2019 BENEFITS OPEN ENROLLMENT

Dear City Employees,

We value your contributions to our city’s success and want to continue rewarding you with a Total Rewards package, which includes compensation, retirement and health benefits. We heard from your responses to the recent employee engagement survey that you value our benefit offerings, and we understand the importance of continuing to provide comprehensive benefits that not only keep us competitive in the marketplace, but that support our employees and their families.

After two years with no employee increase in benefits costs, there will be small increases in Medical and Dental plan premiums in 2019, as well as formulary changes to the prescription benefit. Employees who choose the Advantage Plan will see an increase of $0.50 - $5 per paycheck, depending on the level of coverage. The Premier Plan will increase $5 - $26 per paycheck, and Dental plans will increase $0 - $2 per paycheck. You’ll notice in the monthly rate plans in this guide that the City is also contributing more to your medical and dental plan costs.

As our medical and dental plans are self-funded, it is vital for all of us to become wise and savvy healthcare consumers and become more engaged in healthcare and benefit choices. Simply put, our insurance rates increase when employees’ healthcare costs increase. Continue to use Castlight (mycastlighthealth.com) to find in-network providers, cost and quality comparisons, Flexible Spending Account – Health Care and Health Reimbursement Account (HRA) balances, and more information to make the most of your medical plan. Take advantage of our wellness program, preventive care benefits, chronic care condition programs, and the many resources available to you. When you take care of yourself and are a smart consumer of healthcare, you do make a difference – for your own health and for everyone on the plan.

Our annual open enrollment period is about to begin. We encourage you to review the benefits options and think carefully about your choices and family needs. You will find details in this guide and on the Benefits & Wellness Intranet page.

Thank you for your contributions to our organization. Your efforts play a critical role in making the City of Colorado Springs one of the very best cities and the most desirable place to live in the nation.

Jeff Greene, Chief of Staff
Michael Sullivan, Chief Human Resources Officer

This benefits guide is not intended to include all benefit details. It is an outline of coverage available and is not intended to be a legal contract. If a discrepancy exists between this document and the Plan Documents, the Plan Documents govern.

The benefit summaries apply to all City of Colorado Springs Civilian, Police, Fire department employees, unless otherwise noted.

NOTE: ANNUAL APPROPRIATIONS REQUIREMENT: Other than those benefits specifically required by Federal State law, the benefit plans provided by the City of Colorado Springs for employees are subject to annual review and budget appropriations by City Council. The City and employee contribution toward the cost of the benefit plans as well as the benefit plan designs may be changed or discontinued altogether at the Mayor’s discretion. Specific details are available at coloradosprings.gov in the Policy and Procedures Manual (PPM).
Employees MUST log into Employee Self Service and review their current benefit elections. If you wish to re-enroll in a Flexible Spending Account for Health Care and/or Dependent Care and/or the Vacation Buy program you MUST re-elect these programs for 2019.

It is important to review your personal information in Employee Self Service, including smoker status to ensure you are charged the appropriate rate for being a current tobacco user. Contact the HR Solutions Center at HR@springsgov.com or (719) 385-5125 if you need to change your status in Employee Self Service.

We will be offering several in-person meetings to review the 2019 benefit programs. Select departments will be offering on-site meetings as well. Please check with your manager for details.

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<thead>
<tr>
<th>Date</th>
<th>Where</th>
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<td>Noon</td>
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<tr>
<td>Tuesday, October 30</td>
<td>POC</td>
<td>3:00 PM</td>
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<td>Tuesday, November 6</td>
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<tr>
<td>Tuesday, November 6</td>
<td>CAB</td>
<td>1:00 PM</td>
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CAB – City Administration Building, 30 South Nevada Avenue
POC – Police Operations Center, 705 South Nevada Avenue
OPEN ENROLLMENT

MONDAY, OCTOBER 29, 2018
THROUGH
FRIDAY, NOVEMBER 9, 2018

Employees MUST log into Employee Self Service and review their current benefit elections. If you wish to re-enroll in a Flexible Spending Account for Health Care and/or Dependent Care and/or the Vacation Buy program you MUST re-elect these programs for 2019.

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Open Enrollment Information Meetings

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CAB – City Administration Building, 30 South Nevada Avenue
POC – Police Operations Center, 705 South Nevada Avenue

2019 PLAN CHANGES

**Medical**

- Diagnostic Mammograms now covered at 100%

**Pharmacy**

- Exclude Brand Proton Pump Inhibitors (PPIs)
- Exclude Brand Ophthalmic Antihistamines
- Exclude Erectile Dysfunction Medicines
- Exclude Brand Nasal Steroids
- Exclude select Oral Acne Medicines
- Implement Step Therapy on Testosterone Products
- Limit Opioids to 7 day first fill

**Unum**

Long Term Care rates for those who have the old policy (Policy number 220508) will be increasing in 2019. Current policy holders will be receiving a packet in the mail with more details. Employees may choose to cancel their policy or make changes to the type of coverage in order to offset the rate increase.

Contact UNUM at (866) 679-3054 for more information.
Will I receive a dental ID card?
Dental cards are not issued. When you visit your dental provider, provide your 6-digit employee ID with 3 leading zeros in place of your social security number. Example: 000XXXXXX.

Will I receive a vision ID card?
VSP does not issue vision ID cards. When you visit your vision provider, provide your 6-digit employee ID number.

Is the City Employee Medical Clinic (CEMC) co-pay included in the deductible & out-of-pocket max?
The CEMC co-pay does not apply to your deductible, however, it does apply to your out-of-pocket max for the year.

Are prescription co-pays included in the deductible and out-of-pocket max?
Prescription co-pays do not apply to your deductible, however, they do apply to your out-of-pocket max for the year.

How do I find out information about the tobacco premium surcharge?
Refer to the Tobacco Surcharge FAQ, available on the Benefits and Wellness Intranet page.

What can be treated through Teladoc?
- Cold and flu symptoms
- Allergies
- Bronchitis
- Urinary tract infection
- Respiratory infection
- Sinus problems
- And more!

How do I get reimbursed from my Health Reimbursement Account (HRA)?
You can submit claims to ASIFlex via mail, fax, mobile app, or online at asiflex.com. Phone: (800) 659-3035 Fax: (877) 879-9038

How quickly will I receive my FSA or HRA reimbursements?
Claims are processed daily. If you set up a direct deposit with ASIFlex you will receive your money faster than if they need to send you a check in the mail. Call ASIFlex at (800) 659-3035 to set up your direct deposit.

What is an eligible expense for the HRA and health care FSA?
Most allowable medical expenses include co-pays for services or prescriptions, deductible payments, dental work, frames, contact lenses and more. Contact ASIFlex for more information.

Who is eligible for the HRA?
All employees who enroll in the Advantage Plan will receive a HRA. Each year the employer will contribute $500 if enrolled in employee only coverage and $750 if enrolled in any other coverage tier.

How does the HRA interact with my health care FSA?
If you are enrolled in the health care FSA, claims will be paid from the FSA first, and then any remainder paid from the HRA. Note: You cannot change this order of payment.

Will I receive a debit card automatically if I have an HRA or health care FSA?
No. Download the Debit Card form by going to asiflex.com/debitcards. Submit the form to ASIFlex if you would like to receive a debit card. Remember to keep your debit card for use in 2019.

Will I have to provide documentation when I use my debit card?
Yes. If documentation is required to substantiate your claim you will need to submit the documentation to ASIFlex as soon as possible to avoid suspension of your debit card.

What happens if I do not provide substantiation for debit card transactions?
Your debit card will be deactivated and the amount becomes taxable income to you. Always remember to submit proper documentation to substantiate your claims via fax, mobile app, mail, or online.
HELPFUL REMINDERS

Benefits Information
Learn all about your benefits by visiting the Benefits and Wellness Intranet page.

Let us help!
If you need help with your benefits, please contact the HR Solutions Center at (719) 385-5125 or HR@springsgov.com.

Coordination of Benefits
You must submit your Coordination of Benefits form to Ameriben on an annual basis. You may complete the COB form and mail to Ameriben, call the customer care center at (866) 955-1482 or log into myameriben.com to update your information.

Flexible Spending Accounts
You must re-enroll in the Flexible Spending Accounts – Health Care and/or Dependent Care each year! Don’t forget to elect these benefit options during Open Enrollment!

Vacation Buy
Remember – you must re-elect this benefit if you want to purchase hours in 2019. Elect up to 40 hours (for full-time employees) of vacation buy with pre-tax deductions. Vacation buy hours must be used by December 31st and are not allowed to be carried over.

ASIFlex Reminder
Keep your ASIFlex Debit Card for use in 2019. The card will be reloaded with your Flexible Spending Account - Health Care election and/or your Health Reimbursement Account monies for use in 2019.

Deadline to Submit
You have until March 31, 2019, to submit for reimbursement requests for 2018 expenses.

Debit Card Documentation
If you are required to provide documentation that the debit card was used for an eligible reimbursable expense – be sure to follow through. Otherwise, your card will be deactivated and the expenses will be considered taxable to you.

Insurance Cards
Medical: All plan members will receive new medical cards. To request a replacement or additional medical cards contact Ameriben at (866) 955-1482.
Prescription: All plan members should keep their prescriptions cards. To request a replacement or additional prescription cards contact MaxorPlus at (806) 324-5430.

Health Reimbursement Account (HRA)
Your entire HRA balance will carry over into 2019 (maximum balance of $8,000). Please remember to submit for 2018 expenses by March 31, 2019. Funding for 2019 remains the same - $500 for employee only coverage and $750 for all other coverage levels on the Advantage Plan only.
Reminder, if you submit for a reimbursement from your HRA for a dependent you will need to certify that the dependent is covered by a group health plan.

Over-the-Counter Medications
Want to save money on your over-the-counter medications? The City Employee Pharmacy offers a wide variety of items at a great discount.
ELIGIBILITY

All regular, probationary, and special employees scheduled to work 20 hours or more each week may participate in the City of Colorado Springs’ Benefit Programs unless otherwise noted. Employees who elect coverage for themselves are eligible to elect coverage for their eligible spouse and eligible dependents.

NOTE: Hourly employees may be eligible for medical benefits as mandated by Patient Protection and Affordability Care Act.

You will be required to provide proof of dependent eligibility to enroll them in benefits. Eligible dependents include spouse and children (up to age 26), as defined by the City’s medical plan. Additionally, you are required to provide social security numbers for dependents enrolled on the medical plan to comply with employer reporting requirements to the IRS for form 1095.

QUALIFYING EVENTS

Due to IRS regulations, once you have made your elections for 2019, you cannot change your benefits until the next annual enrollment period. The only exception is if you have a qualified change in family status. Election changes must be consistent with your status change.

QUALIFYING EVENTS

- Marriage
- Legal separation or divorce
  - You may be held liable for any claims expenses for ineligible dependents remaining on the plan over 30 days.
- Change in civil union status
- Birth or adoption of a child
- Change in employment status for you or your spouse
- Change in a dependent's benefits eligibility (e.g., a dependent child exceeding maximum age for coverage)
- A significant change in the cost or coverage of your spouse's benefits
- Change in place of residence causing a loss of eligibility (i.e. moving outside of the service area)
- Change in the cost of dependent care (only for the dependent care FSA)
- Loss of a dependent (death)
- Reduction of hours of service
- Enrollment in a Qualified Health Plan through the Health Insurance Marketplace
- Retirement

To change your benefits, you must notify the HR Solutions Center in writing by completing and submitting a Benefits Change Form and providing documentation of the qualifying event within 30 days of the event.

