coverage be made?
The first payment for COBRA continuation coverage is due within 45 days after election of COBRA. If a first payment is not made within the 45 days, all continuation coverage rights are lost. The first payment must cover the cost of continuation coverage from the time coverage would have otherwise terminated up to the time of the first payment. After the first payment for continuation coverage has been made, each subsequent monthly payment is due on the first day of the month. There is a 30-day grace period to make the monthly payment. If a monthly payment is not made before the end of the grace period for that payment, all rights to continuation coverage will be lost. All monthly payments for COBRA continuation coverage should be sent to the plan administrator (see Important Contacts at the back of this guide).

When will coverage terminate?
Under the law, continuation coverage may be terminated before the end of the maximum period of coverage for, but not limited to, any of the following reasons:
- The plan is terminated (in which case qualified beneficiaries may have the opportunity for coverage under other group health plans sponsored by the employer).  
- The premium for COBRA continuation coverage is not paid by the end of the grace period for that month.  
- Coverage is obtained under another group health plan as an employee, spouse/Same Gender Domestic Partner or dependent of an employee. In the event another group health plan has a pre-existing condition clause or limitation, continuation coverage may be continued until the 18-month period has been exhausted or the pre-existing condition clause under the new group health plan has been satisfied, whichever comes first. 
- Qualified beneficiaries become entitled to Medicare (Part A, Part B, or both) after the date COBRA continuation coverage is elected, other than as an End-Stage Renal Disease (ESRD) beneficiary.  
- A qualified beneficiary extends coverage for up to 29 months due to a disability, and there has been final determination that the qualified beneficiary is no longer disabled.

When can coverage be changed?
Qualified beneficiaries may change health plans and add or remove eligible dependents during open enrollment. The change will become effective the following open enrollment. Additionally, a qualified beneficiary has the same special enrollment rights under HIPAA rules as similarly situated active employees.

If you have questions about COBRA
This section is only a summary of continuation coverage. More information about continuation coverage and your rights is available in your EOC or from the plan administrator. If you have questions about your COBRA continuation coverage, you should contact the plan administrator (see the Important Contacts page of this guide). You may also contact the nearest regional or district office of the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA). Addresses and telephone numbers of the regional and district EBSA offices are available through EBSA’s website at www.dol.gov/ebsa.

Keep the plan administrator informed of address changes
In order to protect your family’s rights, you should keep the plan administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the plan administrator.

SPECIAL ENROLLMENT RIGHTS
HIPAA SPECIAL ENROLLMENT RULES
If you have declined enrollment in UCHA’s medical plan for you or your dependents because of other health insurance coverage, you or your dependents may be able to enroll in health coverage under this plan without waiting for the next open enrollment period, provided that you request enrollment within 31 days after your other coverage ends. In addition, 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 dependents, provided you request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.
CHILDREN’S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT OF 2009

UCHA will allow a special enrollment opportunity if you or your eligible dependents either:

- Lose Medicaid or Children’s Health Insurance Program (CHIP) coverage because you are no longer eligible, or
- Become eligible for a state’s premium assistance program under Medicaid or CHIP.

For these new enrollment opportunities, you will have 60 days – instead of 31 – from the date of the Medicaid/CHIP eligibility change to request enrollment in the UCHA health plan. Note that this new 60-day extension does not apply to enrollment opportunities other than the Medicaid/CHIP eligibility change.

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 are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can 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 live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following is current as of January 31, 2013. You should contact your State for further information on eligibility.

**COLORADO – Medicaid**

Website: [http://www.colorado.gov/](http://www.colorado.gov/)
Phone: 1-800-221-3943

**NEBRASKA – Medicaid**

Website: [www.ACCESSNebraska.ne.gov](http://www.ACCESSNebraska.ne.gov)
Phone: 1-800-383-4278

**WYOMING – Medicaid**

Website: [http://health.wyo.gov/healthcarefin/equalitycare](http://health.wyo.gov/healthcarefin/equalitycare)
Phone: 307-777-7531

To see if any other States have a premium assistance program, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
[www.dol.gov/ebtsa](http://www.dol.gov/ebtsa)
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
[www.cms.hhs.gov](http://www.cms.hhs.gov)
1-877-267-2323, Ext. 61565

EXPANDED WOMEN’S PREVENTIVE CARE SERVICES EFFECTIVE JULY 1, 2013

Under the Patient Protection and Affordable Care Act (health care reform), more women’s preventive health services are covered 100 percent by the plan with no copay, coinsurance or deductible when care is received in-network. Services include:

