



Improving your health, one benefit at a time

CITY OF COLORADO SPRINGS BENEFIT GUIDE



2016

CONTENTS

HELPFUL INFORMATION	1	HEALTH REIMBURSEMENT ACCOUNT (HRA).....	12
ELIGIBILITY	1	LONG TERM CARE (LTC)	12
QUALIFYING EVENTS.....	1	BASIC LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE.....	13
TERMS TO KNOW	2	AETNA VOLUNTARY TERM LIFE (VTL) AND BASIC LIFE INSURANCE.....	13
PROGRAMS AND BENEFIT COVERAGES IN PLACE FOR YOU TO OPTIMIZE YOUR HEALTH	2	EMPLOYEE ASSISTANCE PROGRAM (EAP).....	14
WHAT DOES HEALTH CARE REFORM MEAN FOR YOU?	4	SHORT AND LONG TERM DISABILITY (STD/LTD)	14
NON-GRANDFATHER STATUS	4	CIVILIAN PENSION PLAN (PERA).....	15
AVAILABLE RESOURCES	5	MEDICARE.....	15
CITY EMPLOYEE PHARMACY	5	SWORN FIRE AND POLICE EMPLOYEES.....	15
CITY EMPLOYEE MEDICAL CLINIC (CEMC).....	5	ICMA ROTH IRA (VOLUNTARY).....	15
TELADOC.....	6	ICMA 457 PLANS (VOLUNTARY DEFERRED COMPENSATION)	16
WELLNESS PROMOTION SERVICES.....	6	PAID TIME OFF	16
REACH YOUR PEAK YEAR 12	6	VACATION.....	16
MEDICAL INSURANCE	7	VACATION BUY.....	16
PRESCRIPTION PROGRAM	8	SICK LEAVE	16
DENTAL INSURANCE	9	HOLIDAYS	17
VISION INSURANCE.....	10	PARKING	17
2016 BENEFIT RATE MONTHLY CHART PLAN COSTS	11	CITY BUS SYSTEM.....	17
FLEXIBLE SPENDING ACCOUNTS.....	12	TUITION ASSISTANCE	17
FSA – HEALTH CARE SPENDING ACCOUNT.....	12	NOTICES.....	18
FSA – DEPENDENT DAY CARE ACCOUNT.....	12	DIRECTORY	22
FSA FUND AVAILABILITY	12		

The City of Colorado Springs provides a comprehensive and competitive Benefit Program. We are proud to offer this extensive selection of benefits to meet the needs of our employees and their families. As part of that effort, we want to provide you with resources that help guide your health decisions and ensure you select the best plans and coverage needed for you and your family.

We encourage you to make a personal commitment to your health and become wise health care consumers. Get engaged in the wellness program, health management programs, and understand how you can seek better health care value by using quality and cost comparison tools.

We hope you find this guide helpful as you make important decisions about your benefits. Commit to your health and help us make the City of Colorado Springs the best place to live, work, and play!

Mike Sullivan

Director, Human Resources

HELPFUL INFORMATION

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.

Coverage begins the first of the month after your date of hire if required forms are submitted within the deadline.

QUALIFYING EVENTS

Due to IRS regulations, once you have made your elections for 2016, 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
- 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 a 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 Benefits & Wellness in writing by completing and submitting a Benefits Change Form and providing documentation of the qualifying event within 30 days of the event.

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.

Formulary/Brand — 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. Note: The City's out-of-network out-of-pocket maximum will not pay more than \$25,000 per member.

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.

PROGRAMS AND BENEFIT COVERAGES IN PLACE FOR YOU TO OPTIMIZE YOUR HEALTH

▶ **Preventive care services are at no charge when you see an in-network provider**

• **Preventive exam incentive**

Employees and their spouses enrolled on the city's health plans are eligible to receive a \$75 cash incentive for having preventive care service, such as an annual exam, well woman exam, mammogram or colonoscopy. Incentive payments are limited to one type of exam per individual per year - \$75 for employee and \$75 for spouse (max of \$150 per year). The incentive payments are taxable and will be included on the employee's paycheck.

▶ **Reach Your Peak Wellness Program – earn \$300 (see program description for details)**

▶ **Health Management programs – (Voluntary, Confidential & no cost to you!)**

• **Ameriben Medical Management health management program (800-388-3193)**

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.

Eligible for waived co-pays generic and select brands if engaged in program:

- Asthma
- Coronary Artery Disease
- COPD
- Diabetes
- GERD
- Hypertension
- Program support for other chronic and high risk conditions, and a Maternal Health Program for expectant moms.

• **City Employee Medical Clinic - (719-385-5841)**

Nurse Practitioners and Certified Health Coaches can assist with your chronic disease management.

• **AspenPointe – Depression Care and Sleep Care Management Programs (888-845-2881)**

Telephone support from nurse case manager to help you navigate and get the best care you need for depression. Working with your health care provider, the nurse case manager is a resource

- **Diabetes Ten City Challenge – (719-385-2262)**

Personalized one-on-one coaching with a pharmacist to help you manage your diabetes. Working with your health care provider, the pharmacist will provide customized education and develop a care plan that strives to improve your quality of life. Waived co-pays for diabetic medications and supplies for plan members who are engaged in the program. Voluntary, confidential and no cost to you.

