

City of Colorado Springs

Health Reimbursement Account Program

Section 105

Plan Document

Effective: January 1, 2012

Restated: January 1, 2014

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INTRODUCTION

The City of Colorado Springs, (herein referred to as the Employer and/or Plan Administrator), hereby establishes this Section 105 Health Reimbursement Account (HRA) program, in order to permit reimbursement of certain Health Care Expenses. The HRA program is intended to be a self-funded health reimbursement account plan under Code Section 105, so that all benefits payable hereunder are excluded from gross income. Employees do not contribute to the HRA program, and this HRA program does not interact with a Section 125 cafeteria plan in such a way to permit employees to use salary reduction to indirectly fund the HRA. In no event will benefits be provided in the form of cash or any other taxable or nontaxable benefit, except for reimbursement as provided in this plan. The HRA program shall not be deemed to constitute a contract between the Entity and any employee. Subject to the above, the HRA program is governed by the terms, provisions and conditions described herein.

The HRA program is effective January 1, 2014.

If there is any difference between information described in this Program Summary and the rules, regulations, and interpretations per Section 105 of the Internal Revenue Code, the rules, regulations and interpretations will control.

HEALTH REIMBURSEMENT ACCOUNT

The HRA allows you to be reimbursed for qualifying medical, dental, and/or vision out of pocket health expenses incurred by you and your eligible dependents that are not reimbursable under the medical health insurance plan. You are reimbursed tax free for qualified medical expenses up to your available account balance. The HRA program is designed to empower you to have control over your current and future health care needs

The HRA is funded through the employee benefit health fund. The amount of the HRA may vary from year to year depending on the plan design and overall plan experience.

Special rules apply to the types of expenses eligible for reimbursement under the HRA plan. This document provides guidelines for using this type of account and lists some possible eligible expenses. If you have questions about the HRA program, contact the Plan Administrator:

The City of Colorado Springs
City Human Resources Benefits & Wellness
30 South Nevada, Suite 702
P.O. Box 1575, Mail Code 702
Colorado Springs, CO 80901
(719) 385-5125

ELIGIBILITY

Eligibility for the HRA is as follows:

- If you are a regular, probationary, or special employee of the Employer and are scheduled to work 20 hours or more each week
- You must be enrolled in the City of Colorado Springs Advantage Plan
- Employees become eligible on Jan. 1 of the plan year following their open enrollment election.
- HRA funding is based on the dependent tiers elected and will be available to employees effective Jan. 1 following open enrollment.
- HRA funding will be prorated on a monthly basis for new hires during the course of the plan year. Funding will be available on the same effective date as the Advantage Plan enrollment.
- HRA funding amount is established by enrollment as of January 1st or when first enrolled as a new hire. It does not change during the course of the plan year due to mid-year qualifying family status changes.

An employee must be actively enrolled in the City of Colorado Springs Advantage Plan to be eligible for any part of the HRA funding. If enrolled the Advantage Plan for the previous plan year but elect to enroll in a plan other than the Advantage Plan or Waive Medical coverage for the following plan year, you will forfeit your unused HRA balance. The HRA is a component of the medical plan; it does not operate independently as its own plan. The HRA is subject to COBRA; refer to Appendix A for more information.

Eligibility – Special Circumstances

1. Deceased employees: In the event an employee deceases, any remaining HRA balance in the deceased employees account at the time of death will be transferred to the surviving spouse's account, if a surviving spouse exists. The surviving spouse will not be entitled to any additional HRA funding unless a COBRA open enrollment medical plan election is made for the following plan year. As a result of a COBRA open enrollment medical election, additional HRA funds will be made available Jan. 1 of the following plan year, if applicable. In the event there is no surviving spouse, any remaining HRA balance amount is made available for reimbursement of eligible claims. Expenses can be reimbursed from Jan. 1 of the current year up to the date of death.
2. COBRA participants: Refer to Appendix A of this Plan document for details.
3. Both employees who are covered under the City of Colorado Springs' Advantage Medical plan with an HRA balance become **divorced or legally separated** through a mid-year qualifying event. The ex-spouse now elects medical plan coverage on the Advantage Plan and is entitled to the same HRA balance that the employee had at the time of divorce.

