



**Medical Benefit Plan
Plan Document**

**Amended and Restated
January 1, 2014**

TABLE OF CONTENTS

SECTION I— INTRODUCTION	1
SECTION II— SCHEDULE OF BENEFITS	4
A. Schedules of Benefits.....	4
B. Network and Non-Network Services	5
C. Schedule of Medical Benefits — Premier PPO Plan	7
D. Consumer Directed Health Plan (Advantage Plan).....	20
E. How does this Plan work?.....	20
F. How will the Administrators know when I've satisfied the Deductible?.....	20
G. Schedule of Benefits — Advantage Plan	21
H. Schedule of Prescription Drug Benefits — Premier PPO and Advantage Plan.....	34
I. Reach Your Peak Wellness Program	35
SECTION III— ELIGIBILITY	37
A. Eligibility Requirements.....	37
B. Medicare Part D Prescription Drug Plans for Medicare Eligible Participants.....	41
C. Funding	41
D. How does payment for my coverage work?	41
E. Enrollment	41
F. Waiving Medical Coverage.....	42
G. Change in Status	42
H. Special Enrollment Periods	42
I. Open Enrollment.....	44
J. Restrictions on Elections during <i>Open Enrollment</i>	44
K. Failure to Make a New Election During Open Enrollment	44
L. National Medical Support Notice (NMSN) Special Rule for Enrollment.....	44
M. Effective Date	45
N. Termination of Coverage.....	46
O. Family and Medical Leave Act/Family Care Act	47
P. Active Military Duty.....	47
Q. Leave of Absence.....	48
R. Reinstatement of Coverage After Leaves of Absence.....	48
SECTION IV— MEDICAL BENEFITS	49
A. Deductible	49
B. Co-Insurance.....	49
C. Co-Payments.....	49
D. Benefit Payment.....	49
E. Out-of-Pocket Maximum	49
F. Wellness Program Notice.....	49
G. Women's Health and Cancer Rights Act of 1998 (WHCRA).....	50
H. Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) – Effective Jan. 1, 2010	50
I. Autism Colorado State Law – effective Jan 1, 2011	50
J. Eligible Medical Expenses	51
K. Medical Plan Exclusions	56
SECTION V— HEALTH CARE MANAGEMENT PROGRAM.....	62
A. Utilization Review	62
B. How the Program Works	63
C. Penalty for Failure to Pre-Certify	63
D. Retroactive Review.....	64
E. Concurrent Review and Discharge Planning.....	64
F. Second and/or Third Opinions.....	64
G. Preadmission Testing Service.....	64
H. Ambulatory Surgery.....	64
I. Case Management.....	65
J. Special Care Case Management.....	65

K.	Special Rules Regarding Maternity and Newborns	65
L.	Second and/or Third Opinion Program	66
M.	Concurrent (Continued Stay) Review	66
N.	Retrospective Certification.....	67
O.	Diabetes Ten City Challenge.....	67
SECTION VI— DISEASE MANAGEMENT PROGRAM.....		68
A.	How the Disease Management Program Works	68
B.	Managing Chronic Conditions.....	68
C.	How to Enroll	68
SECTION VII— MATERNAL HEALTH PROGRAM.....		69
A.	How it Works.....	69
B.	How to Enroll	69
SECTION VIII— CLINICAL TRIALS		70
A.	Approved Clinical Trial	70
B.	Qualified Individual or Qualified Participant.....	70
C.	Life-Threatening Condition.....	70
D.	Limitations on Coverage	71
SECTION IX— TRANSPLANT PROGRAM.....		72
A.	What is the Transplant Program?.....	72
B.	Program Benefits.	72
C.	Requirements.....	72
SECTION X— PHARMACY BENEFIT MANAGEMENT PROGRAM.....		74
A.	Purpose of the Pharmacy Benefit Management (PBM) Program	74
B.	The Pharmacy Benefit Manager (PBM) is MAXORPLUS.....	74
C.	MAXORPLUS Preferred Network	74
D.	The City Employee Pharmacy Program.....	74
E.	MAXORPLUS Preferred Drug Formulary.....	75
F.	Generic Medications	75
G.	Days’ Supply and Refills.....	75
H.	Covered Drugs	75
I.	Quantity Limitations	76
J.	Additional Prior Authorizations.....	76
K.	Limitations.....	76
L.	Exclusions	76
M.	Specialty Pharmacy.....	77
N.	Prior Authorization (PA).....	78
O.	Claims Procedures	78
P.	Appeals Procedures.....	78
Q.	Using a Non-participating or Out-of-Network Pharmacy (Very Important Information).....	80
R.	Emergencies (Very Important Information)	80
SECTION XI— CLAIMS AND APPEALS.....		82
A.	Assignment of Benefits	82
B.	Filing Non-Urgent Pre-Service Claims	82
C.	Filing Urgent Care Claims.....	82
D.	Filing Post-Service Claims	82
E.	Status of Benefit Verifications.....	83
F.	Notification of Benefit Determinations.....	83
G.	Concurrent Care Claims	84
H.	National Medical Support Notice (NMSN).....	86
I.	Notification of Adverse Benefit Determination.....	86
J.	Appeals.....	87
K.	Time Period for Deciding Appeals	88
L.	Notification of Appeal Denials.....	88
M.	Second Level Appeal of Post-Service Claims	89

N.	External Review Rights.....	89
O.	External Review of Claims.....	90
P.	Limitation on When a Lawsuit May Be Started	92
Q.	Workers' Compensation.....	92
SECTION XII— COORDINATION OF BENEFITS		93
A.	Coordination of the Benefit Plans.....	93
B.	Benefit Plan.....	93
C.	Allowable Charge	93
D.	General Limitations.....	93
E.	Automobile Limitations	93
F.	Benefit Plan Payment Order.....	94
G.	Claims Determination Period	95
H.	Right to Receive or Release Necessary Information.....	95
I.	Facility of Payment	95
J.	Right of Recovery.....	95
SECTION XIII— REIMBURSEMENT AND RECOVERY PROVISION		96
A.	Right of Subrogation and Refund	96
B.	Amount Subject to Subrogation or Refund	96
C.	Recovery from Another Plan.....	96
D.	Rights of <i>Plan Administrator</i>	96
SECTION XII – CONTINUATION COVERAGE RIGHTS UNDER COBRA.....		97
A.	What is COBRA Continuation Coverage?.....	97
B.	Who Can Become a Qualified Beneficiary?.....	97
C.	What is a Qualifying Event?.....	98
D.	What Factors Should be Considered when Determining to Elect COBRA Continuation Coverage?.....	98
E.	What is the Procedure for Obtaining COBRA Continuation Coverage?	99
F.	What is the Election Period and How Long Must it Last?	99
G.	Is a Covered Employee or Qualified Beneficiary Responsible for Informing the Plan Administrator of the Occurrence of a Qualifying Event?	99
H.	What is a Notice of Unavailability of COBRA Continuation Coverage?	100
I.	Is a Waiver Before the End of the Election Period Effective to End a Qualified Beneficiary's Election Rights?	100
J.	Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare?	100
K.	When May a Qualified Beneficiary's COBRA Continuation Coverage be Terminated?.....	100
L.	What are the Maximum Coverage Periods for COBRA Continuation Coverage?.....	101
M.	Under What Circumstances Can the Maximum Coverage Period be Expanded?	102
N.	How Does a Qualified Beneficiary Become Entitled to a Disability Extension?	102
O.	Does the Plan Require Payment for COBRA Continuation Coverage?.....	102
P.	Must the Plan Allow Payment for COBRA Continuation Coverage to be Made in Monthly Installments?.	102
Q.	What is Timely Payment for Payment for COBRA Continuation Coverage?.....	102
R.	Must a Qualified Beneficiary be Given the Right to Enroll in a Conversion Health Plan at the End of the Maximum Coverage Period for COBRA Continuation Coverage?.....	103
S.	If You Have Questions.....	103
T.	Keep Your Plan Administrator Informed of Address Changes	103
U.	If You Wish to Appeal	103
SECTION XIV— RESPONSIBILITIES FOR PLAN ADMINISTRATION.....		104
A.	Plan Administrator	104
B.	Duties of the <i>Plan Administrator</i>	104
C.	Plan Administrator Compensation	104
D.	Third Party Administrator is Not a Fiduciary.....	104
E.	Discretionary Authority of Medical Claims Administrator and Designees.....	104
F.	Fiduciary.....	104
G.	Fiduciary Duties.....	105
H.	The Named Fiduciary.....	105

I.	Facility of Payment	105
SECTION XV— ADDITIONAL PLAN INFORMATION		106
V.	Funding the Plan and Payment of Benefits	106
W.	Plan is Not an Employment Contract.....	106
X.	Clerical Error	106
Y.	Amending and Terminating the Plan	106
Z.	Your IMPORTANT Notice Obligations (When COBRA is available)	106
AA.	Death or Incompetence.....	107
SECTION XVI— DEFINED TERMS		108
SECTION XVII— COMPLIANCE WITH HIPAA PRIVACY STANDARDS		126
BB.	Compliance With HIPAA Privacy Standards.....	126
CC.	Compliance With HIPAA Electronic Security Standards	127
DD.	Breach Notification for Unsecured Protected Health Information.....	128
SECTION XVIII— GENERAL PLAN INFORMATION		129
A.	Type of Administration	129
B.	Employer	129
C.	Plan Name	129
D.	Plan Number	129
E.	Plan Year	129
F.	Plan Effective Date	129
G.	Type of Plan	129
H.	Plan Funding.....	129
I.	Trustees	129
J.	Plan Sponsor	130
K.	Plan Administrator	130
L.	Title and Address of HIPAA Privacy and Security Officers	130
M.	Third Party Administrator	130
N.	Employer’s Right to Terminate	130
O.	Adoption.....	131

SECTION I—INTRODUCTION

The City of Colorado Springs, (herein referred to as *City*) provides medical benefits to certain eligible *employees* as described in this Plan. This document constitutes the Medical Benefits Plan for eligible *employees* and *dependents* of the *employer*. The *City* is collectively referred to herein as the *employer* and *Plan Administrator*. The Medical Benefits Plan, herein referred to as the Plan, described in this document is effective as of January 1, 2014. If you have declined any of the coverages described in this document, the chapters pertaining to those declined coverages do not apply to you.

This document is a description of The City of Colorado Springs Medical Benefit Plan (the Plan). No oral interpretations can change this Plan. The Plan described is designed to protect *participants* against certain catastrophic health expenses.

Coverage under the Plan will take effect for an eligible *employee* and designated *dependents* when the *employee* and such *dependents* satisfy the waiting period and all the eligibility requirements of the Plan.

The City of Colorado Springs fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue, or amend the Plan at any time and for any reason.

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, *deductibles*, maximums, *co-payments*, exclusions, limitations, definitions, eligibility, and the like.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, utilization review or other cost management requirements, lack of *medical necessity*, lack of timely filing of *claims* or lack of coverage. These provisions are explained in summary fashion in this document; additional information is available from the *Plan Administrator* at no extra cost.

Read your benefit materials carefully. Before you receive any services you need to understand what is covered and excluded under your benefit plan, your cost-sharing obligations and the steps you can take to minimize your *out-of-pocket* costs.

Review your Explanation of Benefits (EOB) forms, other *claim* related information and available *claims* history. Notify the *Claims Administrator* of any discrepancies or inconsistencies between amounts shown and amounts you actually paid.

The Plan will pay benefits only for the expenses *incurred* while this coverage is in force. No benefits are payable for expenses *incurred* before coverage began or after coverage terminated. An expense for a service or supply is *incurred* on the date the service or supply is furnished.

As the Plan is amended from time to time, the *Plan Administrator* will send you information explaining the changes. If those later notices describe a benefit or procedure that is different from what is described here, you should rely on the later information.

Neither this Plan nor The City of Colorado Springs provides or ensures quality of care. *Employees* always have the choice of services you receive and choice of *providers* regardless of what the Plan covers or pays.

The Plan, *Plan Administrator* or any of their designees are **not** engaged in the practice of medicine, nor do any of them have any control over any diagnosis, treatment, care or lack thereof, or any health care services provided or delivered to you by any health care provider. Neither the Plan, *Claims Administrator*, nor any of their designees, will have any liability whatsoever for any loss or *injury* caused to you by any health care *provider* by reason of negligence, by failure to provide care or treatment, or otherwise.

This document summarizes the *Plan* rights and benefits for covered *employees* and their *dependents* and is divided into the following parts:

1. **Schedule of Benefits.** Provides an outline of the *Plan* reimbursement formulas as well as payment limits on certain services.
2. **Eligibility, Funding, Effective Date and Termination.** Explains eligibility for coverage under the *Plan*, funding of the *Plan* and when the coverage takes effect and terminates.
3. **Medical Benefits.** Explains when the benefit applies and the types of charges covered and medical plan exclusions.
4. **Claim Provisions.** Explains the rules for filing a *claim* and the *claims* and *appeal* process.
5. **Coordination of Benefits.** Shows the *Plan* payment order when a person is covered under more than one (1) plan.
6. **Defined Terms.** Defines those *Plan* terms that have a specific meaning.

A copy of this document may be obtained from Human Resources at the *City* or may be found electronically on the *employer's* internet site (www.springsgov.com). This Plan in its entirety is not subject to ERISA regulations.

QUICK REFERENCE

WHO TO CALL FOR HELP OR INFORMATION

Call 444-CARE if you need advice from a nurse or need help finding an *in-network physician* accepting new patients. If you need further assistance, call the phone numbers listed in the following Quick Reference chart.

SERVICE PROVIDED & TYPE OF INFORMATION	CONTACT THE FOLLOWING:
<p><u>MEDICAL CLAIMS AND COBRA ADMINISTRATOR</u> Medical claim processing, COBRA Administration services, and producer of Certificates of Creditable coverage.</p>	<p>Vendor: AmeriBen Address: P.O. Box 7186, Boise, ID 83707-1186 Phone: 1-866-955-1482 Fax: 1-208-424-0595 Email: custserv@ameriben.com Website: www.myameriben.com</p>
<p><u>NETWORK ADMINISTRATOR</u> Preferred Provider Organization (PPO) network for in-network services and provider management.</p>	<p>Vendor: Anthem Address: P.O. Box 5747, Denver, CO, 80217-5747 Phone: 1-800-810-BLUE Website: www.anthem.com</p>
<p><u>CITY EMPLOYEE PHARMACY</u></p>	<p>City Employee Pharmacy 30 S. Nevada, Suite L04 MC 890 Colorado Springs, CO 80903 Refill line: 1-800-573-6214</p> <p align="right">Phone: 1-719-385-2261 Fax: 1-719-385-2264 Refill line: 1-800-573-6214</p>
<p><u>CITY EMPLOYEE MEDICAL CLINIC</u></p>	<p>City Employee Medical Clinic 30 S. Nevada, Suite 103 MC 135 Colorado Springs, CO 80903</p> <p align="right">Phone: 1-719-385-5841 Fax: 1-719-385-5842</p>
<p><u>UTILIZATION/MEDICAL MANAGEMENT VENDOR</u> Pre-Certification and medical reviews for certain outpatient and all inpatient care, as well as Medical Case Management & Health Management services.</p>	<p>Vendor: AmeriBen COMPASS Medical Management Address: P.O. Box 7186, Boise, ID 83707-1186 Phone: 1-800-383-3193 Fax: 1-877-955-3548 Website: www.myameriben.com</p>
<p><u>HEALTH MANAGEMENT VENDOR</u> A program designed to target certain high-risk chronic conditions, which may be helped by interventions from a professional health management counselor.</p>	<p>Vendor: AmeriBen COMPASS Medical Management Address: P.O. Box 7186, Boise, ID 83707-1186 Phone: 1-800-383-3193 Fax: 1-877-955-3548 Website: www.myameriben.com</p>
<p><u>MATERNAL HEALTH PROGRAM VENDOR</u> A program designed to provide education, support, and a personal nurse who will help you and your baby stay healthy and avoid complications—before, during and after your pregnancy.</p>	<p>AmeriBen COMPASS Medical Management Address: P.O. Box 7186, Boise, ID 83707-1186 Phone: 1-800-383-3193 Fax: 1-877-955-3548 Website: www.myameriben.com</p>
<p><u>PHARMACY BENEFIT MANAGEMENT VENDOR</u> Outpatient Prescription Drug Network. Prescription Drug Claims, Mail Order Program, Prior Authorization, Specialty Pharmacy and In-Network and Retail Pharmacy Providers.</p>	<p>Vendor: MaxorPlus (For City Medical Plan Participant Use <u>Only</u>) Address: 320 S. Polk Street, Suite 200 Amarillo, Texas 79101 Phone: 800-687-0707 Web site: www.maxor.com</p>

SECTION II—SCHEDULE OF BENEFITS

A. Schedules of Benefits

All benefits described in these schedules of benefits are subject to the exclusions and limitations described more fully herein including, but not limited to, the *Plan Administrator's* determination that: care and treatment is *medically necessary*, that charges are *reasonable and customary amounts*, that services, supplies and care are not *experimental/investigational*. The meanings of these italicized terms are in the **Defined Terms** section of this document.

The *Plan Administrator* retains the right to audit claims to identify treatment(s) that are, or were, not *medically necessary*; are, or were, *experimental*; are, or were, *investigational*; and are, or were, not *reasonable and customary*.

Pre-Certification

The following services must be *pre-certified* or **no benefits may be payable under the Plan**.

1. *pre-certification* of the *medical necessity* for the following listed non-emergency services before medical and/or surgical services are provided:
 - a. all *hospital* admissions (surgical and non-surgical), except maternity admissions
For emergency admissions (subject to extenuating circumstances), such authorization must be obtained within forty-eight (48) hours following admission.
 - b. partial hospitalization
 - c. all *substance abuse* treatment
 - d. *inpatient mental disorder* treatment
 - e. *outpatient mental disorder* treatment after twenty (20) visits
 - f. sleep apnea testing/sleep studies
 - g. *skilled nursing facility* / rehabilitation facility, long term acute care facility (LTAC) – not *custodial care*
 - h. weight loss *surgery*
 - i. *out-of-network* referrals for Premier PPO or Advantage plan *in-network* benefits only (when services are not available within the PPO network)
 - j. *outpatient* pediatric rehabilitation up to age ten (10)
 - k. hearing aids for children up to age eighteen (18)
 - l. all transplants and all other transplant procedures, including tissue, stem cell, and bone marrow
 - m. Botox injections
 - n. all foot care *surgeries*
 - o. all infusion medications given in a *physician's* office in which the medication is given from the *physician's* own supply
 - p. non-emergent oral/dental *surgery* where anesthesia is necessary
 - q. genetic testing and counseling
 - r. clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition

This Plan does not cover clinical trials related to other diseases or conditions. Refer to the Clinical Trials section for a further description and limitations of this benefit.

2. retrospective review of the *medical necessity* of the listed services provided on an *emergency* basis
3. concurrent review, based on the admitting diagnosis, of the listed services requested by the attending *physician*
4. certification of services and planning for discharge from a *medical care facility* or cessation of medical treatment

Please see the **Health Care Management Program** section in this booklet for details.

B. Network and Non-Network Services

Network Provider Information

The Plan has entered into an agreement with a Preferred Provider Organization (PPO), or a *network*. The Plan's Preferred Provider Organization (PPO) is a network of *hospitals physicians*, urgent care facilities, medical laboratories, and other *health care providers*, who have agreed to provide *medically necessary* services and supplies for favorable negotiated fees applicable only to *plan participants*. Therefore, when a *participant* uses a *network provider*, that *participant* will receive better benefits from the Plan than when a *non-network provider* is used. It is the *participant's* choice as to which *provider* to use.

A directory of *health care providers* who are members of the Plan's PPO *network* can be viewed online at www.anthem.com. *Physicians* and *health care providers* who participate in the Plan's PPO *network* are added and deleted during the year. At any time, you can find out if any *health care provider* is a member of the PPO by checking on the website address above.

Non-Network Provider Information

Non-network providers have no agreements with the *Plan* and are generally free to set their own charges for the services or supplies they provide. The *Plan* will reimburse the *plan participant* for the *allowed charges* for any *medically necessary* services or supplies, subject to the *Plan's deductibles, co-insurance, co-payments*, limitations and exclusions. *Plan participants* must submit proof of *claim* before any such reimbursement will be made. The *plan participant* may be balanced billed for charges over *reasonable and customary* amounts.

Before you obtain services or supplies from a *non-network* provider, you can find out whether the *Plan* will provide *network* or *non-network* benefits for those services or supplies by contacting the *Third Party Administrator*.

Choosing a Physician – Patient Protection Notice

The Plan does not require you to select a *primary care physician (PCP)* to coordinate your care and you do not have to obtain a referral to see a specialist.

You do not need prior authorization from the Plan or *Claims Administrator*, or from any other person (including your *PCP*) in order to obtain access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology. The health care *provider*, however, may be required to comply with certain procedures, including obtaining *pre-certification* for certain services, following a pre-approved treatment plan, or procedures for making referrals.

Under the following circumstances, the higher *network* payment will be made for certain *non-network* services:

- **Medical Emergency**. In a *medical emergency*, a *participant* should try to access a *network provider* for treatment. However, if immediate treatment is required and this is not possible, the services of *non-network providers* will be covered until the *participant's* condition has stabilized to the extent that they can be safely transferred to a *network provider's* care. At that point, if the transfer does not take place, *non-network* services will be covered at *non-network* benefit levels.
- **No Choice of Provider**. If, while receiving treatment at a *network* facility and/or a *network provider*, a *participant* receives ancillary services or supplies from a *non-network provider* or facility in a situation in which they have no control over *provider* or facility selection (such as in the selection of an emergency room physician, an anesthesiologist, or a provider for diagnostic services), such *non-network* services or supplies will be covered at *network* benefit levels.

Additional information about this option, as well as a list of *network providers*, will be given to *participants*, at no cost, and updated as needed.

Anthem Blue Cross Blue Shield, not The City of Colorado Springs, has selected the group of health care professionals and facilities for its network. *Network* doctors and *hospitals* are affiliated with the managed care vendor and have no contract with the City of Colorado Springs.

Additional information about this option, as well as a list of *network providers* is available by contacting the *network* using the information below. This list will include *providers* who specialize in obstetrics or gynecology.

You may obtain more information about the *providers* in the *network* by contacting the *network* by phone or by visiting their website.



P.O. Box 5747
Denver, CO 80217-5747

1-800-810-BLUE

www.anthem.com

And Click:
FIND A DOCTOR
(Hospital)

Regardless of how you access a directory, it is recommended that you (1) verify your provider's participation in the network before seeking treatment and (2) confirm PPO participation with your provider when making your appointment.

City Employee Medical Clinic

City employees and their covered family members enrolled in a City of Colorado Springs medical plan are able to access the City Employee Medical Clinic for a \$15 *co-payment*. Parking for medical clinic appointments is free provided customers park in the *City* garage located at 130 S. Nevada Ave.

This clinic does not replace the *employee's primary care physician* or existing urgent care facilities, but provides an additional option for receiving medical treatment by *City* members. Members accessing the clinic must present their medical ID card and their six (6) digit employee ID number at the time of service.

City Employee Pharmacy

City employees and their covered family members enrolled in a City of Colorado Springs medical plan are able to access the City Employee Pharmacy. The City Employee Pharmacy is located in the lower level of the City Administration Building, Room L04. There is only one (1) *pharmacy* location. Mail order and retail *pharmacy* sales are available at this location. Parking for prescription drop off and pick up is free provided customers park in the *City* garage located at 130 S. Nevada Ave.

C. Schedule of Medical Benefits — Premier PPO Plan

Premier PPO Medical Plan

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Lifetime Maximum The lifetime maximum includes prescription drug charges.		
Per participant	Unlimited	
Deductible The in-network deductible does not apply to services received at the City Employee Medical Clinic.		
Per participant	\$300	\$1,250
Per family	\$900	\$2,500
Out-of-Pocket Maximum The out-of-pocket-maximum amount includes co-payments and deductibles.		
Per participant	\$2,000	\$4,050
Per family	\$6,000	\$12,150

The Plan will pay the designated percentage of *covered expenses* until *out-of-pocket maximums* are reached, at which time the Plan will pay 100% of the remainder of *covered expenses* for the rest of the *benefit year* unless stated otherwise.

Note: The following charges do not apply toward the medical plan out-of-pocket expense amount:

- expenses not covered
- charges in excess of *reasonable and customary amounts*
- *prescription drug co-payments* and expenses

Note: The following charges do not apply to the plan year deductible:

- *alternative medicine*
- Health Management Programs
- hearing aids (pediatric)
- oxygen equipment and supplies
- substance abuse drug screenings
- Diabetes Care Management Program
- first \$50 for diagnostic lab and x-ray

Note: The plan out-of-pocket amounts accumulate separately for in-network and out-of-network services.

Note: The plan deductible amounts accumulate separately for in-network and out-of-network services.

Premier PPO Plan

COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
HOSPITAL SERVICES			
Emergency Services			All hospital admissions must be <i>pre-certified</i> within forty-eight (48) hours.
Emergency Room	\$150 <i>co-payment</i>	\$150 <i>co-payment</i> U&C will not apply	Other services, including <i>physician</i> fees (other than emergency room physician charges), diagnostic lab and radiology fees and expenses, <i>surgery</i> fees, and other fees <i>incurred</i> in connection with the emergency room charges will be reimbursed in accordance with the <u>Schedule of Medical Benefits</u> for such services.
Emergency Physician Services	100%	100%	
Urgent Care Facility	\$30 <i>co-payment</i> ; diagnostic and <i>surgical co-insurance</i> applies	\$60 <i>co-payment</i> ; diagnostic and <i>surgical co-insurance</i> applies	
Hospital Services (Inpatient and Outpatient)	75% after <i>deductible</i>	60% after <i>deductible</i>	<p><i>Pre-certification</i> is required for inpatient services.</p> <p>Room and board in semi-private rooms with general nursing services. Private room is covered only if <i>medically necessary</i> or if the facility does not provide semi-private rooms. Benefits will be limited to the cost of a semi-private room.</p> <p>If <i>pre-certification</i> is not obtained before services are provided, then no benefits may be payable under the Plan.</p>
Ambulatory Surgical Facility/Outpatient Surgery Facility	\$150 <i>co-payment</i> then 75% after <i>deductible</i>	60% after <i>deductible</i>	
PHYSICIAN SERVICES			
Allergy Testing	100% after <i>deductible</i>	60% after <i>deductible</i>	
Allergy Treatment			
Allergy Serum	75% after <i>deductible</i>	60% after <i>deductible</i>	
Desensitization and hypo- sensitization (allergy shots given at periodic intervals)	\$8 <i>co-payment</i> (single) or \$20 <i>co-payment</i> (multiple) then 100% after <i>deductible</i>	60% after <i>deductible</i>	Desensitization injections are covered only when provided by a licensed health care practitioner.