NOTE: Benefits are effective the first of the month after the HR Solutions Center receives all necessary paperwork.
HEALTH CARE REFORM

The Patient Protection & Affordable Care Act (commonly referred to as ACA or Health Care Reform) is a federal law passed in March of 2010 with the goal of improving the availability, affordability, and quality of health care coverage in the United States. In its current form, the law has produced a steady stream of regulations and guidance by federal agencies charged with clarifying employer-requirements under the law. As your employer, we continue to implement provisions to comply with the requirements of the health care reform law.

HEALTH CARE REFORM FAQS

Am I required to have health insurance?

Health Care Reform required most U.S. citizens and legal immigrants to have a basic level of health coverage (called “minimum essential coverage”) starting January 1, 2014 or else face a tax penalty. This requirement under the law is called the individual mandate.

In December 2017, Congress passed a new law (the Tax Cuts and Jobs Act) that reduced the Individual Mandate penalty to zero starting in 2019, so starting in 2019 there will no longer be a federal mandate to maintain medical plan coverage or face a financial penalty.

What if I currently don’t have any health care coverage?

The Health Care Reform penalty for being without medical plan coverage still applies in 2018. If you don’t have minimum essential health care coverage, you may be subject to a tax penalty based on the number of months in the 2018 tax year you were without coverage. The penalty applies to each adult in the household who does not have coverage (dependent children under age 18 without coverage are subject to half the penalty). The maximum penalty per family is limited to three times the amount of the individual adult penalty.

No penalty will apply in certain situations, called health coverage exemptions. One situation is if the cost of the least expensive medical plan offered to you by your employer is considered “unaffordable” (meaning that it costs more than a certain percentage of your household income). For more information on whether you qualify for a health coverage exemption, see https://www.healthcare.gov/exemptions-tool/#!.

The City’s medical plan options are considered to be both minimum essential coverage and affordable under Health Care Reform. If you are in a benefits-eligible position and choose not to be covered by one of the City’s medical plan options, you must maintain medical plan coverage elsewhere in 2018 or you can purchase health insurance through a Marketplace (www.healthcare.gov), typically at the Marketplace annual enrollment in the fall each year.

What is the Health Insurance Marketplace?

The Marketplace is comprised of state and federal run websites (called Exchanges) where people can compare and buy individual policies for health care coverage. Plans on the Marketplace may also be eligible for a tax credit that lowers monthly premiums. Anyone can purchase coverage through the Marketplace and the plans may not deny coverage to those with pre-existing medical conditions. However, if you have coverage through the City, you may not qualify for a premium tax credit or other savings. In Colorado, our Marketplace where coverage can be purchased is called “Connect for Health Colorado” available at connectforhealthco.com. The federal Marketplace website is www.healthcare.gov. People may only enroll in a Health Insurance Marketplace during the Marketplace’s open enrollment period or if they have a special enrollment event permitted by the Marketplace.
What if I don’t have any health care coverage in 2019?

In December 2017, Congress passed a law (the Tax Cuts and Jobs Act) that reduced the federal Individual Mandate penalty to zero starting in 2019. This means that starting in 2019 there will no longer be a federal individual mandate penalty for failure to maintain medical plan coverage.

Note that if you are a resident of certain states, such as Massachusetts, New Jersey, or Vermont, you may be subject to a state income tax penalty if you fail to maintain medical plan coverage that meets that state’s minimum coverage requirements. Colorado has not currently adopted a state individual mandate penalty.

NON-GRANDFATHER STATUS
The Medical Plan is a “non-grandfathered” health care plan under the Patient Protection and Affordable Care Act (“Health Care Reform”). Being a non-grandfathered plan means the plan must comply with certain consumer protections, as outlined under Health Care Reform, which have been incorporated within this document. Questions regarding these Health Care Reform provisions can be directed to the HR Solutions Center or you may contact the U.S. Department of Health and Human Services at healthcare.gov.

PERA UPDATES

CURRENT MEMBERS

- Increase the member contribution rate by an additional 2 percent of pay (phase-in beginning July 1, 2019) to bring the member contribution rate to 10 percent for most members by July 1, 2021
- Require a three-year waiting period for retirees before receiving the first annual increase in pension benefit.
- Set the annual retiree pension increase cap to 1.5 percent
- Redefine PERA-includable salary to include sick leave payout, cell phone allowance and vehicle allowance.
- Increase to five year the Highest Average Salary (HAS) calculation for non-vested members (for those fewer than five years of service credit as of January 1, 2020); increase to three-year HAS for Judicial Division members who do not have five years of service credit as of January 1, 2020.

For more information, visit www.copera.org.
2019 BENEFIT RATES
City of Colorado Springs
City Employee Benefit Rate Chart

Regular, Probationary & Special Employees regularly scheduled to work 20 or more hours weekly and Hourly Employees who meet eligibility requirements for medical benefits

Key: EE Only = Employee Only; EE/Sp = Employee + Spouse; EE/Ch = Employee + Child(ren); EE/Family = Employee + Family

*Note: There is an additional $50 per month surcharge for employees on the medical plan who are tobacco users. To get your rates per pay period please divide Employee Share by 2.

**Premier Medical Plan Rates - Monthly**

<table>
<thead>
<tr>
<th>Level of Coverage</th>
<th>Total Plan Cost</th>
<th>Employer Share</th>
<th>Employee Share*</th>
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<tbody>
<tr>
<td>EE Only</td>
<td>$675</td>
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<td>EE/Sp</td>
<td>$1,339</td>
<td>$933</td>
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<td>EE/Ch</td>
<td>$1,259</td>
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<td>EE/Family</td>
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**Advantage Medical Plan Rates - Monthly**

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<th>Employer Share</th>
<th>Employee Share*</th>
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<td>EE/Sp</td>
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**Delta Standard Option PPO Dental Plan Rates - Monthly**

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<th>Level of Coverage</th>
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<th>Employer Share</th>
<th>Employee Share</th>
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<tbody>
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<td>EE/Ch</td>
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<td>EE/Family</td>
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**Delta Hi-Option PPO Dental Plan Rates - Monthly**

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<th>Employer Share</th>
<th>Employee Share</th>
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<tr>
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**Vision Service Plan Rates - Monthly**

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<td>EE/Ch</td>
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<tr>
<td>EE/Family</td>
<td>$25.93</td>
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MEDICAL INSURANCE

YOU MAKE A DIFFERENCE WITH A SELF-FUNDED PLAN

Can one person really make a difference in the cost of premiums to all employees? Yes! With a self-funded plan all of the employee and employer premiums are placed into a fund to pay for members’ claims throughout the year. If members spend more in claims than what has been collected in premiums, our fund will go negative and premiums would likely need to go up each year.

Smart consumers shop for high quality, affordable health care using Castlight’s transparency tool available on mycastlighthealth.com, receive their preventive care benefits, and use the correct facility or provider for services. When you are a smart consumer of health care, you do make a difference.

MEDICAL

The City offers two self-funded medical plans: The Premier Plan and the Advantage Plan coupled with a Health Reimbursement Account (HRA) component. Both plans feature an in-network and out-of-network benefit. The medical plans give you the option to pay your premiums with pre-tax dollars. Anthem Blue Cross Blue Shield is our PPO Network for both plans. AmeriBen is the medical claims administrator.

Employees and their eligible dependents enrolled in the City’s medical plans may also use the City Employee Medical Clinic (CEMC) located in the Lane Center for Academic Health Sciences Building on the second floor and the City Employee Pharmacy located on the lower level of the
City Administration Building. There is a $15 co-pay for office visits at the CEMC. Preventive Care appointments are a $0 co-pay at the CEMC.

**TELEMEDICINE**

Teladoc gives you access 24 hours, 7 days a week to a U.S. board certified doctor through the convenience of phone, video or mobile app visits. The best part about this is that it is free to all members enrolled in the medical plan. Call 800-835-2362 or online at [www.teladoc.com](http://www.teladoc.com).

Teladoc doctors can treat many medical conditions including:

- Cold & flu symptoms
- Allergies
- Pink eye
- Respiratory infections
- Sinus problems
- Skin problems
- And more!

**MEDICAL/RX**

**MEDICAL PLAN TERMS TO KNOW**

**Coinsurance** — A percentage of covered expenses paid by you after you meet the deductible.

**Coordination of Benefits** — When a member is covered by another group health plan in addition to the City’s coverage, one plan pays its benefits first and the other plan applies its benefits to the remaining balance.

**Co-pay** — A fixed dollar amount you are responsible for paying at the time covered services are received.

**Covered Services** — Services for which benefits are payable. If you receive care for services not covered under the plan, the amount you pay for those services will not apply toward your deductible or out of pocket maximum.

**Deductible** — The amount you must pay out of your pocket for covered services in a benefit year before the health plan begins to pay.

**Enhanced Personal Health Care (EPHC) Provider** — This is Anthem’s approach to patient-centered care. It helps doctors do what they do best – take care of their patients. And it helps you get the right level of care, from the right kind of health care provider, at the right time. All of that helps you live a better, healthier life.

Anthem helps the doctors who are part of the EPHC treat you as a whole person – not as a sore throat or a backache. Anthem does this by giving your doctor tools and information to help you make the best decisions for your health care together. Anthem encourages your doctor to be available by phone or email, so you don’t need an office visit when you just want to ask a quick question. If you need to see a doctor, you may be able to see one when it’s best for you – early mornings, evenings or weekends.

**Formulary** — The list of medicines covered by a health plan.
**Out-of-Pocket Maximum** —The maximum you will be required to pay for covered services in a benefit year. Under this provision, the health plan will pay 100 percent of the allowable amount for most covered services after you have reached the out-of-pocket limit.

**Prior Authorization** —Review performed by Ameriben Medical Management for certain procedures and services before they are provided to determine if the services are approved for coverage under a benefit plan.

**TOBACCO PREMIUM SURCHARGE**

Employees who are current tobacco users will be assessed a $50 per month premium surcharge if enrolled in one of the City’s medical plans. Current use is defined as more than 4 times a week in the previous 6 months. Tobacco products include but are not limited to: cigarettes, cigars, cigarillos, pipes, chewing tobacco, snuff, dip, and loose tobacco smoked via pipe, hookah or hand rolled cigarettes.

Tobacco use status is based on employee attestation and can be changed any time during the year if they no longer meet the definition of current use or complete a tobacco cessation program. For more details, review the Tobacco Premium Surcharge FAQ available on the Benefits and Wellness Intranet page.

**ALTERNATIVE MEDICINE BENEFIT**

If you enroll in the City’s medical plan, you can be reimbursed for services including acupuncture, massage therapy, chiropractic services, homeopathic, naturopathic and foot care (not otherwise eligible per plan) services. The maximum for this benefit is 50% of each claim, up to $1,000 total for the family. The 50% coinsurance does not apply to your deductible, but does apply to your annual out-of-pocket maximum.

Additionally, you may see a dietician and/or nutritionist for up to eight (8) visits each per year (no max dollar limit) under the Alternative Medicine Benefit.

Submit a completed Ameriben claim form, found on the Benefits and Wellness Intranet page, along with a copy of your receipt to Ameriben for reimbursement.