- Breast-feeding support, supplies and counseling, including costs for renting or purchasing specified breast-feeding equipment from a network provider or national durable medical equipment supplier
- Domestic violence screening and counseling
- FDA-approved contraception methods, sterilization procedures and contraceptive counseling
- Gestational diabetes screening for all pregnant women
- HIV counseling and screening for all sexually active women
- Human papillomavirus DNA testing for all women 30 years and older
- Sexually transmitted infection counseling for all sexually active women annually
- Well-woman visits including preconception counseling and routine, low-risk prenatal care

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
- Treatment of physical complications of the mastectomy, including lymphedema

These benefits will be provided subject to the same deductibles and coinsurance or copays applicable to other medical and surgical benefits provided under this Plan. Therefore, the deductibles and coinsurance shown in the Medical section of this guide apply. If you would like more information on WHCRA benefits, call your Plan Administrator at 720-848-6800.
RESOURCES

HOW TO ENROLL

Enroll for your health and welfare benefits online using Lawson Employee Self Service.

1. Log on to Lawson Employee Self Service. Your username and password are the same username and password you use to access the system daily.

2. Click Dependents' to verify all spouse and/or child information is correct for those dependents you wish to cover under any benefits or to enter dependent information. (If electing the CU Health Plan – Exclusive, enter Primary Care Physician (PCP) ID numbers for each dependent.)

3. Enter your Primary Care Physician (PCP) ID number, if electing the CU Health Plan – Exclusive.

4. Click Open Enrollment or New Hire (as applicable) to begin making elections for your benefits.

5. Before closing, be sure to print your benefit elections and retain a copy for your records.

6. Logout of the ESS (click Logout).

7. Complete the Employee Life Beneficiary Form enclosed in your new hire packet if you are a new or newly benefits-eligible employee. Please send this form to the Benefits Department/Human Resources for retention. To update your beneficiary designation, contact your benefits representative.

Once you've enrolled, your benefit elections will remain in effect until June 30, 2014.

IF LOGGING ON AT HOME

Internet Explorer versions 7 and 8 are the only browsers that can be used for accessing Lawson Employee Self Service. Pop-up blockers must be disabled, and your firewall settings may block the connection.

If you have problems enrolling from home, please complete your enrollment at work.

The Help Desk cannot provide support for personal devices such as smart phones, tablet computers, Safari or Google Chrome browsers, or home networks.

1 Dependents must be in Lawson before you begin the electronic enrollment program. You must provide Social Security numbers for all family members. Adding your dependents' information under the Dependent link does not enroll them in any benefit.
## 2013 - 2014 Employee Premiums

### Medical Rates Per Pay Period

<table>
<thead>
<tr>
<th></th>
<th>CU Health Plan – Exclusive</th>
<th>CU Health Plan – High Deductible</th>
<th>CU Health Plan – Kaiser</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Full-Time</td>
<td>Part-Time</td>
<td>Full-Time</td>
</tr>
<tr>
<td>Employee Only</td>
<td>$32.91</td>
<td>$113.00</td>
<td>$0.00</td>
</tr>
<tr>
<td>Employee plus Spouse</td>
<td>$78.36</td>
<td>$230.63</td>
<td>$0.00</td>
</tr>
<tr>
<td>Employee plus Child(ren)</td>
<td>$71.55</td>
<td>$217.07</td>
<td>$0.00</td>
</tr>
<tr>
<td>Employee plus Family</td>
<td>$106.28</td>
<td>$322.16</td>
<td>$0.00</td>
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### Dental Rates Per Pay Period

<table>
<thead>
<tr>
<th></th>
<th>EPO</th>
<th>PPO</th>
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</thead>
<tbody>
<tr>
<td>Employee Only</td>
<td>$9.27</td>
<td>$17.80</td>
</tr>
<tr>
<td>Employee plus Spouse</td>
<td>$16.04</td>
<td>$30.74</td>
</tr>
<tr>
<td>Employee plus Child(ren)</td>
<td>$18.76</td>
<td>$34.20</td>
</tr>
<tr>
<td>Employee plus Family</td>
<td>$27.13</td>
<td>$51.99</td>
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</tbody>
</table>

### Vision Rates Per Pay Period

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>Employee Only</td>
<td>$3.61</td>
</tr>
<tr>
<td>Employee plus 1</td>
<td>$6.56</td>
</tr>
<tr>
<td>Employee plus Family</td>
<td>$9.99</td>
</tr>
</tbody>
</table>

### Group Legal

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate Per Pay Period</td>
<td>$8.13</td>
</tr>
</tbody>
</table>

---

*PAYING FOR YOUR COVERAGE*

Premium deductions will be made out of the first and second paycheck each month for a total of 24 deductions during the plan year.