Premier PPO Plan

COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
PHYSICIAN SERVICES (continued)			
Alternative Medicine	50%	50%	<p>Services provided by and/or for <i>acupuncture</i>, massage therapy, dietician, nutritionist, chiropractic, homeopathic, and <i>naturopathic services</i>.</p> <p>Chiropractic services are only covered under the Alternative Medicine benefit. X-rays will be reimbursed under the Diagnostic Lab and X-ray benefit.</p> <p>Includes foot orthotics/corrective shoes and foot care expenses not otherwise eligible under this Plan.</p> <p>Itemized <i>claims</i> are not required for this benefit except for foot care.</p> <p>A license for a <i>provider</i> is <u>NOT required</u> in the state of Colorado for homeopathic and <i>naturopathic services</i>.</p> <p>Annual family maximum: \$1,000</p>
Ambulance Service	\$100 <i>co-payment</i> then 100%	\$100 <i>co-payment</i> then 100% U&C will not apply	
Blood Transfusions/ Autologous Donations	75% after <i>deductible</i>	60% after <i>deductible</i>	
Cardiac and Pulmonary Rehabilitation	\$30 <i>co-payment</i> then 100% after <i>deductible</i>	60% after <i>deductible</i>	Annual maximum: <i>Outpatient</i> pulmonary rehabilitation is limited to one hundred eighty (180) days per <i>injury</i> or <i>illness</i> combined with all other <i>outpatient</i> therapy.
Chemotherapy	100% after <i>deductible</i>	60% after <i>deductible</i>	
Radiation	100% after <i>deductible</i>	60% after <i>deductible</i>	

Premier PPO Plan

COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
PHYSICIAN SERVICES (continued)			
Colonoscopy			Payment includes all related charges at 100%.
Diagnostic	100% <i>deductible</i> waived	60% after <i>deductible</i> Subject to U & C	
Screening	100% <i>deductible</i> waived	60% after <i>deductible</i> Subject to U & C	Preventative Colonoscopy frequency shall be in accordance with the American Medical Association (AMA), U.S. Preventive Services Task Force (USPSTF), guidelines.
Compression stockings, Sleeves and Gloves	75% after <i>deductible</i>	60% after <i>deductible</i>	Annual maximum: Two (2) pair
Diabetes Care Management			100% deductible waived in-network benefit requires participation in on-going Diabetes Care Management.
Diabetic Insulin Pumps and Supplies	100% 75% after <i>deductible</i> if not participating in Diabetes Management	50% after <i>deductible</i>	75% after <i>deductible in-network</i> if there is no participation in on-going Diabetes Care Management. Includes repair, adjustment, or servicing of a pump beyond the normal warranty period. <i>Participants</i> must participate in the Diabetes Ten City Challenge or provide documentation, quarterly, of proof of ongoing diabetes care management no later than fifteen (15) days prior to the end of each quarter in the <i>calendar year</i> .
Diagnostic Labs and X-Rays	100% if for preventive service otherwise 100% up to \$50 per <i>calendar year</i> then 75% after <i>deductible</i>	60% after <i>deductible</i>	If diagnostic labs and x-rays are performed in conjunction with a preventive service listed on U.S. Preventive Service Task Force List A or B or preventive care for children under Bright Future guidelines, or additional women's preventive care services then the service is covered at 100%. For more information about preventive services please refer to the following website: https://www.healthcare.gov/what-are-my-preventive-care-benefits/

Premier PPO Plan

COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
PHYSICIAN SERVICES (continued)			
Dialysis	100% after <i>deductible</i>	60% after <i>deductible</i>	
Health Management Programs	100% <i>deductible</i> waived	Not Covered	To enroll in the program contact the Utilization/Medical Management Vendor.
Durable Medical Equipment	100% after <i>deductible</i>	60% after <i>deductible</i>	<p>Excludes oxygen and related equipment and supplies.</p> <p>Pediatric hearing aids covered at 75% up to age eighteen (18). <i>Pre-certification is required.</i></p> <p>Rental is paid up to allowable purchase price.</p> <p>In-network breast feeding equipment and related supplies will be covered at 100%-deductible waived and is limited to the rental or purchase of one (1) breast pump per pregnancy as prescribed by a physician.</p> <p>Annual maximum: unlimited with the exception of breast feeding equipment.</p>
Fertility/Infertility Services	75% after <i>deductible</i>	50% after <i>deductible</i>	<p>Evaluation, counseling and treatment for the <i>employee</i> and <i>spouse</i> only.</p> <p>Prescription drugs for fertility and infertility are not covered by the Plan.</p> <p>Medications to treat erectile dysfunction are covered under Maxor Plus with clinical prior authorization.</p>
Foot Care Services	75% after <i>deductible</i>	60% after <i>deductible</i>	<p><i>Pre-certification is required</i> for foot care <i>surgeries</i>.</p> <p>Expenses for routine and preventive services are not covered (See Alternative Medicine).</p>

Premier PPO Plan

COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
PHYSICIAN SERVICES (continued)			
Healthy Weight Management	75% after <i>deductible</i>	60% after <i>deductible</i>	<p><i>Pre-certification is required for weight loss surgery.</i></p> <p>Covers dietary counseling and weight loss <i>surgery</i> including pre-consultative physiological visit for weight loss <i>surgery</i>.</p> <p>Dietary counseling can be self-referred for the diagnosis of morbid obesity.</p> <p>The <i>Health Management Program</i> includes healthy weight management and dietary counseling. The <i>co-payment</i> and <i>deductible</i> for Health Management is waived.</p> <p>National Institutes of Health (NIH) criteria is used to determine if bariatric <i>surgery</i> is appropriate [candidate must either have a BMI greater than forty (40) or a BMI of thirty-five (35) to thirty-nine point nine (39.9) with serious co-morbidities].</p> <p>Initial consultation, post-operative <i>office visits</i> and associated <i>outpatient</i> diagnostic services will be paid according to the appropriate <u>Schedule of Medical Benefits</u> contained herein.</p> <p>Lifetime maximum: One (1) weight loss <i>surgery</i>.</p>
Hearing Aids (Pediatric)	75% <i>deductible</i> waived	60% after <i>deductible</i>	<p>Children up to age eighteen (18) who have been medically diagnosed with a congenital defect and/or a birth abnormality.</p> <p><i>Pre-certification is required.</i></p>
Home Health Care and Home Infusion	75% after <i>deductible</i>	60% after <i>deductible</i>	Covers up to two (2) hours in a twenty-four (24) hour period.
Hormone Pellet Implants	75% after <i>deductible</i>	60% after <i>deductible</i>	

Premier PPO Plan

COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
PHYSICIAN SERVICES (continued)			
Hospice Care	\$150 one-time <i>co-payment</i> then 100% after <i>deductible</i>	60% after <i>deductible</i>	<i>Hospice</i> care benefits include <i>inpatient</i> care, <i>physician's</i> services, <i>prescription drugs</i> , <i>home health care</i> services, emotional support services for the patient and the patient's family, bereavement services, and homemaker services.
Immunizations	100% if listed on Advisory Committee on Immunization Practices guidelines	60% after <i>deductible</i>	<p>Non-routine immunizations and injections due to <i>medical necessity</i>.</p> <p>If listed on Advisory Committee on Immunization Practices guidelines then the service is covered at 100% for <i>in-network</i> providers. For more information, refer to the following website: http://www.cdc.gov/vaccines/</p> <p>Botox injections must be pre-certified.</p> <p>Specialty and chronic injectables covered under the 4th and 5th tier of the pharmacy benefit, including oral chemotherapy medications must be obtained through Maxor Specialty Pharmacy.</p>
Inpatient Physician Visits	75% after <i>deductible</i>	60% after <i>deductible</i>	
Maternity			
Obstetrician/Physician	\$30 <i>co-payment</i> - PCP \$40 <i>co-payment</i> – Specialist then 100% after <i>deductible</i>	60% after <i>deductible</i>	<i>Co-payment</i> on first <i>office visit</i> only.
Nurse Midwife	\$30 <i>co-payment</i> - PCP \$40 <i>co-payment</i> – Specialist then 100% after <i>deductible</i> (<i>In-network</i> obstetrician affiliation only)	60% after <i>deductible</i>	
All other covered expenses billed by the physician for maternity care	75% after <i>deductible</i>	60% after <i>deductible</i>	

Premier PPO Plan

COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
PHYSICIAN SERVICES (continued)			
Medical Supplies	100% after <i>deductible</i>	60% after <i>deductible</i>	Supplies used in conjunction with <i>durable medical equipment</i> , ostomy supplies and tracheotomy tubes and related supplies. Ostomy supplies limited to a ninety (90) day supply at a time. Tracheotomy supplies include only tubing, gloves, mask, collar, and care kit.
Office Visits			
PCP	\$30 <i>co-payment</i> then 100% after <i>deductible</i>	60% after <i>deductible</i>	<i>Primary care physician (PCP)</i> is defined as general/family practice, internal medicine, OB/GYN, Doctor of Osteopathy (D.O.), pediatrics, physician's assistant and nurse practitioner if services are provided under the supervision of a <i>physician</i> . <i>Physicians</i> in other practice specialties are considered specialists.
Specialist	\$40 <i>co-payment</i> then 100% after <i>deductible</i>	60% after <i>deductible</i>	If a <i>primary care physician</i> also provides services as a specialist, those services will be treated as having been provided by a specialist for the purposes of this Plan.
Oxygen Equipment and Supplies	100%	60% after <i>deductible</i>	Not subject to rental limitations or plan year maximums.
Prosthetic and Orthotic Devices	100% after <i>deductible</i>	60% after <i>deductible</i>	One (1) pair of eyeglasses or contact lenses is covered as a prosthetic device following ocular <i>surgery</i> .
Reconstructive Services	75% after <i>deductible</i>	60% after <i>deductible</i>	Includes two (2) mastectomy bras and one (1) mastectomy camisole (with prostheses) each calendar year.

Premier PPO Plan

COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
PHYSICIAN SERVICES (continued)			
Rehabilitation Services			Includes speech, physical and occupational therapy.
Outpatient	\$30 <i>co-payment</i> then 100% after <i>deductible</i>	60% after <i>deductible</i>	<p>Annual maximum: <i>Outpatient</i> rehabilitation services limited to one hundred eighty (180) days per <i>injury</i> and <i>illness</i> combined with cardiac and pulmonary therapy.</p> <p>Annual Maximum: sixty (60) visits combined per <i>participant</i>.</p> <p>Pediatric rehabilitation therapy for <i>participants</i> up to age ten (10) limited to sixty (60) combined visits per plan year.</p>
Inpatient	75% after <i>deductible</i>	60% after <i>deductible</i>	<p>The level of benefits for occupational therapy, physical therapy, or speech therapy shall exceed the limit of sixty (60) visits per plan year if such therapy is <i>medically necessary</i> to treat autism spectrum disorders.</p> <p>Initial evaluation does not count toward maximums and is paid under <i>office visit</i>.</p> <p>Pre-Certification is required for pediatric rehabilitation therapy for pediatrics [up to age ten (10)].</p>
Skilled Nursing Facility	50% after <i>deductible</i>	50% after <i>deductible</i>	<p><i>Skilled nursing facility</i> and related prescriptions.</p> <p>Lifetime maximum: three hundred sixty-five (365) days.</p> <p>Pre-Certification is required.</p>
Spinal Manipulation			
Office Visit	\$30 <i>co-payment</i> then 100% after <i>deductible</i>	60% after <i>deductible</i>	<i>Office visit</i> and/or manipulation services provided by a D.O.
Manipulation	\$5 <i>co-payment</i> then 100% after <i>deductible</i>	60% after <i>deductible</i>	For services rendered by a Chiropractor, see the Alternative Medicine benefit.

Premier PPO Plan

COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
PHYSICIAN SERVICES (continued)			
Surgical Services			
Primary Procedures	75% after <i>deductible</i>	60% after <i>deductible</i>	Anesthesia and radiology fees will be covered as <i>in-network</i> if rendered in an <i>in-network</i> facility.
Secondary, Tertiary and All Additional Procedures	75% after <i>deductible</i>	60% after <i>deductible</i>	For multiple <i>surgeries</i> through the same incision or operational field.
Secondary, Tertiary and All Additional Procedures	75% after <i>deductible</i>	60% after <i>deductible</i>	For multiple <i>surgeries</i> through separate incisions or operative fields performed at the same operative session.
Explanations and Limitations	<p>An assistant surgeon will be treated as an <i>in-network provider</i> if the facility and the primary surgeon are <i>in-network</i>.</p> <p>If the assistant surgeon is an <i>in-network provider</i>, the assistant surgeon's allowable fees will be limited to 20% of the allowable fees of the primary surgeon.</p> <p>If the assistant surgeon is not an <i>in-network provider</i>, the assistant surgeon's allowable fees will be limited to 20% of the <i>reasonable and customary</i> fees of the primary surgeon.</p>		
Surgical Sterilization	75% after <i>deductible</i>	60% after <i>deductible</i>	<i>Outpatient</i> (e.g. vasectomies) tubal ligations and other forms of female sterilization are covered at 100% <i>in-network</i> .
Termination of Pregnancy	75% after <i>deductible</i>	60% after <i>deductible</i>	<i>Medically necessary</i> terminations.
Oral, Craniofacial and TMJ Services	75% after <i>deductible</i>	60% after <i>deductible</i>	<p>Oral and/or craniofacial <i>surgery</i> is limited to cutting procedures to remove tumors, cysts, controlling bacterial infection, abscess, acute injury, or other procedures deemed <i>medically necessary</i> to treat conditions not related to teeth.</p> <p><i>TMJ</i> services are covered except for orthognathic.</p> <p>Non-emergency pediatric oral surgery requiring complete sedation is covered including anesthesia, <i>physician</i>, and facility charges. Pre-certification is required along with a letter of <i>medical necessity</i> from the treating pediatrician.</p>
Wigs	75% after <i>deductible</i>	60% after <i>deductible</i>	Lifetime Maximum: One (1) wig, toupee, or hairpiece after chemotherapy.

Premier PPO Plan

COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
MENTAL HEALTH & SUBSTANCE ABUSE			
Detoxification	75% after <i>deductible</i>	60% after <i>deductible</i>	<i>Pre-certification</i> is required.
Mental Health			
Inpatient	75% after <i>deductible</i>	60% after <i>deductible</i>	<i>Pre-certification</i> is required.
Outpatient	\$30 <i>co-payment</i> then 100% after <i>deductible</i>	60% after <i>deductible</i>	<i>Pre-certification</i> is required after the first twenty (20) visits.
Medicine Monitoring	100% <i>deductible</i> waived	60% after <i>deductible</i>	
Substance Abuse/Chemical Dependency			<i>Pre-certification</i> is required for all substance abuse/chemical dependency services.
Inpatient	75% after <i>deductible</i>	60% after <i>deductible</i>	
Outpatient	\$30 <i>co-payment</i> then 100% after <i>deductible</i>	60% after <i>deductible</i>	
Drug Screenings	100% <i>deductible</i> waived	100% <i>deductible</i> waived	Drug screenings administered in connection with a <i>Substance Abuse</i> Treatment Program.
Medicine Monitoring	100% <i>deductible</i> waived	60% after <i>deductible</i>	
PREVENTIVE CARE			
<p>If a service is listed as A or B rated on the U.S. Preventive Service Task Force, or preventive care for children under Bright Future guidelines, then the service is covered at 100% <i>in-network</i>, if the primary reason for the appointment is preventive care. For more information about preventive services please refer to the following website:</p> <p align="center"><u>https://www.healthcare.gov/what-are-my-preventive-care-benefits/</u></p>			
Routine Wellness (child)	100% <i>deductible</i> waived	60% <i>deductible</i> waived	Services include diagnostics, and routine childhood immunizations in connection with such visits. A \$30 co-payment will apply when the primary reason for the appointment is NOT preventive care.

Premier PPO Plan

COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
PREVENTIVE CARE (continued)			
Hearing Examinations [Inpatient Newborn and outpatient up to age ten (10)]	100% <i>deductible waived</i>	60% <i>deductible waived</i>	Covered if performed by a specialist and/or Certified Audiologist.
Hearing Examinations [Outpatient to age twenty-six (26)]	100% <i>deductible waived</i>	60% after <i>deductible</i>	
Routine Eye Examination [Newborn to age eighteen (18)]	100% <i>deductible waived</i>	60% after <i>deductible</i>	Routine eye examinations are excluded when the <i>participant</i> is also covered by The City of Colorado Springs's Vision Service Plan. Routine eye exam performed by a specialist.
Routine Wellness (adult)	100% <i>deductible waived</i>	60% <i>deductible waived</i>	Annual routine physical exam and associated diagnostic services (including laboratory, radiology fees, and carrier fees) in connection with such visits, gynecological exam and pap test, digital rectal exam including PSA blood test. Annual routine physical exam limited to one (1) per plan year. A \$30 co-payment will apply when the primary reason for the appointment is NOT preventive care.
Hearing Examinations	100% <i>deductible waived</i>	60% after <i>deductible</i>	Covered if performed by a specialist and/or Certified Audiologist..
Routine Eye Examination	100% <i>deductible waived</i>	60% after <i>deductible</i>	Routine eye examinations are excluded when the <i>participant</i> is also covered by The City of Colorado Springs's Vision Service Plan. Routine eye exam performed by a specialist.
Annual Diagnostic Sigmoidoscopy & Colonoscopy	100% <i>deductible waived</i>	60% after <i>deductible</i>	
Annual Bone Density Screening	100% <i>deductible waived</i>	60% <i>deductible waived</i>	
Annual Mammogram	100% <i>deductible waived</i>	60% <i>deductible waived</i>	

Premier PPO Plan

COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
PREVENTIVE CARE (continued)			
Contraceptive Services	100% <i>deductible</i> waived	60% after <i>deductible</i>	<p>Services include FDA approved contraceptive methods, sterilization procedures, and patient education and counseling, not including drugs that induce abortion.</p> <p>Benefit Limitations: Services are available to all female <i>participants</i>.</p>
CLINICAL TRIALS			
Clinical Trials	75% after <i>deductible</i>	60% after <i>deductible</i>	<p>Refer to the Clinical Trials section for a further description and limitations of this benefit.</p> <p>Pre-certification is required.</p>
TRANSPLANTS			
Organ and Tissue Transplantation	75% after <i>deductible</i>	Not Covered	<p>All transplants must be performed within the PPO network to have the <i>in-network</i> benefit apply.</p> <p>Maximum Benefits Period: Transplantation expenses must be <i>incurred</i> during the period the patient is covered under the Plan and during a benefit period per transplant of five (5) days before and eighteen (18) months after the <i>surgery</i>.</p> <p>Lifetime maximum: unlimited</p> <p>Pre-certification is required</p>

D. Consumer Directed Health Plan (Advantage Plan)

A Consumer Directed Health Plan (CDHP) with a Health Reimbursement Account provides comprehensive coverage for high cost medical events. The Plan gives you greater control over how health care benefits are used.

E. How does this Plan work?

This Plan features higher annual *deductibles* and *out-of-pocket maximums* than other traditional health plans. With the exception of preventive care, you must meet the annual *deductible* before the Plan pays benefits. It is called a Consumer Directed Health Plan or **CDHP**. **Preventive care services are not subject to the deductible. These benefits are paid at 100%.**

It is paired with a Health Reimbursement Account (**HRA**).

The City of Colorado Springs Section 105 Health Reimbursement Account (referred to as HRA) is a component of the Advantage Plan. Active employees enrolled in the Advantage Plan will be automatically enrolled in the HRA. The HRA allows you to be reimbursed for qualifying healthcare expenses that you or your eligible dependents may *incur*. To help you understand the HRA and the funds that the *City* has set aside in the account refer to the HRA Plan Document, which is located on the *City's* website.

F. How will the Administrators know when I've satisfied the Deductible?

If you have not met your *deductible*, you will be responsible for 100% of the allowed amount for your health care expenses. If you use a *network provider*, the *provider* will submit the *claim* to your health care company on your behalf. If you use a *non-network provider*, your *physician* may ask you to pay for the services provided before you leave the office. In that case, you must submit your *claim* to the *Claims Administrator* so that your expenses are applied to the *deductible*. You will subsequently receive an *Explanation of Benefits* from the *Claims Administrator* stating how much the negotiated payment amount is, and that you are responsible for 100% of this negotiated amount.

Example: Kate is a City of Colorado Springs *employee* eligible for benefits. She has elected single coverage and her *deductible* is \$1,500. In March she *incurs* \$500 of medical expenses. She must pay the \$500 because she has not met her *deductible*. Her *deductible* is now \$1,000. Once she pays the remainder of her *deductible*, the Plan will pay a percentage of her health care expenses according to the **Schedule of Medical Benefits**.

G. Schedule of Benefits — Advantage Plan

Advantage Plan

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Lifetime Maximum The lifetime maximum includes prescription drug charges.		
Per participant	Unlimited	
Deductible The in-network deductible does not apply to services received at the City Employee Medical Clinic.		
Per participant	\$1,500	\$4,500
Per family	\$3,000	\$9,000
Out-of-Pocket Maximum The out-of-pocket-maximum amount includes co-payments and deductibles.		
Per participant	\$3,000	\$9,000
Per family	\$6,000	\$18,000
<p>The Plan will pay the designated percentage of <i>covered expenses</i> until <i>out-of-pocket maximums</i> are reached, at which time the Plan will pay 100% of the remainder of <i>covered expenses</i> for the rest of the <i>benefit year</i> unless stated otherwise.</p> <p>Note: The following charges do not apply toward the medical plan out-of-pocket expense amount:</p> <ul style="list-style-type: none"> • expenses not covered • charges in excess of usual & customary • prescription drug <i>co-payments</i> and expenses <p>Note: The following charges do not apply to the plan year deductible:</p> <ul style="list-style-type: none"> • <i>alternative medicine</i> • Health Management Programs • hearing aids (pediatric) • oxygen equipment and supplies • substance abuse drug screenings • Diabetes Care Management Program <p>Note: The plan out-of-pocket amounts accumulate separately for in-network and out-of-network services.</p> <p>Note: The plan deductible amounts accumulate separately for in-network and out-of-network services.</p>		

Advantage Plan

COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
HOSPITAL SERVICES			
Emergency Services			All hospital admissions must be <i>pre-certified</i> within forty-eight (48) hours.
Emergency Room	80% after <i>deductible</i>	80% after <i>deductible</i> U&C will not apply	Other services, including <i>physician</i> fees (other than emergency room <i>physician</i> charges), diagnostic lab and radiology fees and expenses, <i>surgery</i> fees, and other fees <i>incurred</i> in connection with the emergency room charges will be reimbursed in accordance with the <u>Schedule of Medical Benefits</u> for such services.
Emergency Physician Services	100% after <i>deductible</i>	100% after <i>deductible</i>	
Urgent Care Facility	80% after <i>deductible</i>	60% after <i>deductible</i>	
Hospital Services (Inpatient and Outpatient)	80% after <i>deductible</i>	60% after <i>deductible</i>	<i>Pre-certification</i> is required for <i>inpatient</i> services. Room and board in semi-private rooms with general nursing services. A private room is covered only if <i>medically necessary</i> or if the facility does not provide semi-private rooms. Benefits will be limited to the cost of a semi-private room. If <i>pre-certification</i> is not obtained before services are provided, then no benefits may be payable under the Plan.
Ambulatory Surgical Facility/Outpatient Surgery Facility	80% after <i>deductible</i>	60% after <i>deductible</i>	
PHYSICIAN SERVICES			
Allergy Testing	80% after <i>deductible</i>	60% after <i>deductible</i>	
Allergy Treatment			
Allergy Serum	80% after <i>deductible</i>	60% after <i>deductible</i>	
Desensitization and hypo- sensitization (allergy shots given at periodic intervals)	80% after <i>deductible</i>	60% after <i>deductible</i>	Desensitization injections are covered only when provided by a licensed health care practitioner.

Advantage Plan

COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
PHYSICIAN SERVICES (continued)			
Alternative Medicine	50%	50%	<p>Services provided by and/or for <i>acupuncture</i>, massage therapy, dietician, nutritionist, chiropractic, homeopathic and <i>naturopathic services</i>.</p> <p>Chiropractic services are only covered under the Alternative Medicine benefit. X-rays will be reimbursed under the Diagnostic Lab and X-ray benefit.</p> <p>Includes foot orthotics/corrective shoes and foot care expenses not otherwise eligible under this Plan.</p> <p>Itemized <i>claims</i> are not required for this benefit except for foot care.</p> <p>A license for a <i>provider</i> is NOT required in the state of Colorado for homeopathic and <i>naturopathic services</i>.</p> <p>Annual family maximum: \$1,000</p>
Ambulance Service	80% after <i>deductible</i>	80% after <i>deductible</i>	
Blood Transfusions/ Autologous Donations	80% after <i>deductible</i>	60% after <i>deductible</i>	
Cardiac and Pulmonary Rehabilitation	80% after <i>deductible</i>	60% after <i>deductible</i>	Annual maximum: <i>Outpatient</i> pulmonary rehabilitation is limited to one hundred eighty (180) days per <i>injury</i> or <i>illness</i> combined with all other <i>outpatient</i> therapy.
Chemotherapy	100% after <i>deductible</i>	60% after <i>deductible</i>	
Radiation	100% after <i>deductible</i>	60% after <i>deductible</i>	
Colonoscopy			
Diagnostic	100% <i>deductible</i> waived	60% after <i>deductible</i> Subject to U & C	
Screening	100% <i>deductible</i> waived	60% after <i>deductible</i> Subject to U & C	Payment includes all related charges at 100%. Screening colonoscopy frequency shall be in accordance with the American Medical Association (AMA), U.S. Preventive Services Task Force (USPSTF), guidelines.