**HEALTH REIMBURSEMENT ACCOUNT (HRA)**

Employees enrolled in the Advantage Plan are eligible to receive an employer funded Health Reimbursement Account (HRA). The annual funding level is based on your coverage tier, $500 for employee only coverage or $750 for all other coverage tiers. The funding is pro-rated for new enrollees during the year. This account allows you to pay for certain medical, dental and vision expenses with tax free dollars funded by the City. If you enroll in pre-tax Flexible Spending Account (FSA) for Health Care, you must first exhaust the balance in your FSA for Health Care before you can be reimbursed from your HRA. The maximum balance you may accrue is $8,000. Visit www.ASIFlex.com or call 800-659-3035 for more information on your account.

**Fund Availability:** Your full annual employer funded amount of $500 for individual only coverage and $750 for all other coverage tiers (if you elected the Advantage Plan) is available to you on January 1st of the plan year.

*Remember you have until March 31 of the following year to submit claims for all FSA and HRA reimbursements.*

**LEARN MORE**

Additional information is located on the Benefits and Wellness Intranet page. Contact the HR Solutions Center at (719) 385-5125 or HR@springsgov.com for additional questions.
## MEDICAL PLAN COMPARISON

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Premier Plan</th>
<th>Advantage Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network Benefit</td>
<td>Out-of-Network Benefit</td>
</tr>
<tr>
<td><strong>Lifetime maximum</strong></td>
<td>unlimited</td>
<td>unlimited</td>
</tr>
<tr>
<td><strong>Annual Deductible</strong></td>
<td>$500 Individual $1250 Family</td>
<td>$1,250 Individual $2,500 Family</td>
</tr>
<tr>
<td><strong>Coinsurance(1)</strong></td>
<td>You pay 20%</td>
<td>You pay 50%</td>
</tr>
<tr>
<td><strong>Annual Out-of-Pocket Maximum (OPM)/ Coinsurance(1)</strong></td>
<td>$2,500 Individual $7,500 Family</td>
<td>$4,050 Individual $12,150 Family</td>
</tr>
<tr>
<td><strong>Primary Care Office Visit(2)</strong></td>
<td>EPHC - $25 co-pay, deductible waived; All others - $35 after deductible.</td>
<td>You pay 50% after deductible.</td>
</tr>
<tr>
<td><strong>Specialist Office Visit(2)</strong></td>
<td>Tier I - $40 co-pay, deductible waived; All others - $60 after deductible.</td>
<td>You pay 50% after deductible.</td>
</tr>
<tr>
<td><strong>Mental Health Office Visit</strong></td>
<td>$25 co-pay, deductible waived.</td>
<td>You pay 50% after deductible.</td>
</tr>
<tr>
<td><strong>Urgent Care</strong></td>
<td>$50 co-pay, deductible waived; coinsurance for diagnostic &amp; surgical services.</td>
<td>You pay 50% after deductible.</td>
</tr>
<tr>
<td><strong>Emergency Room Visits</strong></td>
<td>$250 co-pay, then you pay 20% for diagnostic and surgical services, deductible waived.</td>
<td>If admitted to the hospital, ER co-pay waived.</td>
</tr>
<tr>
<td><strong>Diagnostic Services</strong></td>
<td>You pay 20% after deductible.</td>
<td>You pay 50% after deductible.</td>
</tr>
<tr>
<td><strong>Inpatient Mental Health</strong></td>
<td>You pay 20% after deductible.</td>
<td>You pay 50% after deductible.</td>
</tr>
<tr>
<td><strong>Inpatient Hospital Services</strong></td>
<td>Utilize an UCHealth Facility - you pay 15% after deductible.</td>
<td>You pay 50% after deductible.</td>
</tr>
<tr>
<td></td>
<td>All hospital services and all other facilities - You pay 20% after deductible.</td>
<td></td>
</tr>
<tr>
<td><strong>Advanced Imaging (MRI/CT/PET)</strong></td>
<td>Freestanding Facility - you pay 10% after deductible; All other facilities - you pay 20% after deductible.</td>
<td>You pay 50% after deductible.</td>
</tr>
<tr>
<td><strong>Outpatient/Ambulatory Surgery</strong></td>
<td>Freestanding Facility - you pay 10% after deductible; All other facilities - you pay 20% after deductible.</td>
<td>You pay 50% after deductible.</td>
</tr>
<tr>
<td><strong>Preventive Care</strong></td>
<td>You pay $0</td>
<td>You pay 50%; deductible waived.</td>
</tr>
<tr>
<td><strong>Alternative Medicine</strong></td>
<td>Plan Pays 50% of each claim up to an annual family maximum of $1000, deductible waived.</td>
<td>Nutritionists &amp; Dieticians – maximum of 8 visits per year per each, 50% coinsurance, deductible waived</td>
</tr>
</tbody>
</table>

**Notes:**
1. The OPM and coinsurance are accounted separately for in-network and out-of-network services.
2. Co-pay applies to office visit only. Deductible and co-insurance apply for diagnostic and surgical services performed in the office setting.

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PRESCRIPTION COVERAGE

Employees and their eligible dependents enrolled in the City medical plans can fill their prescriptions at the City Employee Pharmacy. In addition, you and your eligible dependents can fill your prescriptions through one of the MaxorPlus participating network pharmacies. You will save money if you fill your prescription at the City Employee Pharmacy.

Maxor provides services relating to specialty injectables, specialty drugs, and certain respiratory therapies through its subsidiary, IVSolutions. This Specialty Injectable and Specialty Drug Program will benefit you, the patient, and help contain the costs of expensive medications. IVSolutions will be working in conjunction with the City Employee Pharmacy to fill medications through this program. If you have any questions, please call (800) 658-6046 to speak with an IVSolutions Customer Service Representative. More information can be found at cityemployeepharmacy.com.

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### Pharmacy Tier Prescription Type Cost

<table>
<thead>
<tr>
<th>City Employee Pharmacy</th>
<th>MaxorPlus Retail Network Pharmacies</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1st Tier</strong></td>
<td><strong>1st Tier</strong></td>
</tr>
<tr>
<td>Generic $6 co-pay (30 day supply)</td>
<td>Generic $25 (30 day supply)</td>
</tr>
<tr>
<td>Preferred Brand $35 co-pay (30 day supply)</td>
<td>Preferred Brand $55 (30 day supply)</td>
</tr>
<tr>
<td>Non-Preferred Brand $60 co-pay (30 day supply)</td>
<td>Non-Preferred Brand $75 (30 day supply)</td>
</tr>
<tr>
<td>Chronic Injectables &amp; Specialty Drugs $100 (30 day supply)</td>
<td>N/A – Only available through MaxorPlus IV Solutions 🌐</td>
</tr>
</tbody>
</table>

### Specials

- **$15 co-pay**
- **Preventive Care is FREE**

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### City Employee Medical Clinic

- Available to both Advantage and Premier Plan members
- Similar services as your Primary Care Provider
- $15 co-pay
- Preventive Care is FREE

#### Preventive Services
- Physical Exams (ages 5 and up)
- School & Sports Physicals
- Women’s Health
- Immunizations

#### Chronic Care Services
- Diagnosis, treatment and management of chronic conditions such as:
  - High Blood Pressure
  - Asthma
  - Diabetes
  - High Cholesterol

#### Acute Care Services (Ages 3 & Up)
- Diagnosis and treatment of acute illness
- Evaluation and treatment of injuries
- Referrals to specialists, including diagnosticians

#### On-Site Lab Services
- By Appointment

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Lane Center for Academic Health Sciences Building
4863 North Nevada Avenue
Second Floor
Colorado Springs, CO 80918

Phone: (719) 385-5841
Fax: (719) 385-5842

Hours: M, Tu, Th, F 7:30 AM – 4:30 PM
Wed 9 AM – 6 PM

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### City Employee Pharmacy

- Available to both Advantage and Premier Plan Members
- Home & Desk Delivery Available
- Validated Parking
- Text Messaging Alerts (charges may apply)

#### Refills:
- Automated Refill Line (800) 573-6214
- Mobile App
- Over-the-counter discounts on medications, vitamins & supplies

City Administration Building
30 South Nevada Avenue
Suite L03 (Lower Level)
Colorado Springs, CO 80903

Phone: (719) 385-2261
Fax: (719) 385-2264

www.cityemployeepharmacy.com

Hours: Monday-Friday 8:30AM – 5:30PM
PRESCRIPTION COVERAGE

Employees and their eligible dependents enrolled in the City medical plans can fill their prescriptions at the City Employee Pharmacy. In addition, you and your eligible dependents can fill your prescriptions through one of the MaxorPlus participating network pharmacies. You will save money if you fill your prescription at the City Employee Pharmacy.

Maxor provides services relating to specialty injectables, specialty drugs, and certain respiratory therapies through its subsidiary, IVSolutions. This Specialty Injectable and Specialty Drug Program will benefit you, the patient, and help contain the costs of expensive medications. IVSolutions will be working in conjunction with the City Employee Pharmacy to fill medications through this program. If you have any questions, please call (800) 658-6046 to speak with an IVSolutions Customer Service Representative. More information can be found at cityemployeepharmacy.com.

<table>
<thead>
<tr>
<th>Pharmacy</th>
<th>Tier</th>
<th>Prescription Type</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>City Employee Pharmacy</td>
<td>1st Tier</td>
<td>Generic</td>
<td>$ 6 co-pay (30 day supply) $ 15 co-pay (90 day supply)</td>
</tr>
<tr>
<td></td>
<td>2nd Tier</td>
<td>Preferred Brand</td>
<td>$35 co-pay (30 day supply) $70 co-pay (90 day supply)</td>
</tr>
<tr>
<td></td>
<td>3rd Tier</td>
<td>Non-Preferred Brand</td>
<td>$60 co-pay (30 day supply) $120 co-pay (90 day supply)</td>
</tr>
<tr>
<td>Specialty Pharmacy</td>
<td>4th Tier</td>
<td>Preferred Chronic Injectables and other Specialty Drugs</td>
<td>$100 (30 day supply)</td>
</tr>
<tr>
<td></td>
<td>5th Tier</td>
<td>Non-Preferred Chronic Injectables and other Specialty Drugs</td>
<td>$150 (30 day supply)</td>
</tr>
<tr>
<td>MaxorPlus Retail Network Pharmacies</td>
<td>1st Tier</td>
<td>Generic</td>
<td>$25 (30 day supply)</td>
</tr>
<tr>
<td></td>
<td>2nd Tier</td>
<td>Preferred Brand</td>
<td>$55 (30 day supply)</td>
</tr>
<tr>
<td></td>
<td>3rd Tier</td>
<td>Non-Preferred Brand</td>
<td>$75 (30 day supply)</td>
</tr>
<tr>
<td></td>
<td>4th Tier &amp; 5th Tier</td>
<td>Preferred/Non-Preferred Chronic Injectables</td>
<td>N/A – Only available through MaxorPlus IV Solutions</td>
</tr>
</tbody>
</table>

Chronic injectables and Specialty Drugs: $2,500 out-of-pocket maximum per member, per year

Maintenance Prescription Fills - For a complete listing of participating pharmacies go to the Preferred Pharmacy Information at cityemployeepharmacy.com. Plan participants will progressively pay higher co-pays for maintenance prescriptions that are filled at a MaxorPlus Retail Network Pharmacy versus the City Employee Pharmacy. Engagement in health management programs may allow for waived co-pays. Contact the HR Solutions Center at (719) 385-5125 to learn more.

Maintenance Rx filled at any MaxorPlus Retail Network Pharmacy:
- First fill: member pays the normal co-pay
- Second fill: member pays double the co-pay
- Third and subsequent fills: member pays 100% of the retail cost for a maintenance Rx

Select preventive care medications are covered at 100% and may change in accordance with USPSTF guidelines.