- ▶ **CardioRx (719-385-2262)**

This program is available to plan members with cardiovascular disease.

Meet with a pharmacist in the City Employee Pharmacy to learn how to better manage your condition, get hands on education and training, and get assistance in developing tools in improving your health and your lifestyle. Waived co-pays for generic medications for hypertension and statins if enrolled and engaged in the program. Voluntary, confidential and no cost to you.

- ▶ **Tobacco Use Premium Surcharge and Tobacco Cessation Program**

Tobacco Use:

Employees who are current tobacco users will be assessed a **\$50/month** premium surcharge if enrolled on one of the city's medical plans.

Current use is defined as four (4) or more times a week in the last six (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 of their status and can be changed during the year if they no longer meet the definition of current use or enroll in a tobacco cessation program.

New in 2016 – Tobacco Cessation Programs:

A tobacco cessation program – Quit with Nancy! is available to employees at no cost. This program offers individualized, one-on-one guidance through an 8-hour DVD program and personal workbook. Watch the DVD at home at your leisure, and receive RN coaching support throughout the quitting process on a schedule that meets your needs. Call Ameriben Medical Management at 800-388-3193 to enroll.

In-person support available during the quitting process. Sign up for a tobacco cessation program with the UCCS Wellness Nurse who is trained to use the Quit for Life program through the American Cancer Society. This program offers customized one-on-one program support along with a personal workbook at no cost to you. Call the UCCS Wellness Nurse at 719-385-5190 to enroll.

WHAT DOES HEALTH CARE REFORM MEAN FOR YOU?

The Patient Protection & Affordable Care Act was enacted on March 23, 2010, and has been amended many times already. This law was intended to help more people get affordable health care coverage and receive better medical care. In its current form, the law has resulted in a steady stream of regulations and guidance as various governmental entities clarified employer's' requirements under the law over the past three years. As your employer, we continue to implement provisions to comply with the requirements of the health care reform law.

FREQUENTLY ASKED QUESTIONS

Q: Am I required to have health insurance?

Health care reform requires most U.S. citizens and legal immigrants to have a basic level of health coverage starting January 1, 2014 – this is called the individual mandate.

Q: What if I don't have any health care coverage?

If you don't have minimal essential health care coverage, you may be subject to a tax penalty based on the number of months in a given year you are without coverage. The city's health plan counts as minimum essential coverage.

Q: Can anyone get health care coverage?

Yes, anyone can get coverage. Insurance companies can no longer deny coverage to anyone who has a pre-existing medical condition.

Q: What are the Health Insurance Marketplaces?

They are state or federal run websites where people can buy health care coverage. It is available to people who are uninsured or buy insurance on their own. The Connect for Health Colorado Exchange coverage can be purchased at www.connectforhealthco.com.

NON-GRANDFATHER STATUS

The Medical Plan is "non-grandfathered" a health care plan under the Patient Protection and Affordable Care Act ("Health Care Reform"). Being non-grandfathered means that 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 Plan Administrator or you may contact the U.S. Department of Health and Human Services at www.healthcare.gov.

AVAILABLE RESOURCES

- View your Explanation of Benefits (EOB), find an in-network provider and much more by visiting www.myameriben.com
- Visit Anthem website for a cost of service estimator tool or to locate an in-network provider www.anthem.com
- Estimate your healthcare costs by visiting www.fairhealthconsumer.org
- Find fair prices for surgery, hospital stays, doctors visits, medical tests and more by visiting www.healthcarebluebook.com
- Learn how the hospital of your choice rates with regard to safety and quality by visiting www.leapfroggroup.org
- Learn more about the providers of your choice with regard to their experience and patient satisfaction by visiting www.healthgrades.com
- Health tools and resources are available by visiting www.healthyroads.com

CITY EMPLOYEE PHARMACY

- ▶ Available to both Advantage and Premier Plan members
- ▶ Home delivery available
- ▶ Automated refill line
 - (800) 573-6214
- ▶ Validated parking

CITY EMPLOYEE PHARMACY

City Administration Building
30 S. Nevada Ave.
Suite L04 (Lower Level)
Colorado Springs, CO 80903
Phone: 719-385-2261
Fax: 719-385-5864

Email: www.cityemployeepharmacy.com

Hours: Monday-Friday 8:30 a.m.- 5:30 p.m.

CITY EMPLOYEE MEDICAL CLINIC (CEMC)

- ▶ Available to both Advantage and Premier Plan members
- ▶ Similar services as your Primary Care Provider
- ▶ Services by UCCS nurse practitioners and medical staff
- ▶ \$15 co-pay
- ▶ Preventive care is FREE
- ▶ Validated parking

PREVENTIVE SERVICES

- Physical Exams (ages 5 and up)
- School and Sports Physicals
- CDL Physicals (non-City work related)
- Women's Health
- Immunizations

ACUTE CARE SERVICES (AGES 3 AND UP)

- Diagnosis and treatment of acute illness
- Evaluation and treatment of injuries
- Referrals to specialists; including diagnostics

CHRONIC CARE SERVICES

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

ON-SITE LAB SERVICES

- By appointment, Monday through Friday from 8:00-11:30 a.m.