HOW THE HRA WORKS

You can use your HRA to pay for a variety of out of pocket expenses related to health care during the plan year or you can carry over your unused balance into subsequent years. The

maximum balance that can be accrued at any time is \$2500. If you qualify for any HRA funding, it will be posted on Jan. 1, following open enrollment. Below are the current HRA funding amounts for Jan. 1, 2014, and is subject to change annually.

Coverage Level	HRA Annual Funding
Employee Only	\$500
Employee + Spouse	\$750
Employee + Children	\$750
Employee + Family	\$750

- If you enroll in the City of Colorado Springs Advantage Medical Plan with Employee Only coverage, you will be entitled to the HRA Employee Only funding amount.

- If you enroll in the City of Colorado Springs Advantage Medical Plan under Employee & Spouse, Employee & Child(ren), or Employee & Family coverage tiers, you will be entitled to the HRA Employee + Spouse, Employee + Child(ren) or Employee + Family funding amounts, which is the same amount for these tiers.

- As an active employee, on Jan. 1, you will have access to the full amount in your HRA account to pay for out-of-pocket health expenses that qualify for reimbursement.

- Per Internal Revenue Code, depending on eligible tax dependent status, civil union partners or their children may not qualify as eligible family members for reimbursement of HRA expenses. Exception to the exclusion may exist if persons have entered a same-sex marriage in a state recognizing such and file their federal income tax return under the married filing jointly or married filing separately status.

- When you and/or your eligible dependents incur eligible health expenses and if you want to be reimbursed from your HRA, you will need to submit a reimbursement claim form together with the original or copy of the itemized bill or receipt of the Explanation of Benefits (EOB) form from our claims processor. An expense is incurred when services are provided and not when the bill is sent or payment is made.

- Note: A dependent turning age 26 during the plan year loses eligibility for health care coverage at the end of the month in which they turn age 26.

- COBRA participants should reference Appendix A for details regarding HRA provisions.

Important note: If you also enrolled in a Health Care Spending Account (HCSA), claims will be reimbursed from your HCSA first, until your account balance is depleted, then claims will then be reimbursed from your HRA if you choose. You may choose not to utilize your HRA account dollars and carry your unused balance forward to subsequent plan years so long as you remain enrolled in the City of Colorado Springs Advantage Plan.

- Claim expenses in any amount may be submitted for processing.

- Claim reimbursements are processed daily by our spending account administrator.

SUBMITTING A CLAIM

You can submit a claim for an eligible health care expense at any time during the Plan Year. Obtain a reimbursement claim form from the claims administrator, Flores & Associates' web site at www.flores-associates.com. Once you obtain the form, fill it out, sign in the signature box under the authorization section, attach a copy of the original itemized bill or receipt for an expense not covered under your medical, dental, and/or vision plan or the explanation of benefits from the claims processor and fax to the claim administrator's toll free fax number (800) 726-9982 or mail to the address on the form. You may also choose to upload your claim form and receipts to Flores' web-site for processing. E-mailed claims are not accepted.

Important note: If you are also enrolled in a Health Care Spending Account, reimbursements will first be deducted from your HCSA until your total annual election amount is depleted. At that point, reimbursements will be taken from your HRA, if you choose. If you choose not to utilize your HRA account, you will need to check mark the box on the claim form(s) indicating **NOT** to reimburse expenses from your HRA.

The reimbursement form, when signed, provides your acknowledgement that you have not been reimbursed by any other insurance or benefit plan.

Flores & Associates
P.O. Box 31397
Charlotte, NC 28231-1397
Fax: (800) 726-9982

You must submit claims to Flores for reimbursement by March 31 (post marked date) following the end of the Plan year to be reimbursed for the previous Plan year's qualifying expenses.

ACCOUNT STATUS

You may use the Flores Information Center to view your current balance, track your claim and contribution history, download reimbursement claim forms, as well as view a list of allowable expenses at www.flores-associates.com. Access the participant section of the web site by using your assigned Personal Identification username (PID) plus your Personal Identification password (PIN). You may change your PIN number at anytime. If you have forgotten or misplaced your PID or PIN, you will need to contact Flores at 800-532-3327. For your protection, participants may no longer use Social Security Numbers to access Flores' website.