Advantage Plan

COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
PHYSICIAN SERVICES (continued)			
Compression stockings, Sleeves and Gloves	80% after <i>deductible</i>	60% after <i>deductible</i>	Calendar year maximum: Two (2) pair
Diabetes Care Management			100% deductible waived in-network benefit requires participation in on-going Diabetes Care Management.
Diabetic Insulin Pumps and Supplies	100% <i>deductible</i> waived 80% after <i>deductible</i> if not participating in Diabetes Management	50% after <i>deductible</i>	80% after <i>deductible in-network</i> if there is no participation in on-going Diabetes Care Management. Includes repair, adjustment or servicing of a pump beyond the normal warranty period. <i>Participants</i> must participate in the Diabetes Ten City Challenge or provide documentation, quarterly, of proof of ongoing diabetes management no later than fifteen (15) days prior to the end of each quarter in the <i>calendar year</i> .
Diagnostic Labs and X-Rays	100% if for preventive service otherwise 80% after <i>deductible</i>	60% after <i>deductible</i>	If diagnostic labs and x-rays are performed in conjunction with a preventive service listed on U.S. Preventive Service Task Force List A or B, or preventive care for children under Bright Future guidelines, or additional women’s preventive care services then the service is covered at 100%. For more information about preventive services please refer to the following website: https://www.healthcare.gov/what-are-my-preventive-care-benefits/

Advantage Plan

COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
PHYSICIAN SERVICES (continued)			
Dialysis	100% after <i>deductible</i>	60% after <i>deductible</i>	
Health Management Programs	100% <i>deductible</i> waived	Not Covered	To enroll in the program contact the Utilization/Medical Management Vendor.
Durable Medical Equipment	100% after <i>deductible</i>	60% after <i>deductible</i>	<p>Excludes oxygen and related equipment and supplies.</p> <p>Pediatric hearing aids covered at 80% up to age eighteen (18) when obtained <i>in-network</i>. Pre-certification is required.</p> <p>Rental is paid up to allowable purchase price.</p> <p>In-network breast feeding equipment and related supplies will be covered at 100%-deductible waived and is limited to the rental or purchase of one (1) breast pump per pregnancy as prescribed by a physician.</p> <p>Annual maximum: unlimited with the exception of breast feeding equipment.</p>
Fertility/Infertility Services	80% after <i>deductible</i>	60% after <i>deductible</i>	<p>Evaluation, counseling and treatment for the employee and spouse only.</p> <p>Prescription drugs for fertility and infertility are not covered by the Plan.</p> <p>Medications to treat erectile dysfunction are covered under Maxor Plus with clinical prior authorization.</p>
Foot Care Services	80% after <i>deductible</i>	60% after <i>deductible</i>	<p>Pre-certification is required for foot care <i>surgeries</i>.</p> <p>Expenses for routine and preventive services are not covered (See Alternative Medicine).</p>

Advantage Plan

COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
PHYSICIAN SERVICES (continued)			
Healthy Weight Management	80% after <i>deductible</i>	60% after <i>deductible</i>	<p><i>Pre-certification is required for weight loss surgery.</i></p> <p>Covers dietary counseling and weight loss surgery including pre-consultative physiological visit for weight loss <i>surgery</i>.</p> <p>Dietary counseling can be self-referred for the diagnosis of morbid obesity.</p> <p>The Health Management Program includes healthy weight management and dietary counseling.</p> <p>National Institutes of Health (NIH) criteria is used to determine if bariatric surgery is appropriate [candidate must either have a BMI greater than forty (40) or a BMI of thirty-five (35) to thirty-nine point nine (39.9) with serious co-morbidities].</p> <p>Initial consultation, post-operative <i>office visits</i> and associated <i>outpatient</i> diagnostic services will be paid according to the appropriate <u>Schedule of Medical Benefits</u> contained herein.</p> <p>Lifetime maximum: One (1) weight loss <i>surgery</i>.</p>
Hearing Aids (Pediatric)	80% <i>deductible waived</i>	60% after <i>deductible</i>	<p>Children up to age eighteen (18) who have been medically diagnosed with a congenital defect and/or a birth abnormality.</p> <p><i>Pre-certification is required.</i></p>
Home Health Care and Home Infusion	80% after <i>deductible</i>	60% after <i>deductible</i>	Covers up to two (2) hours in a twenty-four (24) hour period.

Advantage Plan

COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
PHYSICIAN SERVICES (cont.)			
Hormone Pellet Implants	80% after <i>deductible</i>	60% after <i>deductible</i>	
Hospice Care	80% after <i>deductible</i>	60% after <i>deductible</i>	<i>Hospice</i> care benefits include inpatient care, <i>physician's</i> services, <i>prescription drugs</i> , <i>home health care</i> services, emotional support services for the patient and the patient's family, bereavement services, and homemaker services.
Immunizations	100% if listed on Advisory Committee on Immunization Practices guidelines Non-Routine Immunizations 80% after <i>deductible</i>	60% after <i>deductible</i>	Non-routine immunizations covered at 80% for <i>in-network providers</i> . If listed on Advisory Committee on Immunization Practices guidelines then the service is covered at 100% for <i>in-network providers</i> . For more information, refer to the following website: http://www.cdc.gov/vaccines/
Injections (medically necessary)	80% after <i>deductible</i>	60% after <i>deductible</i>	Injections due to <i>medical necessity</i> . Botox injections must be pre-certified. Specialty and chronic injectables covered under the 4 th and 5 th tier of the pharmacy benefit, including oral chemotherapy medications must be obtained through Maxor Specialty Pharmacy.
Inpatient Physician Visits	80% after <i>deductible</i>	60% after <i>deductible</i>	
Maternity			
Obstetrician/Physician	80% after <i>deductible</i>	60% after <i>deductible</i>	
Nurse Midwife	80% after <i>deductible</i> (<i>In-network</i> obstetrician affiliation only)	60% after <i>deductible</i>	
All other covered expenses billed by the physician for maternity care	80% after <i>deductible</i>	60% after <i>deductible</i>	

Advantage Plan

COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
PHYSICIAN SERVICES (continued)			
Medical Supplies	100% after <i>deductible</i>	60% after <i>deductible</i>	Supplies used in conjunction with <i>durable medical equipment</i> , ostomy supplies, and tracheotomy tubes and related supplies. Ostomy supplies limited to a ninety (90) day supply at a time. Tracheotomy supplies include only tubing, gloves, mask, collar, and care kit.
Office Visits			<i>Primary care physician (PCP)</i> is defined as general/family practice, internal medicine, OB/GYN, Doctor of Osteopathy (D.O.), pediatrics,
PCP	80% after <i>deductible</i>	60% after <i>deductible</i>	physician's assistant and nurse practitioner if services are provided under the supervision of a <i>physician</i> . <i>Physicians</i> in other practice specialties are considered specialists. If a <i>primary care physician</i> also provides services as a specialist, those services will be treated as having been provided by a specialist for the purposes of this Plan.
Specialist	80% after <i>deductible</i>	60% after <i>deductible</i>	
Oxygen Equipment and Supplies	100%	60% after <i>deductible</i>	Not subject to rental initiations or plan year maximums.
Prosthetic and Orthotic Devices	100% after <i>deductible</i>	60% after <i>deductible</i>	One (1) pair of eyeglasses or contact lenses is covered as a prosthetic device following ocular surgery.
Reconstructive Services	80% after <i>deductible</i>	60% after <i>deductible</i>	Includes two (2) mastectomy bras and one (1) mastectomy camisole (with prostheses) each calendar year.

Advantage Plan

COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
PHYSICIAN SERVICES (continued)			
Rehabilitation Services			Includes speech, physical and occupational therapy.
Outpatient	80% after <i>deductible</i>	60% after <i>deductible</i>	<p>Annual maximum: <i>Outpatient</i> rehabilitation services limited to one hundred eighty (180) days per <i>injury</i> and <i>illness</i> combined with cardiac and pulmonary therapy.</p> <p>Annual Maximum: sixty (60) visits combined per <i>participant</i>.</p> <p>Pediatric rehabilitation therapy for <i>participants</i> up to age ten (10) limited to sixty (60) combined visits per plan year.</p>
Inpatient	80% after <i>deductible</i>	60% after <i>deductible</i>	<p>The level of benefits for occupational therapy, physical therapy, or speech therapy shall exceed the limit of sixty (60) visits per plan year if such therapy is <i>medically necessary</i> to treat autism spectrum disorders.</p> <p>Initial evaluation does not count toward maximums and is paid under <i>office visit</i>.</p> <p>Pre-Certification is required for pediatric rehabilitation therapy for pediatrics [up to age ten (10)].</p>
Skilled Nursing Facility	50% after <i>deductible</i>	50% after <i>deductible</i>	<p><i>Skilled nursing facility</i> and related prescriptions.</p> <p>Lifetime maximum: three hundred sixty-five (365) days.</p> <p>Pre-Certification is required.</p>
Spinal Manipulation			<i>Office visit</i> and/or manipulation services provided by a D.O.
Office Visit	80% after <i>deductible</i>	60% after <i>deductible</i>	
Manipulation	80% after <i>deductible</i>	60% after <i>deductible</i>	For services rendered by a Chiropractor, see the Alternative Medicine benefit.

Advantage Plan

COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
PHYSICIAN SERVICES (continued)			
Surgical Services			
Primary Procedures	80% after <i>deductible</i>	60% after <i>deductible</i>	Anesthesia and radiology fees will be covered as <i>in-network</i> if rendered in an <i>in-network</i> facility.
Secondary, Tertiary and All Additional Procedures	80% after <i>deductible</i>	60% after <i>deductible</i>	For multiple <i>surgeries</i> through the same incision or operational field.
Secondary, Tertiary and All Additional Procedures	80% after <i>deductible</i>	60% after <i>deductible</i>	For multiple <i>surgeries</i> through separate incisions or operative fields performed at the same operative session.
Explanations and Limitations	<p>An assistant surgeon will be treated as an <i>in-network provider</i> if the facility and the primary surgeon are <i>in-network</i>.</p> <p>If the assistant surgeon is an <i>in-network provider</i>, the assistant surgeon's allowable fees will be limited to 20% of the allowable fees of the primary surgeon.</p> <p>If the assistant surgeon is not an <i>in-network provider</i>, the assistant surgeon's allowable fees will be limited to 20% of the <i>reasonable and customary</i> fees of the primary surgeon.</p>		
Surgical Sterilization	80% after <i>deductible</i>	60% after <i>deductible</i>	<i>Outpatient</i> (e.g. vasectomies) tubal ligations and other methods of female sterilization are covered at 100% <i>in-network</i> .
Termination of Pregnancy	80% after <i>deductible</i>	60% after <i>deductible</i>	<i>Medically necessary</i> terminations.
Oral, Craniofacial and TMJ Services	80% after <i>deductible</i>	60% after <i>deductible</i>	<p>Oral and/or craniofacial <i>surgery</i> is limited to cutting procedures to remove tumors, cysts, controlling bacterial infection, abscess, acute <i>injury</i>, or other procedures deemed <i>medically necessary</i> to treat conditions not related to teeth.</p> <p><i>TMJ</i> Services are covered except for orthognathic.</p> <p>Non-emergency pediatric oral <i>surgery</i> requiring complete sedation is covered including anesthesia, <i>physician</i>, and facility charges. Pre-certification is required along with a letter of <i>medical necessity</i> from the treating pediatrician.</p>
Wigs	80% after <i>deductible</i>	60% after <i>deductible</i>	Lifetime Maximum: One (1) wig, toupee, or hairpiece after chemotherapy.

Advantage Plan

COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
MENTAL HEALTH & SUBSTANCE ABUSE			
Detoxification	80% after <i>deductible</i>	60% after <i>deductible</i>	<i>Pre-certification is required.</i>
Mental Health			
Inpatient	80% after <i>deductible</i>	60% after <i>deductible</i>	<i>Pre-certification is required.</i>
Outpatient	80% after <i>deductible</i>	60% after <i>deductible</i>	<i>Pre-certification is required after the first twenty (20) visits.</i>
Medicine Monitoring	100% <i>deductible</i> waived	60% after <i>deductible</i>	
Substance Abuse/Chemical Dependency			<i>Pre-certification is required for all substance abuse/chemical dependency services.</i>
Inpatient	80% after <i>deductible</i>	60% after <i>deductible</i>	
Outpatient	80% after <i>deductible</i>	60% after <i>deductible</i>	
Drug Screenings	100% after <i>deductible</i>	100% after <i>deductible</i>	Drug screenings administered in connection with a <i>Substance Abuse Treatment Program</i> .
Medicine Monitoring	100% <i>deductible</i> waived	60% after <i>deductible</i>	

Advantage Plan

COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
PREVENTIVE CARE			
<p>If a service is listed as A or B rated on the U.S. Preventive Service Task Force, or preventive care for children under Bright Future guidelines, then the service is covered at 100% <i>in-network</i>, if the primary reason for the appointment is preventive care. For more information about preventive services please refer to the following website:</p> <p style="text-align: center;">https://www.healthcare.gov/what-are-my-preventive-care-benefits/</p>			
Routine Wellness (child)	100% <i>deductible</i> waived	60% <i>deductible</i> waived	Services include diagnostics, and routine childhood immunizations in connection with such visits. Covered if performed by a specialist and/or Certified Audiologist
Hearing Examinations [Inpatient Newborn and Outpatient to age ten (10)]	100% <i>deductible</i> waived	60% <i>deductible</i> waived	
Hearing Examinations [Outpatient to age twenty-six (26)]	100% <i>deductible</i> waived	60% after <i>deductible</i>	
Routine Eye Examination [Newborn to age eighteen (18)]	100% <i>deductible</i> waived	60% after <i>deductible</i>	<p>Routine eye examinations are excluded when the <i>participant</i> is also covered by The City of Colorado Springs's Vision Service Plan.</p> <p>Routine eye exam performed by a specialist.</p>
Routine Wellness (adult)	100% <i>deductible</i> waived	60% <i>deductible</i> waived	<p>Annual routine physical exam and associated diagnostic services (including laboratory, radiology fees and carrier fees) in connection with such visits, gynecological exam and pap test, digital rectal exam including PSA blood test.</p> <p>Annual routine physical exam limited to one (1) per plan year.</p>
Hearing Examinations	100% <i>deductible</i> waived	60% after <i>deductible</i>	Covered if performed by a specialist and/or Certified Audiologist
Routine Eye Examination	100% <i>deductible</i> waived	60% after <i>deductible</i>	<p>Routine eye examinations are excluded when the <i>participant</i> is also covered by The City of Colorado Springs's Vision Service Plan.</p> <p>Routine eye exam performed by a specialist.</p>

Advantage Plan

COVERED SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS	SPECIAL COMMENTS
PREVENTIVE CARE (continued)			
Annual Diagnostic Sigmoidoscopy & Colonoscopy	100% <i>deductible waived</i>	60% after <i>deductible</i>	
Annual Bone Density Screening	100% <i>deductible waived</i>	60% <i>deductible waived</i>	
Annual Mammogram	100% <i>deductible waived</i>	60% <i>deductible waived</i>	
Contraceptive Services	100% <i>deductible waived</i>	60% after <i>deductible</i>	<p>Services include FDA approved contraceptive methods, sterilization procedures, and patient education and counseling, not including drugs that induce abortion.</p> <p>Benefit Limitations: Services are available to all female <i>participants</i>.</p>
CLINICAL TRIALS			
Clinical Trials	80% after <i>deductible</i>	60% after <i>deductible</i>	<p>Refer to the Clinical Trials section for a further description and limitations of this benefit.</p> <p>Pre-certification is required.</p>
TRANSPLANTS			
Organ and Tissue Transplantation	80% after <i>deductible</i>	Not Covered	<p>All transplants must be performed within the PPO network to have the <i>in-network</i> benefit apply.</p> <p>Maximum Benefits Period: Transplantation expenses must be <i>incurred</i> during the period the patient is covered under the Plan and during a benefit period per transplant of five (5) days before and eighteen (18) months after the <i>surgery</i>.</p> <p>Lifetime maximum: unlimited</p> <p>Pre-certification is required</p>

H. Schedule of Prescription Drug Benefits — Premier PPO and Advantage Plan

ALL CITY OF COLORADO SPRINGS PRESCRIPTION DRUG BENEFIT			
City Employee Pharmacy Option		(30 Day Supply)	(90 Day Supply)
Tier 1	Generic Drugs	\$ 8.00 <i>co-payment</i>	\$20.00 <i>co-payment</i>
Tier 2	Preferred Brand	\$30.00 <i>co-payment</i>	\$60.00 <i>co-payment</i>
Tier 3	Non-Preferred Brand	\$50.00 <i>co-payment</i>	\$100.00 <i>co-payment</i>
Specialty Pharmacy Tier 4	Preferred Chronic Injectables and other Specialty Drugs	\$100.00 <i>co-payment</i>	\$200.00 <i>co-payment</i>
Specialty Pharmacy Tier 5	Non- Preferred Chronic Injectables and other Specialty Drugs	\$150.00 <i>co-payment</i>	\$300.00 <i>co-payment</i>
Chronic Injectables and Specialty Drugs: \$2,500 out-of-pocket maximum per participant, per year.			
MaxorPlus Retail Network Pharmacies		(30 Day Supply)	(90 Day Supply)
Tier 1	Generic Drugs	\$20.00 <i>co-payment</i>	Not Applicable
Tier 2	Preferred Brand	\$50.00 <i>co-payment</i>	Not Applicable
Tier 3	Non-Preferred Brand	\$75.00 <i>co-payment</i>	Not Applicable
Specialty Pharmacy Tier 4 or Tier 5	Preferred/Non- Preferred Chronic Injectables and other Specialty Drugs	Not Applicable	Not Applicable
Diabetic Supplies (Maximum 90-day Supply)	Covered at 100% (no <i>co-pay</i>) if obtained through the City Employee Pharmacy Program [maximum ninety (90) day supply]. If supplies are obtained through the MaxorPlus Retail Network Pharmacy, then the regular retail <i>co-pay</i> will apply. <i>Plan participants</i> have to participate in the Diabetes Ten City Challenge or prove ongoing health management of their diabetes no later than fifteen (15) days prior to the end of each quarter in the calendar year.		
<p><i>Plan participants</i> will progressively pay higher <i>co-pays</i> for maintenance prescriptions that are filled at a MaxorPlus Retail Network Pharmacy versus the City Employee Pharmacy.</p> <p>Maintenance Rx filled at any MaxorPlus Retail Network Pharmacy:</p> <ul style="list-style-type: none"> • First fill: member pays the normal <i>co-pay</i> • Second fill: member pays double the <i>co-pay</i> • Third and subsequent fills: member pays 100% of the retail cost for a maintenance Rx 			
Maintenance Prescription Fills (For a complete listing of participating pharmacies go to the Preferred Provider Information on the Clinic and Pharmacy information section of the Benefits and Wellness website.)			
<p>Certain prescription medications mandated under PPACA (including preferred generic and brand contraceptives) received by a network pharmacy are covered at 100%, and the deductible/co-payment/co-insurance (if applicable) is waived.</p> <p>Please refer to the following website for information on the types of payable preventive medications: https://www.healthcare.gov/what-are-my-preventive-care-benefits/.</p>			
Refer to the <i>Prescription Drug</i> Section for details on the <i>Prescription Drug</i> benefit.			

I. Reach Your Peak Wellness Program

Premier PPO and Advantage Medical Plans The Reach Your Peak: 3 Step Wellness Program Year 10

The Reach Your Peak (RYP) 3 Step Wellness Program Year 10 will be offered between November 1, 2013 and October 31, 2014. The City's Wellness vendor, Healthyroads, will provide access via their website to Personal Health Assessments, health education and healthy challenges to encourage and promote healthy lifestyles. Healthyroads will be responsible for the monitoring of required and voluntary activities and the allocation of RYP points to be used to qualify employees and retirees for the wellness incentive rewards. Benefits eligible *active employees*, *FPPA retirees* on the Medical plan and *FPPA retirees* in the Medical Waiver program will be eligible for the rewards. The program works as follows:

- **STEP 1:** Have a City Health Screening. Health Screenings **must** be done at a City sponsored Health Screening (available at different locations throughout the year), or the City Employee Medical Clinic. The credit will be entered for you on the RYP website. Health Screenings from your personal provider **will not** be accepted; however, if you have had lab work done in the past six (6) months **AND** you bring a copy of the original typed lab results to the screening, you can bypass the finger stick station. Results must include glucose, total cholesterol, HDL and LDL cholesterol, and triglycerides. The rest of the Health Screening is still a requirement. (Retirees who live out of the Front Range Area and cannot get to a City Health Screening should contact a Wellness Nurse at 1-719-385-5190 or City HR Benefits and Wellness at 1-719-385-5125.)

If you have a Risk Factor you must show a 10% reduction or get below the threshold in order to be eligible for the incentive.

Risk Factors are considered:

- Total Cholesterol/HDL Ratio: Over 5
 - LDL: Greater than 130
 - Triglycerides: Greater than 200
 - Blood Sugar: Greater than 105
 - Blood Pressure:
 - Systolic: Greater than 139 OR
 - Diastolic: Greater than 89
 - Elevated BMI & Waist Circumference
 - BMI: Greater than 29
 - Waist Circumference
 - Women: Greater than 35 inches
 - Men: Greater than 40 inches
 - Tobacco: Current use of tobacco products
- **STEP 2:** Complete the Personal Health Assessment by 10 p.m. MST on 10/31/2014. Personal Health Assessment is available on www.Healthyroads.com website.
 - **STEP 3:** Earn fifteen (15) Health Improvement Program (HIP) credits and enter the credits online by 10 p.m. MST on 10/31/2014. HIP credits can be earned by participating in Challenges, Health Coach Activities, Department Level Activities, Community Classes, Fitness Tracking, having a preventive care service, serving on the Wellness Committee, or meeting with a Wellness Nurse.

REWARD: Complete all Steps and requirements and enter all credits on the RYP website by 10 p.m. MST on 10/31/14 and you will receive a \$300 taxable award in December, 2014.

The City is committed to helping you work towards your best health. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact a UCCS Wellness Nurse at 719-385-5192 or email at cityhealthcoach@springsgov.com and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

Additional Program Information

- *Spouses* and dependents are not eligible for the \$300 wellness reward.
- If you elect to permanently waive out of the Retiree Medical Plan or if your employment is terminated with the City of Colorado Springs any time between November 1, 2013 and October 31, 2014, this award is forfeited.

See complete program information at www.Healthyroads.com.

SECTION III—ELIGIBILITY

A. Eligibility Requirements

Eligible Classes of Employees. All regular or special *employees* of The City of Colorado Springs are eligible for medical coverage based upon the following:

1. *Employees* who are regularly scheduled to work twenty (20) to twenty-nine (29) hours per week are eligible to participate in the Plan and contribute based upon the half time rates.
2. *Employees* who are regularly scheduled to work thirty (30) or more hours per week are eligible to participate in the Plan and contribute based upon the full-time rates.
3. *Employees* who have a legal mutual agreement contract for extended benefit coverage beyond employment dates due to a reduction in force, early retirement, or other mutual agreement reasons. For more information contact your City Human Resources Department.
4. **Former employees of Memorial Hospital who elected COBRA coverage or had a qualifying event on or before September 30, 2012. Coverage will be extended until the end of the appropriate COBRA length of time.**

This amendment will sunset effective September 30, 2015, and coverage will terminate for any of these COBRA participants and for any of their *claims incurred* after September 30, 2015.

Eligibility Requirements for Employee Coverage. A person is eligible for *employee* coverage the first day of the month following:

1. The date benefit elections are submitted provided they are submitted within thirty (30) calendar days of the date of hire.
2. The Plan will not allow a person to be covered both as an *employee* and as a *dependent*. No person may be covered as a *dependent* of more than one (1) *employee*.
3. An *employee* that experiences a qualified family status change may be eligible to enroll in the plan if they do so within thirty (30) days of the event.

Eligible Classes of Dependents. A dependent is any one (1) of the following persons:

1. a covered *employee's* spouse

The term spouse shall mean the employee's partner in marriage pursuant to the provisions of the Uniform Marriage Act, Part 1 of Article 2 of Title 14 or Colorado common law; or the employee's partner in a civil union pursuant to the Colorado Civil Union Act, Article 15 of Title 14. The plan administrator may require documentation proving a legal marital or civil union relationship.

In the case of an employee who seeks to establish a person as his or her spouse by common law, a completed Common Law Marriage Request Form (with supporting documentation) or a notarized Affidavit of Common Law Marriage is required. In the case of an employee that requests preferential tax treatment of benefits for a civil union partner pursuant to the Colorado Civil Union Act, Article 15 of Title 14 or same-sex partner in circumstances where the employee and partner validly entered a marriage in a state whose laws authorize the marriage of two (2) individuals of the same sex, a completed Certification of Tax Dependent Status for a Civil Union Partner/Children (with supporting documentation) is required.

An *employee's* opposite or same-sex partner as recognized by civil union will be eligible for coverage if a valid Certificate of Civil Union obtained at City Hall is provided to the *Plan Administrator*.