CITY EMPLOYEE MEDICAL CLINIC

City Administration Building
30 S. Nevada Ave.
Suite 103 (1st floor)
Colorado Springs, CO 80903
Phone: 719-385-5841
Fax: 719-385-5842

Hours: Monday-Friday 7:30 a.m.- 4:30 p.m.

TELADOC

Teladoc gives you 24/7/365 access to U.S. board-certified doctors through the convenience of phone or video consults for a \$40 co-pay. It's an affordable alternative to costly urgent care and ER visits when you need care now. Teladoc does not replace your primary care provider. Teladoc can treat many medical conditions, including:

- Cold & flu symptoms
- Allergies
- Bronchitis
- Urinary tract infection
- Respiratory infection
- Sinus problems
- And more!

Contact: Teladoc.com or Teladoc.com/mobile
1-800-Teladoc

WELLNESS PROMOTION SERVICES

- ▶ Confidential on-site health screening
- ▶ Flu shot clinics
- ▶ Smoking cessation program
- ▶ Health coaching and chronic condition management support
- ▶ Weight management support

WELLNESS OFFICE

By appointment

City Administration Building
30 S. Nevada Ave.
Suite L03 (Lower Level)
Colorado Springs, CO 80903
Phone: 719-385-5190

UCCS
Wellness
Nurses



REACH YOUR PEAK YEAR 12

**NOVEMBER 1, 2015 –
OCTOBER 31, 2016**

3 STEP PROGRAM

- 1. Complete the Biometric Screening***
- 2. Complete an On-line Personal Health Assessment**
- 3. Earn 20 Points**

EXCITING NEWS FOR YEAR 12

- ▶ Earn points for your Biometric Screen results – up to 14 max
- ▶ 20 total points that must be earned (includes Biometric Screen Points)
- ▶ Fitbit drawings throughout the program year for participation in the Wellness Program
- ▶ Get “Connected!” by going online to www.healthyroads.com; sync your fitness device or app and earn points for:
 - Your steps
 - Your workout durations
 - Your fitness facility check-ins

Visit www.healthyroads.com or call a UCCS Wellness Nurse at 385-5190 for more information.

* The City is committed to helping you work towards your best health. Rewards for participating in a wellness program are available to benefit eligible employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact a Wellness Nurse and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

MEDICAL INSURANCE

The City offers two self-funded medical plans: The Premier Plan and the Advantage Plan with a Health Reimbursement Account (HRA). 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 that are enrolled in the City medical plans may also use the City Employee Medical Clinic (CEMC) located on the first floor of the City Administration Building 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. Wellness Visits are \$0 co-pay at the CEMC.

2016 MEDICAL PLAN COMPARISON CHART

Type of service	Premier Plan		Advantage Plan	
	In-Network Benefit	Out-of-Network Benefit	In-Network Benefit	Out-of-Network Benefit
Lifetime maximum	unlimited		unlimited	
Annual deductible ⁽¹⁾	\$500 Individual \$1250 Family	\$1,250 Individual \$2,500 Family	\$1,500 Individual \$3,000 Family	\$4500 Individual \$9000 Family
Coinsurance ⁽¹⁾	You pay 25%	You pay 50%	You pay 20%	You pay 50%
Annual out-of-pocket maximum (OPM)/ Coinsurance ⁽¹⁾	\$2,500 Individual \$7,500 Family	\$4,050 Individual \$12,150 Family	\$3,500 Individual \$8000 Family	\$9,000 Individual \$18,000 Family
Office visits to physician/health care practitioner	\$30 co-pay for PCP; \$40 co-pay for specialist.	Subject to deductible and coinsurance.	Subject to deductible and coinsurance.	Subject to deductible and coinsurance.
Urgent care For minor episodic care at urgent care facility, not for routine care.	\$30 co-pay; diagnostic and surgical coinsurance applies.	\$60 co-pay; diagnostic and surgical coinsurance applies.	Coinsurance only, deductible waived.	Coinsurance only, deductible waived.
Emergency room visits	\$250 co-pay; diagnostic and surgical coinsurance for hospital costs will apply. Not subject to deductible. If admitted to the hospital, emergency room co-pay is waived.		Subject to deductible and 20% coinsurance.	
Diagnostic services	Subject to deductible and coinsurance.	Subject to deductible and coinsurance	Subject to deductible and coinsurance.	Subject to deductible and coinsurance.
Inpatient hospital services	Subject to deductible and coinsurance.	Subject to deductible and coinsurance.	Subject to deductible and coinsurance.	Subject to deductible and coinsurance.
Outpatient surgery	Coinsurance applies; plus \$150 co-pay if performed in an ambulatory surgical facility.	Subject to deductible and coinsurance.	Subject to deductible and coinsurance.	Subject to deductible and coinsurance.
Wellness benefit ⁽²⁾ Services include, but not limited to, well baby care, annual physicals.	100% covered – not subject to deductible.	Coinsurance only; deductible waived.	100% covered – not subject to deductible.	Coinsurance only; deductible waived.
Alternative medicine Acupuncture, massage therapy, nutritionist, chiropractic services, homeopathic, naturopathic and foot care (not otherwise eligible under the plan) services.	Plan Pays 50% of each claim up to an annual family maximum of \$1000 (not subject to the OPM).			
Inpatient mental health Pre-certification is required for all plans.	Subject to deductible and coinsurance.	Subject to deductible and coinsurance.	Subject to deductible and coinsurance.	Subject to deductible and coinsurance.
Outpatient mental health	\$30 office co-pay.	Subject to deductible and coinsurance.	Subject to deductible and coinsurance.	Subject to deductible and coinsurance.