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## DENTAL INSURANCE

The City offers two dental plans with different options: Delta Hi-Option PPO Dental Plan and Delta Standard DPO Dental Plan. Both options pay 100% for cleanings, oral exams and x-rays if you use a PPO Dentist. Please refer to the current year Dental Plan Comparison and Rate Chart and/or the Delta Dental Plan Document for more information. Call Delta Dental at (800) 610-0201 or visit deltadentalco.com to find a PPO Provider.

<table>
<thead>
<tr>
<th>Type of Benefit</th>
<th>Delta Hi-Option PPO (1)</th>
<th>Delta Standard-Option PPO (1)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PPO Dentist</td>
<td>Premier &amp; Non-Participating Dentists</td>
</tr>
<tr>
<td>Annual Maximum Plan Will Cover</td>
<td>$2,000 per individual</td>
<td>$1,500 per individual</td>
</tr>
<tr>
<td>Annual Deductible</td>
<td></td>
<td>$50</td>
</tr>
<tr>
<td>Per Person</td>
<td></td>
<td>$150</td>
</tr>
<tr>
<td>Per Family</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine Dentistry (2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cleaning</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>Oral Exams</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>X-Rays</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>Sealants (3)</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>Basic Dentistry (4) (6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fillings</td>
<td>90%</td>
<td>50%</td>
</tr>
<tr>
<td>Extraction</td>
<td>90%</td>
<td>50%</td>
</tr>
<tr>
<td>Root Planning/Quadrant</td>
<td>90%</td>
<td>50%</td>
</tr>
<tr>
<td>Major Dentistry (6)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crown (full cast)</td>
<td>60%</td>
<td>50%</td>
</tr>
<tr>
<td>Denture Repair</td>
<td>60%</td>
<td>50%</td>
</tr>
<tr>
<td>Bridge</td>
<td>60%</td>
<td>50%</td>
</tr>
<tr>
<td>Orthodontia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orthodontic Benefit</td>
<td>60%</td>
<td></td>
</tr>
<tr>
<td>Lifetime Maximum</td>
<td>$2,500</td>
<td></td>
</tr>
<tr>
<td>Implant Coverage</td>
<td>All steps included</td>
<td></td>
</tr>
<tr>
<td>Prevention First</td>
<td>Included</td>
<td></td>
</tr>
</tbody>
</table>

**Notes:**

1. Member and plan receive discounted contract pricing if a PPO & In-Network provider is utilized. The Non-Participating % of benefits is limited to the non-participating Maximum Plan Allowance. You will be responsible for the difference between the non-participation Maximum plan Allowance and the full fee charged by the Dentist.
2. Deductible does not apply to routine dentistry services.
3. Sealants for permanent teeth for children through age 14 are a covered benefit on all plans as a routine dentistry service. Sealants for pre-molars are covered.
4. Resin or Composite filling will be covered at the same benefit as amalgam filling.
5. Services received by a Non-Participating dentist are reimbursed at the allowable Maximum Plan Allowance (MPA) for non-contracted dentist. Members will be responsible for the difference between the allowable fee for non-contracted provider and the billed amount. By using a Delta Dental contracted provider PPO the member will not be balanced billed for the difference between the allowable MPA fee and the billed amount, must be written off by provider.
6. The deductible applies to these services:
   - The plan will pay 50% coinsurance for one occlusal mouth guard per lifetime to prevent grinding.
   - Over-the-counter (OTC) mouth guards will be excluded under the Dental Plan.
   - The coinsurance will apply towards the Annual Plan Maximum.

This table is not intended to include all benefit details. It is an outline of coverage available and is not intended to be a legal contract. If a discrepancy exists between this document and the official Plan Documents, the Plan Documents govern.
### VISION INSURANCE

The City offers one vision plan option. This plan provides coverage once per plan year for routine eye exams, frames, lenses and contact lenses and provides other services such as member preferred pricing on contact lenses and direct delivery to the home. Please refer to the current year Plan Summary and Rate Chart and/or Vision Plan Document for more information, or call VSP at (800) 877-7195. Visit [vsp.com](http://vsp.com) to find a VSP Provider and learn about additional discounts.

*Note: You are not eligible for eyeglasses and contact lenses in the same benefit period. Although this plan does offer limited out-of-network benefits, coverage is much better if you use a VSP provider.*

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Description</th>
<th>Co-pay</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>WellVision Exam</td>
<td>• Focuses on your eyes and overall wellness</td>
<td>$20</td>
<td>Every calendar year</td>
</tr>
<tr>
<td>Frames</td>
<td>• $175 allowance for a wide selection of frames</td>
<td>$15</td>
<td>Every calendar year</td>
</tr>
<tr>
<td></td>
<td>• $195 allowance for featured frame brands</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• $95 allowance at Costco</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• 20% savings on the amount over your allowance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lenses</td>
<td>• Single vision, lined bifocal, and lined trifocal lenses</td>
<td>$10</td>
<td>Every calendar year</td>
</tr>
<tr>
<td>Prescriptions Glasses</td>
<td>• Standard progressive lenses</td>
<td>$55</td>
<td>Every calendar year</td>
</tr>
<tr>
<td></td>
<td>• Premium progressive lenses</td>
<td>$95 - $105</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Custom progressive lenses</td>
<td>$150 - $175</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Average savings of 20-25% on other lens enhancements</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contacts (instead of glasses)</td>
<td>• $175 allowance for contacts; co-pay does not apply</td>
<td>Up to $60</td>
<td>Every calendar year</td>
</tr>
<tr>
<td></td>
<td>• Contact lens exam (fitting and evaluation)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetic Eyecare Plus Program</td>
<td>• Services related to diabetic eye disease, glaucoma and age-related macular degeneration (AMD). Retinal screening for eligible members with diabetes. Limitations and coordination with medical coverage may apply. Ask your VSP doctor for details.</td>
<td>$20</td>
<td>As needed</td>
</tr>
</tbody>
</table>
| Glasses and Sunglasses       | • Extra $20 to spend on featured frame brands. Go to vsp.com/special offers for details.  
                              | • 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam. |        |                 |
| Retinal Screening            | • No more than a $39 co-pay on routine screening as an enhancement to a WellVision Exam. |        |                 |
| Laser Vision Correction      | • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities. |        |                 |

#### Your Coverage with Out-of-Network Providers

Visit vsp.com for details, if you plan to see a provider other than a VSP network provider.

<table>
<thead>
<tr>
<th>Item</th>
<th>Out-of-Network Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exam................up to $45</td>
<td>Contacts................up to $105</td>
</tr>
<tr>
<td>Frame........up to $70</td>
<td>Lined Bifocal Lenses.....up to $50</td>
</tr>
<tr>
<td>Single Vision Lenses..........up to $30</td>
<td>Lined Trifocal Lenses.....up to $65</td>
</tr>
<tr>
<td>Lined Trifocal Lenses..........up to $65</td>
<td>Progressive Lenses.....up to $50</td>
</tr>
</tbody>
</table>

Coverage with a participating retail chain may be different. Once your benefit is effective, visit vsp.com for details.

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WELLNESS AND DISEASE MANAGEMENT

REACH YOUR PEAK WELLNESS PROGRAM
The Reach Your Peak Year 15 Wellness program is November 15, 2018 through October 31, 2019. You can earn a $300 incentive. For more information visit the Benefits and Wellness intranet page, visit www.cosreachyourpeak.com or call (719) 314-3535.

You must be a medical plan member to participate in the RYP program.

CITY EMPLOYEE MEDICAL CLINIC (CEMC)
Employees and their dependents on the City’s medical plan are able to access the City Employee Medical Clinic (CEMC) for a $15 co-pay. This is a valuable benefit we hope you and your family utilize. Contact the CEMC and schedule an appointment by calling (719) 385-5841.

These services are no charge when you see an in-network provider. Find an in-network provider at mycastlighthealth.com. Preventive Care Incentive – Earn $75 for you and your spouse (max $150) if enrolled on the medical plan. Review the Preventive Care FAQ available on the Benefits and Wellness Intranet page for more details.

EMPLOYEE ASSISTANCE PROGRAM (EAP)
This FREE and confidential program through Profile EAP is available to all benefit eligible employees and their eligible dependents. EAP is a professional and completely confidential counseling service designed to help employees and dependents resolve personal and/or work-related issues such as marital, chemical dependency, stress and emotional problems. EAP provides up to six assessment counseling visits for each problem area each year at no charge. The employee medical plan may help cover additional treatment if needed.

You may call Profile EAP at (719) 634-1825 or (800) 645-6571 any hour of the day or night.

In addition to counseling services, Profile EAP offers a Life Cycle Services program at no cost for you. Looking for support in caring for aging parents? Preparing for your child’s college education? No cost legal and financial initial consults with discounts for additional services. And so much more! Find online resources or call Profile EAP at 719-634-1825 for more information.


AMERIBEN MEDICAL MANAGEMENT PROGRAMS
Telephonic support from a RN to help you manage your condition and work with your provider to ensure you are getting the best care plan and quality care you need. You will be eligible for waived co-pays, generic and select brands, if engaged in a program:

- ✓ Asthma
- ✓ Coronary Artery Disease
- ✓ COPD
- ✓ Diabetes
- ✓ GERD
- ✓ Hypertension

There is support and additional programs for other chronic and high risk conditions, including a Maternal Health Program.

Contact Ameriben Medical Management at (800) 388-3193 for more information.

*Waived prescription co-pays if engaged in Ameriben Medical Management programs, Diabetes Ten City Challenge and/or CardioRx programs, up to an annual maximum.
TOBACCO CESSATION PROGRAMS

- Quit with Nancy! through Ameriben Medical Management – (800) 388-3193
  This program offers individualized, one-on-one guidance through an 8 hour DVD program and personal workbook. Watch the DVD at home and receive RN coaching support throughout the quitting process based on a schedule that meets your needs.
- City Employee Medical Clinic (CEMC) – (719) 385-5841
  No co-pay if appointment is for tobacco cessation. Nurse Practitioners can write prescriptions for tobacco cessation medications and/or over the counter products. You must be enrolled in a City medical plan to use this CEMC.

DIABETES TEN CITY CHALLENGE (DTCC)
Personalized one-on-one coaching with a pharmacist to help you manage your diabetes. Working with your health care provider, the pharmacist will provide a customized education and develop a care plan that strives to improve your quality of life. Waived co-pays for diabetic medications for plan members who are engaged in the program*. Voluntary and confidential. Schedule an appointment by calling (719) 385-2262.

CARDIORX
Meet with a pharmacist in the City Employee Pharmacy to learn how to better manage your Cardiovascular Disease. Receive hands on education and training and assistance in developing tools in improving your health and your lifestyle. Waived co-pays for generic medications for hypertension if enrolled and engaged in the program*. Voluntary and confidential. Call (719) 385-2262 to schedule an appointment.

*Waived prescription co-pays if engaged in Ameriben Medical Management programs, Diabetes Ten City Challenge and/or CardioRx programs, up to an annual maximum.

FINANCIAL SEMINARS
Monthly financial seminars through ICMA-RC which are focused on different topics including:
- Social Security Planning – with a Public Sector Focus
- Credit and Debt Do’s and Don’ts
- How Much Will Retirement Cost Workshop
- College Smarts
- And More

An ICMA-RC representative will also offer on-site personalized appointments throughout the year. If you would like to meet one-on-one with our ICMA representative or attend a seminar/webinar, you can find information on the Benefits and Wellness Intranet page. It is never too late to start saving!