2. a covered *employee's* child(ren)

An *employee's* child includes his natural child, stepchild, foster children, adopted child, or a child placed with the *employee* for adoption. An *employee's* child will be an eligible dependent until reaching the limiting age of twenty-six (26), without regard to student status, marital status, financial dependency, or residency status with the *employee* or any other person. When the child reaches the applicable limiting age, coverage will end on the last day of the child's birthday month.

The phrase placed for adoption refers to a child whom a person intends to adopt, whether or not the adoption has become final, who has not attained the age of eighteen (18) as of the date of such placement for adoption. The term placed means the assumption and retention by such person of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

3. a covered *employee's* qualified dependents

The term qualified dependents shall include children for whom the *employee* is a *legal guardian*.

To be eligible for dependent coverage under the Plan, a qualified dependent must be under the limiting age of twenty-six (26) years and primarily dependent upon the covered *employee* for support and maintenance (as described in Section 152 of the Internal Revenue Code). Coverage will end at the end on the last day of the child's birthday month in which the qualified dependent ceases to meet the applicable eligibility requirements.

Any child of a *plan participant* who is an alternate recipient under a Qualified Medical Child Support Order (QMCSO) shall be considered as having a right to qualified dependent coverage under this Plan.

A *participant* of this Plan may obtain, without charge, a copy of the procedures governing Qualified Medical Child Support Order determinations from the *Plan Administrator*.

The *Plan Administrator* may require documentation proving eligibility for *dependent* coverage, including birth certificates, tax records or initiation of legal proceedings severing parental rights.

4. a covered *dependent* child or qualified dependent who reaches the limiting age and (a) is *totally disabled*, (b) is incapable of self-sustaining employment by reason of mental or physical handicap, (c) primarily dependent upon the covered *employee* for support and maintenance and (d) is unmarried

The *Plan Administrator* may require, at reasonable intervals continuing proof of the child's *total disability* and dependency.

The *Plan Administrator* reserves the right to have such dependent examined by a *physician* of the *Plan Administrator's* choice, at the Plan's expense, to determine the existence of such incapacity.

Ineligible Dependent(s):

Unless otherwise provided in this plan document, the following are not considered *eligible dependents*:

- a) other individuals living in the covered *employee's* home, but who are not eligible as defined
- b) the legally separated or divorced former *spouse* of the *employee*
- c) any person who is on active duty in any military service of any country; or any person who is covered under the Plan as an *employee*
- d) a person who is eligible as an *employee* under the Plan
- e) any other person not defined above in the subsection entitled Eligible Classes of Dependent(s)

If a person covered under this Plan changes status from *employee* to dependent or dependent to *employee*, and the person is covered continuously under this Plan before, during, and after the *change in status*, credit will be given for *deductibles* and all amounts applied to maximums.

If both mother and father are *employees*, their children will be covered as dependents of the mother or father, but not of both.

Eligibility Requirements for Dependent Coverage. A family member of an *employee* will become eligible for dependent coverage on the **later** of the day you become eligible for your own medical coverage or the day you acquire an eligible dependent, either by birth, adoption, or placement for adoption.

At any time, the Plan may require proof that a *spouse* or a child qualifies, or continues to qualify, as a dependent as defined by this Plan.

Section 111 of Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA). A federal law that became effective January 1, 2009, requires employer self-funded plans to report specific information for the purpose of

coordinating with Medicare benefits. Due to this law, you will need to ensure Social Security Numbers have been provided to the *Plan Administrator* for all eligible dependents, or you will be asked to complete the Centers for Medicare & Medicaid Services (CMS) form and return the form to Human Resources.

FPPA Retiree Coverage

Retiree Coverage

Members who retire from active service with the *City* and who are eligible for and begin receiving pension benefit payments may elect coverage as follows:

If the retired member is under age sixty-five (65) or if the member is age sixty-five (65) or older and is not entitled to *Medicare* Part A and B, the member may participate in this medical plan.

If the retiree may not participate in this Plan but may participate in a plan offered through Extend Health, and the *spouse* of the retiree or any child of the retiree does not qualify for a plan as provided through Extend Health, the *spouse* or child, as appropriate, may participate in this Plan only if the retiree participates in a plan offered through Extend Health.

Except in those cases where an *employee* is entitled to COBRA Continuation Coverage, retirees other than retired vested members of the Fire and Police Pension Association (*FPPA*) are not eligible for coverage under this Plan. Members of *FPPA* who are uniformed *employees*, who retire from active service with the *City* regardless of enrollment in the current medical plan, who are eligible for and begin receiving pension benefit payments, will be eligible for medical coverage as an *FPPA Retiree*, subject to the following:

1. An *FPPA Retiree* may enroll or add eligible children or a spouse during any open enrollment period, or on the occurrence of an event giving rise to special enrollment, any special enrollment period. Notwithstanding the above, *FPPA Retirees* may continue coverage through COBRA upon initial retirement. If an *FPPA Retiree* defaults in the payment of their premiums for COBRA continuation coverage, and as a result they lose continuation coverage, they will have thirty (30) days from the later of (a) the date of loss of COBRA continuation coverage or (b) the expiration of any period to pay their premium for COBRA coverage to re-enroll in the Plan as an *FPPA Retiree*. At the time of re-enrollment, the *FPPA Retiree* **must** pay all premiums from coverage as an *FPPA Retiree* from the date of loss of COBRA continuation coverage. If payment is timely made, coverage as an *FPPA Retiree* shall be effective from the date of loss of COBRA continuation coverage. Any failure to re-enroll within the applicable thirty (30) day period shall constitute a permanent waiver of the right to participate in the Plan as an *FPPA Retiree* due from the date of loss of COBRA continuation coverage.
2. In the event of the death of an *FPPA Retiree* who is (a) covered under this Plan or (b) whose coverage has been temporarily waived, the surviving *spouse* of such deceased *FPPA Retiree* (the *FPPA Retiree Surviving Spouse*) may either:
 - a. continue or (if a temporary waiver is in effect) commence *FPPA Retiree* health care for the *FPPA Retiree Surviving Spouse* and the dependent children of the *FPPA Retiree Surviving Spouse* under this Plan
 - b. continue the temporary waiver of coverage, as described in 5, below
 - c. permanently waive coverage under the Plan, as described in 5, below
 - 1) Such *FPPA Retiree* coverage shall commence upon the later of (i) the death of the *FPPA Retiree*; (ii) the expiration or termination of any COBRA Continuation Coverage elected by the *spouse* or the dependent children of the deceased *FPPA Retiree* or (iii) the termination, by the *FPPA Retiree Surviving Spouse* of a temporary waiver of coverage in effect upon the death of the *FPPA Retiree*.
 - 2) Members who retire from active service with the *City* and who are eligible for and begin receiving pension benefit payments can elect the same Plan coverage that was in effect prior to the loss of coverage or a lesser plan provided the change meets the consistency rule. In order for the *FPPA Retiree Surviving Spouse* to be entitled to continued coverage, the *FPPA Retiree Surviving Spouse* **must** notify The City of Colorado Springs of the death of the *FPPA Retiree* within sixty (60) days of his or her death.
 - 3) New *spouses* of *FPPA Retiree Surviving Spouses* are not eligible to participate or be beneficiaries in the Plan.

- 4) No FPPA Retiree Surviving Spouse shall be entitled to elect to commence coverage under the Plan if coverage under the Plan was permanently waived by the *FPPA Retiree* prior to his death.
 - 5) A dependent child of an FPPA Retiree Surviving Spouse shall be eligible for *FPPA Retiree* coverage only while the FPPA Retiree Surviving Spouse is covered under the Plan and only while the person qualifies as a dependent child of the FPPA Retiree Surviving Spouse under the terms of this Plan.
 - 6) The FPPA Retiree Surviving Spouse who is electing to continue *FPPA Retiree* coverage will have to pay the full cost of coverage under the Plan as determined for *FPPA Retirees* (including the cost of any *dependent* coverage), less the amount of the FPPA Retiree Medical Plan Subsidy, if eligible.
3. An active member of the *FPPA* who terminates employment with The City of Colorado Springs and later begins a deferred vested retirement is not eligible for coverage by the Plan.
 4. Each *FPPA Retiree* and FPPA Retiree Surviving Spouse is required to obtain written verification from the Social Security Administration of their or (in the case of a *FPPA Retiree*) their *spouse's* Medicare eligibility approximately three (3) months before reaching age sixty-five (65). Failure to submit eligibility information will result in a reduction in benefits until provided, and benefits will be determined assuming all Medicare offsets would apply. The *Claims Administrator* noted in the **Introduction** section is responsible for verification of Medicare eligibility.
 - a. If eligible for Medicare, you are encouraged to enroll in Medicare Parts A and B as Medicare offsets apply regardless of your Medicare enrollment.
 - b. If you are not eligible for Medicare please submit proof of ineligibility to remain in a non-Medicare eligible coverage tier.
 5. During the Plan's annual *open enrollment period*, *FPPA Retirees* and FPPA Retiree Surviving Spouses who are enrolled in the Medical Plan may select one (1) of the following options:
 - a. continue coverage in the Plan
 - b. permanently waive coverage in the Plan

This means that the *FPPA Retiree* or FPPA Retiree Surviving Spouse is choosing to waive all options to return to the Plan. Any such *FPPA Retiree* or FPPA Retiree Surviving Spouse who, under the City Ordinance, would be eligible to receive a contribution of the *FPPA Retiree Medical Plan Subsidy* if the *FPPA Retiree* had continued participation in the Plan shall be entitled to a payment from The City of Colorado Springs of the *FPPA Retiree Medical Plan Subsidy*
 - c. waive current coverage, but maintain the right to return to the Plan by enrolling in the Waiver Program
 6. *FPPA Retirees* and FPPA Retiree Surviving Spouses who enroll in the Waiver Program may re-enter the Plan at a later date during any *open enrollment period* or as a result of an event giving rise to a Special Enrollment Right, provided that the *FPPA Retiree* can provide proof of continuous medical coverage. At such time, *FPPA Retirees* who re-enter the Plan may also elect coverage for their *spouse* or dependents and FPPA Retiree Surviving Spouses who re-enter the Plan may also elect coverage for their dependent children. *FPPA Retirees* and FPPA Retiree Surviving Spouses who fail to complete the Waiver Program Form prior to leaving the Plan will not be allowed to re-enter the Plan at a future date.
 7. *FPPA Retirees* and FPPA Retiree Surviving Spouses who choose to enroll in the Waiver Program and are eligible to receive the *FPPA Retiree Medical Plan Subsidy*, must decline receipt of the *FPPA Retiree Medical Plan Subsidy* during the waived period. The *FPPA Retiree Medical Plan Subsidy* will be re-instated when the *FPPA Retiree* or FPPA Retiree Surviving Spouse re-joins the Plan. If the *FPPA Retiree* or FPPA Retiree Surviving Spouse elects to permanently waive at a later date, or (because of the failure to timely pay premiums or the failure of a FPPA Retiree Surviving Spouse to notify The City of Colorado Springs of the death of an *FPPA Retiree*) is deemed to have permanently waived coverage through the Plan, the *FPPA Retiree* or FPPA Retiree Surviving Spouse will begin receiving the *FPPA Retiree Medical Plan Subsidy* through the direct pay program.

Ninety (90) Day Survivor Coverage

The enrolled eligible children and surviving *spouse* of an *employee* who dies while actively employed will be provided continued health care medical coverage for ninety (90) calendar days at no charge.

After ninety (90) calendar days, *COBRA* continuation coverage (as described under the **Continuation Coverage Rights Under COBRA** section contained within this document) will be offered for existing Medical, Prescription, Vision, Dental, HIP, and EAP coverage. Continuation of existing Medical, Prescription, Vision, Dental, HIP, and EAP coverage will be offered under *COBRA* to dependents and the surviving *spouse*, as a thirty-six (36) month qualifying event after the ninety (90) day survivor coverage has expired.

For FPPA retirees only: If the deceased *employee* was eligible to retire and the death is employment related, health care coverage may be continued for eligible dependent children and surviving *spouses* as though the employee retired. Such coverage may continue in accordance with provisions of this plan.

B. Medicare Part D Prescription Drug Plans for Medicare Eligible Participants

Participants enrolled in either Part A or Part B of Medicare are also eligible for *Medicare* Part D *prescription drug* benefits. Annually the *City* will determine and report if the *prescription drug* coverage provided is creditable coverage. When this Plan's *prescription drug* coverage is reported as credible, you do not need to enroll in *Medicare* Part D to avoid a late penalty under *Medicare*. If you enroll in *Medicare* Part D while covered under this Plan, payments under this Plan will coordinate benefit payment with *Medicare*. Refer to the **Coordination of Benefits** section of the Plan for information on how this Plan will coordinate benefit payment.

C. Funding

Cost of the Plan. The City of Colorado Springs shares the cost of *employee* and dependent coverage under this Plan with the covered *employees*. The enrollment application for coverage will include a payroll deduction authorization. This authorization must be filled out, signed, and returned with the enrollment application.

The level of any *employee* contributions is set by the *Plan Administrator*. The *Plan Administrator* reserves the right to change the level of *employee* contributions.

The *employer* makes a *Cafeteria Plan* available for its *employees*. Pursuant to the *Cafeteria Plan*, *employees* may pay their contributions for the Plan coverages on a pre-tax basis or on an after-tax basis.

D. How does payment for my coverage work?

The specific amount you must pay for coverage is announced each plan year. You may pay your contributions for medical coverage on a before-tax basis. This means that your health care plan premium payments come from your pay before federal, and in most cases, state taxes are withheld.

The amount and frequency of that contribution is determined by The City of Colorado Springs (within permissible government guidelines) and announced on an annual basis. **The City does not provide tax advice and nothing in this paragraph should be construed as providing tax advice.**

E. Enrollment

Enrollment Requirements. You must enroll within thirty (30) calendar days of your eligibility date. If you desire dependent health coverage, you must also enroll your eligible dependents at this time. You enroll yourself and any desired dependents by filling out and signing an enrollment application provided by The City of Colorado Springs. If you do not have any eligible dependents at the time of initial enrollment, but acquire eligible dependents at a later date, you must enroll the dependent(s) within thirty (30) calendar days of the date they become eligible. If you do not enroll yourself or your dependents within thirty (30) calendar days after becoming eligible, you (and they) will not be allowed to enroll until the next annual *open enrollment period*. You may be required to obtain and provide The City of Colorado Springs with a Social Security Number for each covered dependent.

Enrollment Requirements for Newborn Children. A newborn child, a child placed for adoption, or a newly adopted child of a covered *employee* who has dependent coverage is covered for the first thirty (30) days, but is not automatically enrolled in this Plan. You must enroll your newborn child, child placed for adoption, or newly adopted child within thirty

(30) calendar days of the date of birth, date of placement for adoption, or date of adoption. Your claim for maternity expenses is not considered as notification to The City of Colorado Springs for coverage.

It is your responsibility to advise The City of Colorado Springs in writing on a benefits change form of any change in dependent status including marriage, divorce, legal separation, the addition of newborns, adopted children, and deletion of covered children. Failure to provide this information could result in loss of eligibility and/or coverage under the Plan.

All benefit enrollment/change forms and/or electronic enrollment procedures may be obtained from City HR Benefits and Wellness at The City of Colorado Springs.

F. Waiving Medical Coverage

You may affirmatively elect to waive medical coverage under this Plan for yourself and dependents (including spouse). *Employees* may elect to waive coverage through the applicable enrollment process. If, at a later date, you want the coverage you declined for yourself, you may be able to enroll under the *open enrollment period* or special enrollment provisions.

G. Change in Status

You are allowed to change your enrollment elections during a *benefit year* if you have a qualifying *change in status*. *Employees* and special enrollees must be entitled to enroll in any benefit option that is available to newly eligible *employees* upon special enrollment. If you have a qualifying *change in status*, you may change your enrollment decision within thirty (30) days of the *change in status* by notifying The City of Colorado Springs and completing and returning any required forms. Your change in enrollment election must be consistent with your *change in status*. In other words, you may only change your election if the *change in status* causes you, your *spouse*, or your child to gain or lose eligibility for coverage under this or another plan, and the election change must correspond with the effect on coverage.

You cannot keep ineligible dependents on the Plan and must notify the *Plan Administrator* if your dependent(s) loses eligibility within thirty (30) calendar days of the date of loss of eligibility in order to effect a change. If you wait longer than sixty (60) calendar days to notify City HR Benefits and Wellness in writing, the dependent(s) who lost eligibility will not be offered *COBRA* continuation coverage as explained further below. If you keep an ineligible dependent(s) on the Plan and *claims* are inadvertently paid during the period of ineligibility, the Plan will seek collection from the *employee* for those *claims* paid in error. Premium amounts collected during the period of ineligibility will not be refunded.

See When Coverage Ends below for information about the events which lead to a loss of eligibility.

See the Defined Terms section for more information regarding a *change in status*.

H. Special Enrollment Periods

Coverage for anyone who enrolls under a Special Enrollment Period will become effective on the first of the month following receipt of a timely change, except with respect to coverage of a newborn or newly adopted dependent child. *Employees* and special enrollees must be entitled to enroll in any benefit options that are available to newly eligible *employees* upon special enrollment.

1. Newborn children are automatically covered at the date of birth for the first thirty (30) calendar days, but must be enrolled within thirty (30) calendar days after birth and the *participant* must also pay the required contribution for that dependent child's coverage in order for coverage to continue.
2. Coverage of a newly adopted dependent child who is enrolled within thirty (30) calendar days after adoption or placement will become effective as of the date of the child's adoption or placement for adoption, whichever occurs first.
3. If you are not enrolled for individual coverage and if you acquire a *spouse* by ceremony establishing the marriage as recognized by law or establishing a common law marriage in accordance with the requirements of this Plan, or if you acquire any dependent children by birth, adoption, or placement for adoption (other than an adoption of an adult), you

may enroll yourself and your newly acquired *spouse* and/or any dependent child(ren) no later than thirty (30) calendar days after the date of the ceremony establishing the marriage as recognized by law, establishment of a common law marriage, birth, adoption, or placement for adoption.

4. If the eligible dependent will not require a change in the coverage tier under the Plan (for example, you are already enrolled in family coverage), you may, at any time subsequent to the initial thirty (30) calendar day enrollment period, enroll such dependent in the Plan. Any such enrollment shall be effective on the first day of the calendar month commencing after delivery of a benefits change form to the City HR Benefits and Wellness office at the City.

You may also enroll yourself, your *spouse*, and/or any *dependent* Child(ren), who are not currently enrolled in the Plan, if either:

1. you, your *spouse*, and/or any dependent child(ren) is covered under a *Medicaid* or CHIP plan and coverage is terminated as a result of the loss of eligibility for *Medicaid* or CHIP coverage
2. *Medicaid* and state Child Health Insurance Programs. An *employee* or dependent who is eligible, but not enrolled in this Plan, may enroll if:
 - a. The *employee* or dependent is covered under a *Medicaid* plan under Title XIX of the Social Security Act or a state Child Health Insurance Plan (CHIP) under Title XXI of such Act, and coverage of the *employee* or dependent is terminated due to loss of eligibility for such coverage, and the *employee* or dependent requests enrollment in this Plan within sixty (60) days after such *Medicaid* or CHIP coverage is terminated.
 - b. The *employee* or dependent becomes eligible for assistance with payment of *employee* contributions to this Plan through a *Medicaid* or CHIP plan (including any waiver or demonstration project conducted with respect to such plan), and the *employee* or dependent requests enrollment in this Plan within sixty (60) days after the date the *employee* or dependent is determined to be eligible for such assistance.

Individuals losing other coverage. An *employee* or dependent who is eligible, but not enrolled in this Plan, may enroll if each of the following conditions is met:

1. The *employee* or *dependent* was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.
2. If required by the *Plan Administrator*, the *employee* stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.
3. The coverage of the *employee* or dependent who had lost the coverage was under *COBRA* and the *COBRA* coverage was exhausted, or was not under *COBRA* and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or The City of Colorado Springs contributions toward the coverage were terminated.
4. The *employee* or dependent requests enrollment in this Plan no later than thirty (30) calendar days after the date of exhaustion of *COBRA* coverage or the termination of coverage or The City of Colorado Springs contributions, described above. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.

If the *employee* or dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim), that individual does not have a Special Enrollment Right.

Dependent Beneficiaries. If:

1. The *employee* is a *participant* under this Plan (or has met the waiting period applicable to becoming a *participant* under this Plan and is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period).
2. If a person becomes a dependent of the *employee* through marriage, birth, adoption, or placement for adoption, then the dependent (and if not otherwise enrolled, the *employee*) may be enrolled under this Plan as a covered dependent of the covered *employee* **but only if you have completed the prescribed enrollment procedures and if you also enroll in coverage on that day.** The *spouse* of the covered *employee* may be enrolled as a dependent of the covered *employee* if the spouse is otherwise eligible for coverage.

3. The dependent Special Enrollment Period is a period of thirty (30) calendar days and begins on the date of the marriage, birth, adoption, or placement for adoption.
4. The coverage of the dependent enrolled in the Special Enrollment Period will be effective:
 - a. in the case of marriage, the first day of the first month beginning after the date of the completed request for enrollment is received
 - b. in the case of a dependent's birth, as of the date of birth
 - c. in the case of a *dependent's* adoption or placement for adoption, the date of the adoption or placement for adoption
 - i. If a child is placed for adoption with you, and if the adoption does not become final, coverage of that child will terminate at the end of the month in which you no longer have a legal obligation to support that child.
 - ii. A copy of the placement agreement entered into between you and an authorized placement agency must be provided as supporting documentation with the completed benefit enrollment/change form.

I. Open Enrollment

Every year during the annual *open enrollment period*, covered *employees*, *FPPA Retirees*, and *COBRA* qualified beneficiaries and their covered dependents will be able to change some of their benefit decisions based on which benefits and coverages are right for them.

Benefit choices made during the *open enrollment period* will become effective January 1 and remain in effect until the next January 1 unless there is a change in family status during the year (birth, death, marriage, divorce, adoption) or loss of coverage due to loss of a *spouse's* employment.

Open enrollment is the only period during which you can change your pre-tax or post-tax deduction elections.

Note that deletions of coverage of dependents during the *open enrollment period* are not qualifying events under *COBRA*. However, in the event the *employee* drops spouse coverage during the *open enrollment period* in anticipation of the finalization of a divorce not yet completed (including anticipation of legal separation or dissolution of common law marriage), the ex-spouse may qualify for *COBRA* continuation effective on the date of the final divorce order. The Plan must receive notice within sixty (60) calendar days of the event (divorce decree of dissolution of marriage including for a marriage under common law) per *COBRA* regulations. (See the **Continuation Rights Under COBRA** section if this situation applies to you.)

Participants will receive detailed information regarding the *open enrollment period* from The City of Colorado Springs.

J. Restrictions on Elections during Open Enrollment

1. The Plan will not allow a person to be covered both as an *employee* and as a dependent. No person may be covered as a dependent of more than one (1) *employee*.
2. Enrollment must be completed before the end of the *open enrollment period*.

K. Failure to Make a New Election During Open Enrollment

1. If you have been enrolled for coverage and you fail to make a new election during the *open enrollment period*, you will be considered to have made an election to retain the same medical coverage you had during the preceding plan year. If under the *Cafeteria Plan* you have previously elected to have your premiums paid on a pre-tax basis that election will remain in effect.

L. National Medical Support Notice (NMSN) Special Rule for Enrollment

1. According to federal law, a National Medical Support Notice, or NMSN, is a child support order of a court or state administrative agency that usually results from a divorce or legal separation, that has been received by the Plan, and that includes all of the following:

- a. designates the *employee* to pay for a child's health plan coverage
 - b. indicates the name and last known address of the *employee* required to pay for the coverage and the name and mailing address of each child covered by the NMSN
 - c. contains a reasonable description of the type of coverage to be provided under the designated *employee's* health care plans or the manner in which such type of coverage is to be determined
 - d. states the period for which the NMSN applies
 - e. identifies each health care plan to which the NMSN applies
2. An order is not a NMSN if it requires the Plan to provide any type or form of benefit or any option that the Plan does not otherwise provide, or if it requires an *employee* who is not eligible to be covered by the Plan to provide coverage for a dependent child, except as required by a state's *Medicaid* related child support laws. For a state administrative agency order to be a NMSN, state statutory law must provide that such an order will have the force and effect of law, and the order must be issued through an administrative process established by state law.
 3. If a court or state administrative agency has issued an order with respect to health care coverage for any of the *employee's* dependent children, the *Plan Administrator* or its designee will notify the *employee* and the child(ren) (or their designated representative) of the receipt of the order, and will provide such persons (a) the name and contact information of the person acting on behalf of the *Plan Administrator* and (b) a copy of these rules for enrollment pursuant to NMSN orders. The *Plan Administrator* will then determine if that order is a NMSN as defined by federal law, and that determination will be binding on the *employee*, the other parent, the child and any other party acting on behalf of the child. If the *Plan Administrator* determines that an order is not a NMSN, or that coverage of the child is not required to be provided under the terms of the Plan, the *Plan Administrator* will notify the parents and each child named in the NMSN (or such child's designated representative) of the basis for the *Plan Administrator's* determination. If an order is determined to be a NMSN, and if the *employee* is covered by the Plan, the *Plan Administrator* or its designee will so notify the parents and each child identified in the NMSN (or such children's designated representative), and advises them of the Plan's procedures that must be followed to provide coverage of the dependent child(ren).
 4. If the *employee* is a *participant* in the Plan, the NMSN may require the Plan to provide coverage for the *employee's* dependent child(ren) and to accept contributions for that coverage from a parent who is not a *Plan participant*. The Plan will accept a special enrollment of the dependent child(ren) specified by the NMSN from either the *employee* or the custodial parent. Coverage of the dependent child(ren) shall become effective on the date of receipt of the NMSN order and shall be subject to all terms and provisions of the Plan, and limits on selection of provider and requirements for authorization of services, insofar as is permitted by applicable law.
 5. If the *employee* is not a participant in the Plan at the time the NMSN is received, but satisfies the Plan's eligibility conditions, and the NMSN orders the *employee* to provide coverage for the dependent child(ren) of the *employee*, the Plan will enroll the *employee* and the dependent child(ren) specified by the NMSN with coverage effective on the first of the month following receipt of NMSN order, and shall be subject to all terms and provisions of the Plan.
 6. No coverage will be provided for any dependent child under a NMSN unless the applicable *employee* contributions for that dependent child's coverage are paid, and all of the Plan's requirements for coverage of that dependent child have been satisfied. Contributions required for coverage under a NMSN are the total *employer* contributions required for coverage of the *employee* and all members of the *employee's* family who are enrolled in the Plan, minus the contributions otherwise actually being paid by the *employee*.
 7. Coverage of a dependent child under a NMSN will terminate when coverage of the *employee* terminates for any reason, including failure to pay any required contributions, subject to the dependent child's right to elect *COBRA* Continuation Coverage if that right applies.
 8. For *additional* information regarding the procedures for payment of *claims* under a NMSN, see the **Claims and Appeals** section of this document.