ELIGIBLE HEALTH CARE EXPENSES

Eligible health care expenses include most expenses that qualify as health care expenses under the Internal Revenue Code. A partial listing of eligible expenses follows. Items marked with an asterisk (*) may require additional documentation or reimbursement may be limited to the difference between a normal item and a special need item.

Deductibles, co-payments and charges which exceed "reasonable and customary" limits:

- *Office visit co-pays*

- *Coinsurance for diagnostic services, emergency room visits, outpatient surgery, hospital stays and prescriptions.*

Dental expenses:

- *Routine and preventive services*
- *X-rays*
- *Orthodontia and appliances*
- *Restorative and major services including fillings, crowns, implants, bridges*
- *Dentures*
- *Periodontal services*
- *Occlusal guards to prevent teeth grinding*

Vision expenses:

- *Exam (Optometrist or Ophthalmologist)*
- *Rx glasses and contact lenses including supplies (i.e., contact care solutions)*
- *Reading glasses*
- *Corrective surgery (RK & Lasik)*

Prescription expenses

- *Medications, vitamins, birth control pills and smoking cessation products.*
- *Weight loss program*
- *Over-the-Counter (OTC) medications with a prescription (non-prescription OTC medications are not reimbursable under the plan).*

Medical equipment:

- *Wheelchairs or lifts*
- *Crutches*
- *Oxygen equipment and supplies*
- *Air purifiers/filters**
- *Special beds or mattresses**
- *Blood pressure monitor*
- *Blood sugar monitor*
- *Ear plugs prescribed by a physician*
- *Medic alert bracelet or necklace*
- *Medical monitors and testing devices (e.g., syringes, glucose kits, etc)**

Mileage allowance will be reimbursed in accordance with the annual IRS annual limit. Reimbursement will be made for mileage incurred for driving to doctor's appointments, the hospital or outpatient treatment centers or to the pharmacy. Claims must submit substantiation such as a receipt for services on the same date, along with their claim for mileage. For the most current mileage reimbursement rate, visit Flores & Associates web-site at www.flores-associates.com.

Diabetic supplies including test strips, insulin, alcohol swabs, lancets, and testing equipment, etc.

Hearing expenses:

- *Testing*

- *Hearing aids; batteries and repairs*

Counseling and psychiatric treatment:

- *Psychiatrist, psychotherapist, psychologists*
- *Legal fees related to commitment of mentally ill person*

Therapy:

- *Treatment for alcoholism or drug/chemical dependency*
- *Physical therapy or Speech therapy*

Physical examinations:

- *School and work physicals*
- *Annual physical exam including pap smears, mammograms and prostate screening*

Assistance for disabled persons:

- *Braille or other special books/items or cost of specially equipping home or care for access by disabled person*
- *Guide animals (purchase and care)*
- *Special alert systems*
- *Learning disability (special school or specifically trained teacher)*
- *Language training for disabled child*

Fees and services:

- *Physicians, surgeons, anesthesiologists, OB/GYN, nursing, other specialists*
- *Ambulance (Air & Ground)*
- *Fertility treatment (except expense paid to or for an in-vitro surrogate)*
- *Sterilization and reversals*
- *Legal abortion*
- *Medically necessary cosmetic services (i.e., following accident or mastectomy, etc.)*
- *Flu shots and immunizations*

Alternative/holistic services: medically necessary treatment by licensed or certified practitioners including acupuncture and massage therapy.

Other:

- *Medical records*
- *Travel necessary to seek medical treatment (limitations apply)*
- *Organ/tissue donation expenses*
- *Orthotics, prosthesis, artificial limbs*
- *Disability tests and consultations*
- *Non-medicated band-aids or gauze*
- *First-aid kits that do not contain any medication or medicated adhesives/coverings within the kit.*

If you use the HRA to pay for a particular health care expense, you cannot claim the same expense as a deduction on your income tax return.