UCCS WELLNESS PROGRAMS
All benefit eligible City employee can mix and match up to 4 UCCS programs listed below for free! Eligible employees can also earn Reach Your Peak points.
- Personal Training
- Group Fitness Classes
- Cooking Classes
- Health Topics
FLEXIBLE SPENDING ACCOUNTS (FSA)

Flexible Spending Accounts (FSA) are a great cost savings tool to help with common medical and/or dependent care expenses not covered by your insurance. You can elect a portion of your pay to be deducted, on a pre-tax basis, from each paycheck to use for reimbursements of qualified out-of-pocket expenses throughout the plan year. Visit www.ASIFlex.com or call 800-659-3035 for more information on your account.

FSA – HEALTH CARE

An FSA for Health Care allows you to allocate money on a pre-tax basis to reimburse yourself for qualified medical, dental and vision expenses for you and your family. Qualified expenses include anything from co-pays, deductibles, prescriptions and much more. Up to $500 may be rolled over to the following year if you do not incur sufficient eligible expenses for reimbursements.

Minimum Annual Election: $120                                    Maximum Annual Election: $2,650

Fund Availability: Your full annual election is available to you on January 1st of the plan year.

FSA – DEPENDENT DAY CARE

An FSA for Dependent Day Care allows you to allocate money on a pre-tax basis to reimburse yourself for dependent care services. Remember, there is a “use it or lose it” rule with FSA for Dependent Day Care, so any contributions remaining in your account that cannot be applied toward current year dependent day care expenses are not refundable.

Minimum Annual Election: $120                                    Maximum Annual Election: $5,000

Fund Availability: Unlike the FSA for Health Care, the entire elected amount is not available on the first day of the plan year, but rather as contributions are received and services have been provided.

Please see the FSA – Dependent Day Care Plan Document for more details on eligibility and maximum elections allowed.

Remember you have until March 31 of the following year to submit claims for all FSA and HRA reimbursements.

VACATION BUY

Benefit eligible employees may purchase up to 40 hours of vacation time pre-tax, based upon their hourly rate of pay effective January 1 of each benefit year. The minimum purchase amount is eight hours for full-time employees. Eligible employees may purchase additional hours in one-hour increments up to forty hours maximum.

Reminder!

The order of use for vacation buy is:

1) Your accrued vacation for the year
2) Vacation Buy hours purchased
3) Carryover from the previous year

If you have any questions contact the HR Solutions Center at (719) 385-5125 or HR@springsgov.com
LIFE INSURANCE

BASIC LIFE AND AD&D

The City of Colorado Springs pays for basic life insurance and accidental death and dismemberment coverage equal to one and one-half times your annual salary through Aetna US Healthcare. The maximum coverage amount for any employee is $500,000. Please refer to the life insurance information on the Benefits and Wellness Intranet page for further details.

VOLUNTARY TERM LIFE (VTL)

You may also purchase voluntary term life insurance for yourself, your spouse and your children.

• No individual may be covered as a dependent of more than one employee.
• Employees and spouses may increase their coverage level in multiple increments of $25,000, children in multiple increments of $5,000. (Children must be eligible dependents).
• This policy is portable and convertible if you separate from the City.
• Evidence of Insurability (EOI) will be required on all increases or if you are enrolling for the first time.
• VTL premiums are based on age as of January 1, the amount of coverage chosen and whether you use tobacco.
• You must be tobacco-free for 12 months prior to electing non-tobacco user rates.

<table>
<thead>
<tr>
<th>Coverage Level</th>
<th>Minimum Coverage</th>
<th>Maximum Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td>$25,000</td>
<td>The lesser of 10 times salary or $500,000</td>
</tr>
<tr>
<td>Spouse</td>
<td>$25,000</td>
<td>$250,000</td>
</tr>
<tr>
<td>Child(ren)</td>
<td>$5,000</td>
<td>$25,000</td>
</tr>
</tbody>
</table>

**VTL Rate Structure**

<table>
<thead>
<tr>
<th>Age Bracket</th>
<th>Non-Tobacco User Per $1,000</th>
<th>Tobacco User Per $1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 30</td>
<td>.04</td>
<td>.07</td>
</tr>
<tr>
<td>30-34</td>
<td>.06</td>
<td>.10</td>
</tr>
<tr>
<td>35-39</td>
<td>.07</td>
<td>.11</td>
</tr>
<tr>
<td>40-44</td>
<td>.08</td>
<td>.15</td>
</tr>
<tr>
<td>45-49</td>
<td>.11</td>
<td>.23</td>
</tr>
<tr>
<td>50-54</td>
<td>.17</td>
<td>.34</td>
</tr>
<tr>
<td>55-59</td>
<td>.32</td>
<td>.57</td>
</tr>
<tr>
<td>60-64</td>
<td>.50</td>
<td>.83</td>
</tr>
<tr>
<td>65-69</td>
<td>.97</td>
<td>1.37</td>
</tr>
<tr>
<td>70-74</td>
<td>1.64</td>
<td>2.79</td>
</tr>
<tr>
<td>Over 74</td>
<td>2.06</td>
<td>2.85</td>
</tr>
</tbody>
</table>

Cost Example:
Desired Purchase Amount .................. $150,000
Age on January 1 ......................... 35
Smoking Status .................. Non-Tobacco User

$150,000 / 1,000 = 150
150 X .07 = $10.50
$10.50 Monthly / 2 = $5.25
Semi-monthly cost = $5.25

Changes during Open Enrollment:
Contact the HR Solutions Center at (719) 385-5125 or HR@springsgov.com for information on how to enroll during Open Enrollment. Important: You will be required to complete an Evidence of Insurability (EOI) to enroll or increase your and/or your spouse’s VTL coverage. You must contact the HR Solutions Center on or before the last day of Open Enrollment to be eligible to complete an EOI through Aetna.
DISABILITY INSURANCE

If you are not currently enrolled in a disability plan and elect coverage for the first time, your coverage is subject to Evidence of Insurability (EOI). Coverage and premiums begin when approval is received from the provider. Cost is based on current age, salary and class. Premiums will be adjusted with changes in pay or vesting during the year. Please note: If you become PERA vested prior to five years of service with the City of Colorado Springs due to other past PERA covered employment, it is your responsibility to notify the HR Solutions Center.

Class Based On Years of Service with a PERA Employer

Class 1 = All active Non PERA vested regular full, part-time or special employees over age 18 working at least 20 hours per week, who have less than 5 years of PERA service, all active full-time Sworn employees over age 18 working at least 20 hours per week upon employment use Class I rates for Short Term Disability.

Class 2 = All active PERA vested regular full, part-time or special employees over age 18 working at least 20 hours per week, who have 5 or more years of PERA service.

Class 3 = Full-time sworn employees over age 18 working at least 20 hours per week (Long Term Disability only).

SHORT TERM DISABILITY

Benefits are payable for non-work related injuries or illnesses only, and offsets apply.

- For accident and illness, benefits begin after 7 days or after accumulated sick leave is exhausted, whichever is greater.
- Benefits are paid for a maximum of 25 weeks for Class 1, and 8 weeks for Class 2.
- This plan pays a benefit of up to 60% of your weekly covered earnings to a maximum of $1250 per week. Benefits are reduced by any amounts payable to you from other income sources.
- Initial premium is based on current age, salary and class. Premiums will be adjusted with changes in pay or vesting during the year.
- Premium is based on Monthly Benefit Amount divided by $100, multiplied by the Age Factor.

<table>
<thead>
<tr>
<th>Age Bracket</th>
<th>Class 1</th>
<th>Class 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 30</td>
<td>.554</td>
<td>.254</td>
</tr>
<tr>
<td>30 – 34</td>
<td>.531</td>
<td>.254</td>
</tr>
<tr>
<td>35 – 39</td>
<td>.484</td>
<td>.231</td>
</tr>
<tr>
<td>40 – 44</td>
<td>.531</td>
<td>.254</td>
</tr>
<tr>
<td>45 – 49</td>
<td>.577</td>
<td>.277</td>
</tr>
<tr>
<td>50 – 54</td>
<td>.692</td>
<td>.323</td>
</tr>
<tr>
<td>55 – 59</td>
<td>.808</td>
<td>.323</td>
</tr>
<tr>
<td>60 – 64</td>
<td>1.061</td>
<td>.461</td>
</tr>
<tr>
<td>65 plus</td>
<td>1.246</td>
<td>.554</td>
</tr>
</tbody>
</table>

Cost Example:
Annual Base Salary........................................ $45,000
Monthly Base Salary........................................ $3750.00
Years of Service............................................. 4 (Class 1)
Age on January 1............................................... 35

Short Term Disability $3750 X 60% = $2,250
$2,250 / 100 = $22.50
$22.50 X .484 = $10.89
$10.89 Monthly / 2 = $5.45
Semi-monthly cost = $5.45

Long Term Disability $3750 / $100 = $37.50
$37.50 X .464 = $17.40
$17.40 Monthly / 2 = $8.70
Semi-monthly cost = $8.70
LONG TERM DISABILITY

- The disability plans do not pay benefits for any disability resulting from a pre-existing condition unless the disability occurs after you have been insured under this plan for 12 consecutive months. Pre-existing conditions are those for which you have incurred expenses, taken prescription drugs or medicines, received medical treatment, care or services (including diagnostic measures), or consulted a physician during the 6 months immediately prior to the most recent effective date of insurance.
- All classes will have offsets applied for Workers’ Compensation, PERA Disability, Social Security, sick leave, salary continuation, etc.
- Before benefits are payable you must be continuously disabled for 180 days following your date of disability.
- To receive benefits under the plan, you must be disabled (as defined by the plan). Benefits are payable until the end of the benefit period or until you no longer qualify for benefits, whichever occurs first.
- The plan pays a benefit of up to 60% of your monthly covered earnings to a maximum of $7,500 per month. Your benefit will be reduced by any amounts payable to you from other income sources (minimum benefit is $50).
- Premium is Monthly Covered Earnings divided by $100, multiplied by the Age Factor.

<table>
<thead>
<tr>
<th>Age Bracket</th>
<th>Class 1</th>
<th>Class 2</th>
<th>Class 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 – 24</td>
<td>.190</td>
<td>.058</td>
<td>.132</td>
</tr>
<tr>
<td>25 – 29</td>
<td>.232</td>
<td>.075</td>
<td>.174</td>
</tr>
<tr>
<td>30 – 34</td>
<td>.339</td>
<td>.132</td>
<td>.257</td>
</tr>
<tr>
<td>35 – 39</td>
<td>.464</td>
<td>.182</td>
<td>.389</td>
</tr>
<tr>
<td>40 – 44</td>
<td>.927</td>
<td>.315</td>
<td>.629</td>
</tr>
<tr>
<td>45 – 49</td>
<td>1.499</td>
<td>.563</td>
<td>1.101</td>
</tr>
<tr>
<td>50 – 54</td>
<td>1.954</td>
<td>.861</td>
<td>1.731</td>
</tr>
<tr>
<td>55 – 59</td>
<td>2.153</td>
<td>1.027</td>
<td>2.078</td>
</tr>
<tr>
<td>60 – 64</td>
<td>1.962</td>
<td>.985</td>
<td>1.938</td>
</tr>
<tr>
<td>65 plus</td>
<td>1.962</td>
<td>.985</td>
<td>1.938</td>
</tr>
</tbody>
</table>

Cost Example:
Annual Base Salary…………………………… $45,000
Monthly Base Salary………………………… $3750.00
Years of Service……………………………. 4 (Class 1)
Age on January 1…………………………………….. 35

Short Term Disability
$3750 X 60% = $2,250
$2,250 / 100 = $22.50
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Long Term Disability
$3750 / $100 = $37.50
$37.50 X .464 = $17.40
$17.40 Monthly / 2 = $8.70
Semi-monthly cost = $8.70

Changes during Open Enrollment:
If you are NOT making changes – No action is required.
If you would like to enroll in Short and/or Long Term Disability – Contact the HR Solutions Center at (719) 385-5125 or hr@springsgov.com for information on how to enroll during Open Enrollment. IMPORTANT: You will be required to complete an Evidence of Insurability (EOI) to enroll. You must contact the HR Solutions Center on or before the last day of Open Enrollment to be eligible to complete the EOI through Cigna.
LONG TERM CARE (LTC)

You, your spouse, parents and grandparents, are eligible for LTC insurance. This plan is designed to provide financial assistance in the event that you lose at least two activities of daily living. These are defined as bathing, dressing, toileting, transferring, continence, or feeding that would result in you or a family member needing care in a long term care facility, at home or another similar place. Insurance for long term care pays you a monthly payment for loss of functional capacity or cognitive impairment.