M. Effective Date

Effective Date of Coverage. An *employee* will be covered under this Plan as of the first day of the month following:

1. the date benefit elections are submitted provided they are submitted within thirty (30) calendar days of the date of hire

Active Employee Requirement. An *employee* must be an *active employee* (as defined by this Plan) for this coverage to take effect.

Effective Date of Dependent Coverage. A dependent's coverage will take effect on the day that the eligibility requirements are met; the *employee* is covered under the Plan; and all enrollment requirements are met.

N. Termination of Coverage

When coverage under this Plan stops, *participants* will receive a certificate that will show the period of creditable coverage under this Plan. The Plan maintains written procedures that explain how to request this certificate. Please contact the *Plan Administrator* for a copy of these procedures and for further details.

The *employer* or Plan has the right to rescind any coverage of the *employee* and/or retiree and/or dependents for cause, making a fraudulent claim or an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan. The *employer* or Plan may either void coverage for the *employee* and/or covered retirees and/or covered dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least thirty (30) days' advance written notice of such action. The *employer* will refund all contributions paid for any coverage rescinded however, claims paid will be offset from this amount. The *employer* reserves the right to collect additional monies if claims are paid in excess of the *employee's* and/or retiree's and/or dependent's paid contributions.

When Employee Coverage Terminates. Your coverage ends on the earliest of these dates (except in certain circumstances, a covered *employee* may be eligible for *COBRA* continuation coverage. For a complete explanation of when *COBRA* continuation coverage is available, what conditions apply and how to select it, see the section entitled **Continuation Coverage Rights under COBRA**):

1. the end of the month in which your employment ends
2. the end of the month in which you no longer are eligible to participate in the Plan
3. the date the Plan ends
4. the end of the month for which contributions were paid for your coverage

When the Plan Can End Your Coverage for Cause. The *Plan Administrator* or its designee may end your coverage and/or the coverage of any of your covered dependents for cause retrospectively back to the date of improper coverage after the Plan provides you and/or the affected dependent(s) a thirty (30) day advanced written notice of its findings that you or your covered dependent(s):

1. made a fraudulent statement, a material misrepresentation, or omitted any material information in any enrollment procedure or form, *claim*, or other form in order to obtain coverage, services or benefits under the Plan
2. allowed someone else to use the identification card that entitles you or your covered dependent to coverage, services or benefits under the Plan
3. altered any prescription furnished by a *physician*
4. committed fraudulent, disruptive, or illegal acts
5. engaged in conduct that was abusive, obstructive, or otherwise detrimental to a participating *provider* as determined by the *Plan Administrator* or its designee

When Dependent Coverage Terminates. Coverage of your covered dependents ends on the **earliest** of:

1. the date your own coverage ends
2. the end of the month in which your covered *spouse* or dependent child(ren) no longer meets the definition of *spouse* or dependent child(ren)
3. the end of the month for which contributions were paid for their coverage

You, your spouse, or any of your dependent children must notify City HR Benefits and Wellness no later than thirty (30) calendar days (to change enrollment elections), and no later than sixty (60) calendar days (to preserve COBRA rights) following the date of:

1. a divorce, legal separation, or annulment
2. a dependent child reaching the Plan's limiting age of twenty-six (26)
3. a dependent child entering the military or similar service (e.g. Military Academy)
4. has any physical or mental disability
5. ceases to have any physical or mental disability

O. Family and Medical Leave Act/Family Care Act

Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the Family and Medical Leave Act (FMLA) of 1993 as promulgated in regulations issued by the Department of Labor and Colorado's Family Care Act.

During any leave taken under FMLA/FCA, the *employer* will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered *employee* had been continuously employed during the entire leave period as long as the *employee* continues to pay their portion of the cost of benefits.

If Plan coverage terminates during the FMLA/FCA leave, coverage will be reinstated for the *employee* and his or her covered dependents if the *employee* returns to work in accordance with the terms of the FMLA/FCA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA/FCA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated. For example, waiting periods will not be imposed unless they were in effect for the *employee* and/or his or her dependents when Plan coverage terminated.

If an *employee* does not return to work after twelve (12) weeks of FMLA/FCA leave and has exhausted all other applicable leaves, **the Plan is entitled to collect the cost of contributions made on the employer's behalf** for *employee* and *employee* dependent medical coverage during the FMLA leave and recovery will be sought by the *Plan Administrator* for any monies not yet paid by the *employee* or dependents.

P. Active Military Duty

Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act (USERRA) under the following circumstances. These rights apply only to *employees* and their dependents covered under the Plan immediately before leaving for military service.

1. The maximum period of coverage of a person and the person's dependents under such an election shall be the lesser of:
 - a. the twenty-four (24) month period beginning on the date on which the person's absence begins
 - b. the day after the date on which the person was required to apply for or return to a position of employment and fails to do so
2. A person who elects to continue health plan coverage must pay up to 102% of the full contribution under the Plan, except a person on active duty for thirty (30) days or less cannot be required to pay more than the *employee's* share, if any, for the coverage.
3. An exclusion or waiting period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or waiting period may be imposed for coverage of any *illness* or *injury* determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

If the *employee* wishes to elect this coverage or obtain more detailed information, contact the *Plan Administrator*. The *employee* may also have continuation rights under USERRA. In general, the *employee* must meet the same requirements for electing USERRA coverage as are required under COBRA continuation coverage requirements. Coverage elected

under these circumstances is concurrent not cumulative. The *employee* may elect USERRA continuation coverage for the *employee* and their dependents. Only the *employee* has election rights. Dependents do not have any independent right to elect USERRA health plan continuation.

Q. Leave of Absence

For any other approved leave, you may be required to pay the full cost for your medical coverage during any unpaid leave of absence after the first thirty (30) calendar days of such unpaid leave of absence.

R. Reinstatement of Coverage After Leaves of Absence

If your coverage ends while you are on an approved leave, your coverage will be reinstated on the day you return to active employment, subject to all accumulated individual benefit maximums that were *incurred* prior to the leave of absence.

Any period of approved leave of absence including a leave of absence under the provisions of the Family and Medical Leave Act or the Uniformed Service Employment and Reemployment Rights Act will **not** be counted as a break in coverage for purposes of determining medical benefits.

Questions regarding your entitlement to an approved leave of absence and to the continuation of medical coverage should be referred to your City Human Resources Department.

SECTION IV—MEDICAL BENEFITS

Medical benefits apply when *covered charges* are incurred by a *participant* for care of an *injury* or *illness* and while the person is covered for these benefits under the Plan.

A. Deductible

Deductible Amount. This is an amount of *covered charges* for which no benefits will be paid. Before benefits can be paid in a *benefit year* a *participant* must meet the *deductible* shown in the Schedule of Medical Benefits.

Family Limit. When the maximum amount shown in the Schedule of Medical Benefits has been incurred by members of a family toward their *benefit year deductibles*, the *deductibles* of all members of that family will be considered satisfied for that year.

B. Co-Insurance

For *covered charges incurred* with a *network provider*, the Plan pays a specified percentage of the negotiated rate. This percentage varies, depending on the type of eligible expense, and is specified in the Schedule of Medical Benefits. You are responsible for the difference between the percentage the Plan pays and 100% of the negotiated rate.

For *covered charges incurred* with a *non-network provider*, the Plan pays a specified percentage of *covered charges* at the *reasonable and customary* amount. In those circumstances, you are responsible for the difference between the percentage the Plan pays and 100% of the billed amount.

These amounts for which you are responsible are known as *co-insurance*.

C. Co-Payments

In certain cases, instead of paying a *co-insurance*, you must pay a specific dollar amount, as specified in the Schedule of Medical Benefits. This amount for which you are responsible is known as a *co-payment*, and is typically payable to the *health care provider* at the time services or supplies are rendered.

D. Benefit Payment

Each *benefit year*, benefits will be paid for the *covered charges* of a *participant* that are in excess of the *deductible*, any *co-payments*, and any amounts paid under basic benefits for the same services. Payment will be made at the rate shown under reimbursement rate in the Schedule of Medical Benefits. No benefits will be paid in excess of any listed limit of the Plan.

E. Out-of-Pocket Maximum

Covered charges are payable at the percentages shown each *benefit year* until the *out-of-pocket maximum* shown in the Schedule of Medical Benefits is reached. Then, *covered charges incurred* by a *participant* will be payable at 100% (except for any excluded charges) for the rest of the *benefit year*.

When a family unit reaches the *out-of-pocket maximum*, *covered charges* for that family unit will be payable at 100% (except for any excluded charges) for the rest of the *benefit year*.

F. Wellness Program Notice

The wellness program may include a health assessment and intervention programs, which includes a personal health risk questionnaire. Participation in the wellness program may result in financial incentives or rewards under the Plan. If it is unreasonably difficult due to a medical condition for you to achieve the standards for any reward under the wellness

program, or if it is medically inadvisable for you to attempt to achieve the standards for a reward, contact the *Plan Administrator* to determine an alternative method for you to qualify for the reward.

G. Women’s Health and Cancer Rights Act of 1998 (WHCRA)

The Women’s Health and Cancer Rights Act of 1998 (WHCRA) requires that you be informed of your rights to *surgery* and prostheses following a covered mastectomy.

The Plan will pay charges *incurred* for a *participant* who is receiving benefits in connection with a mastectomy and then elects breast reconstruction in connection with the mastectomy. Coverage will include (a) reconstruction of the breast on which the mastectomy has been performed; (b) *surgery* and reconstruction of the other breast to produce a symmetrical appearance; and (c) prosthesis and treatment of physical complications of all stages of mastectomy, including lymphedemas.

H. Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) – Effective Jan. 1, 2010

MHPAEA requires *employers* that sponsor group health plans for *employees* and their families to ensure that there is parity between the medical and surgical benefits and the mental health or substance use disorder benefits provided under the plans. In particular, MHPAEA requires group health plans to ensure that: (1) the financial requirements applicable to mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to medical and surgical benefits under the plan; (2) there are no separate cost-sharing requirements that are applicable only to mental health or substance use disorder benefits; (3) the treatment limitations applicable to mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to medical and surgical benefits under the plan; and (4) there are no separate treatment limitations that are applicable only to mental health or substance use disorder benefits.

I. Autism Colorado State Law – effective Jan 1, 2011

When not otherwise excluded, the Plan covers *medically necessary* services for the treatment of autism spectrum disorders (ASD) with the criteria of the Diagnostic and Statistical Manual of Mental Health Disorders, Fourth Edition, Text Revision (DSM-IV-TR) are met. Autism spectrum disorders includes the following neurobiological disorders: Autistic disorder, Asperger’s disorder, and atypical autism as a diagnosis within pervasive developmental disorder not otherwise specified, as defined in the most recent edition of the diagnostic and statistical manual of mental disorders, at the time of diagnosis. Please refer to the coverage on speech/language therapy, occupation therapy and physical therapy for specific coverage criteria for the therapies.

The Plan covers genetic testing for ASD as *medically necessary* for the following situations:

1. for confirmation testing for FMR1 gene mutation when fragile X syndrome is suspected in the presence of either dysmorphic features or mental retardation
2. for confirmation testing for MECP2 gene mutations when Rett’s Disorder is suspected
3. for carrier testing when there is a positive family history of fragile X syndrome or Rett’s disorder in a first – or second-degree relative
4. for prenatal or preimplantation genetic diagnosis (PGD) testing when either parent is a known carrier of a disease-causing mutation of genes FMR1 or MECP2

Treatment for autism spectrum disorders including: evaluation and assessment services, behavior training and behavior management, and applied behavior analysis, including consultations, direct care, supervision, or treatment, habilitative or rehabilitative care, including occupational therapy, physical therapy, or speech therapy, pharmacy care and medication (if covered by the insurance plan for other illness), psychiatric care, psychological care, including family counseling,; and therapeutic care.

J. Eligible Medical Expenses

Eligible expenses are the *reasonable and customary amounts* that are *incurred* for the following items of service and supply. These charges are subject to the benefit limits, exclusions and other provisions of this Plan. A charge is *incurred* on the date that the service or supply is performed or furnished.

1. **Accidental Injuries.** Services and supplies to treat *accidental injuries*. The *deductible* will be waived for medical expenses *incurred* within ninety (90) days of an *accidental injury*.
2. **Ambulance.** Benefits will be provided for licensed ground, air, and sea *ambulance* services used to transport you from the place where you are *injured* or stricken by *illness* or *injury* to the nearest accredited general hospital with adequate facilities for treatment. Benefits will be provided for inter-facility *ambulance* transport as deemed *medically necessary*.
3. **Anesthetics.** Includes anesthetic; oxygen; blood, and blood derivatives that are not donated or replaced; intravenous injections/solutions, and the administration of these items.
4. **Assistant Surgeon.** An assistant surgeon will be treated as an *in-network provider* if the facility and the primary surgeon are *in-network*. If the assistant surgeon is an *in-network provider*, the assistant surgeon's allowable fees will be limited to 20% of the allowable fees of the primary surgeon. If the assistant surgeon is not an *in-network provider*, the assistant surgeon's allowable fees will be limited to 20% of the *reasonable and customary* fees of the primary surgeon.
5. **Autism Spectrum Disorders.**
6. **Bereavement Counseling.**
7. **Blood.** Non-replaced blood, blood plasma, blood derivatives, and their administration and processing.
8. **Breast Pump and Supplies.** Covered expenses include: The rental or purchase of one (1) breast pump per pregnancy as ordered or prescribed by a physician; Tubing for breast pump, replacement; Adapter for breast pump, replacement; Cap for breast pump bottle, replacement; Breast shield and splash protector for use with breast pump, replacement; Polycarbonate bottle for use with breast pump, replacement; Locking ring for breast pump, replacement; Breast pump, manual, any type; Breast pump, electric (ac and/or dc), any type; Breast pump, hospital grade, electric (ac and / or dc), any type.
9. **Cardiac Rehabilitation.** As deemed *medically necessary* provided services are rendered:
 - a. under the supervision of a *physician*
 - b. in connection with a myocardial infarction, coronary occlusion, or coronary bypass *surgery*
 - c. initiated within twelve (12) weeks after other treatment for the medical condition ends
 - d. in a *medical care facility* as defined by this Plan
10. **Cataract Surgery.** Services and supplies associated with cataract *surgery*, including the initial purchase of eyeglasses or contact lenses following the *surgery*.
11. **Chemotherapy.** Radiation or chemotherapy and treatment with radioactive substances. The materials and services of technicians are included.
12. **Chiropractic.** Chiropractic services by a licensed M.D., D.O., or D.C., including any necessary related diagnostic x-rays.
13. **Clinical Trials.** Refer to the Clinical Trials section for a further description and limitations of this benefit. **Pre-certification is required.**
14. **Congenital Defects.** Services for physical, occupational, and speech therapy for *participants* age ten (10) and above for congenital defects. All specific benefit maximums apply.
15. **Dental Injuries.** *Injury* to or care of the mouth, teeth, gums, and alveolar processes will be *covered charges* under this Plan only if that care is for the following oral *surgical* procedures:
 - a. excision of tumors and cysts of the jaw, cheeks, lips, tongue, roof and floor of the mouth
 - b. emergency repair due to injury to sound natural teeth

- c. *surgery* needed to correct *accidental injuries* to the jaws, cheeks, lips, tongue, floor and roof of the mouth
- d. excision of benign bony growths of the jaw and hard palate
- e. external incision and drainage of cellulitis
- f. incision of sensory sinuses, salivary glands or ducts
- g. removal of bony impacted teeth
- h. reduction of dislocations and excision of *temporomandibular joints (TMJ)*

NOTE: No charge will be covered under this Plan for dental and oral *surgical* procedures involving orthodontic care of teeth, periodontal disease, and preparing the mouth for fitting of or continued use of dentures.

16. **Diabetic Care Management.** Ongoing diabetic care management shall mean quarterly document proof, no later than fifteen (15) days prior to the end of the quarter, to the *City's* designated program coordinator of one (1) or more of the following:
 - a. proof of a *physician office visit* specifically scheduled for the monitoring of diabetes
 - b. proof of a scheduled visit with the Diabetes Ten City Challenge program coordinator
 - c. proof of attendance at a diabetic support group or educational class
17. **Diabetic Education.** Services and supplies used in *outpatient* diabetes self-management programs are covered under this Plan when they are provided by a health care professional for the treatment of diabetes. For the purposes of this diabetic instruction benefit, health care professional means *physicians*, nurses, pharmacists, and registered dietitians who are knowledgeable about diabetes and the treatment of a person with diabetes.
18. **Dialysis.** *Allowable expenses* for dialysis shall mean 130% of *Medicare* allowable as published by the Centers for Medicare and Medicaid Services. The patient must apply for *Medicare* before coverage under this Plan begins. If you have chronic kidney failure and need hemodialysis or peritoneal dialysis, the City of Colorado Springs will cover these services on an ambulatory or home basis to the extent set forth below:
 - a. In a hospital-based or freestanding facility, dialysis treatment is covered on a walk-in basis if the appropriate government authorities approve the dialysis program. Home treatment is covered. The City of Colorado Springs will cover the reasonable rental cost of equipment as determined by the Plan, and all appropriate and necessary supplies required for home dialysis treatment.
 - b. These dialysis benefits will be available until the patient becomes eligible for coverage under *Medicare*. *Medicare* is the secondary payer during a period of thirty (30) months of actual *Medicare* coverage for beneficiaries who have *Medicare* solely on the basis of permanent kidney failure and have coverage under this Plan.
19. **Durable Medical Equipment.** Rental of *durable medical equipment* if deemed *medically necessary*. The total rental fee for *durable medical equipment* will not exceed the purchase price of the equipment.
20. **Family Planning.** Services for vasectomy, Tubal ligation, and other female sterilization procedures, and contraceptive injections will be covered without cost sharing.
21. **Habilitative Therapy.** Habilitative physical therapy, occupational therapy or speech therapy is care provided for conditions which have limited the normal age appropriate motor, sensory or communication development. To be considered habilitative, functional improvement and measurable progress must be made toward achieving functional goals within a predictable period of time toward a *participant's* maximum potential.
22. **Home Health Care.** Charges for *home health care* services and supplies are covered only for care and treatment of an *injury* or *illness* when *hospital* or *skilled nursing facility* confinement would otherwise be required. The diagnosis, care, and treatment must be certified by the attending *physician* and be contained in a *home health care* plan.
23. **Home Infusion Therapy.**
24. **Hospice Care.** *Hospice* care services up to a six (6) month period as an alternative to hospitalization for a terminally ill *participant*. Services must be rendered by a state-licensed *hospice* care agency and included in a written *hospice* care plan established and periodically reviewed by the attending *physician*. The *physician* must certify the *participant* is terminally ill and that *hospital* confinement would be required in the absence of the *hospice* care.

The *hospice* care plan shall also describe the services and supplies for palliative care and *medically necessary* treatment to be provided to the *participant* by the *hospice* care agency. Benefits are provided for:

- a. rental of *durable medical equipment* needed for treatment
 - b. medical supplies
 - c. visits by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.), Physical Therapist, Respiratory Therapist, Speech Therapist, Occupational Therapist, Master Of Social Work (M.S.W.), or a Home Health Aide, not to exceed four (4) hours in duration per visit
 - d. respite care limited to one hundred twenty (120) hours each three (3) month period of *hospice* care to relieve all persons caring for and residing with a homebound *participant* from their duties. The three (3) month period begins on the initial date of *hospice* care covered under this program.
25. **Hospital Care.** The medical services and supplies furnished by a *hospital* or *ambulatory surgical facility* or a *birthing center*. After twenty-three (23) observation hours, a confinement will be considered an *inpatient* confinement.
- a. Services for general anesthesia and related *hospital* or *ambulatory surgical center* services if *medically necessary* for dental procedures if (a) the *participant* is under age seven (7), (b) is disabled physically or developmentally and has a dental condition that cannot be safely and effectively treated in a dental office, or (c) the *participant* has a medical condition besides the dental condition needing treatment that the attending *provider* finds would create an undue medical risk if the treatment were not done in a *hospital* or *ambulatory surgical center*. This benefit does not cover the *dentist's* services.
26. **Infertility.** Services include *office visits* and diagnostic testing.
27. **Intensive Care Unit.** Charges for an *intensive care unit* stay.
28. **Laboratory Studies.**
29. **Maternity.** Pregnancy and complications of pregnancy shall be covered as any other *illness* for the *employee* or *spouse*, or eligible dependent(s). Benefits include pre-and post-natal care, obstetrical delivery, caesarean section, miscarriage, and complications resulting from the pregnancy.
- Note:** Breastfeeding support, supplies, and counseling are also available without cost-sharing when services are received from an *in-network provider*.
30. **Medical Supplies.** *Surgical* dressings, splints, casts, and other devices used in the reduction of fractures and dislocations. Supplies and dressing when *medically necessary* for *surgical* wounds, cancer, burns, or diabetic ulcers, colostomy bags and catheters, and *surgical* and orthopedic braces.
31. **Mental Disorders.** Services and supplies used for the treatment of *mental disorders*.
32. **Midwife Services.** Benefits for midwife services performed by a Certified Nurse Midwife (C.N.M.) who is certified/licensed as such and acting within the scope of his or her license, unless expressly not covered by this Plan. This Plan will not provide benefits for lay midwives or other individuals who become midwives by virtue of their experience in performing deliveries. Midwives may not independently manage moderate or high-risk mothers, admit to a *hospital*, or prescribe all types of medications.
33. **Naturopathic/Homeopathic Care.** Services provided by a licensed naturopath/homeopath. This benefit does not include charges for naturopathic/homeopathic supplies or solutions.
34. **Orthotic Appliances.** The initial purchase, fitting, and repair of orthotic appliances such as braces, splints, or other appliances which are required for support for an *injured* or deformed part of the body as a result of a disabling congenital condition or an *injury* or *illness*.
35. **Oxygen.** Oxygen and its administration.
36. **Physician Care.** The professional services of a *physician* for medical services.
37. **PKU Formula.**
38. **Pre-Admission Testing.** Pre-admission testing includes diagnostic lab and x-rays and EKG's that you obtain on an *outpatient* basis prior to your scheduled admission to the *hospital*. However, you should make sure your *hospital* will accept the results of these tests and not simply repeat them.

39. **Prenatal Testing.** Services for prenatal diagnosis or congenital disorders by the fetus by means of screening and diagnostic procedures will be provided the same as for any other condition during your covered pregnancy. Such services must be *medically necessary* in accordance with standards set in rule by the Board of Health.
40. **Prosthetic Devices.** The initial purchase, fitting, and repair of fitted prosthetic devices which replace body parts. Benefits for repair or replacement of a prosthesis due to normal use, adolescent growth, or pathological changes will be provided.
41. **Reconstructive Surgery.** Reconstructive surgery expenses are covered in only the following three (3) circumstances:
- when needed to correct damage caused by a birth defect resulting in the malformation or absence of a body part
 - to correct damage caused by an *accidental injury*
 - for breast reconstruction following a total or partial mastectomy as follows
 - reconstruction of the breast on which the mastectomy has been performed
 - surgery* and reconstruction of the other breast to produce a symmetrical appearance
 - prosthesis and treatment of physical complications of all stages of mastectomy, including lymphedemas
42. **Rehabilitation Services.** Services include physical therapy, occupational therapy, and speech therapy rendered on an *inpatient* or *outpatient* basis.
43. **Routine Nursery Care.** Routine well newborn nursery care is care while the newborn is *hospital* confined after birth and includes room, board, and other normal care for which a *hospital* makes a charge. Charges for covered routine nursery care will be applied toward the Plan of the newborn child.
44. **Routine Preventive Care.** Benefits will be provided for routine preventive care including, but not limited to, routine physical exams, gynecological exams, pap smears, mammograms, prostate exams, necessary diagnostic lab and x-ray services, well-baby and well-child care, and routine immunizations and vaccinations. A current listing of preventive care services can be accessed at <https://www.healthcare.gov/what-are-my-preventive-care-benefits/>.
45. **Second Surgical Opinion.** If your doctor recommends *surgery* or other medical treatment, it is often in your best interest to obtain a second opinion with a specialist regarding the necessity of the procedure. In many cases, an alternative method of treatment is available that would save you the discomfort of *surgery* or other medical treatment as well as the time and extra expenses.
46. **Sleep Studies.** Sleep studies done in the home or a facility.
47. **Skilled Nursing Facility.** Benefits for care in a public or private facility, licensed and operated according to law, that primarily provides skilled nursing and related services to people who require medical or nursing care and that rehabilitates *injured*, disabled, or sick people, and that meets **all** of the following requirements:
- It is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as a *skilled nursing facility* or is recognized by *Medicare* as a *skilled nursing facility*.
 - It is regularly engaged in providing room and board and continuously provides twenty-four (24) hour-a-day skilled nursing care of sick and *injured* persons at the patient's expense during the convalescent stage of an *injury* or *illness*, maintains on its premises all facilities necessary for medical care and treatment, and is authorized to administer medication to patients on the order of a licensed *physician*.
 - It provides services under the supervision of *physician*.
 - It provides nursing services by or under the supervision of a licensed Registered Nurse (R.N.), with one (1) licensed Registered Nurse on duty at all times.
 - It maintains a daily medical record of each patient who is under the care of a licensed *Physician*.
 - It is not (other than incidentally) a home for maternity care, rest, domiciliary care, or care of people who are aged, alcoholic, blind, deaf, drug addicted, mentally deficient, mentally ill, or suffering from tuberculosis.
 - It is not a hotel or motel.

h. A *skilled nursing facility* that is part of a *hospital*, as defined in this document, will be considered a *skilled nursing facility* for the purposes of this Plan.