If you receive a reimbursement from your HRA and reimbursement for the same expense through your medical or dental coverage or another health care plan, you must refund the reimbursement you received from your HRA to the Plan.

HEALTH CARE EXPENSES NOT ELIGIBLE FOR REIMBURSEMENT

Not all health care expenses are eligible for reimbursement from your health reimbursement spending account. Here are some examples of expenses, which are **not** eligible for reimbursement:

- Over-the-counter medications without a written prescription.
- Cosmetic expenditures (e.g., teeth whitening/bleaching, dermabrasion, chemical peels or spider vein treatment).
- General wellness expenses that are merely beneficial to the general health (e.g., health club dues, special foods, exercise programs and equipment, or weight loss programs, non-prescription eyewear, sunglasses or clips).
- Insurance premiums (e.g., replacement insurance for contact lenses or other health plan policies).
- Shipping & handling charges (other than for prescription medications), missed appointments, late payments or interest charges.
- Marriage/family counseling

TERMINATION OF PARTICIPATION

The coverage of any Covered Person shall terminate the earlier of the following dates:

- a. On an annual basis during Open Enrollment Cover Person may elect to opt-out of the Plan while still enrolled in the Advantage Plan;
- b. The date the Plan terminates;
- c. The date the Group Health Plan terminates; or
- d. The date the Covered Person ceases to be covered by the Group Health Plan, unless coverage is continued under this Plan pursuant to a COBRA election.

UNUSED HRA BALANCE

Any unused monies in your HRA at the end of the Plan Year will be rolled over for use during the following plan year(s) after the claims run out period (March 31), so long as you are actively enrolled as an employee in the City of Colorado Springs Advantage Medical Plan and remain an active employee of the City of Colorado Springs. The maximum balance that can be accumulated is two thousand five hundred dollars (\$2500.00). If you opt-out of the Plan remaining monies will be forfeited after the claims run out period (March 31).

CONTINUATION DURING LEAVE OF ABSENCE

If a participant goes on an FMLA leave, coverage under this HRA program shall continue if coverage continues under the Group Health Plan, as allowed by the FMLA. If the leave of absence is not covered by the FMLA for any reason, then coverage under this HRA

program shall continue if coverage under the Group Health Plan continues. Further, coverage under this program shall continue as required by the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (“USERRA”).

TERMINATION OF EMPLOYMENT

Under separation of employment, you forfeit any unused HRA amounts left in your account. When employment ends, you may request reimbursement of eligible expenses incurred through the end of the month in which your coverage terminates; however claims must be submitted for reimbursement by March 31 (90 days) following the close of the plan year. Under separation, if you elect COBRA continuation of coverage, you will have access to any monies that were remaining in your HRA as of the last day of the month in which you separated or in the date that your benefits terminated.

ADDITIONAL CLAIM REQUIREMENTS

Claims must be filed within 90 days after the end of the Plan year in which expenses were incurred. If not filed in a timely manner the Plan will not reimburse the expense.

Within 30 days after receipt by the Claims Administrator of a claim for reimbursement, the Plan will make reimbursement for Medical Care Expenses that are payable by the Plan. If the expense submitted is not reimbursable by the Plan, the Participant will be notified within 30 days that his or her claim has been denied.

The 30-day period described above may be extended for up to 15 days if necessary due to matters beyond the control of the Plan, including situations where a reimbursement claim is incomplete. A written notice of any 15-day extension will be provided prior to the expiration of the initial 30-day period. An extension notice will describe the reasons for the extension and the date a decision on the claim is expected to be made. If the extension is necessary due to failure of the claimant to submit information necessary to decide the claim, the notice of extension will describe the required information and will allow the Participant 45 days from receipt of the notice in which to provide the required information. In the meantime, any decision on the claim will be suspended.

If a claim is denied, the Participant will be provided with a written or electronic notification identifying (1) the specific reason or reasons for the denial, (2) reference to the specific plan provisions on which the denial is based, (3) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary, (4) a description of the plan’s review procedures and the time limits applicable to such procedures, following a denial on review; and (5) if an internal rule, guideline, protocol, or similar criteria was relied on in making the determination, you will be provided either the specific rule, guideline, protocol, or other similar criteria, or you will be given a statement that such a rule, guideline, etc., was relied on and that a copy of the rule, guideline, etc., will be provided free of charge upon request. If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant’s medical circumstances, or a statement that such explanation will be provided free of charge on request.