Under the LTC benefit, you may choose from different plans as well as select inflation protection. Your premium depends on your age when you enter the plan, which plan you elect, and, if you elect the inflation protection option.

Changes during Open Enrollment:

If you are NOT making changes – No action is required.

If you would like to enroll in Long Term Care – Visit the Benefits and Wellness Intranet page for the Unum LTC Evidence of Insurability (EOI) Website Link. The EOI form must be completed and submitted to Unum on or before the last day of Open Enrollment.
NOTICES

THE WOMEN’S HEALTH AND CANCER RIGHTS ACT OF 1998
ANNUAL NOTIFICATION

The United States Congress passed the Women’s Health and Cancer Rights Act of 1998. This act affects both group and individual health plans that provide medical/surgical coverage for a mastectomy. This act requires these health plans to provide coverage for reconstructive surgery and related services that may follow a mastectomy.

In compliance with the law, City of Colorado Springs medical plans cover the following benefit services for any covered individual electing breast reconstruction surgery:

- All stages of reconstructive surgery of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and physical complications for all stages of mastectomy, including lymphedemas.

The plans’ deductibles, coinsurance and co-payments that are in effect at the time service is provided will apply to the coverage described above. Please refer to the Medical Benefits Plan for further benefit coverage information.

All other terms and conditions of your medical plan will apply to this coverage.

If you have any questions about the Plan provisions, please call AmeriBen Solutions, the claims administrator, at (800) 786-7930.

HIPAA SPECIAL ENROLLMENT NOTICE

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (of if the employer stops contributing towards your or your dependent’s other coverage). However, you must request enrollment within 30 days after you or your dependents’ other coverage ends (or after the employer stops contributing toward the other coverage).

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. However, you must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

To request special enrollment or obtain more information, contact the HR Solutions Center at (719) 385-5125.

NOTICE OF NEWBORN & MOTHERS HEALTH PROTECTION ACT

Under Federal law; Group Health Plans and health insurance issuers offering Group Health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48-hours following a vaginal delivery, or less than 96-hours following a delivery by cesarean section, the minimum lengths of stay. However, the plan or issuer may pay for a shorter stay if the attending provider, which is an individual licensed under applicable state law to provide maternity or pediatric care to a mother or newborn child and who is directly responsible for providing such care, after consultation with the mother, discharges the mother or newborn earlier. Maternity care and nursery care at birth are not subject to pre-certification for the minimum lengths of stay. If the length of stay for the mother or newborn is in excess or the minimum length of stay, a Pre-certification is required. Also, under Federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

Please carefully review this notice. It describes how medical information about you may be used and disclosed and how you can get access to this information. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on the use and disclosure of individual health information by the City of Colorado Springs health plans. This information, known as protected health information, includes almost all individually identifiable health information held by a plan — whether received in writing, in an electronic medium, or as an oral communication. This notice describes the privacy practices of these plans: The City of Colorado Springs Health Plans. The plans covered by this notice may share health information with each other to carry out treatment, payment, or health care operations. These plans are collectively referred to as the Plan in this notice, unless specified otherwise.

The Plan’s duties with respect to health information about you
The Plan is required by law to maintain the privacy of your health information and to provide you with this notice of the Plan’s legal duties and privacy practices with respect to your health information. If you participate in an insured plan option, you will receive a notice directly from the Insurer. It’s important to note that these rules apply to the Plan,
not City of Colorado Springs as an employer — that’s the way the HIPAA rules work. Different policies may apply to other City of Colorado Springs programs or to data unrelated to the Plan.

How the Plan may use or disclose your health information

The privacy rules generally allow the use and disclosure of your health information without your permission (known as an authorization) for purposes of health care treatment, payment activities, and health care operations. Here are some examples of what that might entail:

- Treatment includes providing, coordinating, or managing health care by one or more health care providers or doctors. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referrals between providers. For example, the Plan may share your health information with physicians who are treating you.
- Payment includes activities by this Plan, other plans, or providers to obtain premiums, make coverage determinations, and provide reimbursement for health care. This can include determining eligibility, reviewing services for medical necessity or appropriateness, engaging in utilization management activities, claims management, and billing; as well as performing “behind the scenes” plan functions, such as risk adjustment, collection, or reinsurance. For example, the Plan may share information about your coverage or the expenses you have incurred with another health plan to coordinate payment of benefits.

- Health care operations include activities by this Plan (and, in limited circumstances, by other plans or providers), such as wellness and risk assessment programs, quality assessment and improvement activities, customer service, and internal grievance resolution. Health care operations also include evaluating vendors; engaging in credentialing, training, and accreditation activities; performing underwriting or premium rating; arranging for medical review and audit activities; and conducting business planning and development. For example, the Plan may use information about your claims to audit the third parties that approve payment for Plan benefits.

The amount of health information used, disclosed or requested will be limited and, when needed, restricted to the minimum necessary to accomplish the intended purposes, as defined under the HIPAA rules. If the Plan uses or discloses PHI for underwriting purposes, the Plan will not use or disclose PHI that is your genetic information for such purposes.

How the Plan may share your health information with the City of Colorado Springs

The Plan, or its health insurer, may disclose your health information without your written authorization to the City of Colorado Springs for plan administration purposes. The City of Colorado Springs may need your health information to administer benefits under the Plan. The City of Colorado Springs agrees not to use or disclose your health information other than as permitted or required by the Plan documents and by law. Human Resources and Finance are the only City of Colorado Springs employees who will have access to your health information for plan administration functions.

Here’s how additional information may be shared between the Plan and the City of Colorado Springs, as allowed under the HIPAA rules:

- The Plan, or its insurer, may disclose “summary health information” to City of Colorado Springs, if requested, for purposes of obtaining premium bids to provide coverage under the Plan or for modifying, amending, or terminating the Plan. Summary health information is information that summarizes participants’ claims information, from which names and other identifying information have been removed.
- The Plan, or its insurer, may disclose to the City of Colorado Springs information on whether an individual is participating in the Plan or has enrolled or disenrolled in an insurance option offered by the Plan.
- In addition, you should know that the City of Colorado Springs cannot and will not use health information obtained from the Plan for any employment-related actions. However, health information collected by the City of Colorado Springs from other sources — for example, under the Family and Medical Leave Act, Americans with Disabilities Act, or workers’ compensation programs — is not protected under HIPAA (although this type of information may be protected under other federal or state laws).

Other allowable uses or disclosures of your health information

In certain cases, your health information can be disclosed without authorization to a family member, close friend, or other person you identify who is involved in your care or payment for your care. Information about your location, general condition, or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). You’ll generally be given the chance to agree or object to these disclosures (although exceptions may be made — for example, if you’re not present or if you’re incapacitated). In addition, your health information may be disclosed without authorization to your legal representative.
The Plan also is allowed to use or disclose your health information without your written authorization for the following activities:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Workers’ compensation</td>
<td>Disclosures to workers’ compensation or similar legal programs that provide benefits for work-related injuries or illness without regard to fault, as authorized by and necessary to comply with the laws</td>
</tr>
<tr>
<td>2) Necessary to prevent serious threat to health or safety</td>
<td>Disclosures made in the good-faith belief that releasing your health information is necessary to prevent or lessen a serious and imminent threat to public or personal health or safety, if made to someone reasonably able to prevent or lessen the threat (or to the target of the threat); includes disclosures to help law enforcement officials identify or apprehend an individual who has admitted participation in a violent crime that the Plan reasonably believes may have caused serious physical harm to a victim, or where it appears the individual has escaped from prison or from lawful custody</td>
</tr>
<tr>
<td>3) Public health activities</td>
<td>Disclosures authorized by law to persons who may be at risk of contracting or spreading a disease or condition; disclosures to public health authorities to prevent or control disease or report child abuse or neglect; and disclosures to the Food and Drug Administration to collect or report adverse events or product defects</td>
</tr>
<tr>
<td>4) Victims of abuse, neglect, or domestic violence</td>
<td>Disclosures to government authorities, including social services or protected services agencies authorized by law to receive reports of abuse, neglect, or domestic violence, as required by law or if you agree or if the Plan believes that disclosure is necessary to prevent serious harm to you or potential victims (you’ll be notified of the Plan’s disclosure if informing you won’t put you at further risk)</td>
</tr>
<tr>
<td>5) Judicial and administrative proceedings</td>
<td>Disclosures in response to a court or administrative order, subpoena, discovery request, or other lawful process (the Plan may be required to notify you of the request or receive satisfactory assurance from the party seeking your health information that efforts were made to notify you or to obtain a qualified protective order concerning the information)</td>
</tr>
<tr>
<td>6) Law enforcement purposes</td>
<td>Disclosures to law enforcement officials required by law or legal process, or to identify a suspect, fugitive, witness, or missing person; disclosures about a crime victim if you agree or if disclosure is necessary for immediate law enforcement activity; disclosures about a death that may have resulted from criminal conduct; and disclosures to provide evidence of criminal conduct on the Plan’s premises</td>
</tr>
<tr>
<td>7) Decedents</td>
<td>Disclosures to a coroner or medical examiner to identify the deceased or determine cause of death; and to funeral directors to carry out their duties</td>
</tr>
<tr>
<td>8) Organ, eye, or tissue donation</td>
<td>Disclosures to organ procurement organizations or other entities to facilitate organ, eye, or tissue donation and transplantation after death</td>
</tr>
<tr>
<td>9) Research purposes</td>
<td>Disclosures subject to approval by institutional or private privacy review boards, subject to certain assurances and representations by researchers about the necessity of using your health information and the treatment of the information during a research project</td>
</tr>
<tr>
<td>10) Health oversight activities</td>
<td>Disclosures to health agencies for activities authorized by law (audits, inspections, investigations, or licensing actions) for oversight of the health care system, government benefits programs for which health information is relevant to beneficiary eligibility, and compliance with regulatory programs or civil rights laws</td>
</tr>
<tr>
<td>11) Specialized government functions</td>
<td>Disclosures about individuals who are Armed Forces personnel or foreign military personnel under appropriate military command; disclosures to authorized federal officials for national security or intelligence activities; and disclosures to correctional facilities or custodial law enforcement officials about inmates</td>
</tr>
<tr>
<td>12) HHS investigations</td>
<td>Disclosures of your health information to the Department of Health and Human Services to investigate or determine the Plan’s compliance with the HIPAA privacy rule</td>
</tr>
</tbody>
</table>

Except as described in this notice, other uses and disclosures will be made only with your written authorization. For example, in most cases, the Plan will obtain your authorization before it communicates with you about products or programs if the Plan is being paid to make those communications. If we keep psychotherapy notes in our records, we will obtain your authorization in some cases before we release those records. The Plan will never sell your health information unless you have authorized us to do so. You may revoke your authorization as allowed under the HIPAA rules. However, you can’t revoke your authorization with respect to disclosures the Plan has already made. You will be notified of any unauthorized access, use, or disclosure of your unsecured health information as required by law.