48. **Substance Abuse.** Services and supplies used for the treatment of *substance abuse*.

49. **Surgery.** Benefits for the treatment of *illnesses* and *injuries* including fractures and dislocations are covered for the surgeon, assistant surgeon, anesthesiologist, and surgical supplies.

50. **Transplants.** Services and supplies that are incurred for care and treatment due to an organ or tissue transplant are subject to the following limits:

a. The transplant must be performed to replace an organ or tissue of the *participant*.

b. Charges for obtaining donor organs or tissue are *covered charges* under the Plan when the recipient is a *participant*. The donor expenses will be covered up to \$10,000. If the donor is a *participant*, his or her expenses will not be covered unless the recipient is also a *participant* and the \$10,000 limit for the donors expenses shall apply. Donor charges include those for:

- evaluating the organ or tissue
- removing the organ or tissue from the donor
- transportation of the organ or tissue from within the United States or Canada to the place where the transplant is to take place

Refer to the **Transplant Program** section for further details regarding this benefit.

51. **TMJ.** Benefits for medical or dental services for treatment of temporomandibular joint disorders.

52. **Vision.** Routine vision services are only considered for benefits if the *participant* is not covered under Vision Service Plan (VSP). Services include a routine eye exam and/or refractive analysis.

53. **Wigs, Toupees or Hairpieces.** Charges associated with the initial purchase of a wig, toupee, or hairpiece after chemotherapy.

54. **X-Rays.** Diagnostic x-rays.

K. Medical Plan Exclusions

The Plan will not provide benefits for any services or supplies not listed in the Eligible Medical Expenses section or Schedule of Medical Benefits, regardless of *medical necessity* or recommendation of a *health care provider*. The following list is intended to give you a general description of expenses for services and supplies not covered by the Plan. This list is not exhaustive.

This exclusion does not apply if the *injury* resulted from an act of domestic violence (victim of the violence only, not the aggressor) or a medical (including both physical and mental health) condition.

1. **Abortion.** Services, supplies, care, or treatment in connection with an abortion unless the life of the mother is endangered by the continued pregnancy or the pregnancy is the result of rape or incest.
2. **Armed Forces.** Services or supplies furnished, paid for, or for which benefits are provided or required by reason of past or present service of any covered *participant* in the armed forces of a government.
3. **Before or After Eligibility.** Services, supplies, or accommodations provided prior to the *participant's* effective date or after the termination of coverage.
4. **Behavioral Health Care.** Expenses for residential care services for behavioral health care related to the following (excludes treatment for autism spectrum disorders):
 - a. all court-ordered behavioral health care services (to include but not limited to DUI, DWAI, DUID, domestic violence, anger management)
 - b. custody evaluations and counseling for subscriber and/or dependents
 - c. developmental disabilities, mental retardation, vocation disabilities without a diagnosis for a spectrum disorder
 - d. learning disabilities to include evaluation for education purposes to include education planning
 - e. psychotherapy credited towards earning a degree or required for educational purposes
5. **Blood.** Expenses for donation, collection, or administration incurred as a result of non-autologous donation or collection of blood, blood products, or biological serum.
6. **Chelation Therapy.** Expenses for chelation therapy, except as may be *medically necessary* for treatment of acute arsenic, gold, mercury, or lead poisoning, and for diseases due to clearly demonstrated excess of copper or iron.
7. **Clinical Trials.** Services and supplies specifically excluded in the requirements set forth in the *PPACA* mandate. Refer to the Clinical Trials section for additional information.
8. **Corrective Appliances and Durable Medical Equipment Exclusions.**
 - a. expenses for replacement of lost, missing, or stolen *corrective appliances*, including orthotic devices, prosthetic appliances, or *durable medical equipment*
 - b. expenses for duplicate *corrective appliances*, including orthotic devices, prosthetic appliances, or *durable medical equipment*
 - c. expenses for services or supplies designed to personalize (unless *medically necessary*), orthotic devices and/or *durable medical equipment* (including exercise or hygienic equipment)
 - d. expenses for *corrective appliances* and *durable medical equipment* to the extent they exceed the cost of standard models of such *corrective appliances* or *durable medical equipment*
9. **Cosmetic.** *Surgery* or medical treatment to improve or preserve physical appearance, but not physical function. *Cosmetic surgery or treatment* includes, but is not limited to removal of tattoos, breast augmentation, or other medical or *surgical* treatment intended to restore or improve physical appearance, such as enlargement, reduction, or to change the appearance of the lips, jaw, chin, nose, ears, or genitals as determined by the *Plan Administrator* or its designee. Notwithstanding the foregoing, any complications from such procedures are eligible for coverage. The Medical Plan does cover breast reconstruction after a mastectomy and to correct or repair the physical functioning of or damage to a body part as a result of a functional disorder due to an *injury* or *illness*. To determine the extent of this coverage, see the Schedule of Medical Benefits.

10. **Counseling.** Benefits for counseling in the absence of *illness* or *injury*, including, but not limited to, premarital or marital counseling, family counseling, education, social, behavioral, or recreational therapy, sex or interpersonal relationship counseling, or counseling with a *participant's* friends, *employer*, school counselor, or school teacher.
11. **Custodial Care.** Expenses for *custodial care*, regardless of where they are provided, including, without limitation, adult day care, child day care, services of a homemaker, or personal care, except when *custodial care* is provided as part of a covered *hospice* program, or when the services of home health aides are payable as home health care services as described in the Schedule of Medical Benefits.
12. **Dental Services.** Expenses for dental prosthetics, dental services, or dental supplies of any kind, including restoration or replacement of *injured* teeth even if they are necessary because of symptoms, *illness*, or *injury* affecting another part of the body. Expenses for dental services may be covered under the Medical Plan if they are to restore the jaw if damaged by an external object in an accident. For the purposes of this coverage by the Plan, an accident does not include any *injury* caused by biting or chewing. See Oral, Craniofacial and TMJ Services in the Schedule of Medical Benefits to determine if those services are covered. Expenses for orthodontia and treatment of prognathism, retrognathism, and orthognathic surgery. Expenses for oral *surgery* to remove impacted teeth, gingivectomies, treatment of dental abscesses, and root canal (endodontic) therapy, other than tumors.
13. **Educational or Vocational Testing.** Services for educational or vocational testing or training.
14. **Employer-Provided Services.** Expenses for services rendered through a medical department, clinic, or similar facility provided or maintained by the *employer*, or if benefits are otherwise provided under this Plan or any other plan that the *employer* contributes to or otherwise sponsors, such as HMOs.
15. **Excess Charges.** The part of an expense for care and treatment of an *injury* or *illness* that is in excess of the *reasonable and customary amount*.
16. **Exercise Programs.** Exercise programs for treatment of any condition.
17. **Expenses Exceeding Maximum Plan Benefits.** Expenses that exceed any Plan benefit limitation, annual maximum benefits, or overall (*lifetime*) maximum benefits as described in the Schedule of Medical Benefits subsection and Medical Benefits section of this document.
18. **Experimental/Investigational or not Medically Necessary.** Expenses for any medical services, supplies, or drugs or medicines that are determined by the *Plan Administrator* or its designee to be *experimental and/or investigational*, as defined in the Defined Terms section of this document, except as set forth in the Clinical Trials section of this plan document. Notwithstanding the foregoing, any complications from such procedures are eligible for coverage.
19. **Faith or Spiritual Healing.** Expenses for prayer, religious healing, or spiritual healing including services provided by a Christian Science Practitioner.
20. **Family Member.** Professional services performed by a person who ordinarily resides in the *participant's* home or is related to the *participant* as a *spouse*, parent, child, brother, or sister, whether the relationship is by blood or exists in law.
21. **Foot Care.** Expenses for routine and non-surgical foot care services and supplies including:
 - trimming or treatment of toenails
 - treatment of corns and calluses
 - removal of thick/cracked skin
 - arch supports, corrective shoes or foot orthotics whether customized or over the counter

This exclusion does not apply to *medically necessary* treatment of the feet (e.g., the removal of nail roots, other podiatry *surgeries*, or foot care services necessarily due to a metabolic or peripheral-vascular disease), or for those individuals who have been diagnosed with diabetes or as otherwise covered under the Plan.

22. **Foreign Travel.** Expenses for services received or supplies purchased outside the United States, if travel outside the United States is for the purpose of treatment.
23. **Gender.** Treatment for transsexualism, gender dysphoria, or sexual reassignment or change including drugs, medication, implants, or other *surgical* treatment, or psychiatric care or treatment.

24. **Genetic Testing and Counseling.** Expenses for genetic services are excluded except when *medically necessary* for treating an *illness* or *injury*, and not preventive in nature.
25. **Government.** Services furnished by or for the U.S. government or any other government. This exclusion does not apply to *Medicaid* or if otherwise prohibited by law.
26. **Hair Loss.** Care and treatment for hair loss including wigs, hair transplants, or any drug that promises hair growth, whether or not prescribed by a *physician*, except for losses due to chemotherapy or radiation therapy.
27. **Hearing.** Expenses for the purchase, servicing, fitting, and/or repair of hearing aid devices, including, but not limited to, hearing aids and cochlear implants, with the exception of hearing aids for children up to age eighteen (18), who have been medically diagnosed with a congenital defect and/or a birth abnormality, and who have obtained a *pre-certification* for the hearing aid. See the Schedule of Medical Benefits.
28. **Homeopathic and Naturopathic Supplies.** Services provided by a licensed naturopath/homeopath are covered. This benefit does not include charges for naturopathic/homeopathic supplies or solutions.
29. **Hospice Care.** Services for pastoral or spiritual counseling, services performed by a family member or volunteer workers, homemaker or housekeeping services, food services (such as Meals on Wheels), legal and financial counseling services, and services or supplies not included in the *hospice* treatment plan or not specifically set forth as a *hospice* benefit.
30. **Hospital Employees.** Professional services billed by a *physician* or nurse who is an employee of a *hospital* or *skilled nursing facility* and paid by the *hospital* or facility for the service.
31. **Hospital Services.** *Hospital* services when hospitalization is primarily for diagnostic studies or physical therapy when such procedures could have been done adequately and safely on an *outpatient* basis.
32. **Immunizations.** Immunizations and vaccinations for the purpose of travel outside of the United States.
33. **Impotence.** Care, treatment, drugs, medicines, devices, services, or supplies in connection with treatment for impotence or infertility.
34. **Infertility.** Expenses *incurred for and in preparation of* (including expenses *incurred* as follow-up treatment to) in vitro fertilization, low tubal transfer, artificial insemination, embryo transfer, gamete transfer, zygote transfer, surrogate parenting, donor semen, adoption, and reversal of sterilization procedures. Normal expenses of pregnancy and pregnancy complications are eligible for coverage as provided under the Plan.
35. **Laetrile.**
36. **Marital or Premarital Counseling.**
37. **Maternity.** Charges for services related to surrogate pregnancy.
38. **Medically Unnecessary Services.** Services or supplies determined by the medical *Claims Administrator* or its designee not to be *medically necessary* as defined in the Defined Terms section of this document.
39. **Midwife.** A midwife may **not** independently manage moderate or high-risk mothers, admit to a *hospital*, or prescribe all types of medications. Expenses for pre-planned home delivery.
40. **Milieu Therapy.** A treatment program based on manipulation of the *participant's* environment for their benefit.
41. **Modifications of Homes or Vehicles.** Expenses for construction or modification to a home, residence, or vehicle required as a result of an *injury*, *illness*, or disability of a *participant*.
42. **Negligence.** Care and treatment of an *injury* or *illness* that results from activity where the *plan participant* is found by a court of competent jurisdiction and/or a jury of his/her peers to have been negligent in his/her actions, as negligence is defined by the jurisdiction where the activity occurred.
43. **No Charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.
44. **No Physician Prescription.** Expenses for services rendered or supplies provided that are not recommended or prescribed by a *physician*, except for covered services provided by a Behavioral Health Practitioner, Midwife or Nurse Midwife, Chiropractor, or Podiatrist, *dentist*, nurse, Audiologist, Osteopath, Optometrist, Physician's Assistant, Therapist or other licensed professional or other authority consistent with the laws of the State of Colorado.

45. **Nondurable Supplies.** Expenses for goods or supplies that cannot withstand repeated use and/or that are considered disposable and limited to either use by a single person or one-time use, including, but not limited to bandages, diapers, soap or cleansing solutions. Only those nondurable supplies that are identified in the Medical Supplies Schedule of Medical Benefits section are covered by this Plan. All others are excluded.
46. **Non-Eligible Institutions.** Any services or supplies furnished by a non-eligible institution, which is defined as an institution other than a legally operated *hospital* or *Medicare* approved *skilled nursing facility*, or which is primarily a place of rest, a place for the aged, a nursing home, or any similar institution, regardless of how denominated.
47. **Non-Medical Expenses.** Expenses for preparing medical reports or itemized bills, services for telephone consultations, expenses for failure to keep a scheduled visit or appointment.
48. **Non-Prescription Medication.** Drugs and supplies not requiring a prescription order, including but not limited to, aspirin, antacid, benzyl peroxide preparations, cosmetics, medicated soaps, food supplements, syringes, and bandages, Antabuse, Methadone, Minoxidil, or Rogaine hair preparations; special foods or diets, vitamins, minerals, dietary and nutritional supplements, and nutritional therapy; *experimental* drugs, including those labeled “Caution: Limited by Federal Law to Investigational Use;” and prescription medications related to health care services which are not covered under this Plan, with the exception of:
- a. when provided during hospitalization
 - b. for prenatal vitamins or prenatal minerals requiring a prescription
 - c. as a result of, or in preparation for, a *medically necessary* surgical procedure as approved/*pre-certified* by the Utilization/Medical Management Vendor for a six (6) week limited supply

Certain over-the-counter medications are considered preventive and are therefore covered under the *prescription drug* benefit at a \$0 *co-payment*. Refer to the **Pharmacy Benefit Management Program** section for details.

49. **No Obligation to Pay.** Services for which there is no legal obligation to pay or charges which would not be made but for the existence of this benefit Plan.
50. **Not Specified as Covered.** Medical services, treatments, and supplies which are not specified as covered under this Plan.
51. **Occupational or Workers’ Compensation.** Care and treatment of an *injury* or *illness* that is occupational; that is, arises from work for wage or profit including self-employment or gain, which could entitle the *plan participant* to a benefit under Workers’ Compensation or similar legislation, whether or not enrolled, if eligible.
52. **Orthotic Devices.** Orthotic devices used for the sole purpose of recreational sports activities.
53. **Personal Comfort Items.** Expenses for services for personal hygiene, comfort, beautification, or convenience items, even if deemed *medically necessary*, including, but not limited to, air conditioners, air purifiers, vaporizers, humidifiers, spas, hot tubs, whirlpool baths, waterbeds, swimming pools, physical fitness equipment or programs, heating pads, contour chairs, or therapeutic beds (not including certified, standard model *hospital* beds which will be paid as *durable medical equipment*), telephones, television, guest trays or meals, personal hygiene items or services, homemaker or housekeeping services, except by home health aides as ordered in a *hospice* treatment plan.
54. **Personal Injury Insurance.** Expenses in connection with an automobile accident for which benefits payable hereunder are or would be otherwise covered by no fault automobile insurance or any other similar type of personal *injury* insurance required by state or federal law, without regard to whether or not the *plan participant* actually had such mandatory coverage. This exclusion does not apply if the *injured* person is a passenger in a non-family owned vehicle, or is a pedestrian.
55. **Physical Examinations or Tests for Employment.** Expenses for pre-employment or work-related physical examinations and testing required for employment, which include but are not limited to Commercial Driver’s License (CDL) physicals.
56. **Private Duty Nursing.** Charges in connection with care, treatment, or services of a private duty nurse, except when *medically necessary*.
57. **Private Room in a Hospital or Specialized Health Care Facility.** The use of a private room in a *hospital* or other specialized health care facility, unless the facility has only private room accommodations or unless the use of a private room is certified as *medically necessary* by the medical *Claims Administrator* or its designee.

58. **Rehabilitation Therapies (Inpatient or Outpatient).** Expenses for massage therapy (except under Alternative Medicine in the Schedule of Medical Benefits), Rolfing and related services.
- Expenses *incurred* at an *inpatient* rehabilitation facility for any *inpatient rehabilitation therapy* services provided to an individual who is unconscious, comatose, or in the judgment of the Utilization/Medical Management vendor or its designee, is otherwise incapable of participating in a purposeful manner with the therapy services (passive), including, but not limited to coma stimulation programs and services.
 - Expenses for *passive rehabilitation* therapy in which a patient does not actively participate because the patient does not have the ability to learn and/or remember (that is, has a cognitive deficit), or is comatose or otherwise physically or mentally incapable of *active rehabilitation* participation. *Passive rehabilitation* may be covered by the Plan, but only during a course of hospitalization for acute care, and then only until the patient is capable of being discharged from the *hospital* because hospitalization for the condition requiring acute *hospital* care is no longer *medically necessary*. Continued hospitalization for the sole purpose of providing *passive rehabilitation* will not be considered *medically necessary* for the purposes of this Plan.
 - Expenses for *maintenance rehabilitation*, as defined in the **Defined Terms** section of this document.
 - Expenses for speech therapy for functional purposes including, but not limited to, stuttering, stammering, articulation, and conditions of psychoneurotic origin.
 - Confinement, treatment, services, or materials for educational or training problems or learning disorders.
 - Programs related to smoking cessation are not covered by the Plan, except as required under applicable federal or state law.
59. **Replacement Braces.** Replacement of braces of the leg, arm, back, neck, or artificial arms, or legs, unless there is sufficient change in the *participant's* physical condition to make the original device no longer functional.
60. **Services Performed by Certain Health Care Practitioners.** Services of a medical student, intern, or resident. Stand-by *physicians* or *health care providers*. Expenses for any *physician* or other *health care provider* who did not directly provide or supervise medical services to the patient, even if the *physician* or *health care provider* was available to do so on a stand-by basis.
61. **Self-Inflicted.** Expenses *incurred* as a result of an intentionally self-inflicted *injury* or attempted suicide. This exclusion does not apply if the *injury* resulted from an act of domestic violence (victim only, not the aggressor) or a medical (including both physical and mental health) condition.
62. **Surgical Sterilization Reversal.** Care and treatment for reversal of surgical sterilization.
63. **Therapy.** Speech, physical, or occupational therapy services to maintain function at a level to which it has been restored, or when no further significant practical improvement can be expected.
64. **Third Party Responsibility.** Expenses for services or supplies for which a third party is required to pay because of the negligence or other tortious or wrongful act of that third party. See the provisions relating to Third Party Liability in the **Coordination of Benefits** section of this document for an explanation of the circumstances under which the Plan will advance the payment of benefits until it is determined the third party is required to pay for those services or supplies.
65. **Transplant (Organ and Tissue).** Expenses for human organs, tissue transplants, or implants for donor acquisition and selection (e.g., screening) for a recipient not covered by the Plan. Transplant procedures that are experimental or investigational as determined by the *Plan Administrator* or its designee under the Utilization Management Program.
- nonhuman (*Xenografted*) organ and/or tissue transplants or implants, except heart valves
 - insertion and maintenance of an artificial heart or other organ or related device, except heart valves and kidney dialysis, and all complications thereof
 - expenses for human organs, tissue transplants, or implants for donor acquisition and selection (e.g., screening) for a recipient not covered by the Plan
 - transplantation* procedures that are *experimental* or *investigational* as determined by the *Plan Administrator* or its designee under the Utilization Management Program
 - gene manipulation therapy

- f. *transplantation* lodging and travel expenses for those items noted in the Personal Comfort Items exclusion listed above
66. **Travel or Accommodations.** Travel expenses whether or not recommended by a *physician*, or travel expenses incurred by a *physician* attending a *participant*, except as otherwise specifically provided herein. See the **Transplant Program** section for information regarding instances when these types of expenses may be covered.
67. **Vision Care.** Expenses for surgical correction of refractive errors and refractive keratoplasty procedures including, but not limited to, Lasek, Lasik, Radial Keratotomy (RK) and Automated Keratoplasty (ALK). Purchase, fitting, and repair of eyeglasses or lenses and associated supplies, except one (1) pair of eyeglasses or contact lenses provided as a prosthetic device following ocular *surgery*. Vision therapy, supplies, and orthoptics. Routine eye examinations when the *participant* is also enrolled in the *employer's* vision plan.
68. **War.** Services provided to a *participant* who suffers an *injury* while participating in war, (whether declared or undeclared), civil war, insurrection, rebellion, or revolution, or to any act or condition incident to any of the foregoing.
69. **Weight Management and Physical Fitness.** Expenses for medical or *surgical* treatment of obesity, including, but not limited to, gastric restrictive procedures, intestinal bypass and reversal procedures, weight loss programs, and any complications thereof, except as *medically necessary* and provided by the Plan regarding morbid obesity. National Institutes of Health (NIH) criteria is used to determine if bariatric *surgery* is appropriate [candidate must have either a BMI greater than forty (40) or a BMI of thirty-five (35) to thirty-nine point nine (39.9) with serious co-morbidities]. Memberships in or visits to health clubs, exercise programs, gymnasiums, and/or any other facility for physical fitness programs.

SECTION V—HEALTH CARE MANAGEMENT PROGRAM

Health Care Management Program Phone Number

AmeriBen COMPASS Medical Management

1-800-388-3193

The provider, patient, or family member must call this number to receive certification of certain Health Care Management Services. This call must be made at least forty-eight (48) hours in advance of services being rendered or within forty-eight (48) hours after an emergency.

A. Utilization Review

Utilization review is a program designed to help insure that all *plan participants* receive necessary and appropriate health care while avoiding unnecessary expenses.

The program consists of:

1. *pre-certification* of the *medical necessity* for the following listed non-emergency services before medical and/or surgical services are provided:
 - a. all *hospital* admissions (surgical and non-surgical), except maternity admissions
For emergency admissions (subject to extenuating circumstances), such authorization must be obtained within forty-eight (48) hours following admission.
 - b. partial hospitalization
 - c. all *substance abuse* treatment
 - d. *inpatient mental disorder* treatment
 - e. *outpatient mental disorder* treatment after twenty (20) visits
 - f. sleep apnea testing/sleep studies
 - g. *skilled nursing facility* / rehabilitation facility, long term acute care facility (LTAC) – not *custodial care*
 - h. weight loss *surgery*
 - i. *out-of-network* referrals for Premier PPO or Advantage plan *in-network* benefits only (when services are not available within the PPO network)
 - j. *outpatient* pediatric rehabilitation up to age ten (10)
 - k. hearing aids for children up to age eighteen (18)
 - l. all transplants and all other transplant procedures, including tissue, stem cell, and bone marrow
 - m. Botox injections
 - n. all foot care *surgeries*
 - o. all infusion medications given in a *physician's* office in which the medication is given from the *physician's* own supply
 - p. non-emergent oral/dental *surgery* where anesthesia is necessary
 - q. genetic testing and counseling
 - r. clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition

This Plan does not cover clinical trials related to other diseases or conditions. Refer to the Clinical Trials section for a further description and limitations of this benefit.

2. retrospective review of the *medical necessity* of the listed services provided on an *emergency* basis

3. concurrent review, based on the admitting diagnosis, of the listed services requested by the attending *physician*
4. certification of services and planning for discharge from a *medical care facility* or cessation of medical treatment

The purpose of the program is to determine what charges may be eligible for payment by the Plan. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending *physician* or other health care provider.

If a particular course of treatment or medical service is not certified, it means that either the Plan will not pay for the charges, or the Plan will not consider that course of treatment as appropriate for the maximum reimbursement under the *Plan*. The patient is urged to find out why there is a discrepancy between what was requested and what was certified before *incurring* charges.

The attending *physician* does not have to obtain *pre-certification* from the Plan for prescribing a maternity length of stay that is forty-eight (48) hours or less for a vaginal delivery or ninety-six (96) hours or less for a cesarean delivery.

Your *employer* has contracted with AmeriBen COMPASS Medical Management in order to assist you in determining whether or not proposed services are appropriate for reimbursement under the Plan. The program is not intended to diagnose or treat medical conditions, guarantee benefits, or validate eligibility.

In order to maximize Plan reimbursements, please read the following provisions carefully.

B. How the Program Works.

Pre-certification

Before a *plan participant* enters a *medical care facility* on a non-emergency basis or receives other listed medical services, the Medical Management Administrator will, in conjunction with the attending *physician*, certify the care as appropriate for *Plan* reimbursement. A non-emergency stay in a *medical care facility* is one that can be scheduled in advance.

The utilization review program is set in motion by a telephone call from, or on behalf of, the *plan participant*. Contact the Medical Management Administrator AmeriBen COMPASS Medical Management 1-800-388-3193 **at least forty-eight (48) hours before** services are scheduled to be rendered with the following information:

1. the name of the patient and relationship to the covered *employee*
2. the name, *employee* identification number, and address of the covered *employee*
3. the name of the *employer*
4. the name and telephone number of the attending *physician*
5. the name of the *medical care facility*, proposed date of admission, and proposed length of stay
6. the proposed medical services
7. the proposed rendering of listed medical services

If there is an **emergency** admission to the *medical care facility*, the patient, patient's family member, *medical care facility* or attending *physician* must contact AmeriBen COMPASS Medical Management within **forty-eight (48) hours** of the first business day after the admission.