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*The cost for Group Legal is the same, regardless of the number of family members you insure.*
OPTIONAL LIFE AND AD&D INSURANCE
You may enroll for:
- Optional Employee Life Insurance in $10,000 increments, up to the lesser of 5x annual base pay or $1,000,000 (guaranteed issue: $350,000)
- Spouse Life Insurance in $10,000 increments, up to the lesser of 100% of employee amount or $500,000 (guaranteed issue: $50,000)
- Optional Employee AD&D Insurance in $10,000 increments, up to the lesser of 5x annual base pay or $1,000,000
- Spouse AD&D Insurance in $10,000 increments, up to the lesser of 100% of employee amount or $500,000
- Child Term Life Insurance of $10,000 per child

To determine cost for Optional Employee and Spouse coverage:
- Divide the amount of coverage you want to purchase by 1,000 to get the number of units of coverage
- Number of units x age-based rate ÷ 2 = per pay period cost

The cost for Child Life Insurance is $0.42 per pay period, regardless of the number of children you insure.

SUPPLEMENTAL SHORT TERM DISABILITY (STD)
You may enroll for Supplemental STD coverage to increase your Basic STD benefit from 60 percent of your weekly base pay to 70 percent of your weekly base pay.

To determine cost for Supplemental STD coverage:
- Divide your annual base salary by 12 to get your monthly base pay
- Then divide your monthly base pay by 100 to get the number of units of coverage
- Number of units x $0.33 ÷ 2 = per pay period cost

SUPPLEMENTAL LONG TERM DISABILITY (LTD)
You may enroll for Supplemental LTD coverage to increase your Basic LTD benefit from 50 percent of your monthly base salary to:
- 60 percent of your monthly base salary, or
- 66-2/3 percent of your monthly base salary.

To determine cost for Supplemental LTD coverage:
- Divide your annual base salary by 12 to get your monthly base pay
- Then divide your monthly base pay by 100 to get the number of units of coverage
- Number of units x age-based rate ÷ 2 = per pay period cost

---

Rates for Employee and Spouse
Optional Term Life and AD&D Insurance

<table>
<thead>
<tr>
<th>Age</th>
<th>Life Insurance</th>
<th>AD&amp;D Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 30</td>
<td>$0.024</td>
<td>$0.02</td>
</tr>
<tr>
<td>30 – 34</td>
<td>$0.031</td>
<td>$0.02</td>
</tr>
<tr>
<td>35 – 39</td>
<td>$0.046</td>
<td>$0.02</td>
</tr>
<tr>
<td>40 – 44</td>
<td>$0.070</td>
<td>$0.02</td>
</tr>
<tr>
<td>45 – 49</td>
<td>$0.112</td>
<td>$0.02</td>
</tr>
<tr>
<td>50 – 54</td>
<td>$0.183</td>
<td>$0.02</td>
</tr>
<tr>
<td>55 – 59</td>
<td>$0.287</td>
<td>$0.02</td>
</tr>
<tr>
<td>60 – 64</td>
<td>$0.382</td>
<td>$0.02</td>
</tr>
<tr>
<td>65 – 69</td>
<td>$0.610</td>
<td>$0.02</td>
</tr>
<tr>
<td>70 – 74</td>
<td>$1.070</td>
<td>$0.02</td>
</tr>
<tr>
<td>75+</td>
<td>$1.926</td>
<td>$0.02</td>
</tr>
</tbody>
</table>

1 Rates for both employee and spouse are based on the employee’s age

Rate for Supplemental STD Coverage

<table>
<thead>
<tr>
<th>Supplemental Coverage at 70%</th>
<th>Cost Per $100 Monthly Base Pay Per Month</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$0.33</td>
</tr>
</tbody>
</table>

Rates for Supplemental LTD Coverage

<table>
<thead>
<tr>
<th>Age</th>
<th>Cost Per $100 Monthly Base Pay Per Month</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>60%</td>
</tr>
<tr>
<td>&lt; 25</td>
<td>$0.074</td>
</tr>
<tr>
<td>25 – 29</td>
<td>$0.089</td>
</tr>
<tr>
<td>30 – 34</td>
<td>$0.125</td>
</tr>
<tr>
<td>35 – 39</td>
<td>$0.177</td>
</tr>
<tr>
<td>40 – 44</td>
<td>$0.292</td>
</tr>
<tr>
<td>45 – 49</td>
<td>$0.482</td>
</tr>
<tr>
<td>50 – 54</td>
<td>$0.615</td>
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<tr>
<td>55 – 59</td>
<td>$0.725</td>
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<tr>
<td>60 – 64</td>
<td>$0.738</td>
</tr>
<tr>
<td>65+</td>
<td>$0.709</td>
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</table>
## IMPORTANT CONTACTS