APPEAL PROCESS

In the event a claim for benefits is denied, the claimant or his or her duly authorized representative may appeal the denial to the Plan Administrator (the "Entity") within 180 days after receipt of written notice of the denial. If the claimant has had no response to the initial filed claim within 30 days (including a notice indicating that an extension to decide the claim is necessary), then the claim shall be deemed denied, and an appeal must be filed, if at all, within 180 days of the deemed denial, in accordance with this paragraph. The appeal process described here must be followed, or you will lose the right to appeal the denial. In pursuing an appeal, the claimant or the duly authorized representative:

- a. must request in writing that the Plan Administrator review the denial;
- b. may review (on request and free of charge) all documents, records, and other information relevant to the claim; and
- c. may submit written issues and comments, documents, records, and other information regarding the claim.

Your appeal will be reviewed by the Plan Administrator, and your written comments, documents, records, and other information you submitted will be taken into account. The review will not defer to the initial adverse determination, will not be conducted by the individual(s) who made the initial adverse determination, and will not be conducted by a subordinate of that individual(s). In deciding an appeal that is based in whole or in part on a medical judgment, the Plan Administrator shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This professional will be someone who was not involved with the initial denial, nor the subordinate of anyone who was involved with the initial denial. On request, the identification of the medical expert whose advice was obtained will be provided, without regard to whether the advice was relied upon.

The decision on review shall be made in writing within 60 days after receipt of your appeal. If the decision on review is adverse to you, the written decision will be written in a manner calculated to be understood by the claimant, and will include (1) the specific reason or reasons for the adverse determination; (2) references to the specific plan provisions on which the denial is based; and (3) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim. If an internal rule, guideline, protocol, or other similar criteria was relied upon in making the decision, you will be provided either the specific rule, guideline, protocol, or other similar criterion, or you will be given a statement that such rule, guideline, etc., was relied upon and that a copy of the rule, guideline, etc. will be provided free of charge upon request. If the adverse decision is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

The claim and appeal procedures explained above will be interpreted consistent with regulations issued by the U.S. Department of Labor.

ADDITIONAL INFORMATION

Plan Administrator:

The City of Colorado Springs
City Human Resources Benefits & Wellness
30 South Nevada, Suite 702
P.O. Box 1575, Mail Code 702
Colorado Springs, CO 80901
(719) 385-5125

Claims Administrator:

Flores & Associates, LLC
Post Office Box 31397
Charlotte, NC 28231-1397
(800) 532-3327

COBRA Administrator:

AmeriBen/IEC Group
P.O. Box 7186
Boise, ID 83707
(800) 786-7930

HIPAA Privacy and Security Officer:

The City of Colorado Springs
Human Resources Director
30 South Nevada, Suite 702
P.O. Box 1575, Mail Code 702
Colorado Springs, CO 80901
(719) 385-5904

Plan Year:

The Plan's fiscal records are kept on a Calendar Year basis beginning on January 1 and ending on December 31.

Continuation coverage under COBRA is at all times subject to the rules and regulations under COBRA. The Plan Administrator reserves the right to terminate your COBRA coverage retroactively if you are determined to be ineligible.

Type of Plan

The Plan is authorized under Section 105(h) of the Internal Revenue Code. It reimburses specific medical expenses as described herein.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified above. For more information about your rights including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa.

Name of the Plan

The City of Colorado Springs Section 105 Health Reimbursement Plan.

Eligibility and benefits under the Plan

The requirements for eligibility, participation, and benefits are described in the preceding sections. The Plan reimburses limited medical expenses as described above. The procedures governing claims for benefits, for filing claim forms, and requesting an appeal and review of denied claims are described in the preceding sections. Circumstances that may result in ineligibility, loss of benefits, offset, etc. are described in the preceding pages.

Plan's records

Records are maintained for a Plan Year for the maximum number of years required by law.

