

2017

Open Enrollment Guide

City of Colorado Springs

Contact us for help!

Benefits and Wellness

(719) 385-5125

Citybenefitshelp@springsgov.com



Benefits and Wellness

Improving your health, one benefit at a time

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2017 OPEN ENROLLMENT

Welcome to Open Enrollment for the 2017 Employee Benefits Plan!

This is the time of year to re-evaluate your existing benefit elections, review the benefit offerings for 2017, determine the programs that are appropriate for you and your family, and make changes that best fit your needs. We are pleased to continue to offer a robust and competitive benefit package. **And, we are excited to share there will be no changes to your health care premiums in 2017.**

During 2016, many of our medical plan members rose to the challenge of committing to their health. These folks became more savvy health care consumers as shown by higher engagements in the wellness and disease management programs, as well as higher utilization of the quality and cost comparison tools. These efforts support our strategic goals in this area: better health for our employees and their families, better care, and lower employer and employee cost. The 2017 medical plan design changes provide increased incentive for choosing high quality and cost effective providers and facilities.

We are proud of the benefits we are offering you in 2017, and we continually strive to make plan enhancements and improvements you and your families will find valuable.

Thank you each for what you do every day to serve our great community.

Best Health,
Mike Sullivan
Chief Human Resource Officer

OPEN ENROLLMENT IS MONDAY, OCTOBER 31, 2016 THROUGH MONDAY, NOVEMBER 14, 2016

Employees MUST log into Employee Self Service (ESS) and review their current benefit elections. If you want 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 2017.

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 Benefits and Wellness if you need to change your status in ESS.

We will be offering several in-person meetings to review the 2017 benefit changes. See the list for meeting information. Select departments will be offering an on-site meeting as well. Please check with your manager for details.

Open Enrollment Information Meetings		
Date	Where	Time
Thursday, November 3	CAB	11:30 AM
Monday, November 7	POC	3:00 PM
Tuesday, November 8	CAB	1:00 PM
Wednesday, November 9	POC	9:00 AM

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. And 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.

2017 PLAN ENHANCEMENTS

- **Teladoc** – Now \$0 when you need a consultation.
- **Enhanced Person Health Care (EPHC) Primary Care Providers** – Co-pays when you see these providers.
- **UCHealth Savings** - increased benefit coverage for utilizing UCHealth Inpatient facilities.
- **Premier Plan** – you pay 20% coinsurance for in-network services.
- **Site of Service program** – Save money on advanced imaging and outpatient surgery. The Site of Service program helps you get quality care for less money. Just choose a free-standing, independent imaging provider or ambulatory surgery center from the Anthem network.

2017 PLAN CHANGES

MEDICAL

Premier Plan In-Network Changes		
Type of Service	2016	NEW for 2017
Co-insurance	You pay 25%	You pay 20%
Co-pay EPHC Primary Care Provider	N/A	\$25; deductible waived.
Co-pay for Tier I Specialist	N/A	\$40; deductible waived.
Co-pay for all other PPO Primary Care Providers	\$30	\$35; after deductible.
Co-pay for all other PPO Specialist	\$40	\$60; after deductible.
Co-pay for Outpatient Mental Health	\$30	\$25; deductible waived.
Urgent Care in-network	\$30 co-pay, deductible waived; coinsurance for diagnostic and surgical services.	\$50 co-pay, deductible waived; coinsurance for diagnostic and surgical services.
Urgent Care out-of-network	\$60 co-pay; coinsurance for diagnostic and surgical services.	You pay 50% after deductible.

Advantage Plan In-Network Changes		
Type of Service	2016	NEW for 2017
Co-pay EPHC Primary Care Provider	N/A	\$30; deductible waived.
Co-pay for Tier I Specialist	N/A	\$60; deductible waived.
Co-pay for all other PPO Primary Care Providers	Subject to deductible and coinsurance.	\$40; after deductible.
Co-pay for all other PPO Specialist	Subject to deductible and coinsurance.	\$70; after deductible.
Co-pay for Outpatient Mental Health	Subject to deductible and coinsurance.	\$30; deductible waived.