Notes:

(1) The OPM and coinsurance are accounted for **separately** for in-network and out-of-network services.

(2) Services for the in-network Wellness Benefit are covered at 100%.

A list of Participating Providers for our medical plans is available online at www.myameriben.com or www.anthem.com.

This summary is not intended to include all benefit plan details. Refer to the official Plan Document for additional details. If a discrepancy exists between this document and the Plan Document, the Plan Document will govern.

PRESCRIPTION PROGRAM

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. To save money, you will want to 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; while at the same time help contain the costs of expensive medications. IVSolutions will be working in conjunction with members of the City Employee Pharmacy to fill medications through this program. If you have any questions, please call 1-800-658-6046 to speak with an IVSolutions Customer Service Representative. More information can be found at www.cityemployee pharmacy.com.

2016 PRESCRIPTION COVERAGE

Pharmacy	Tier	Type of Prescription	Cost
City Employee Pharmacy	1 st Tier	Generic	\$ 6 co-pay (30 day supply) \$ 15 co-pay (90 day supply)
	2 nd Tier	Preferred Brand	\$35 co-pay (30 day supply) \$70 co-pay (90 day supply)
	3 rd Tier	Non-Preferred Brand	\$60 co-pay (30 day supply) \$120 co-pay (90 day supply)
Specialty Pharmacy	4 th Tier	Preferred Chronic Injectables and other Specialty Drugs	\$100 (30 day supply) \$200 (90 day supply)
Specialty Pharmacy	5 th Tier	Non-Preferred Chronic Injectables and other Specialty Drugs	\$150 (30 day supply) \$300 (90 day supply)
Chronic Injectables and Specialty Drugs: \$2,500 out-of-pocket maximum per member, per year.			
Diabetes Ten City Challenge coverage for diabetic medications		Diabetic Supplies	Covered at 100% (no co-pay) if obtained through the City Employee Pharmacy Program and you are participating in the Diabetes Ten City Challenge or can provide documentation that you are being case managed. (Maximum 90-day supply) If supplies are obtained through a MaxorPlus Retail Network Pharmacy or if you are not participating in the Diabetes Ten City Challenge or cannot provide documentation that you are being case managed, then the regular retail co-pay will apply.
Enhanced Coverage for Chronic Conditions		GENERIC Medications for Asthma, Coronary Artery Disease, COPD, Diabetes, GERD, and Hypertension	Covered at 100% (no co-pay) if enrolled and engaged in the Disease Management program through Ameriben Medical Management and if obtained through the City Employee Pharmacy.
NEW in 2016 CARDIORx program		GENERIC Medications for Cardiovascular disease	Covered at 100% (no co-pay) if enrolled and engaged in the CARDIORx program through City Employee Pharmacy and if obtained through the City Employee Pharmacy.
MaxorPlus Retail Network Pharmacies	1 st Tier	Generic	\$25 (30 day supply)
	2 nd Tier	Preferred Brand	\$55 (30 day supply)
	3 rd Tier	Non-Preferred Brand	\$75 (30 day supply)
	4 th Tier & 5 th Tier	Preferred/Non-Preferred Chronic Injectables	N/A
Maintenance Prescription Fills (For a complete listing of participating pharmacies go to the Preferred Provider Information on the Clinic and Pharmacy information section of the Benefits and Wellness website.)		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. Maintenance Rx filled at any MaxorPlus Retail Network Pharmacy: <ul style="list-style-type: none"> • 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 	

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DENTAL INSURANCE

The City offers two Delta dental plans with different options: Delta Hi-Option PPO Dental Plan and Delta Standard DPO Dental Plan. All of these 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.

2016 DELTA DENTAL PLAN COMPARISON CHART

The provider panel can change without notice. Employees are responsible for verifying that their provider is part of the network before obtaining services. To verify, contact the provider directly or visit the Delta Dental website at www.deltadentalco.com.