The Medical Management Administrator will determine the number of days of *medical care facility* confinement or use of other listed medical services authorized for payment. **Failure to follow this procedure may reduce reimbursement received from the Plan.**

Warning: Obtaining *pre-certification* of particular services does not guarantee that they will be reimbursed by the *Plan*. Benefits payments are subject to the eligibility and other coverage restrictions and limitations of the *Plan*.

C. Penalty for Failure to Pre-Certify

When the required *pre-certification* procedures are followed, your benefits will be unaffected. However, if you do not follow the *pre-certification* requirements outlined above, **your claim(s) will not be covered by this Plan**. Amounts assessed under this penalty will not go towards satisfaction of your *out-of-pocket limit*. *Pre-certification* decisions are considered *claims* decisions that are subject to *appeal*. See the discussion of pre-service *medical necessity* determination in the section on **Claims and Appeals**.

D. Retroactive Review

Retroactive *pre-certification* is allowed for *medical non-emergency care* situations up to ninety (90) days after the date of service without a penalty.

E. Concurrent Review and Discharge Planning

Concurrent review of a course of treatment and discharge planning from a *medical care facility* are part of the utilization review program. The Medical Management Administrator will monitor the *plan participant's medical care facility* stay or use of other medical services and coordinate with the attending *physician, medical care facilities, and plan participant* either the scheduled release or an extension of the *medical care facility* stay or extension or cessation of the use of other medical services.

If the attending *physician* feels that it is *medically necessary* for a *plan participant* to receive additional services or to stay in the *medical care facility* for a greater length of time than has been *pre-certified*, the attending *physician* must request the additional services or days.

F. Second and/or Third Opinions

Certain surgical procedures are performed either inappropriately or unnecessarily. In some cases, *surgery* is only one of several treatment options. In other cases, *surgery* will not help the condition.

In order to prevent unnecessary or potentially harmful surgical treatments, the second and/or third opinion program fulfills the dual purpose of protecting the health of the *plan participants* and protecting the financial integrity of the Plan.

Benefits will be provided for a second (and third, if necessary) opinion consultation to determine the *medical necessity* of an elective surgical procedure. An elective surgical procedure is one that can be scheduled in advance; that is, it is not an *emergency* or of a life-threatening nature.

The patient may choose any board-certified specialist who is not an associate of the attending *physician* and who is affiliated in the appropriate specialty.

While any surgical treatment is allowed a second opinion, the following procedures are ones for which *surgery* is often performed when other treatments have been exhausted or are not available:

appendectomy	hernia surgery	spinal surgery
cataract surgery	hysterectomy	surgery to knee, shoulder, elbow or toe
cholecystectomy (gall bladder removal)	mastectomy surgery	tonsillectomy and adenoidectomy
deviated septum (nose surgery)	prostate surgery	tympanotomy (inner ear)
hemorrhoidectomy	salpingo-oophorectomy (removal of tubes/ovaries)	varicose vein ligation

G. Preadmission Testing Service

The medical benefits percentage payable will be for diagnostic lab tests and x-ray exams when they are:

1. performed on an *outpatient* basis within seven (7) days before a *hospital* confinement
2. related to the condition which causes the confinement
3. performed in place of tests while *hospital* confined

H. Ambulatory Surgery

Certain surgical procedures can be performed safely and efficiently outside of a *hospital*. *Ambulatory surgical facilities* are equipped for many uncomplicated surgical operations, such as some biopsies, cataract *surgeries*, tonsillectomies and adenoidectomies, dilation and curettages, and similar procedures.

Refer to the Schedule of Medical Benefits for information regarding this benefit and how it pays.

I. Case Management

Case Management is a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet a *plan participant's* health needs, using communication and available resources to promote quality, cost-effective outcomes. The primary objective of Case Management is to identify and coordinate cost-effective medical care alternatives meeting accepted standards of medical practice. Case Management also monitors the care of the patient, offers emotional support to the family, and coordinates communications among *health care providers*, patients, and others.

Cases are identified for possible Case Management involvement based on a request for review or the presence of a number of parameters, such as, but not limited to:

1. admissions that exceed the recommended or approved length of stay
2. utilization of health care services that generates ongoing and/or excessively high costs
3. conditions that are known to require extensive and/or long-term follow-up care and/or treatment

Benefits under Case Management may be provided if the Medical Management Administrator determines that the services are *medically necessary*, appropriate, cost effective, and feasible. All decisions made by Case Management are based on the individual circumstances of that *plan participant's* case. Each case is reviewed on its own merits, and any benefits provided are under individual consideration.

J. Special Care Case Management

Special Care Case Management is designed to help manage the care of patients who have special or extended care *illnesses or injuries*.

The *Plan* may elect, in its sole discretion, when acting on a basis that precludes individual selection, to provide alternative benefits that are otherwise excluded under the Plan. The alternative benefits, called Special Care Case Management, shall be determined on a case-by-case basis, and the Plan's determination to provide the benefits in one instance shall not obligate the Plan to provide the same or similar alternative benefits for the same or any other *plan participant*, nor shall it be deemed to waive the right of the Plan to strictly enforce the provisions of the Plan.

The case manager will coordinate and implement the Special Care Case Management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The *Plan Administrator*, attending *physician*, patient, and patient's family must all agree to the alternate treatment plan.

Once agreement has been reached, the *Plan Administrator* will direct the *Plan* to reimburse for *medically necessary* expenses as stated in the treatment plan, even if these expenses normally would not be paid by the Plan. Unless specifically provided to the contrary in the *Plan Administrator's* instructions, reimbursement for expenses *incurred* in connections with the treatment plan shall be subject to all Plan limits and cost sharing provisions.

Note: All Case Management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate.

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

K. Special Rules Regarding Maternity and Newborns

In compliance with the Newborns' and Mothers' Health Protection Act of 1996 (NMHPA), maternity care and nursery care at birth are not subject to *pre-certification* for the following minimum lengths of stay after delivery: forty-eight (48) hours for a vaginal birth and ninety-six (96) hours for a cesarean section birth. *Pre-certification* is recommended, however, if the length of stay for either the mother or newborn is in excess of the forty-eight (48) or ninety-six (96) hours.

Although maternity care does not require *pre-certification*, it is required by Medical Network that you provide notification of pregnancy. Please contact Medical Network for more information.

If the mother is admitted to the *hospital* during pregnancy for any reason other than delivery, she or her *health care provider* must obtain *pre-certification* for the *hospital* admission.

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any *hospital* length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending *provider*, after consulting with the mother, from discharging the mother or her newborn earlier than forty-eight (48) hours [or ninety-six (96) hours as applicable]. In any case, plans and issuers may not, under federal law, require that a *provider* obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of forty-eight (48) hours [or ninety-six (96) hours].

NOTE: Case management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate.

L. Second and/or Third Opinion Program

Certain *surgical* procedures are performed either inappropriately or unnecessarily. In some cases, *surgery* is only one of several treatment options. In other cases, *surgery* will not help the condition.

In order to prevent unnecessary or potentially harmful surgical treatments, the second and/or third opinion program fulfills the dual purpose of protecting the health of the Plan's *participant* and protecting the financial integrity of the Plan.

Benefits will be provided for a second (and third, if necessary) opinion consultation to determine the *medical necessity* of an elective *surgical* procedure. An elective *surgical* procedure is one that can be scheduled in advance; that is, it is not an emergency or of a life-threatening nature. Benefits for the second (and third, if necessary) opinion will be paid as any other *illness*.

The patient may choose any board-certified specialist who is not an associate of the attending *physician* and who is affiliated in the appropriate specialty.

M. Concurrent (Continued Stay) Review

How Concurrent (Continued Stay) Review Works

1. When you are receiving medical services in a *hospital* or specialized health care facility, the Utilization/Medical Management vendor may contact your *physician* or other *health care providers* to both:
 - assure that continuation of medical services is *medically necessary*
 - help coordinate your medical care with the benefits available under the Plan
2. Concurrent Review may include such services as:
 - coordinating home health care or the provision of *durable medical equipment*
 - assisting with discharge plans
 - determining the need for continued medical services
 - advising your *physician* or other *health care providers* of the various options and alternatives available under this Plan for your medical care

Emergency Hospitalization

If an emergency requires hospitalization, there may be no time to contact the Utilization/Medical Management vendor before you are admitted. If this happens, the Utilization/Medical Management vendor must be notified of the *Hospital* admission **within forty-eight (48) hours** or the next business day. This will enable the Utilization/Medical Management vendor to assist with discharge plans, determine the need for continued medical services, and/or advise your *physician* or other *health care providers* of the various recommendations, options and alternatives for your medical care.

Appeal of a Denial of a Concurrent Review

1. If the Utilization/Medical Management vendor determines that continued health care services are not *medically necessary*, you and/or your *physician* will be notified and have the opportunity to *appeal* if your *physician* disagrees with that determination. **If you and/or your physician disagree with the determination, the obligation to appeal rests entirely with you and your physician. In the absence of an appeal, the Plan has no obligation to provide any review of that decision.** To *appeal* a determination that continued health care services are not *medically necessary*, you and/or your *physician* should follow the regular *appeal* procedures set forth in the section describing *appeal* of a denial of *pre-certification*. in the previous subchapter.
2. If, while you are hospitalized or confined in any other specialized health care facility, you or your *physician* receive a notice that continued stay is **not certified**, you or your *physician* may request an expedited *appeal* by calling the Utilization/Medical Management vendor at the telephone number shown on the Quick Reference chart in the **Introduction** of this document. The Utilization/Medical Management vendor will usually respond to your *physician* by telephone within twenty-four (24) working hours, and its determination will then be confirmed in writing to you, your *physician*, the *hospital* or other specialized health care facility, and the medical *Claims Administrator*.

N. Retrospective Certification

All *claims* for medical services or supplies that have not been reviewed under the Plan's *pre-certification*, or Concurrent (Continued Stay) Review, may be subject to *retrospective certification*, at the option of the *Plan Administrator* or its designee to determine if they were *medically necessary*.

If the *Plan Administrator* or its designee determines that the services or supplies were not *medically necessary*, **no benefits will be provided by the Plan for those services or supplies.** After your *claim* has been processed, you may request a review of the *claim* decision. **For complete information on claim review, see the Claims and Appeals section of this document.**

O. Diabetes Ten City Challenge

As part of the Medical Management Program provided by the Utilization/Medical Management vendor, The City of Colorado Springs has requested that *participants* have access to an *in-network* Health Management Program. The Personal Health Information (PHI) that is provided is not only shared with our contracted vendors but others when deemed appropriate. For example: pharmacist coaches for the Diabetes Ten City Challenge, etc.

The Health Management Program is designed to assist individuals who are suffering from certain chronic conditions, or who have been identified as at risk for a chronic condition. The Health Management Program assists in managing and treating those conditions by providing *participants* with access to personal counseling and education. This service provides programs for patients to educate on the care and management of chronic diseases (such as diabetes, asthma, hyperlipidemia, hypertension, etc.), and is designed to improve patient knowledge of the disease and techniques for self-management and compliance with proper health care procedures required for the patient's well-being.

The Health Management Program allows self-referral, *physician* referral, and referral from some of the peripheral *in-network providers* such as the emergency room of the *in-network hospital* after a patient intervention or through the Health Improvement Program provider. Additionally, *claims* information from the medical *Claims Administrator* will be shared with the Utilization/Medical Management vendor, so that individuals who might benefit from the program may be contacted directly by the Utilization/Medical Management vendor to discuss the program. Participation in the program is voluntary and confidential. The City of Colorado Springs encourages eligible members to participate in The Diabetes Ten City Challenge or to provide documentation, quarterly, of proof of ongoing diabetes management **no later than fifteen (15) days** prior to the end of each quarter during the calendar year in order to get free diabetic medications and supplies. To determine benefits, please see the Health Management Schedule of Benefits.

SECTION VI—DISEASE MANAGEMENT PROGRAM

Your *employer* has contracted with COMPASS, AmeriBen's Medical Management Department, to provide the Disease Management Program. The Disease Management Program is designed to assist individuals who are suffering from chronic conditions, or who have been identified as at risk for a chronic condition. The Disease Management Program assists *plan participants* with managing those conditions by providing *plan participants* with access to education and personal engagement. This service provides programs for patients to gain education on the care and management of chronic diseases (such as diabetes, asthma, high blood pressure, coronary heart disease, etc.) and is designed to improve patient knowledge of the *disease* and techniques for self-management and compliance with proper health care procedures required for the patient's well-being.

A. How the Disease Management Program Works

This program is designed to educate *plan participants* and eligible family members with chronic diseases and help *plan participants* better understand and take control of their condition, proactively participate in care and treatment, and reduce the risk of complications. Participation in the program is voluntary and confidential.

Program Benefits

- It is a benefit of your health care plan at no extra cost to you.
- It provides personal contact between you and a specially trained Registered Nurse (R.N.), who will be your Health Coach.
- The program supports your *physicians* as well as helping you follow your doctor's plan of care.

This program does not replace *physician*-patient relationships. It is designed to complement the relationship and reinforce the treatment plan of care established by you and your *physician*. All personal health information is highly confidential and will be kept confidential as required by law and shall not be improperly used or disclosed.

B. Managing Chronic Conditions

Chronic disease management is a proactive approach that addresses chronic diseases early in the disease cycle to prevent disease progression and reduce potential health complications. Multiple strategies are used to improve the health of all *plan participants* diagnosed with specific conditions, not only those who visit the *provider's* office. This approach allows *plan participants* to maintain their independence and remain healthy for as long as possible.

AmeriBen's dedicated team of Disease Management nurses accomplish this by reinforcing proper treatment plans and educating *plan participants* about their conditions. This typically includes information about:

- the early signs and symptoms of trouble
- medications and the proper way to take them
- following a healthy diet
- managing and maintaining scheduled doctor visits
- preventing *hospital* admissions

While the specific list of conditions and programs will vary, the Disease Management Program's main goal is to empower the *plan participant* to take control and remain healthy.

C. How to Enroll

Your *physician* may refer you to the Disease Management Program, or you may refer yourself or a covered dependent into the program by calling COMPASS directly. Once you are identified as having a chronic condition, your R.N. Health Coach will contact you to discuss the next steps of the program.

SECTION VII—MATERNAL HEALTH PROGRAM

Your *employer* has contracted with Baby Steps, AmeriBen's Maternal Health Program, as part of your healthcare coverage through The City of Colorado Springs Medical Benefit Plan. This program provides education, support, and a personal nurse who will help you and your baby stay healthy and avoid complications—before, during and after your *pregnancy*.

A. How it Works

Upon enrolling, your nurse will contact you and ask you a few questions about your pregnancy, and you can start receiving the following benefits:

1. a personal nurse, who will schedule regular telephone appointments to check on you and your baby
2. access to call your personal nurse with any questions or concerns as often as you like
3. helpful informational and educational *pregnancy* materials
4. help in setting goals, finding a doctor, understanding prenatal tests, and following a safe nutrition and exercise program
5. Upon enrollment, you will receive a FREE copy of the book *What to Expect When You're Expecting*.

B. How to Enroll

You may enroll in the program by calling Baby Steps directly at 1-800-388-3193 or by visiting the following website at: **www.MyAmeriBen.com**.

SECTION VIII—CLINICAL TRIALS

A. Approved Clinical Trial

This *Plan* covers Approved Clinical Trials for qualified individuals. An Approved Clinical Trial is defined as, a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is described in **any** of the following subparagraphs:

1. The study or investigation is approved or funded by one or more of the following:
 - a. The National Institutes of Health
 - b. The Centers for Disease Control and Prevention
 - c. The Agency for Health Care Research and Quality
 - d. The Centers for Medicare and Medicaid Services
 - e. A cooperative group or center of any of the entities described in sub-clauses a. through d. above, or the Department of Defense or the Department of Veterans Affairs.
 - f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
 - g. Any of the following if the following conditions are met: the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines (1) to be comparable to the system of peer review studies and investigations used by the National Institutes of Health, and (2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
 - i. The Department of Veterans Affairs
 - ii. The Department of Defense
 - iii. The Department of Energy
2. The study or investigation is conducted under an *investigational* new drug application reviewed by the Food and Drug Administration.
3. The study or investigation is a drug trial that is exempt from having such an *investigational* new drug application.

B. Qualified Individual or Qualified Participant

A qualified individual or qualified participant is defined as, an individual who is a covered participant or beneficiary in this *Plan* and who meets the following conditions:

1. the individual is eligible to participate in an Approved Clinical Trial according to the trial protocol with respect to the treatment of cancer or other life-threatening disease or condition; and
2. either:
 - a. the referring health care professional is a participating health care provider and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in item (1.), immediately above; or
 - b. the *participant* or beneficiary provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in item (1.), immediately above.

C. Life-Threatening Condition

A "life-threatening condition" is defined as, any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

D. Limitations on Coverage

The following items are excluded from Approved Clinical Trial coverage under this *Plan*:

1. the *investigational* item, device or service, itself
2. items and services that are provided solely to satisfy data collection and analysis needs and are not used in the direct clinical management of the patient
3. a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis

If one or more participating providers do participate in the Approved Clinical Trial, the qualified participant must participate in the Approved Clinical Trial through a participating, *in-network* provider, if the provider will accept the *participant* into the trial.

The *Plan* does not cover routine patient care services that are provided outside of this *Plan*'s health care provider network unless *out-of-network* benefits are otherwise provided under this *Plan*.

SECTION IX—TRANSPLANT PROGRAM

A. What is the Transplant Program?

The transplant program provides access to a *network* of transplant centers that perform many transplants each year and historically have high success rates. They are often affiliated with renowned teaching and research facilities with access to experienced surgeons and advanced medical techniques. Using a *hospital* with transplant experience can result in shorter *hospital* stays, fewer complications, and fewer repeat transplants.

Under the program, the Plan reimburses you for covered services and supplies arising out of, and specifically limited to, the following human organ and tissue transplants for a *participant* recipient:

Eligible Transplants. Reimbursement provided only for *autologous* and *allogenic* (and, in the case of heart valve transplants, *xenographic*) *transplantation* of human organs or tissue, bone marrow, cornea, heart, tissue, kidney, liver, lung(s), pancreas, skin, or stem cells harvested from peripheral blood.

Covered Expenses. Subject to the limitations provided below and specific exclusions related to *experimental* and *investigational* services and *transplantation*, coverage is provided only for:

- facility and professional services
- FDA approved drugs
- *medically necessary* equipment and supplies
- transportation, lodging and meals

B. Program Benefits.

1. access to a transplant network, Center of Excellence or PPO *provider*
2. services of a transplant case manager, who will coordinate services and savings
3. transportation, lodging and meals

Maximum reimbursement during the transplant benefit period for transportation, lodging, and meals is **\$10,000** for expenses *incurred* in association with the *pre-certified* transplant procedure. Benefit includes - Two (2) round trip coach transportation charges for the patient and one (1) family member or companion, to and from the transplant site, lodging and meals for two (2) people [one (1) room]. **Maximum combined reimbursement for lodging and meals is \$200 per day for up to two (2) people, three (3) if the participant is a minor.** Receipts are required when submitting *claim* forms for lodging, meals, and travel expenses for payment consideration. Automobile mileage expenses are reimbursed at IRS permitted per mileage rates for medical use of automobiles. Transportation expense includes bus fares, parking, and taxi fees. See the Medical Plan Exclusions subsection for personal comfort item exclusions.

These benefits will be reimbursed upon the submission to the Plan of dated receipts showing the service provided, the cost of the service, and the name, address, and phone number of the service *provider*. The listed expenses must be *incurred* within five (5) days prior to the transplant and eighteen (18) months after the transplant. The *Plan Administrator* reserves the right not to reimburse any such expenses that it, in its sole discretion, deems inappropriate, excessive, or not in keeping with the intent of this provision.

C. Requirements

Transplant benefits under the Plan are only available when a *participant* fully utilizes a transplant network, Center of Excellence, or PPO *provider* and meets all of the following requirements:

1. Pre-notification of the upcoming transplant **must** be given by the *participant* or the *participant's physician* as soon as the *participant* is identified as a potential transplant candidate.

2. *Pre-certification* **must** be obtained prior to services being obtained as outlined in the **Health Care Management Program** section
3. All transplant services must be rendered at a transplant center facility.

Transplant Exclusions

The following transplant-related expenses are not covered by the Plan:

1. when the organ or tissue is sold rather than donated to the recipient
2. when the recipient is not an eligible *participant*
3. expenses related to transportation costs, including without limitation *ambulance* or air services for the donor or to move a donated organ or tissue
4. expenses that are covered or funded by governmental, foundation, or charitable grants or programs
5. for any artificial or mechanical organ

SECTION X—PHARMACY BENEFIT MANAGEMENT PROGRAM

A. Purpose of the Pharmacy Benefit Management (PBM) Program

1. Your Plan is designed to provide you and your eligible family members with protection from significant health care expenses. The development of new pharmaceutical technology and procedures and the ever-increasing cost of *prescription drugs* make it difficult to control costs and offer affordable health care coverage. To enable your Plan to provide coverage in a cost-effective way, your Plan has adopted a Pharmacy Benefit Management Program designed to help control increasing pharmaceutical costs by avoiding unnecessary services or services that are more costly. By adopting this program, both the *employer* and the *employee* are better able to afford the Plan and all its benefits.
2. You and your *dependents* are responsible for maintaining awareness of the different programs available through the Pharmacy Benefit Management Program.

B. The Pharmacy Benefit Manager (PBM) is MAXORPLUS



For questions concerning your prescription drug program, MaxorPlus Customer Service Representatives are available to assist you by calling 1-800-687-0707 (all times listed are Mountain Time):

Monday thru Friday	—	6:00 AM – 8:00 PM
Saturday	—	7:00 AM – 5:00 PM
Sunday	—	8:00 AM – 4:00 PM

C. MAXORPLUS Preferred Network

MaxorPlus prides itself in having a pharmacy network dedicated to providing you with quality *prescription drug* services. Your *prescription drug* benefit can be used nationwide to obtain prescriptions from any MaxorPlus participating *network pharmacy*.

A MaxorPlus participating pharmacy is available within most cities across the United States. If you need assistance locating a convenient participating pharmacy, please call MaxorPlus Customer Service at 1-800-687-0707.

D. The City Employee Pharmacy Program

To save money on your *co-payments*, you are encouraged to use the City Employee Pharmacy Program to fill your prescriptions.

The City Employee Pharmacy Program serves all *employees* of The City of Colorado Springs and their eligible family members. To utilize this service, you and your eligible *dependents* must be currently enrolled in one of The City of Colorado Springs Medical Plans. There is one (1) City Employee Pharmacy, located at:

30 S. Nevada Ave
Suite L04, MC 890
Colorado Springs, CO 80903
Phone: 1-719-385-2261

To order refills at any time, call to access our twenty-four (24)-hour automated refill system at 1-800-573-6214.

Website: www.cityemployeepharmacy.com

E. MAXORPLUS Preferred Drug Formulary

The MaxorPlus Preferred Drug Formulary will be utilized with your drug program. The formulary is a list of selected drugs from which doctors can prescribe.

A copy of the formulary is available at the City Employee Pharmacy Program, by contacting MaxorPlus Customer Service at 1-800-687-0707, or you can download a copy via MaxorPlus' website (<https://maxsource.maxor.com/maxorplus/formulary.aspx>).

All generic drugs within your evidence of coverage are covered even if they are not listed. As brand name medications become available generically, only the generic will be considered formulary. If you request a brand name drug which has a generic equivalent, you may be responsible for paying your *co-payment* plus the price difference between the generic and equivalent brand name drug.

F. Generic Medications

Generic medications help you and your plan save money. Generics usually cost 30% to 50% less than brand name medications.

The U.S. Food and Drug Administration (FDA) has established strict guidelines to determine if the generic product is therapeutically equivalent to the brand name product. A generic considered therapeutically equivalent to the brand name is given an A rating by the FDA. This means the generic drug contains the same active ingredient in the same strength and dosage form as its brand name equivalent and is expected to have the same clinical effect and safety profile.

A brand name drug is usually known by its trade name (for example, MOTRIN) rather than its chemical or generic name (for example, ibuprofen). Ask your doctor if a generic medication would be right for you.

G. Days' Supply and Refills

For Plan *participants* living within the Colorado Springs region, all mail order prescriptions and prescriptions costing \$300 or more, regardless of the day supply, must be filled through the City Employee Pharmacy Program.

All other thirty (30) day prescriptions may be filled through the City Employee Pharmacy Program or at a MaxorPlus Preferred Network Retail Pharmacy.

For *plan participants* living outside the Colorado Springs region, mail order prescriptions and prescriptions costing \$300 or more may be filled at the City Pharmacy or a MaxorPlus Preferred Network Retail Pharmacy. To help reduce your out-of-pocket expenses and control costs, MaxorPlus will work with you to meet your prescription medication needs by suggesting cost-effective refill options.

If your *health care provider* has authorized refills, you may refill your prescription after 75% of the prescription has been used. For example with a thirty (30) day supply prescription, you may refill the prescription when you have seven (7) days left.

To order refills at any time, access our twenty-four (24) hour automated refill system at 1-800-573-6214.

H. Covered Drugs

1. injectables & non-injectable prescription (legend) drugs, which by state and federal laws require a written prescription by a duly licensed *physician/practitioner* and are not listed under the Limitations or Exclusions subsections below.
2. insulin
3. prenatal vitamins
4. compound medications of which at least one (1) ingredient is a prescription (legend) drug
5. contraceptives (diaphragms, IUD's, implants, injectable, oral & transdermal)
6. diabetic supplies: calibration solutions, insulin pens/needles/syringes, lancet devices, lancets, test strips/tabs, alcohol swabs and ketostix

7. glucometers
8. tobacco cessation drugs
9. generic prescription drugs mandated under the Patient Protection and Affordable Care Act (PPACA)

Certain preventive medications (including contraceptives) received by a *network* pharmacy are covered at 100% and the *deductible/co-payment* (if applicable) is waived. Please refer to the following website for information on the types of payable preventive medications: <https://www.healthcare.gov/what-are-my-preventive-care-benefits/>.