PHARMACY

- Network Change** – Costco will no longer be considered an in-network retail pharmacy. If you are currently using Costco Pharmacy, you will need to have the prescriptions transferred to the City Employee Pharmacy or an in-network retail pharmacy. Visit maxorplus.com for a complete listing of pharmacies.
- Specialty Medication Change** – Specialty Medications will be limited to a 30 day supply, a 90 day supply will no longer be available.

WELLNESS

- New! Wellness Vendor – HealthYou** – On January 1, 2017, we will start Reach Your Peak Year 13 with HealthYou. Watch for more details coming soon!
- Waived prescription co-pays if engaged in any of the following: Ameriben Medical Management program, Diabetes Ten City Challenge and/or CardioRx programs, up to an annual maximum.
- Diabetic Pumps and supplies, testing strips, and insulin are covered at 100% on both Advantage and Premier plans.

BENEFITS AND PROGRAMS TO ENHANCE YOUR HEALTH

REACH YOUR PEAK WELLNESS PROGRAM

Details for the 2017 program year will be coming soon. Watch your work email and home mail for more information.

CITY EMPLOYEE MEDICAL CLINIC

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.

PREVENTIVE CARE

These services are no charge when you see an in-network provider. Find an in-network provider at anthem.com.

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 issue 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 or (800) 645-6571 and hour of the day or night.

You can also visit their website for more information at profileeap.com. **Login ID:** City **Password:** 2000

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.

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, including a Maternal Health Program for expectant moms.

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.
- **UCCS Health Coaches (Wellness Nurses) – (719) 385-5190**
Available and FREE to all benefit eligible employees. Please call to schedule an appointment. The UCCS Health Coaches will work with you in-person or via phone. They will follow up with you by phone or email to provide support, encouragement, and accountability.
- **HealthLink Classes through UCHealth Memorial – (719) 444-2273**
FREE to employees and their dependents. Participate in any class (limit 4 per person). This is a 6 week evening program (counts as 1 class). Call HealthLink for more information and a schedule of classes.

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 and statins 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 & 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 2017 year. If you would like to meet one-on-one with our ICMA representative or attend a seminar, you can find information on the Benefits and Wellness Intranet page. It is never too late to start saving!

BENEFITS AND WELLNESS FAQs

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 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, but 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, but do apply to your out-of-pocket max for the year.

What can be treated through Teladoc?

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

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.

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 of 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 2017!** There is a \$5 fee for lost cards.

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 going to the Benefits and Wellness Intranet page.

WE CAN HELP

If you need help with your benefits, please contact the Benefits Team at (719) 385-5125 or citybenefitshelp@springsgov.com.

FLEXIBLE SPENDING ACCOUNT ENROLLMENT

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 2017. 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 2017. The card will be reloaded with your Flexible Spending Account - Health Care election and/or your Health Reimbursement Account monies for use in 2017.

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.

DEADLINE TO SUBMIT

You have until March 31, 2017 to submit for reimbursement requests for 2016 expenses.

INSURANCE CARDS

Medical: All plan members will receive new medical cards in mid to late December. To request a replacement or additional medical cards contact Ameriben at (866) 955-1482.

Prescription: All plan members will receive new prescription cards in mid to late December. 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 2017. Please remember to submit for 2016 expenses by March 31, 2017. Funding for 2017 remains the same - \$500 for employee only coverage and \$750 for all other coverage levels on the Advantage Plan only. Additionally, beginning in January 2017, 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.

QUALIFYING EVENTS

Due to IRS regulations, once you have made your elections for 2017, 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 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 and Wellness 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 Benefits and Wellness receives all necessary paperwork

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.

Coverage begins the first of the month after your date of hire if required forms are submitted by the deadline to the Benefits and Wellness department.

HEALTH CARE REFORM

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.

HEALTH CARE REFORM FAQs

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.

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.

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.

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 connectforhealthco.com.

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 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 Benefits and Wellness or you may contact the U.S. Department of Health and Human Services at healthcare.gov.

AVAILABLE RESOURCES

- View your Explanation of Benefits (EOB), find an in-network provider and much more by visiting myameriben.com.
- Visit Anthem website for a cost of service estimator tool or to locate and in-network provider anthem.com.
- Learn how the hospital of your choice rates with regard to safety and quality by visiting leapfroggroup.org.
- Many of our vendors offer a mobile app. Search the App Store or Google play to take advantage of technology right at your fingertips. Learn by reading our quarterly newsletter found on the Benefits and Wellness Intranet page.