Acceptance of Legal Notice

The Plan is a legal entity. Legal notices may be filed with, and legal process served as provided below. Service of legal process may also be made on the Plan Administrator.

Legal Service

The agent for service of legal process for the Employer's Health Reimbursement Account Plan is:

City Attorneys Office
PO Box 1103
Colorado Springs, CO. 80947-0940
(719) 668-8032

Future of the Plan

The City of Colorado Springs intends to continue this Plan indefinitely. However, the Entity reserves the right to change or terminate the Plan at any time without the consent of any participant or beneficiary. The Entity or any authorized officer or representative of the Entity can make changes to or terminate the Plan. The following officer(s) or representatives of the Entity may change or terminate the Plan: The City of Colorado Springs Human Resources Director or their designee. Participants will be appropriately notified of any changes or termination.

Certain members of the *employer's* workforce perform services in connection with administration of the Plan. In order to perform these services, it is necessary for these employees from time to time to have access to Protected Health Information (as defined below).

COMPLIANCE WITH HIPAA PRIVACY STANDARDS

Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), these employees are permitted to have such access subject to the following:

1. **General.** The Plan shall not disclose Protected Health Information to any member of the *employer's* workforce unless each of the conditions set out in this HIPAA Privacy section is met. "Protected Health Information" shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information

about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.

2. **Permitted Uses and Disclosures.** Protected Health Information disclosed to members of the *employer's* workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. "Health care operations" generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of health care providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities. Genetic information will not be used or disclosed for underwriting purposes.
3. **Authorized Employees.** The Plan shall disclose Protected Health Information only to members of the *employer's* workforce who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Plan. For purposes of this HIPAA Privacy section, "members of the *employer's* workforce" shall refer to all employees and other persons under the control of the *employer*.
 - a. **Updates Required.** The *employer* shall amend the Plan promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.
 - b. **Use and Disclosure Restricted.** An authorized member of the *employer's* workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.
 - c. **Resolution of Issues of Noncompliance.** In the event that any member of the *employer's* workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including:
 - i. Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;
 - ii. Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include, oral or written reprimand, additional training, or termination of employment;
 - iii. Mitigating any harm caused by the breach, to the extent practicable; and

- iv. Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.
4. **Certification of Employer.** The *employer* must provide certification to the Plan that it agrees to:
- a. Not use or further disclose the Protected Health Information other than as permitted or required by the Plan documents or as required by law;
 - b. Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the *employer* with respect to such information;
 - c. Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the *employer*;
 - d. Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law;
 - e. Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;
 - f. Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;
 - g. Make available the Protected Health Information required to provide any accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;
 - h. Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;
 - i. If feasible, return or destroy all Protected Health Information received from the Plan that the *employer* still maintains in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible; and
 - j. Ensure the adequate separation between the Plan and member of the *employer's* workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards.

COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS

Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"), the *employer* agrees to the following:

1. The *employer* agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the *employer* creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.
2. The *employer* shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.
3. The *employer* shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Compliance with HIPAA Privacy Standards provisions (3) Authorized Employees and (4) Certification of Employers described above.

Breach Notification for Unsecured Protected Health Information.

Pursuant to HIPAA Privacy Regulations effective September 23, 2009, an Interim Final Rule requires notification process when a "breach" has occurred. The Act defines "breach" to mean, generally, the unauthorized acquisition, access, use, or disclosure of protected health information which compromises the security or privacy of such information. The Act provides exceptions to this definition to encompass disclosures where the recipient of the information would not reasonably have been able to retain the information, certain unintentional acquisition, access, or use of information by employees or persons acting under the authority of a covered entity or business associate, as well as certain inadvertent disclosures among persons similarly authorized to access protected health information at a business associate or covered entity.

APPENDIX A—COBRA CONTINUATION OF COVERAGE

A federal law known as COBRA requires that most employers--generally, those with 20 or more employees--sponsoring group health plans offer employees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the terms of the Plan would otherwise end.

As an employee of The City of Colorado Springs covered by the Plan, you have a right to choose this continuation coverage if you are enrolled in the City of Colorado Springs Advantage Plan with an HRA and you lose your coverage under the terms of the Plan because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part).