Delta Dental Plan	Delta Hi-Option PPO ⁽¹⁾ Policy #1512		Delta Standard-Option PPO Policy #1844	
	PPO Dentist	Premier and Non-Participating Dentist	PPO Dentist	Premier and Non-Participating Dentist
Annual Maximum Benefit	\$2,000 per individual	\$1,500 per individual	\$1,500 per individual	
Calendar Year Deductibles				
Per Person	\$50		\$50	
Per Family	\$150		\$150	
Routine Dentistry ⁽²⁾		^{(5) (6)}		⁽⁵⁾
Cleaning	100%	80%	100%	80%
Oral Exams	100%	80%	100%	80%
X-Rays	100%	80%	100%	80%
Sealants ⁽³⁾	100%	80%	100%	80%
Basic Dentistry ^{(4) (6)}		^{(5) (6)}		^{(5) (6)}
Fillings	90%	50%	80%	50%
Extraction	90%	50%	80%	50%
Root Planning/Quadrant	90%	50%	80%	50%
Major Dentistry ⁽⁶⁾		^{(5) (6)}	^{(5) (6)}	
Crown (full cast)	60%	50%	50%	
Denture repair	60%	50%	50%	
Bridge	60%	50%	50%	
Orthodontia	⁽⁶⁾		⁽⁶⁾	
Orthodontic Benefit	60%		Not covered	
Lifetime Maximum	\$2,000		Not covered	
Implant Coverage	All steps included		Not covered	
Prevention First	Included		Included	

Notes:

- (1) Employee and plan receive discounted contract pricing if a PPO In-Network provider is utilized.
- (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 or Premier 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.

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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 1-800-877-7195.

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.

2016 VISION SERVICE PLAN COVERAGE SUMMARY

Benefit	Description	Copay	Frequency
Your Coverage with a VSP Doctor			
WellVision Exam	<ul style="list-style-type: none"> Focuses on your eyes and overall wellness 	\$20	Every calendar year
Prescription Glasses			
Frame	<ul style="list-style-type: none"> \$175 allowance for a wide selection of frames 20% off amount over your allowance 	\$15	Every calendar year
Lenses	<ul style="list-style-type: none"> Single vision, lined bifocal, and lined trifocal lenses Polycarbonate lenses for dependent children 	\$10	Every calendar year
Lens Options	<ul style="list-style-type: none"> Standard progressive lenses Premium progressive lenses Custom progressive lenses Average 20-25% off other lens options 	\$55 \$95 - \$105 \$150 - \$175	Every calendar year
Contacts (instead of glasses)	<ul style="list-style-type: none"> \$175 allowance for contacts: copay does not apply Contact lens exam (fitting and evaluation) 	Up to \$60	Every calendar year
Diabetic Eyecare PlusProgram	<ul style="list-style-type: none"> Services related to type 1 and type 2 diabetes: ask your VSP doctor for details 	\$20	As needed
Extra Savings and Discounts	Glasses and Sunglasses		
	<ul style="list-style-type: none"> 20% off additional glasses and sunglasses, including lens options, from any VSP doctor within 12 months of your last WellVision Exam. 		
	Laser Vision Correction		
<ul style="list-style-type: none"> Average 15% off the regular price or 5% off the promotional price: discounts only available from contracted facilities No more than a \$39 co-pay on routine retinal screening as an enhancement to a WellVision Exam 			
Your Coverage with Other Providers			
Visit vsp.com for details, if you plan to see a provider other than a VSP doctor.			
Exam – up to \$45 Single Vision Lenses – up to \$30 Lined Trifocal Lenses – up to \$65 Contacts – up to \$105 Frame – up to \$70 Lined Bifocal Lenses – up to \$50 Progressive Lenses – up to \$50			
The provider panel can change without notice. Employees are responsible for verifying that their provider is part of the network before obtaining services. To verify, contact the provider directly or VSP at 800-877-7195 or check www.vsp.com.			

This summary is not intended to include all benefit plan details. Refer to the official Plan Document for additional details. If a discrepancy exists between this document and the Plan Document, the Plan Document will govern.

*** Note: There is an additional \$50 per month surcharge for employees on the medical plan who are tobacco users.**

CITY OF COLORADO SPRINGS 2016 BENEFIT RATE MONTHLY CHART PLAN COSTS

For City Employees

**Regular, Probationary & Special Employees regularly scheduled to work 20 or more hours weekly
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

Premier Medical Plan Rates - Monthly *			
Level of Coverage	Total Plan Cost	Employer Share	Employee Share*
EE Only	\$570	\$432	\$138
EE/Sp	\$1,133	\$766	\$367
EE/Ch	\$1,064	\$739	\$325
EE/Family	\$1,610	\$1,119	\$491

Advantage Plan - with HRA - Monthly*				Annual HRA Funding (Employer Only)
Level of Coverage	Total Plan Cost	Employer Share	Employee Share*	
EE Only	\$463	\$432	\$31	\$500
EE/Sp	\$939	\$766	\$173	\$750
EE/Ch	\$893	\$739	\$154	\$750
EE/Family	\$1,354	\$1,119	\$235	\$750

Delta Hi-Option PPO Dental Plan Rates - Monthly			
Level of Coverage	Total Plan Cost	Employer Share	Employee Share
EE Only	\$44	\$31	\$13
EE/Sp	\$100	\$37	\$63
EE/Ch	\$80	\$37	\$43
EE/Family	\$124	\$37	\$87

Delta Standard Option PPO Dental Rates - Monthly			
Level of Coverage	Total Plan Cost	Employer Share	Employee Share
EE Only	\$31	\$31	\$0
EE/Sp	\$73	\$37	\$36
EE/Ch	\$58	\$37	\$21
EE/Family	\$90	\$37	\$53

Vision Service Plan Rates - Monthly			
Level of Coverage	Total Plan Cost	Employer Share	Employee Share
EE Only	\$7.58	\$0	\$7.58
EE + SP	\$15.16	\$0	\$15.16
EE + CH	\$16.23	\$0	\$16.23
EE + FM	\$25.93	\$0	\$25.93

Note: Civil Union cost may have pre-tax and post-tax implications. Contact Benefits and Wellness at 719-385-5125 to discuss further.