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.

2017 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.**

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 Medical Plan Rates - Monthly				
Level of Coverage	Total Plan Cost	Employer Share	Employee Share*	Annual HRA Funding (Employer Only)
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 Plan 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/Family	\$25.93	\$0	\$25.93

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 Anthem's transparency tools available on anthem.com, receive their preventative 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.

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, nutritionist, chiropractic services, homeopathic, naturopathic & 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. This 50% coinsurance does not apply to your deductible, but does apply to your annual out-of-pocket maximum. 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.

LEARN MORE

Additional information is located on the Benefits and Wellness Intranet page. Contact Benefits and Wellness at (719) 385-5125 or Citybenefitshelp@springsgov.com for additional questions.

MEDICAL PLAN COMPARISON

	Premier Plan		Advantage Plan	
Type of service	In-Network Benefit	Out-of-Network Benefit	In-Network Benefit	Out-of-Network Benefit
Lifetime maximum	unlimited		unlimited	
Annual Deductible	\$500 Individual \$1250 Family	\$1,250 Individual \$2,500 Family	\$1,500 Individual \$3,000 Family	\$4500 Individual \$9000 Family
Coinsurance ⁽¹⁾	You pay 20%	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
Primary Care Office Visit	EPHC - \$25 co-pay, deductible waived; All others - \$35 after deductible.	You pay 50% after deductible.	EPHC - \$30 co-pay, deductible waived; All others - \$40 after deductible.	You pay 50% after deductible.
Specialist Office Visit	Tier I - \$40 co-pay, deductible waived; All others - \$60 after deductible.	You pay 50% after deductible.	Tier I - \$60 co-pay, deductible waived; All others - \$70 after deductible.	You pay 50% after deductible.
Mental Health Office Visit	\$25 co-pay, deductible waived.	You pay 50% after deductible.	\$30 co-pay, deductible waived.	You pay 50% after deductible.
Urgent Care	\$50 co-pay, deductible waived; coinsurance for diagnostic & surgical services.	You pay 50% after deductible.	You pay 20%, deductible waived.	You pay 50%, deductible waived.
Emergency Room Visits	\$250 co-pay, then you pay 20% for diagnostic and surgical services, deductible waived. If admitted to the hospital, ER co-pay waived.		You pay 20% after deductible.	
Diagnostic Services	You pay 20% after deductible.	You pay 50% after deductible.	You pay 20% after deductible.	You pay 50% after deductible.
Inpatient Mental Health	You pay 20% after deductible.	You pay 50% after deductible.	You pay 20% after deductible.	You pay 50% after deductible.
Inpatient Hospital Services	Utilize an UCHealth Facility - you pay 15% after deductible. All hospital services and all other facilities - You pay 20% after deductible.	You pay 50% after deductible.	Utilize an UCHealth Facility - you pay 15% after deductible. All hospital services and all other facilities - You pay 20% after deductible.	You pay 50% after deductible.
Advanced Imaging (MRI/CT/PET)	Freestanding Facility - you pay 10% after deductible; All other facilities - you pay 20% after deductible.	You pay 50% after deductible.	Freestanding Facility - you pay 10% after deductible; All other facilities - you pay 20% after deductible.	You pay 50% after deductible.
Outpatient/Ambulatory Surgery	Freestanding Facility - you pay 10% after deductible; All other facilities - you pay 20% after deductible.	You pay 50% after deductible.	Freestanding Facility - you pay 10% after deductible; All other facilities - you pay 20% after deductible.	You pay 50% after deductible.
Preventive Care	You pay \$0	You pay 50%; deductible waived.	You pay \$0	You pay 50%; deductible waived.
Alternative Medicine	Plan Pays 50% of each claim up to an annual family maximum of \$1000, deductible waived.			

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
- CDL Physicals (non-City work related)
- Women's Health
- Immunizations

Acute Care Services (Ages 3 & 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

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

City Employee Pharmacy

- Available to both Advantage and Premier Plan Members
- Home Delivery Available
- Refills:
 - Automated Refill Line
(800) 573-6214
 - Mobile App
- Validated Parking
- Text Messaging Alerts*

*Charges may apply based on your carrier plans.