If you are the spouse of an employee covered by the Plan, you have the right to choose this continuation coverage if you are enrolled in the City of Colorado Springs Advantage Plan with an HRA and you lose your coverage under the terms of the Plan for any of the following three reasons:

1. The death of your spouse;
2. A termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment;
3. Divorce or legal separation from your spouse;

In the case of a dependent child of an employee covered by the Plan, he or she has the right to continuation coverage if he or she is enrolled in the City of Colorado Springs Advantage Plan with an HRA and coverage under the terms of the Plan is lost for any of the following five reasons:

1. The death of a parent;
2. A termination of a parent's employment (for reasons other than gross misconduct) or reduction in a parent's hours of employment;
3. Parents' divorce or legal separation;
4. A parent becomes entitled to Medicare;
5. The dependent ceases to be a "dependent child" under the terms of the Plan.

Individuals described above who are entitled to COBRA continuation coverage are called qualified beneficiaries. If a child is born to a covered employee, or if a child is, before age 18, adopted by or placed for adoption with a covered employee during a period of COBRA continuation coverage, the newborn or adopted child is also a qualified beneficiary. These new dependents can be added to COBRA coverage upon timely notification, in accordance with the terms of the Plan.

HRA Balances Under COBRA

Each qualified beneficiary who elects continuation of coverage of health coverage under COBRA, will be entitled to and have access to any monies that were remaining in the employee's HRA as of the last day of the month in which the employee separated or in the date that benefits terminated.

Under the law, the employee or a family member has the responsibility to inform the Plan Administrator of a divorce, legal separation, or a child losing dependent status under the terms of the Plan. This information must be provided within 60 days of the later of the event or the date on which coverage would end under the terms of the Plan because of the event. If the information is not provided within 60 days, rights to continuation coverage under COBRA will end. The employer has the responsibility to notify the Plan Administrator of the employee's death, termination of employment, or reduction in hours or Medicare entitlement.

When the Plan Administrator is notified that one of these events has happened, the Plan Administrator will in turn notify you that you have the right to choose continuation coverage. Under the law, you have 60 days from the later of the date you are notified of your rights or the date you would lose coverage because of the one of the events described above to inform the Plan Administrator that you want continuation coverage.

If you do not choose continuation coverage in a timely manner, your group health insurance coverage will end. COBRA continuation coverage is not available to any covered individual if coverage is lost due to termination of employment for gross misconduct.

If you choose continuation coverage, the employer is required to give you coverage which, as of the time coverage is being provided, is identical to the coverage provided under the Plan to similarly situated employees or family members. The terms of the coverage are governed by the Plan documentation, which is available upon request from the Plan Administrator in the event you have misplaced your documentation.

Continuation coverage will be cut short for any of the following reasons:

1. The employer no longer provides group health coverage to any of its employees.
2. The premium for your continuation coverage is not paid on time;
3. You become covered under another group health plan which does not contain any exclusion or limitation with respect to any pre-existing condition you have or;
4. You become entitled to Medicare.

You do not have to show that you are insurable to choose continuation coverage. However, continuation coverage under COBRA is provided subject to your eligibility for coverage; the Plan Administrator reserves the right to terminate your COBRA coverage retroactively if you and/or your dependents are determined to be ineligible.

Under the law, you will have to pay all or part of the premium, plus a 2% administration fee, for your continuation coverage. There is a grace period of 30 days for payment of the regularly scheduled premium.

If You Have Questions

Questions about your rights under COBRA should be addressed to The City of Colorado Springs whose address and telephone number are provided in this document. For more information about your COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA

website at www.dol.gov/ebsa. Addresses and phone numbers of regional and district EBSA offices are available through EBSA's website.

Keep the Plan Informed of Address Changes

In order to protect your and your family's rights, you should update any changes in your address and the addresses of family members. You should also keep for your records a copy of any notices you send about COBRA.

ADOPTION

The City of Colorado Springs, hereby adopts the provisions of this plan, and its duly authorized officer has executed this plan document and summary plan description effective the first day of January, 2014.

By: Mrs. Suli
Title: Director, Human Resources

Date: January 3, 2014