<table>
<thead>
<tr>
<th>Contact</th>
<th>Website or Email</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>UHealth Central Questions</td>
<td><a href="mailto:UCH-HRGeneralQuestions@uch.edu">UCH-HRGeneralQuestions@uch.edu</a></td>
<td>UCH Benefits Resource Center</td>
</tr>
<tr>
<td></td>
<td></td>
<td>720-848-6800</td>
</tr>
<tr>
<td>UHealth South Questions</td>
<td><a href="mailto:hrservicecenter@uchealth.org">hrservicecenter@uchealth.org</a></td>
<td>HR Service Center</td>
</tr>
<tr>
<td></td>
<td></td>
<td>719-365-5114, 7:30 a.m. - 5 p.m. Mon - Fri</td>
</tr>
<tr>
<td>UHealth North Questions</td>
<td><a href="mailto:PVHSHRBenefits@uchealth.org">PVHSHRBenefits@uchealth.org</a></td>
<td>Human Resources</td>
</tr>
<tr>
<td></td>
<td></td>
<td>970-495-7810, 970-495-7813 or 970-624-1244</td>
</tr>
<tr>
<td></td>
<td></td>
<td>8 a.m. - 4:30 p.m. Mon - Fri</td>
</tr>
<tr>
<td>Anthem Blue Cross Blue Shield</td>
<td><a href="http://www.anthem.com/cuhealthplan">www.anthem.com/cuhealthplan</a></td>
<td>Before you enroll, call First Impressions: 1-855-646-4752</td>
</tr>
<tr>
<td>CU Health Plan – Exclusive</td>
<td></td>
<td>After you enroll, call Customer Service: 1-800-735-6072</td>
</tr>
<tr>
<td>CU Health Plan – High Deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kaiser (not available to UHealth North)</td>
<td><a href="http://my.kaiserpermanente.org/universityofcolorado">http://my.kaiserpermanente.org/universityofcolorado</a></td>
<td>1-877-883-6698</td>
</tr>
<tr>
<td>CU Health Plan – Kaiser</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group # 03165</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transamerica Life Insurance Company</td>
<td><a href="http://www.tebcs.com">www.tebcs.com</a>, <a href="mailto:tebcustresp@transamerica.com">tebcustresp@transamerica.com</a></td>
<td>1-888-763-7474</td>
</tr>
<tr>
<td>Accident Insurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Critical Illness Insurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Delta Dental of Colorado</td>
<td><a href="http://www.deltadentalco.com">www.deltadentalco.com</a></td>
<td>303-741-9305</td>
</tr>
<tr>
<td>EPO Plan Group # 6473</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Delta Dental PPO Group # 1649</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vision Services Plan (VSP)</td>
<td><a href="http://www.vsp.com">www.vsp.com</a></td>
<td>1-800-877-7195</td>
</tr>
<tr>
<td>The Hartford Life Insurance Company</td>
<td>N/A</td>
<td>1-800-289-9140</td>
</tr>
<tr>
<td>Short Term Disability (STD)</td>
<td></td>
<td></td>
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<tr>
<td>Long Term Disability (LTD)</td>
<td></td>
<td></td>
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<tr>
<td>Life and AD&amp;D Insurance</td>
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<td></td>
</tr>
<tr>
<td>Health Care Spending Account (HCSA)</td>
<td>(HCSA debit card only)</td>
<td></td>
</tr>
<tr>
<td>Dependent Day Care Spending Account (DCSA)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ARAG Group Legal Plan</td>
<td><a href="http://www.ARGALegalCenter.com">www.ARGALegalCenter.com</a></td>
<td>1-800-247-4184</td>
</tr>
<tr>
<td>ComPsych Group Legal Plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee Assistance Program</td>
<td><a href="http://www.guidanceresources.com">www.guidanceresources.com</a></td>
<td>Phone number varies by location; see page 16</td>
</tr>
<tr>
<td>MetLife Auto &amp; Home Insurance</td>
<td><a href="http://www.metlife.com/mybenefits">www.metlife.com/mybenefits</a></td>
<td>1-800-438-6388, Call on or after July 1, 2013 for assistance</td>
</tr>
<tr>
<td>Available on or after July 1, 2013</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Motivano</td>
<td><a href="https://uchealth.benefithub.com">https://uchealth.benefithub.com</a></td>
<td>1-866-664-4621, Call on or after July 1, 2013 for assistance</td>
</tr>
<tr>
<td>Employee Discount Program</td>
<td></td>
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<tr>
<td>Available on or after July 1, 2013</td>
<td></td>
<td></td>
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<tr>
<td>ASI</td>
<td><a href="http://www.ASIcobra.com">www.ASIcobra.com</a></td>
<td>1-877-388-8331</td>
</tr>
<tr>
<td>COBRA Administration</td>
<td></td>
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## UCH PHARMACIES