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

Phone: (719) 385-2261

Fax: (719) 385-842

www.cityemployeepharmacy.com

Hours: Monday-Friday 8:30AM – 5:30PM

Wellness Promotion Services

- Confidential on-site health screening
- Smoking cessation
- Health coaching and chronic condition management support
- Weight management support

Wellness Office

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

Phone: (719) 385-5190

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.

Pharmacy	Tier	Prescription Type	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)
	5 th Tier	Non-Preferred Chronic Injectables and other Specialty Drugs	\$150 (30 day supply)
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 – Only available through MaxorPlus
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 Benefits and Wellness at (719) 385-5125 to learn more.			
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 			

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. Call Delta Dental at (800) 610-0201 or visit deltadentalco.com to find a PPO Provider.

Type of Benefit	Delta Hi-Option PPO ⁽¹⁾		Delta Standard-Option PPO	
	PPO Dentist	Premier and Non-Participating Dentists	PPO Dentist	Premier and Non-Participating Dentists
Annual Maximum Plan Will Cover	\$2,000 per individual	\$1,500 per individual	\$1,500 per individual	
Annual Deductible				
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 & Premier 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.

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 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.

Benefit		Description	Co-pay	Frequency
WellVision Exam		<ul style="list-style-type: none"> Focuses on your eyes and overall wellness 	\$20	Every calendar year
Prescription Glasses	Frames	<ul style="list-style-type: none"> \$175 Allowance for a wide selection of frames \$195 allowance for featured frame brands \$95 allowance at Costco 20% savings on the amount over your allowance 	\$15	Every calendar year
	Lenses	<ul style="list-style-type: none"> Single vision, lined bifocal, and line trifocal lenses Polycarbonate lenses for dependent children 	\$10	Every calendar year
	Lens Enhancements	<ul style="list-style-type: none"> Standard progressive lenses Premium progressive lenses Custom progressive lenses Average savings of 20-25% on other lens enhancements 	\$55 \$95 - \$105 \$150 - \$175	Every calendar year
Contacts (instead of glasses)		<ul style="list-style-type: none"> \$175 allowance for contacts; co-pay does not apply Contact lens exam (fitting and evaluation) 	Up to \$60	Every calendar year
Diabetic Eyecare Plus Program		<ul style="list-style-type: none"> 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. 	\$20	As needed
Extra Savings		<p>Glasses and Sunglasses</p> <ul style="list-style-type: none"> 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. <p>Retinal Screening</p> <ul style="list-style-type: none"> No more than a \$39 co-pay on routine screening as an enhancement to a WellVision Exam. <p>Laser Vision Correction</p> <ul style="list-style-type: none"> 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.				
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		
Coverage with a participating retail chain may be different. Once your benefit is effective, visit vsp.com for details.				

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.

FSA – HEALTH CARE

A 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 Deposit: \$120 Maximum Annual Deposit: \$2,550

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

FSA – DEPENDENT DAY CARE

A 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 Deposit: \$120 Maximum Annual Deposit: \$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.

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.

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.

LONG TERM CARE (LTC)

You and your spouse are eligible for LTC insurance. Your 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. Visit the Benefits and Wellness Intranet page for the Unum LTC Evidence of Insurability (EOI) Website Link.

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 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.

VTL Summary Chart

Coverage Level	Minimum Coverage	Maximum Coverage
Employee	\$25,000	The lesser of 10 times salary or \$500,000
Spouse	\$25,000	\$250,000
Child(ren)	\$5,000	\$25,000

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 = \$0.72 per month		

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

Contact Benefits and Wellness at (719) 385-5125 or Citybenefitshelp@springsgov.com for information on how to enroll for during Open Enrollment. **Note: Evidence of Insurability (EOI) will be due to Benefits and Wellness on or before the last day of Open Enrollment.**

DISABILITY INSURANCE

If you are not currently enrolled in a disability plan and elect coverage for the first time, your coverage is subject to 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.

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 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).

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.

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

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.