The Plan will notify you if it becomes aware that there has been a loss of your health information in a manner that could compromise the privacy of your health information.

Your individual rights
You have the following rights with respect to your health information the Plan maintains. These rights are subject to certain limitations, as discussed below. This section of the notice describes how you may exercise each individual right. See the table at the end of this notice for information on how to submit requests.
Right to request restrictions on certain uses and disclosures of your health information and the Plan’s right to refuse
You have the right to ask the Plan to restrict the use and disclosure of your health information for treatment, payment, or health care operations, except for uses or disclosures required by law. You have the right to ask the Plan to restrict the use and disclosure of your health information to family members, close friends, or other persons you identify as being involved in your care or payment for your care. You also have the right to ask the Plan to restrict use and disclosure of health information to notify those persons of your location, general condition, or death — or to coordinate those efforts with entities assisting in disaster relief efforts. If you want to exercise this right, your request to the Plan must be in writing.

The Plan is not required to agree to a requested restriction. If the Plan does agree, a restriction may later be terminated by your written request, by agreement between you and the Plan (including an oral agreement), or unilaterally by the Plan for health information created or received after you’re notified that the Plan has removed the restrictions. The Plan may also disclose health information about you if you need emergency treatment, even if the Plan has agreed to a restriction.

An entity covered by these HIPAA rules (such as your health care provider) or its business associate must comply with your request that health information regarding a specific health care item or service not be disclosed to the Plan for purposes of payment or health care operations if you have paid out of pocket and in full for the item or service.

Right to receive confidential communications of your health information
If you think that disclosure of your health information by the usual means could endanger you in some way, the Plan will accommodate reasonable requests to receive communications of health information from the Plan by alternative means or at alternative locations.

If you want to exercise this right, your request to the Plan must be in writing and you must include a statement that disclosure of all or part of the information could endanger you.

Right to inspect and copy your health information
With certain exceptions, you have the right to inspect or obtain a copy of your health information in a “designated record set.” This may include medical and billing records maintained for a health care provider; enrollment, payment, claims adjudication, and case or medical management record systems maintained by a plan; or a group of records the Plan uses to make decisions about individuals. However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings. The Plan may deny your right to access, although in certain circumstances, you may request a review of the denial.

If you want to exercise this right, your request to the Plan must be in writing. Within 30 days of receipt of your request (60 days if the health information is not accessible on site), the Plan will provide you with one of these responses:

- The access or copies you requested
- A written denial that explains why your request was denied and any rights you may have to have the denial reviewed or file a complaint
- A written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request

You may also request your health information be sent to another entity or person, so long as that request is clear, conspicuous and specific. The Plan may provide you with a summary or explanation of the information instead of access to or copies of your health information, if you agree in advance and pay any applicable fees. The Plan also may charge reasonable fees for copies or postage. If the Plan doesn’t maintain the health information but knows where it is maintained, you will be informed where to direct your request.

If the Plan keeps your records in an electronic format, you may request an electronic copy of your health information in a form and format readily producible by the Plan. You may also request that such electronic health information be sent to another entity or person, so long as that request is clear, conspicuous, and specific. Any charge that is assessed to you for these copies must be reasonable and based on the Plan’s cost.

Right to amend your health information that is inaccurate or incomplete
With certain exceptions, you have a right to request that the Plan amend your health information in a designated record set. The Plan may deny your request for a number of reasons. For example, your request may be denied if the health information is accurate and complete, was not created by the Plan (unless the person or entity that created the information is no longer available), is not part of the designated record set, or is not available for inspection (e.g., psychotherapy notes or information compiled for civil, criminal, or administrative proceedings).

If you want to exercise this right, your request to the Plan must be in writing, and you must include a statement to support the requested amendment. Within 60 days of receipt of your request, the Plan will take one of these actions:

- Make the amendment as requested
- Provide a written denial that explains why your request was denied and any rights you may have to disagree or file a complaint
- Provide a written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request
Right to receive an accounting of disclosures of your health information
You have the right to a list of certain disclosures of your health information the Plan has made. This is often referred to as an “accounting of disclosures.” You generally may receive this accounting if the disclosure is required by law, in connection with public health activities, or in similar situations listed in the table earlier in this notice, unless otherwise indicated below.
You may receive information on disclosures of your health information for up to six years before the date of your request. You do not have a right to receive an accounting of any disclosures made in any of these circumstances:
- For treatment, payment, or health care operations
- To you about your own health information
- Incidental to other permitted or required disclosures
- Where authorization was provided
- To family members or friends involved in your care (where disclosure is permitted without authorization)
- For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances
- As part of a “limited data set” (health information that excludes certain identifying information)

In addition, your right to an accounting of disclosures to a health oversight agency or law enforcement official may be suspended at the request of the agency or official. If you want to exercise this right, your request to the Plan must be in writing. Within 60 days of the request, the Plan will provide you with the list of disclosures or a written statement that the time period for providing this list will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request. You may make one request in any 12-month period at no cost to you, but the Plan may charge a fee for subsequent requests. You’ll be notified of the fee in advance and have the opportunity to change or revoke your request.

Right to obtain a paper copy of this notice from the Plan upon request
You have the right to obtain a paper copy of this privacy notice upon request. Even individuals who agreed to receive this notice electronically may request a paper copy at any time.

Changes to the information in this notice
The Plan must abide by the terms of the privacy notice currently in effect. This notice takes effect on September 23, 2013. However, the Plan reserves the right to change the terms of its privacy policies, as described in this notice, at any time and to make new provisions effective for all health information that the Plan maintains. This includes health information that was previously created or received, not just health information created or received after the policy is changed. If changes are made to the Plan’s privacy policies described in this notice, you will be provided with a revised privacy notice emailed to you or mailed to your home address.

Complaints
If you believe your privacy rights have been violated or your Plan has not followed its legal obligations under HIPAA, you may complain to the Plan and to the Secretary of Health and Human Services. You won’t be retaliated against for filing a complaint. To file a complaint, you may send a written complaint to the Plan’s Privacy Officer, 30 South Nevada Avenue, Suite 301, Colorado Springs, CO 80903; or you may file a complaint with the Secretary of the Department of Health Human Services, Huber H. Humphrey Building, 2000 Independence Avenue SW., Washington, DC 20201

Contact
For more information on the Plan’s privacy policies or your rights under HIPAA, contact Privacy Officer, 30 South Nevada Avenue, Suite 301, Colorado Springs, CO 80903.
MEDICARE COVERAGE DISCLOSURE NOTICE

This notice includes information about your current prescription drug coverage with the City and prescription drug coverage available to people with Medicare.

The prescription drug coverage the City offers is, on average, expected to pay out as much as standard Medicare prescription drug coverage and is considered creditable coverage.

- You can keep your City coverage and you will not pay extra if you later decide to enroll in Medicare coverage.
- If you drop or lose your coverage with the City and don’t enroll in a credible prescription drug plan or Medicare coverage, you may pay more to enroll in Medicare later.
- If you decide to enroll in a Medicare prescription drug plan and drop your City coverage, you may not be able to get this coverage back.
- You can enroll in a Medicare prescription drug plan when you first become eligible for Medicare and each year from Oct. 15th to Dec. 7th.
- If you leave the City’s coverage, you may be eligible for a special enrollment period to sign up for a Medicare prescription drug plan.
- If you go 63 days or longer without prescription drug coverage that’s at least as good as Medicare’s, your monthly premium will go up at least one percent per month for every uncovered month. For example, 20 months without coverage results in a premium at least 20 percent higher for as long as you have Medicare coverage, and you may have to wait until the following November to enroll.

Please refer to the Medical Summary Plan Description (SPD) for information about how our plan pays benefits for participants also enrolled in Medicare. Our prescription plan is the primary payer. COBRA beneficiaries and dependents who are also covered by Medicare receive the same coverage as active employees and elect coverage during open enrollment. For more information, refer to your COBRA notice. When COBRA ends, or absent a coverage election, coverage under the City plan ends. Please contact the HR Solutions Center at 385-5125 for further information. You will receive this notice annually and as necessary.

For More Information:
- Visit www.medicare.gov or call 800-633-4227, or 877-486-2048 for TTY.
- Call your State Health Insurance Assistance Program (Number listed in the Medicare & You Handbook.) Please keep this notice. You may need to present a copy of this notice when you join a Medicare Part D Plan to show that you are not required to pay a higher Medicare Part D premium.

CHOOSING A PHYSICIAN NOTICE

Designation of a Primary Care Provider (PCP) and Direct Access to a Provider who specializes in Obstetrics and/or Gynecology

The plan does not require you to select a primary care physician (PCP) to coordinate your care and you do not have to obtain a referral to see a specialist; however, payment by the Plan may be less for the use of a non-network provider.

You do not need prior authorization from the Plan, the Claims Administrator, 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 the network who specializes in obstetrics and/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 for procedures for making referrals.

For a list of participating health care professionals who specialize in obstetrics and/or gynecology, visit www.mycastlighthealth.com.

NOTICES REGARDING THE REACH YOUR PEAK EMPLOYEE WELLNESS PROGRAM

PROTECTED HEALTH INFORMATION CONFIDENTIALITY AND OTHER PROTECTIONS

The City of Colorado Springs REACH YOUR PEAK is a voluntary wellness program available to all employees. 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 may choose 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 may also choose to complete a biometric screening, which will include a blood test for cholesterol (HDL, LDL and risk ratio), triglycerides and blood glucose. You are not required to complete the HRA or to participate in the blood test or other medical examinations, such as waist circumference, body weight and blood pressure, which will be taken during the biometric screening.
Employees who choose to participate in the wellness program will receive an incentive of $300 for participating in the wellness program’s activities, such as completing the HRA, participating in the biometric health screening, health coaching sessions, wellness activities and challenges. Employees will be eligible to receive a $300 financial incentive award by participating in any combination of wellness program activities to accumulate 300 points. If you are unable to participate in any of the wellness program activities, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting HealthYou at 719-314-3535 or support@myhealthyou.com.

If you choose these wellness activities, the information from your Health Risk Assessment (HRA) and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as health coaching or participating in a community sponsored program. You also are encouraged to share your results or concerns with your own doctor.

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 the City of Colorado Springs may use aggregate information it collects to design a program based on identified health risks in the workplace, REACH YOUR PEAK Employee 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 your health coach and the City’s Health Promotion/Disease Management vendors in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained 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 HealthYou at 719-314-3535 or support@myhealthyou.com.