FLEXIBLE SPENDING ACCOUNTS

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.

FSA – HEALTH CARE SPENDING ACCOUNT

A Health FSA 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 Deposit: \$120

Maximum Annual Deposit: \$2,550

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

FSA – DEPENDENT DAY CARE ACCOUNT

A Dependent Day Care FSA 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 Dependent Day Care accounts, so any contributions remaining in your account that cannot be applied toward current year dependent day care expenses are not refundable.

Minimum Annual Deposit: \$120

Maximum Annual Deposit: \$5,000

Unlike the Health FSA, 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.

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 for Health Care (FSA-HC), you must first exhaust the balance in your FSA-HC before you can be reimbursed from your HRA.

You have until March 31 of the following year to submit claims for reimbursements from your FSA and HRA accounts..

LONG TERM CARE (LTC)

You and your legal spouse are eligible for LTC insurance. You and your spouse’s parents and grandparents, natural, adoptive or step, are also 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 can 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. For additional information please contact Benefits & Wellness to request a Long Term Care Enrollment Packet.

BASIC LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE

The City of Colorado Springs pays for 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 & Wellness website for further details.

AETNA VOLUNTARY TERM LIFE (VTL) AND BASIC LIFE INSURANCE

The City of Colorado Springs pays for basic life insurance and accidental death and dismemberment coverage equal to 1.5 times your annual salary.

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

No individual may be covered as a dependent of more than one employee.

Guidelines:

- 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.)
- Evidence of Insurability will be required on all increases or if you are enrolling for the first time.
- VTL premiums are based on age as of Jan. 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.
- This policy is portable and convertible if you separate from the City.

VTL Summary Chart

Coverage Level	Maximum Coverage
Employee	The lesser of 10 X salary or \$500,000
Spouse	\$250,000
Child(ren)	\$25,000

Desired Purchase Amount \$150,000
 Age on January 1st 35
 Smoking Status Non-Tobacco User
 Sample Age Rate \$.07

1. \$150,000 / 1,000 = 150
2. 150 x \$.07 = \$10.50
3. \$10.50 Monthly Premium / 2 = \$5.25
4. Semi-monthly employee cost = \$5.25

VTL Rate Structure

Age Bracket	Non-Tobacco User Per \$1,000	Tobacco User Per \$1,000
Under 30	.04	.07
30 – 34	.06	.10
35 – 39	.07	.11
40 – 44	.08	.15
45 – 49	.11	.23
50 – 54	.17	.34
55 – 59	.32	.57
60 – 64	.50	.83
65 – 69	.97	1.37
70 – 74	1.64	2.79
Over 74	2.06	2.85
Child(ren) per \$5,000 = \$.72 per month		

EMPLOYEE ASSISTANCE PROGRAM (EAP)

This free and confidential program 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. The Wellness Option provides counseling for physical health 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 can call Profile EAP at (719) 634-1825 any hour of the day or night.

SHORT AND LONG TERM DISABILITY (STD/LTD)

The STD plan offers income replacement for non-work related injuries or illnesses only. Benefits begin after seven days or when sick leave is exhausted, whichever is greater. Benefit income is 60% of an employee's basic weekly earnings, but will not exceed \$1,250 per week. Benefits are reduced by any amounts payable from other income sources. STD premiums are paid on an after tax basis and are based on current age, salary and class. Premiums will be adjusted with changes in pay or vesting during the year. The City continues collecting premiums from the employee while the employee is receiving STD benefits.

The LTD plan offers income replacement for work related or non-work related injuries or illnesses. The LTD program will pay the lesser of 60% of covered monthly earnings (rounded to the nearest dollar) received immediately prior to the commencement of disability or your Maximum Disability Benefit. The Maximum Disability Benefit is \$7,500 per month (minimum benefit is \$50). Your benefit will be reduced by any amounts payable to you from other income sources. LTD premiums are paid on an after tax basis and are based on current age, salary and class. Premiums will be adjusted with changes in pay or vesting during the year.

Please review the STD and LTD Plan Documents for more detailed information about these benefits.

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 STD.

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 (LTD only).

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

Short Term Disability Age Factor		
Age Bracket	Class 1	Class 2
Under 30	.554	.254
30 – 34	.531	.254
35 – 39	.484	.231
40 – 44	.531	.254
45 – 49	.577	.277
50 – 54	.692	.323
55 – 59	.808	.323
60 – 64	1.061	.461
65 plus	1.246	.554

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

RETIREMENT

CIVILIAN PENSION PLAN (PERA)

Instead of participating in the Social Security System, the City and its Civilian Employees and Elected Officials are members of the State of Colorado pension system that is administered under State law by the Public Employees' Retirement Association (PERA). Participation is mandatory for eligible employees. To fund future pension benefits, employees contribute 8% of PERA-includable salary to their account, and the City contributes 13.7% (to include AED & SAED) of the same earnings to the local government division.