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

If you are NOT making changes – No action is required. **If you would like to enroll in Short and/or Long Term Disability** – Please print the Evidence of Insurability Form that is available on the Benefits and Wellness Intranet page. Once you have completed the form please make a copy for your records and mail the original to: Cigna Group Insurance, CBCA, Inc., PO Box 1326, Fort Worth, TX 76101-1326. **This form must be postmarked on or before the last day of Open Enrollment.**

VENDOR DIRECTORY

Benefit Plan	Vendor Name	Contact Information
Medical Insurance Group Number: 000COG834 Premier Plan Advantage Plan	Ameriben/Anthem Contracted Providers, Claims, Benefits, and Medical ID Cards	(866) 955-1482 www.myameriben.com www.anthem.com
	Ameriben Medical Management Disease Management, Case Management, and Prior Authorization	(800) 388-3193 www.myameriben.com
	City Employee Medical Clinic Medical Services	(719) 385-5841 Fax: (719) 385-5842
	City Employee Pharmacy Pharmacy	(719) 385-2261 Auto refill line: (800) 573-6214 www.cityemployeepharmacy.com
	MaxorPlus Pharmacy Benefit Manager, Contracted Providers, and Pharmacy ID Cards	(800) 687-0707 Auto refill line: (800) 573-6214 www.maxor.com
	Teladoc Medical Services	(800) 835-2362 www.teladoc.com
Dental Insurance	Delta Dental Plans Hi-Option (Premier) Plan # 1512 Standard Option (Preferred) Plan #1844	(800) 610-0201 www.deltadentalco.com
Vision Insurance	Vision Service Plan (VSP) Policy # 12-061804-00-36-0036	(800) 877-7195 www.vsp.com
Employee Assistance Program (EAP)	Profile EAP: Centura Health	(800) 645-6571 www.profileeap.org Username: city Password: 2000
Life Insurance	AETNA U.S. HealthCare Policy/Control: 721111 10 001	(800) 523-5065 www.aetna.com
Disability Insurance	CIGNA Short Term Disability (STD) Policy #LK7822 Long Term Disability (LTD) Policy #LK7823	(800) 362-4462 Claims: (800) 781-2006 www.cigna.com
Long Term Care (LTC)	UNUM Life Insurance Company of America Policy # 220508-001 (Elections prior to 2008) Policy # 127251 (Elections 2008 and forward)	(800) 227-4165 www.unum.com
Flexible Spending Accounts (FSA) & Health Reimbursement Accounts (HRA)	ASIFlex FSA for Health Care & Dependent Care HRA – Available to active employees enrolled in Advantage Plan	(800) 659-3035 Fax: (877) 879-9038 www.asiflex.com
Retirement	Public Employees Retirement Assoc. (PERA)	(800) 753-7372 www.copera.org
	Fire & Police Protective Assoc. (FPPA)	(800) 332-3772 www.fppaco.org
	ICMA-RC Services, LLC – Don Eschbach	(866) 749-5174 deschbach@icmarc.org

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 City Council discretion. Specific details are available at 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.

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.

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

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.

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, 2016. Contact your State for more information on eligibility –

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidprecovery.com/hipp/ Phone: 1-877-357-3268
ALASKA – Medicaid	GEORGIA – Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ARKANSAS – Medicaid	INDIANA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.hip.in.gov Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Medicaid	IOWA – Medicaid
Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	Website: http://www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562

KANSAS – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
KENTUCKY – Medicaid	NEW JERSEY – Medicaid and CHIP
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
LOUISIANA – Medicaid	NEW YORK – Medicaid
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MAINE – Medicaid	NORTH CAROLINA – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	NORTH DAKOTA – Medicaid
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MINNESOTA – Medicaid	OKLAHOMA – Medicaid and CHIP
Website: http://mn.gov/dhs/ma/ Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MISSOURI – Medicaid	OREGON – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
MONTANA – Medicaid	PENNSYLVANIA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/hipp Phone: 1-800-692-7462
NEBRASKA – Medicaid	RHODE ISLAND – Medicaid
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633	Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300
NEVADA – Medicaid	SOUTH CAROLINA – Medicaid
Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: http://www.scdhhs.gov Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	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	WEST VIRGINIA – Medicaid
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
UTAH – Medicaid and CHIP	WISCONSIN – Medicaid and CHIP
Website: Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	WYOMING – Medicaid
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	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, 2016, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/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.