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, 2018. Contact your State for more information on eligibility –

<table>
<thead>
<tr>
<th>ALABAMA – Medicaid</th>
<th>FLORIDA – Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Website: [<a href="http://myalh">http://myalh</a> Hipp.com](<a href="http://myalh">http://myalh</a> Hipp.com)</td>
<td>Website: <a href="http://flmedicaidtplrecovery.com/hipp">http://flmedicaidtplrecovery.com/hipp</a></td>
</tr>
<tr>
<td>Phone: 1-855-692-5447</td>
<td>Phone: 1-877-357-3268</td>
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</table>

<table>
<thead>
<tr>
<th>ALASKA – Medicaid</th>
<th>GEORGIA – Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>The AK Health Insurance Premium Payment Program Website: [<a href="http://myakh">http://myakh</a> Hipp.com](<a href="http://myakh">http://myakh</a> Hipp.com)</td>
<td>Website: <a href="http://chips.health.ga.gov">http://chips.health.ga.gov</a> - Click on Health Insurance Premium Payment (HIPP)</td>
</tr>
<tr>
<td>Phone: 1-866-251-4861</td>
<td>Phone: 404-656-4507</td>
</tr>
<tr>
<td>Email: <a href="mailto:CustomerService@MyAKHIPP.com">CustomerService@MyAKHIPP.com</a></td>
<td>Medicaid Eligibility: <a href="http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx">http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx</a></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ARKANSAS – Medicaid</th>
<th>INDIANA – Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Website: <a href="http://myarhipp.com">http://myarhipp.com</a></td>
<td>Healthy Indiana Plan for low-income adults 19-64 Website: <a href="http://www.in.gov/fssa/hip">http://www.in.gov/fssa/hip</a></td>
</tr>
<tr>
<td>Phone: 1-855-MyARHIPP (855-692-7447)</td>
<td>Phone: 1-877-438-4479</td>
</tr>
<tr>
<td>All other Medicaid Website: <a href="http://www.indianamedicaid.com">http://www.indianamedicaid.com</a></td>
<td>Phone: 1-800-403-0864</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>COLORADO – Health First Colorado (Colorado’s Medicaid Program) &amp; Child Health Plan Plus (CHP+)</th>
<th>IOWA – Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health First Colorado Website: <a href="https://www.healthfirstcolorado.com">https://www.healthfirstcolorado.com</a></td>
<td>Website: <a href="http://dhs.iowa.gov/hawk-i">http://dhs.iowa.gov/hawk-i</a></td>
</tr>
<tr>
<td>Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711</td>
<td>Phone: 1-800-257-8563</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>KANSAS – Medicaid</th>
<th>NEW HAMPSHIRE – Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Website: <a href="http://www.kdheks.gov/hcf">http://www.kdheks.gov/hcf</a></td>
<td>Website: <a href="https://www.dhhs.nh.gov/ombp/nhhpp">https://www.dhhs.nh.gov/ombp/nhhpp</a></td>
</tr>
<tr>
<td>Phone: 1-785-296-3512</td>
<td>Phone: 603-271-5218</td>
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<tr>
<td>Hotline: NH Medicaid Service Center at 1-888-901-4999</td>
<td></td>
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</tbody>
</table>

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<thead>
<tr>
<th>KENTUCKY – Medicaid</th>
<th>NEW JERSEY – Medicaid and CHIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Website: <a href="https://chfs.ky.gov">https://chfs.ky.gov</a></td>
<td>Medicaid Website: <a href="http://www.state.nj.us/humanservices/dmahs/clients/medicaid/">http://www.state.nj.us/humanservices/dmahs/clients/medicaid/</a></td>
</tr>
<tr>
<td>Phone: 1-800-635-2570</td>
<td>Medicaid Phone: 609-631-2392</td>
</tr>
<tr>
<td>CHIP Website: <a href="http://www.njfamilycare.org/index.html">http://www.njfamilycare.org/index.html</a></td>
<td>CHIP Phone: 1-800-701-0710</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LOUISIANA – Medicaid</th>
<th>NEW YORK – Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Website: <a href="http://dhh.louisiana.gov/index.cfm/subhome/1/n/331">http://dhh.louisiana.gov/index.cfm/subhome/1/n/331</a></td>
<td>Website: <a href="https://www.health.ny.gov/health_care/medicaid/">https://www.health.ny.gov/health_care/medicaid/</a></td>
</tr>
<tr>
<td>Phone: 1-888-695-2447</td>
<td>Phone: 1-800-541-2831</td>
</tr>
<tr>
<td>State</td>
<td>Website/Phone/TTY Details</td>
</tr>
<tr>
<td>---------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| **MAINE – Medicaid**| Website: http://www.maine.gov/dhhs-ofi/public-assistance/index.html  
Phone: 1-800-442-6003  
TTY: Maine relay 711                                                                                                                                   |
| **NORTH CAROLINA – Medicaid**| Website: https://dma.ncdhhs.gov  
Phone: 919-855-4100                                                                                                                                       |
| **MASSACHUSETTS – Medicaid and CHIP**| Website: http://www.mass.gov/eoehs/gov/departments/masshealth/  
Phone: 1-800-862-4840                                                                                                                                   |
| **NORTH DAKOTA – Medicaid**| Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/  
Phone: 1-844-854-4825                                                                                                                                     |
| **MINNESOTA – Medicaid**| Website: https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp  
Phone: 1-800-657-3739                                                                                                                                     |
| **OKLAHOMA – Medicaid and CHIP**| Website: http://www.insureoklahoma.org  
Phone: 1-888-365-3742                                                                                                                                       |
| **MISSOURI – Medicaid**| Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm  
Phone: 573-751-2005                                                                                                                                         |
| **OREGON – Medicaid**| Website: http://healthcare.oregon.gov/Pages/index.aspx  
http://www.oregonhealthcare.gov/index-es.html  
Phone: 1-800-699-9075                                                                                                                                     |
| **MONTANA – Medicaid**| Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP  
Phone: 1-800-694-3084                                                                                                                                         |
| **RHODE ISLAND – Medicaid**| Website: http://www.eohhs.ri.gov/  
Phone: 855-697-4347                                                                                                                                         |
| **NEVADA – Medicaid**| Medicaid Website: https://dhcfp.nv.gov  
Medicaid Phone: 1-800-992-0900                                                                                                                                     |
| **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                                                                                                                                         |
| **WASHINGTON – Medicaid**| Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program  
Phone: 1-800-562-3022 ext. 15473                                                                                                                                         |
| **TEXAS – Medicaid**| Website: http://gethippতexas.com/  
Phone: 1-800-440-0493                                                                                                                                         |
| **WEST VIRGINIA – Medicaid**| Website: http://mywvhipp.com/  
Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)                                                                                                                                         |
| **UTAH – Medicaid and CHIP**| Medicaid Website: https://medicaid.utah.gov/  
CHIP Website: http://health.utah.gov/chip  
Phone: 1-877-543-7669                                                                                                                                         |
| **WISCONSIN – Medicaid and CHIP**| Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf  
Phone: 1-800-362-3002                                                                                                                                         |
| **VERMONT– Medicaid**| Website: http://www.greenmountaincare.org/  
Phone: 1-800-250-8427                                                                                                                                         |
| **WYOMING – Medicaid**| Website: https://wyequalitycare.acs-inc.com/  
Phone: 307-777-7531                                                                                                                                         |
| **VIRGINIA – Medicaid and CHIP**| Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm  
Medicaid Phone: 1-800-432-5924  
CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm  
CHIP Phone: 1-855-242-8282                                                                                                                                         |
To see if any other states have added a premium assistance program since July 31, 2018, 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.
## VENDOR DIRECTORY

<table>
<thead>
<tr>
<th>Benefit Plan</th>
<th>Vendor Name</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical Insurance</strong></td>
<td><strong>Ameriben</strong></td>
<td>(866) 955-1482&lt;br&gt;www.myameriben.com&lt;br&gt;Benefit Coverage Questions, Claims, Explanation of Benefits, and Medical ID Cards</td>
</tr>
<tr>
<td>Group Number: 000COG834&lt;br&gt;Premier Plan Advantage Plan</td>
<td><strong>Ameriben Medical Management</strong></td>
<td>(800) 388-3193&lt;br&gt;www.myameriben.com&lt;br&gt;Disease Management, Case Management, and Prior Authorization</td>
</tr>
<tr>
<td><strong>Anthem – Provider network access</strong></td>
<td><strong>Castlight</strong></td>
<td>(800) 684-0624&lt;br&gt;www.mycastlighthealth.com&lt;br&gt;Provider Search, Cost and Quality Comparisons, and health related resources</td>
</tr>
<tr>
<td><strong>City Employee Medical Clinic</strong></td>
<td><strong>City Employee Pharmacy</strong></td>
<td>(719) 385-2261&lt;br&gt;www.cityemployeepharmacy.com&lt;br&gt;Pharmacy&lt;br&gt;Auto refill line: (800) 573-6214</td>
</tr>
<tr>
<td><strong>MaxorPlus</strong></td>
<td><strong>Teladoc</strong></td>
<td>(800) 835-2362&lt;br&gt;www.teladoc.com&lt;br&gt;Medical Services</td>
</tr>
<tr>
<td><strong>Dental Insurance</strong></td>
<td><strong>Delta Dental Plans</strong></td>
<td>(800) 610-0201&lt;br&gt;www.deltadentalco.com&lt;br&gt;Hi-Option Plan # 1512&lt;br&gt;Standard Option Plan #1844</td>
</tr>
<tr>
<td><strong>Vision Insurance</strong></td>
<td><strong>Vision Service Plan (VSP)</strong></td>
<td>(800) 877-7195&lt;br&gt;www.vsp.com&lt;br&gt;Plan # 12061804</td>
</tr>
<tr>
<td><strong>Employee Assistance Program (EAP)</strong></td>
<td><strong>Profile EAP: Centura Health</strong></td>
<td>(800) 645-6571&lt;br&gt;www.profileeap.org&lt;br&gt;User Name: City</td>
</tr>
<tr>
<td><strong>Life Insurance</strong></td>
<td><strong>AETNA U.S. HealthCare</strong></td>
<td>(800) 523-5065&lt;br&gt;www.aetna.com&lt;br&gt;Policy/Control: 7211111 10 001</td>
</tr>
<tr>
<td><strong>Disability Insurance</strong></td>
<td><strong>CIGNA</strong></td>
<td>(800) 362-4462&lt;br&gt;www.cigna.com&lt;br&gt;Claims: (800) 781-2006&lt;br&gt;Short Term Disability (STD) Policy #LK7822&lt;br&gt;Long Term Disability (LTD) Policy #LK7823</td>
</tr>
<tr>
<td><strong>Long Term Care (LTC)</strong></td>
<td><strong>UNUM Life Insurance Company of America</strong></td>
<td>(800) 227-4165&lt;br&gt;www.unum.com&lt;br&gt;Policy # 220508 (Elections prior to 2008)&lt;br&gt;Policy # 127251 (Elections 2008 and forward)</td>
</tr>
<tr>
<td><strong>Flexible Spending Accounts (FSA) &amp; Health Reimbursement Accounts (HRA)</strong></td>
<td><strong>ASI Flex</strong></td>
<td>(800) 659-3035&lt;br&gt;www.asiflex.com&lt;br&gt;FSA for Health Care &amp; Dependent Care&lt;br&gt;HRA – Available to active employees enrolled in Advantage Plan&lt;br&gt;Fax: (877) 879-9038</td>
</tr>
<tr>
<td><strong>Retirement</strong></td>
<td><strong>Public Employees Retirement Assoc. (PERA)</strong></td>
<td>(800) 759-7372&lt;br&gt;www.copera.org&lt;br&gt;Fire &amp; Police Protective Assoc. (FPPA)&lt;br&gt;(800) 332-3772&lt;br&gt;www.fppaco.org</td>
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|                                       | **ICMA-RC Services, LLC – Don Eschbach**    | (866) 749-5174<br>deschebach@icmarc.org<br>
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