PERA is a defined benefit plan, and your retirement income is based upon your age, your years of service, and your three years of Highest Average Salary (HAS). Additional information about PERA benefits is available through PERA at 1-800-759-7372, www.copera.org.

The Colorado PERA retirement plan is a hybrid defined benefit plan. It is designed to attract and retain employees who are interested in working in Colorado PERA-covered employment for a large part of their careers, while providing greater portability for shorter careers than a traditional defined benefit plan.

Over the years, Colorado PERA has worked with the State Legislature and others to address issues such as portability, cost-of-living adjustments, and overall improvement of the benefits Colorado PERA members receive. These changes have made the Colorado PERA defined benefit plan more flexible and portable. Colorado PERA members and the State of Colorado benefit from a conservative yet innovative approach to public pension management.

Colorado PERA is a traditional defined benefit pension plan with many added features, providing members and retirees with a comprehensive benefit package that includes the following:

Lifetime retirement benefits

- Good portability provisions
- Comprehensive disability and survivor benefits
- Tax-deferred interest on member contributions
- Annual cost-of-living increases in retirement benefits

MEDICARE

The City and new employees must each contribute to the Federal Government's Medicare Program at a rate of 1.45% of gross annual earnings.

SWORN FIRE AND POLICE EMPLOYEES

Sworn (Fire and Police) employees to include the Fire Chief and Police Chief are members of the Statewide Defined Benefit Plan (SWDB) through the Fire and Police Pension Association (FPPA) of Colorado in lieu of Social Security. Participation is mandatory for eligible employees. To fund future pension benefits, employees contribute 8% of FPPA-includable salary and the City contributes 8% of the same earnings.

The following types of retirement are available under the SWDB plan: normal, early, vested or deferred. If a member terminates service before retirement eligibility, the member may qualify for a refund of contributions. Additional information about FPPA benefits is available through FPPA at 1-800-332-3772, www.fppaco.org.

ICMA ROTH IRA (VOLUNTARY)

- Jump-start your Savings with the Payroll Deduction Roth IRA!
- Flexible withdrawal options
- A great compliment to your supplemental retirement savings plan ICMA-RC's Payroll Roth IRA provides an easy way for you to save directly from your paycheck.
- Earnings may be tax-free
- Start with any dollar amount
- Access to contributions at any time without penalties or taxes

ICMA 457 PLANS (VOLUNTARY DEFERRED COMPENSATION)

All employees can participate

- A plan similar to a 401(k), but with less restrictions
- Voluntary participation
- Variety of investment choices
- Contributions and earnings are tax-deferred
- www.icmarc.org
- For additional information on the Roth IRA and Deferred Compensation Plan contact: Donald Eschbach, Retirement Plans Specialist, ICMA-RC, Phone: 1-866-749-5174, Email: deschbach@icmarc.org

PAID TIME OFF VACATION

Civilian: New non-management employees accrue 3.38 hours per pay period and for new management employees accrue 4.615 hours per pay period. For additional vacation information, please review the Civilian Policies and Procedures manual available on the Human Resources website at www.coloradosprings.gov.

Sworn: New Police and Fire Employees accrue 3.69 hours per pay period. New firefighters who work 24 hour shifts accrue 6.53 hours per pay period. Battalion Chiefs accrue an additional 3 shifts of vacation or an annual total of 264 hours. For more vacation leave information, please check the Sworn Policies and Procedures manual available on the Human Resources website at www.coloradosprings.gov.

VACATION BUY

Benefit eligible employees may buy up to five additional vacation days, 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.

SICK LEAVE

Civilian: Accrual begins upon employment. You may not take the current pay periods sick leave accrual, only what is in your sick leave bank from the previous pay period.

Full-time employees accrue 8 hours of sick leave per month up to a total accumulation of 1056 hours plus the current year. Part-time employees accrue a pro-rata share of the full-time accrual, based on actual hours worked within the pay period. Sick leave pay must be approved by your supervisor and is to be used solely in the event of you or your immediate family's illness or injury. Family sick leave is limited to 480 hours per calendar year.

For more sick leave information, please check the Civilian Policies and Procedures manual available on the Human Resources website at www.coloradosprings.gov.

Sworn: Forty-hour regular and probationary employees shall accrue sick leave at the rate of 9.33 hours per month of continuous employment. Sick leave may be accrued to a maximum of 1056 hours, plus current year accrual. 24-hour employees accrue sick leave at the rate of 13.07 hours per month of continuous employment. For more sick leave information, please check the Sworn Policies and Procedures manual available on the Human Resources website at www.coloradosprings.gov.

HOLIDAYS

City recognized holidays are:

- New Year's Day
- President's Day
- Labor Day
- Day after Thanksgiving
- Martin Luther King, Jr. Day
- Memorial Day
- Veteran's Day
- Christmas Day
- Independence Day
- Thanksgiving Day

Civilian Holidays: All benefit eligible employees will receive 8 hour paid holidays on these days.

Sworn employees and shift employees: Please refer to the Policy & Procedure Manual for details on how holidays are paid.