<table>
<thead>
<tr>
<th>Contact</th>
<th>Website</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>UCH Mail Order Pharmacy</strong></td>
<td><a href="http://www.uch.edu/pharmacy">www.uch.edu/pharmacy</a></td>
<td>720-848-1432&lt;br&gt;Fax: 720-848-1433</td>
</tr>
<tr>
<td>12605 E. 16th Ave, Mail Stop A014</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aurora, CO 80045</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>UCH Retail Pharmacy Locations</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>UCH Atrium Pharmacy</strong></td>
<td>Refill your UCH Pharmacy prescriptions online through <a href="http://www.uch.edu/myhealthconnection">My Health Connection</a></td>
<td>720-848-4083&lt;br&gt;Fax: 720-848-4084</td>
</tr>
<tr>
<td>12605 E. 16th, Room 1054, Mail Stop A027</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aurora, CO 80045</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hours: 9 a.m. - 8:30 p.m. Mon - Fri</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>UCH Lowry Pharmacy</strong></td>
<td></td>
<td>720-848-9590&lt;br&gt;Fax: 720-848-9593</td>
</tr>
<tr>
<td>8111 E. Lowry Blvd, Ste 110, Mail Stop B01</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Denver, CO 80230</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hours: 8:30 a.m. - 5 p.m. Mon - Fri</td>
<td></td>
<td></td>
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<tr>
<td><strong>UCH AOP Pharmacy</strong></td>
<td></td>
<td>720-848-1020&lt;br&gt;Fax: 720-848-1040</td>
</tr>
<tr>
<td>1635 Aurora Ct., Room 1012, Mail Stop F702</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aurora, CO 80045</td>
<td></td>
<td></td>
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<tr>
<td>Hours: 8:30 a.m. - 6 p.m. Mon - Fri</td>
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<td></td>
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<tr>
<td><strong>UCH IDGP Pharmacy</strong></td>
<td></td>
<td>720-848-4081&lt;br&gt;Fax: 720-848-4082</td>
</tr>
<tr>
<td>1635 Aurora Ct., Room 7284, Mail Stop F702</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aurora, CO 80045</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hours: 8:30 a.m. - 5 p.m. Mon - Fri; closed for lunch 12:30 - 1 p.m.</td>
<td></td>
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<tr>
<td><strong>Memorial Hospital Pharmacy</strong></td>
<td></td>
<td>719-365-2525&lt;br&gt;Fax: 719-365-6252</td>
</tr>
<tr>
<td>1400 E. Boulder Street</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colorado Springs, CO 80909</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hours: 7 a.m. - 5 p.m. Mon - Fri</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>The Apothecary Pharmacy at UMGP</strong></td>
<td></td>
<td>303-499-2879&lt;br&gt;Fax: 303-499-5308</td>
</tr>
<tr>
<td>350 Broadway, Suite 50</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Boulder, CO 80305</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hours: 9 a.m. - 5 p.m. Mon - Fri</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>The Apothecary Pharmacy at Wardenburg Health Center</strong> (CU Boulder campus)</td>
<td></td>
<td>303-492-8553</td>
</tr>
<tr>
<td>Hours: 8 a.m. - 6 p.m. Mon - Thurs, 8 a.m. - 5 p.m. Fri; [9 a.m. - 2 p.m. Sat during Fall/Spring semesters]</td>
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<tr>
<td><strong>UCH Health North Pick Up Locations (pick up 24/7)</strong></td>
<td>These locations are for prescription pick up only. To submit new prescriptions or to request refills, contact the UCH Mail Order Pharmacy.</td>
<td>970-495-8044&lt;br&gt;970-624-3369</td>
</tr>
<tr>
<td><strong>Poudre Valley Hospital Inpatient Pharmacy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1024 S. Lemay Avenue</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Third floor, H3101</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fort Collins, CO 80524</td>
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<tr>
<td><strong>Medical Center of the Rockies Inpatient Pharmacy</strong></td>
<td></td>
<td></td>
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<tr>
<td>2500 Rocky Mountain Ave</td>
<td></td>
<td></td>
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<tr>
<td>Third floor, M3560-1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loveland, CO 80538</td>
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