PERSONAL DAY:

Civilian: In addition to the observed holidays listed above, after six months of employment, employees are eligible for one 8 hour personal day each year.

Sworn: In addition to the observed holidays, after 12 months of Civil Service employment, all employees eligible for paid holidays shall receive one 8-hour personal day each year. When departments credit 88 hours of additional personal holiday credit time, 8 hours of the 88 constitutes the employee's personal day.

PARKING

City employees are eligible to receive a discounted monthly parking card once they obtain a parking space if they park at one of the City parking garages. There are three parking garages: one is located on the southwest corner of Nevada and Colorado Avenues (130 North Nevada) across the street from the City Administration Building, another is located near the City Bus Station at 127 East Kiowa Avenue. The third garage is located at 201 North Cascade.

CITY BUS SYSTEM

The City provides reduced bus fares to City employees who regularly ride City buses to and from work. A bus pass may be purchased at the Transit Administration Office, 1015 Transit Drive, Colorado Springs or through interoffice mail at MC 1449. Call Transit Services at (719) 385-5974 for additional information.

Note: This benefit is available only to employees who are not receiving a discounted parking card.

TUITION ASSISTANCE

The City of Colorado Springs educational assistance program provides financial support for job-related educational coursework. Regular employees are eligible to receive tuition reimbursement for up to two classes per semester for undergraduate or graduate classes.

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. You will find general information in the applicable Benefit Plan Comparison and Rate Charts and even more detailed information in the Plan Document for each benefit option. **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 and fire department employees, unless otherwise noted.

NOTE: ANNUAL APPROPRIATIONS REQUIREMENT: Other than those benefits specifically required by Federal or State law, the benefit plans provided by the City of Colorado Springs for employees are subject to annual review and budget appropriations by the 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 City Council discretion. Specific details are available online at www.coloradosprings.gov in the Policy and Procedures Manual (PPM).

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.

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 of 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

This Notice applies only if you are enrolled in the medical, dental, vision or medical spending account plans.

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:

1) Workers’ compensation	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
2) Necessary to prevent serious threat to health or safety	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
3) Public health activities	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
4) Victims of abuse, neglect, or domestic violence	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 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)
5) Judicial and administrative proceedings	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)
6) Law enforcement purposes	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
7) Decedents	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
8) Organ, eye, or tissue donation	Disclosures to organ procurement organizations or other entities to facilitate organ, eye, or tissue donation and transplantation after death
9) Research purposes	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
10) Health oversight activities	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
11) Specialized government functions	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
12) HHS investigations	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

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 702, 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 702, 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 Benefits and Wellness office 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.

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 Benefits and Wellness at 385-5125.

DIRECTORY

Benefit Plan	Vendor Name	Contact Information
Medical Insurance Group Number: 000COG834 Name: Premier Plan Name: Advantage Plan	Ameriben/Anthem Contracted Providers, Prior Authorization, Claims, and Benefits	www.myameriben.com (866) 955-1482
	Ameriben Medical Management Disease Management, Case Management, and Prior Authorization, Tobacco Cessation	www.myameriben.com (800) 388-3193
	MaxorPlus Pharmacy Benefit Manager, Pharmacy ID Cards, and Contracted Providers	www.maxor.com (800) 687-0707 Auto refill line: (800) 573-6214
	City Employee Pharmacy Pharmacy	www.cityemployeepharmacy.com (719) 385-2261 Auto refill line: (800) 573-6214
	City Employee Medical Clinic Medical Services	For appointments: (719) 385-5841 Fax: (719) 385-5842
Dental Insurance	Delta Dental Plans Hi-Option (Premier) Plan # 1512 Standard Option (Preferred) Plan #1844	www.deltadentalco.com (800) 610-0201
Vision Insurance	Vision Service Plan (VSP) Policy # 12-061804-00-36-0036	www.vsp.com (800) 877-7195
Employee Assistance Program (EAP)	Profile EAP: Centura Health	www.ProfileEAP.org (800) 645-6571 Username: city Password: 2000
Life Insurance	AETNA U.S. HealthCare Policy / Control: 721111 10 001	www.aetna.com (800) 523-5065
Disability Insurance	CIGNA Short Term Disability Policy #LK7822 Long Term Disability Policy #LK7823	www.cigna.com (800) 362-4462 Claims: 800-781-2006
Long Term Care	UNUM Life Insurance Company of America Policy # 220508-001 (elections prior to 2008) Policy # 127251 (elections 2008 and forward)	www.unum.com (800) 227-4165
Flexible Spending Accounts (FSA) and Health Reimbursement Accounts (HRA)	ASIFlex Health Care Spending Accounts Dependent Care Spending Accounts HRA - available to active employees enrolled in Advantage Plan	www.asiflex.com Phone: (800) 659-3035 Fax: (877) 879-9038
AspenPointe – Depression & Sleep Care Management Programs	AspenPointe	www.aspenpointe.org (888) 845-2881
Retirement	Public Employees Retirement Assoc. (PERA)	www.copera.org (800) 759-7372
	Fire & Police Protective Assoc. (FPPA)	www.fppaco.org (800) 332-3772
	ICMA-RC Services, LLC - Don Eschbach	deschbach@icmarc.org (866) 749-5174