I. Quantity Limitations

1. Medication for migraine headaches will be set at six (6) to nine (9) tablets per prescription fill.
2. Diabetic supplies will be limited to one hundred (100) test strips per thirty (30) days or three hundred (300) per ninety (90) days. If a member requires more frequent testing, an override can be put in place to allow an appropriate number of test strips per prescription fill.

J. Additional Prior Authorizations

Prior authorization will be required on the following medications/categories:

1. medications for ADD and ADHD for patients twenty-five (25) years of age or older
2. Provigil which is indicated for day time drowsiness caused by specific conditions such as narcolepsy, sleep apnea, and shift work sleep disturbances
3. Vfend which is an expensive antifungal medication that should be used as second line therapy for documented resistant fungal infections and for first line more severe specific fungal infections
4. Zyvox, which is an expensive antibiotic that should only be used for specific severe infections and when there is a documented diagnosis of a vancomycin-resistant enterococci (VRE)

K. Limitations

1. Retail prescriptions are limited to the lesser of a thirty (30) day supply or two hundred (200) units, and mail service prescriptions are limited to the lesser of a ninety (90) day supply or six hundred (600) units of medication. Certain exceptions & restrictions may apply [for example, Viagra is limited to eight (8) tabs per twenty-eight (28) day supply].
2. Prescription refills in excess of the number specified by the *physician* and any refills dispensed more than one (1) year after the *physician's* order are not covered.
3. A prescription cannot be refilled until 75% of the medication has been used.
4. Prescriptions must be filled at a MaxorPlus Provider Network Pharmacy. Prescriptions filled at non-participating pharmacies, except in cases of a medical emergency, are not covered.
5. Certain medications will require a Prior Authorization (PA) for determination of coverage. Contact your *Plan Administrator* or MaxorPlus for a current listing of drugs requiring Prior Authorization (PA) or refer to the upcoming subsection regarding this topic.

L. Exclusions

1. Drugs that, by law, do not require a prescription are not covered.
2. Devices of any kind, even those requiring a prescription, including but not limited to: therapeutic devices, health appliances, insulin pumps, or similar items are not covered.
3. Any medication which is not *medically necessary* is not covered, including but not limited to medications used for cosmetic improvements.

4. Blood, blood factors or blood plasma, plasma expanders, or proteins.
5. Charges for the administration or injection of any drug.
6. Drugs labeled “Caution – Limited by Federal Law to Investigational Use” or *experimental* drugs.
7. Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed *hospital*, rest home, sanitarium, extended care facility, convalescent *hospital*, nursing home, or similar institution which operates on its premises, a facility for dispensing pharmaceuticals.
8. agents used for treatment of Alopecia (i.e., Rogaine)
9. allergy serums
10. syringes, other than insulin syringes
11. nutritional and dietary supplements
12. agents for weight loss (i.e., Xenical, Meridia, etc.)
13. vitamins, other than prenatal vitamins
14. infertility medications

NOTE: To the extent the list of exclusions set forth herein conflicts with the lists of applicable, required preventive care set forth at <https://www.healthcare.gov/what-are-my-preventive-care-benefits/>, the list of applicable required preventive care set for at <https://www.healthcare.gov/what-are-my-preventive-care-benefits/> shall govern.

M. Specialty Pharmacy

Specialty pharmacy is a drug management program provided in partnership with Maxor Specialty Pharmacy which covers some limited expensive drugs, such as specialty injectables, cancer drugs, and certain respiratory therapies used to treat various chronic conditions. *Specialty pharmacy* also provides case management services, medication compliance, education, a proactive refill process, as well as information about health care needs related to the chronic disease.

The focus of this program is primarily on injectables and other medications involving:

- complex administration methods
- expensive and difficult-to-find medications
- strict compliance requirements
- special storage, handling and delivery
- education, monitoring and ongoing patient support

MaxorPlus’ partnership with Maxor Specialty Pharmacy services help members manage complex health conditions, including, but not limited to, the following:

- Acromegaly
- Chronic Granulomatous Disease
- Cystic Fibrosis
- Gaucher Disease
- growth hormone disorders
- Viral Hepatitis
- HIV/AIDS
- Multiple Sclerosis
- oncology-related conditions
- Psoriasis

- respiratory therapies
- Rheumatoid Arthritis
- solid organ transplant

Specialty pharmacy through Maxor Specialty Pharmacy is available via mail service. To begin receiving prescriptions through this benefit, the member must contact Maxor Specialty Pharmacy at least seven (7) days prior to the prescription being due or before a refill is required at 1-866-629-6779.

As noted in the following section, several classifications of specialty pharmacy medications will require Prior Authorization (PA) or approval **before** they will be covered by the Plan. To initiate a Prior Authorization, call MaxorPlus at 1-800-687-0707.

N. Prior Authorization (PA)

There are some devices and medications that require Prior Authorization (PA). The following list of medications requires Prior Authorization (PA) on an annual basis if dispensed by MaxorPlus through the City Employee Pharmacy Program:

- Retin-A
- Avita
- Differin
- injectable drugs
- agents for weight loss (Xenical, Meridia, etc.)
- growth hormones
- anti-fungals (Sporanox, Lamisil, Vfend etc.)
- Zyvox, and antibiotic
- Provigil, indicated for day time drowsiness
- medications for ADD and ADHD for patients twenty-five (25) or older

Prior Authorization (PA) for Medications Administered in a Physician’s Office – Any medication shown in the preceding list that requires Prior Authorization (PA) and is being administered in a *physician* and/or specialist office (such medications having been independently obtained by the *physician*/specialist through means other than using the City Employee Pharmacy Program, MaxorPlus, and/or Maxor Specialty Pharmacy), Prior Authorization (PA) must be obtained on an annual basis through AmeriBen COMPASS Medical Management.

O. Claims Procedures

When a *participant* has a prescription for a covered drug, the following steps should be followed:

1. Bring your prescription drug card to the City Employee Pharmacy Program or any participating pharmacy in the MaxorPlus preferred pharmacy *network*.
2. Present your *prescription drug* card to the pharmacy and confirm that the most accurate information about you and your family is on file. Participating pharmacies will submit your *claim* electronically to MaxorPlus.
3. Pay the required *co-payment* amount and sign the signature log for your prescription.

P. Appeals Procedures

All active MaxorPlus members have access to the *appeals* process if their request for a non-preferred, non-formulary, or Prior Authorization was denied. Detailed information for the *appeals* process is sent with any adverse determination or denial letter that goes to the *participant*.

Procedure:

A pharmacy, doctor, or MaxorPlus member may call, fax, email, or ask in writing for a re-evaluation to MaxorPlus regarding a denial.

1. All requests must reach MaxorPlus no later than ninety (90) days from the date of the denial letter. Routine reconsiderations will be determined and written notification will be sent to the *participant* and prescriber within thirty (30) calendar days of receipt of all necessary information.
2. In situations where an expedited *appeal* is desired, the request for reconsideration must reach MaxorPlus by mail, fax, email or phone within three (3) working days of receipt of the denial. [This is considered to be five (5) days from the date of the letter] Expedited reconsiderations will be addressed and written confirmation provided within three (3) calendar days [seventy-two (72) hours] of receipt of all necessary information.
3. If the request was denied due to no doctor response or lack of complete information, the doctor may submit clinical information to MaxorPlus for review. This is called a reconsideration of the request. In addition, if the prescriber provided additional information not given before, the request will be reconsidered. The usual Prior Authorization procedures will be followed.
4. The request must include reasons for disagreement with the original decision, as well as any pertinent new information to substantiate further review.
5. Upon receipt of the necessary clinical information, the *appeal* will be reviewed by the MaxorPlus clinical pharmacist staff or if necessary one of the participating *physician* members of the Pharmacy & Therapeutics Committee (who hold an unrestricted license to practice medicine and who was not involved in the original request). The *participant* and member's *provider* will be notified in writing of the outcome. The *appeal* will also be documented in the Prior Authorization system.
6. For appeals involving *physician* specialists, if necessary a *physician* within the specialty of the prescriber (who holds an unrestricted license to practice medicine and is board certified (ABMS or ABOS certified) in their specialty and was not involved in the original request) shall be consulted to assist with the re-review and re-determination of the *appeal*. This shall also exclude *physicians* working in the same practice or *physician* group(s).
7. If the client has their own *appeals* process, MaxorPlus will comply with those requirements if within reason and they are not in violation of any legal requirements.
8. Records for all *appeals* that are initiated shall be maintained within the MaxorPlus Prior Authorization system or as a manual file, these records shall contain the all of the following:
 - a. the name of the *participant* and/or prescriber
 - b. copies of all correspondence from the *participant*, prescriber and MaxorPlus regarding the *appeal*
 - c. the dates of any *appeal* reviews, documentation of actions taken and the final resolution of the *appeal* (approval or upheld denial)
 - d. minutes or transcripts of *appeal* proceedings (if applicable)
 - e. the name and credentials of the clinical peer that reviewed the *appeal* information (if applicable)
 - f. specific clinical review criteria upon which the denial was based
9. A clinical pharmacist or designee will review one (1) percent of the *appeals* to verify turn-around times.
 - a. If results are below threshold, a review of procedures and staffing will take place.
 - b. Appropriate action will be taken, to include but not limited to: revising procedures, modifying staffing, retraining of staff on procedures.
 - c. This information will be documented by the clinical pharmacist or designee.
 - d. The results of this sampling will be reported to the VP of Clinical pharmacy on a monthly basis by the clinical pharmacist or designee.
 - e. The results of this sampling will be provided to clients upon request.
 - f. If the original denial is upheld after the extensive re-review process, then notification of the determination or denial shall be sent in writing to the prescriber and to the *participant* addressing the reason(s) to uphold the

original decision for denial, letting them know that the data or rationale used in the *appeal* decision will be provided, in writing upon request, and information about additional appeal mechanisms available, if any.

Note: All denials (where an *appeal* may arise) are denials based on either medical criteria approved by a Plan's (client) medical director/consultant, based on approved FDA indications, or based on criteria established by the Plan and their medical director/consultant that primarily deal with coverage inclusions and exclusions set forth by the Plan.

Q. Using a Non-participating or Out-of-Network Pharmacy (Very Important Information)

This pharmacy program will cover prescriptions filled by a non-participating or *out-of-network* pharmacy only in after-hours emergency situations. Non-emergency prescriptions filled at a non-participating or *out-of-network* pharmacy **will not be reimbursed** by the Plan.

Should a *plan participant* not have the MaxorPlus *prescription drug* card OR purchase a covered drug from a pharmacy NOT participating in the MaxorPlus *provider network*, the following steps should be followed:

1. Pay for the entire cost of the medication.
2. Obtain and complete a MaxorPlus Prescription Drug Claim Form.
3. Send the claim form with prescription receipt directly to MaxorPlus within ninety (90) days from date of prescription fill.

R. Emergencies (Very Important Information)

The program requires eligible members to use a participating pharmacy in the MaxorPlus preferred pharmacy *network* (which includes the City Employee Pharmacy Program). Prescriptions dispensed at non-participating or *out-of-network* pharmacies are covered only in instances of a **medical emergency** outside the MaxorPlus service area.

If you need to fill a prescription after an emergency room or urgent care visit between 9:00 PM and 8:00 AM weekdays, after 6:00 PM on weekends, or anytime on a holiday when *network* pharmacies are typically not open, it will be considered an emergency prescription. In such emergency situations, you will need to pay 100% of the *prescription drug* cost to a non-participating or *out-of-network* pharmacy at the time of service and obtain a receipt. You must then submit a paper *claim*, along with the prescription receipt and proof of an after-hours emergency room or urgent care visit, for reimbursement to:



320 S. Polk, Suite 200
Amarillo, TX 79101

For non-participating or *out-of-network* emergency prescriptions, MaxorPlus will reimburse you the amount paid to the *out-of-network* pharmacy less the applicable City Employee Pharmacy Program *co-pay*. As a reminder, the prescription receipt and proof of the after-hours emergency room or urgent care visit are required when submitting a paper *claim* to MaxorPlus for reimbursement.

MaxorPlus will pay the appropriate amount directly to the cardholder, usually within four (4) to six (6) weeks. Consequently, it is advantageous to use both the MaxorPlus *prescription drug* card **and** participating *network* pharmacies whenever possible.

You can request *claim* forms directly from MaxorPlus or through the City Employee Pharmacy Program or you can go online at www.maxorplus.com.

Very Important Information: Non-emergency prescriptions filled at a non-participating or *out-of-network* pharmacy **will not be reimbursed** by the Plan.

If you require assistance regarding any aspect of the Pharmacy Benefit Management Program, please call MaxorPlus Customer Service at 1-800-687-0707.



320 S. Polk Street, Suite 200

Amarillo, Texas 79101

1-800-687-0707

www.maxor.com

SECTION XI—CLAIMS AND APPEALS

This section contains the *claims* and *appeals* procedures and requirements for The City of Colorado Springs Medical Benefit Plan. The Plan's representatives will follow administrative processes and safeguards designed to ensure and to verify that benefit *claim* determinations are made in accordance with governing Plan documents and that, where appropriate, the Plan provisions have been applied consistently with respect to similarly situated *claimants*.

A claimant has the right to request a review of an *adverse benefit determination*. This request is an *appeal*. If the *claim* is denied at the end of the *appeal* process, as described below, the Plan's final decision is known as a *final adverse benefit determination*. If the *claimant* receives notice of a *final adverse benefit determination*, or if the Plan does not follow the *appeal* procedures properly, the *claimant* then has the right to request an independent external review. The external review procedures are described in this section.

Both the *claims* and the *appeal* procedures are intended to provide a full and fair review. This means, among other things, that *claims* and *appeals* will be decided in a manner designed to ensure the independence and impartiality of the persons involved in making these decisions.

A *claimant* must follow all *claims* and *appeal* procedures both internal and external, before he or she can file a lawsuit. If a lawsuit is brought, it must be filed within two (2) years after the final determination of an *appeal*.

Any of the authority and responsibilities of the *Plan Administrator* under the *claims* and *appeal* procedures or the external review process, including the discretionary authority to interpret the terms of the Plan, may be delegated to a third party. If you have any questions regarding these procedures, please contact the *Plan Administrator*.

A. Assignment of Benefits

An *assignment of benefits* is an arrangement by which a patient requests that their health benefit payments under this *plan* be made directly to a designated medical *provider* or facility. By completing an *assignment of benefits*, the *participant* authorizes the *plan* to forward payment for a covered procedure directly to the treating medical *provider* or facility. The *plan administrator* expects that an *assignment of benefits* form to be completed, as between the *participant* and the *provider*.

B. Filing Non-Urgent Pre-Service Claims

Procedures for filing *pre-service claims* are discussed in the **Health Care Management Program** section of the Plan document. Under certain circumstances provided by federal law, if you or your *authorized representative* fails to follow the Plan's procedures for filing a *pre-service claim*, the Plan will provide *notice* of the failure and the proper procedures to be followed. This *notification* will be provided as soon as reasonably possible, but no later than five (5) days after receipt of the *claim*. You will then have up to forty-five (45) days from receipt of the notice to follow the proper procedures.

C. Filing Urgent Care Claims

In order to file an *urgent care claim*, you or your *authorized representative* must call the Utilization/Medical Management Administrator as outlined in the **Health Care Management Program** section and provide the Plan: (a) information sufficient to determine whether, or to what extent, benefits are covered under the Plan and (b) a description of the medical circumstances that give rise to the need for expedited review.

If you or your *authorized representative* fails to provide the Plan with the above information, the Plan will provide *notice* as soon as reasonably possible, but no later than twenty-four (24) hours after receipt of your *claim*. You will be afforded a reasonable amount of time under the circumstance, but no less than forty-eight (48) hours, to provide the specified information.

D. Filing Post-Service Claims

In order to file a *post-service claim*, you or your *authorized representative* must submit the *claim* in writing on a form pre-approved by the Plan. Pre-approved *claim* forms are available from The City of Colorado Springs or from the medical *Claims Administrator's* online system at **www.myameriben.com**.

All *claims* must be received by the Plan within a twelve (12) month period from the date of the expense and must include the following information:

1. the *participant's* name, Social Security Number and address
2. patient's name, Social Security number and address if different from the *participant's*
3. *provider's* name, tax identification number, address, degree and signature
4. date(s) of service
5. diagnosis
6. procedure codes (describes the treatment or services rendered)
7. *assignment of benefits*, signed (if payment is to be made to the *provider*)
8. release of information statement, signed
9. coordination of benefits (COB) information if another plan is the primary payer
10. sufficient medical information to determine whether and to what extent the expense is a covered benefit under the Plan

Send complete information to the medical *Claims Administrator* at the following address:

AmeriBen
P.O. Box 7186
Boise, ID 83707

E. Status of Benefit Verifications

Please note that oral or written communications with AmeriBen regarding a *participant's* or beneficiary's eligibility or coverage under the Plan are not *claims for benefits*, and the information provided by AmeriBen or other Plan representative in such communications does not constitute a certification of benefits or a guarantee that any particular *claim* will be paid. Benefits are determined by the Plan at the time a formal *claim for benefits* is submitted according to the procedures outlined above.

F. Notification of Benefit Determinations

The Plan will notify you or your *authorized representative* of its benefit determinations as follows:

Urgent care claims:

Notice of a benefit determination (whether adverse or not) will be provided as soon as possible, taking into account the medical circumstances, but no later than seventy-two (72) hours after receipt of the *claim*. However, if the Plan gives you *notice* of an incomplete *claim*, the *notice* will include a time period of no less than forty-eight (48) hours for you to respond with the requested specified information. The Plan will then provide you with the *notice of benefit determination* within forty-eight (48) hours after the earlier of: receipt of the specified information, or the end of the period of time given you to provide the information. If the *benefit determination* is provided orally, it will be followed in writing no later than three (3) days after the oral *notice*.

If the *urgent care claim* involves a *concurrent care decision*, *notice of the benefit determination* (whether adverse or not) will be provided as soon as possible, but no later than twenty-four (24) hours after receipt of your *claim* for extension of treatment or care, as long as the *claim* is made at least twenty-four (24) hours before the prescribed period of time expires or the prescribed number of treatments ends.

In the case of a claim involving urgent care, the following timetable applies:

<i>Notification to claimant of claim determination</i>	72 hours
Insufficient information on the claim, or failure to follow the Plan's procedure for filing a claim:	
<i>Notification to claimant, orally or in writing</i>	24 hours
<i>Response by claimant, orally or in writing</i>	48 hours
<i>Benefit determination, orally or in writing</i>	48 hours
<i>Notification of adverse benefit determination on appeal</i>	72 hours

G. Concurrent Care Claims

A *concurrent care claim* is a special type of *claim* that arises if the Plan informs a *claimant* that benefits for a course of treatment that has been previously approved for a period of time or number of treatments is to be reduced or eliminated. In that case, the Plan must notify the *claimant* sufficiently in advance of the effective date of the reduction or elimination of treatment to allow the *claimant* to file an *appeal*. This rule does not apply if benefits are reduced or eliminated due to Plan amendment or termination. A similar process applies for *claims* based on a rescission of coverage for fraud or misrepresentation.

In the case of a concurrent care claim, the following timetable applies:

<i>Notification to claimant of benefit reduction</i>	Sufficiently prior to scheduled termination of course of treatment to allow claimant to appeal
<i>Notification to claimant of rescission</i>	30 days
<i>Notification of determination on appeal of urgent care claims</i>	24 hours (provided claimant files appeal more than 24 hours prior to scheduled termination of course of treatment)
<i>Notification of adverse benefit determination on appeal for non-urgent claims</i>	As soon as feasible, but not more than 30 days
<i>Notification of adverse benefit determination on appeal for rescission claims</i>	30 days

Other pre-service claims:

Notice of a benefit determination (whether adverse or not) will be provided in writing within a reasonable period appropriate to the medical circumstances, but no later than fifteen (15) days after receipt of the *claim*. However, this period may be extended one time by the Plan for up to an additional fifteen (15) days if the Plan both determines that such an extension is necessary due to matters beyond its control and provides you written *notice*, prior to the end of the original fifteen (15) day period, of the circumstances requiring the extension and the date by which the Plan expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary

to decide the *claim*, the *notice* of extension will specifically describe the required information, and you will be given at least forty-five (45) days from your receipt of the *notice* to provide the specified information.

Notice of an adverse *benefit determination* regarding a *concurrent care decision* will be provided sufficiently in advance of any termination or reduction of benefits to allow you to *appeal* and obtain a determination before the benefit is reduced or terminates.

In the case of a pre-service claim, the following timetable applies:

<i>Notification to claimant of adverse benefit determination</i>	15 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information on the claim:	
<i>Notification of claim</i>	15 days
Response by <i>claimant</i>	45 days
Notification, orally or in writing, of failure to follow the Plan's procedures for filing a <i>claim</i>	5 days
<i>Notification of adverse benefit determination on appeal</i>	15 days per benefit appeal
Reduction or termination before the end of the treatment	15 days
Request to extend course of treatment	15 days

Post-service claims:

Notice of adverse *benefit determinations* will be provided, in writing within a reasonable period of time, but no later than thirty (30) days after receipt of the *claim*. However, this period may be extended one time by the Plan for up to an additional fifteen (15) days if the Plan both determines that such an extension is necessary due to matters beyond its control and provides you written *notice*, prior to the end of the original fifteen (15) day period, of the circumstances requiring the extension and the date by which the Plan expects to render a decision. If an extension is necessary due to your failure to submit the information necessary to decide the *claim*, the *notice* of extension will specifically describe the required information, and you will be given at least forty-five (45) days from your receipt of the *notice* to provide the specified information.

The applicable time period for the *benefit determination* begins when your *claim* is filed in accordance with the reasonable procedures of the Plan, even if you haven't submitted all the information necessary to make a *benefit determination*. However, if the time period for the *benefit determination* is extended due to your failure to submit information necessary to decide a *claim*, the time period for making the *benefit determination* will be suspended from the date the *notice* of extension is sent to you until the earlier of: (a) the date on which you respond to the request for additional information, or (b) the date established by the Plan for the furnishing of the requested information [at least forty-five (45) days].

If your *claim* is denied based on your failure to submit information necessary to decide the *claim*, the Plan may, in its sole discretion, renew its consideration of the denied *claim* if the Plan receives the additional information within one hundred eighty (180) days after original receipt of the *claim*. In such circumstances, you will be *notified* of the Plan's reconsideration and subsequent *benefit determination*.

In the case of a post-service claim, the following timetable applies:

<i>Notification to claimant of adverse benefit determination</i>	30 days
Extension due to matters beyond the control of the Plan	15 days
Extension due to insufficient information on the <i>claim</i>	15 days
Response by claimant following notice of insufficient information	45 days
<i>Notification of adverse benefit determination on appeal</i>	30 days per benefit appeal

H. National Medical Support Notice (NMSN)

A *National Medical Support Notice (NMSN)* may require the Plan to pay Plan benefits on account of expenses *incurred* by or on behalf of the dependent child(ren) covered by the Plan either to the *health care provider* who rendered the services or to the custodial parent of the dependent child(ren). If coverage of the dependent child(ren) is actually provided by the Plan, and if the *Plan Administrator* or its designee determines that it has received an *NMSN*, it will pay Plan benefits on account of expenses incurred by or on behalf of the dependent child(ren) to the extent otherwise covered by the Plan as required by that *NMSN*. For additional information regarding *NMSN*, see the **Eligibility** section of this document.

I. Notification of Adverse Benefit Determination

Except with *urgent care claims*, when the *notification* may be oral followed by written or electronic *notification* within three (3) days of the oral *notification*, the medical *Claims Administrator* shall provide written or electronic *notification* of any adverse *benefit determination*. The notice will state, in a manner calculated to be understood by the *claimant*:

1. Identification of the *claim*, including date of service, name of *provider*, *claim* amount (if applicable), and a statement that the diagnosis code and treatment code and their corresponding meanings will be provided to the *claimant* as soon as feasible upon request; the specific reason(s) for the adverse *benefit determination*; including the denial codes and its corresponding meaning, and the Plan's standard, if any, used in denying the *claim*.
2. Reference to the specific Plan provisions on which the determination was based.
3. A description of any additional information or material needed from you to complete the *claim* and an explanation of why such material or information is necessary.
4. A description of the Plan's review procedures, incorporating any voluntary *appeal* procedures offered by the Plan, and the time limits applicable to such procedures. This will include a statement of the *claimant's* right to bring a civil action following an adverse benefit determination on review.
5. 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*.
6. You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office.
7. If the adverse *benefit determination* was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the adverse *benefit determination* and a copy will be provided free of charge to the *claimant* upon request.
8. If the adverse *benefit determination* is based on the *medical necessity* or *experimental or investigational* treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the *claimant's* medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.
9. Information about the availability of and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal *claims* and *appeals* and *external review* process.

J. Appeals

General Procedures

You may *appeal* any adverse *benefit determination* to the medical *Claims Administrator*. The *Plan Administrator* is the sole fiduciary of the Plan, and exercises all discretionary authority and control over the administration of the Plan and has sole discretionary authority to determine eligibility for Plan benefits and to construe the terms of the Plan. When a claimant receives notification of an adverse *benefit determination*, the claimant generally has **one hundred eighty (180)** days following receipt of the notification in which to file a written request for an *appeal* of the decision. However, for *concurrent care claims*, the *claimant* must file the *appeal* prior to the scheduled reduction or termination of treatment. For a *claim* based on rescission of coverage, the *claimant* must file the *appeal* within thirty (30) days. A *claimant* may submit written comments, documents, records, and other information relating to the *claim*.

The medical *Claims Administrator* will conduct a full and fair review of all benefit *appeals*, independently from the individual(s) who made the adverse *benefit determination* or anyone who reports such individual(s) and without affording deference to the adverse *benefit determination*. You will, upon request and free of charge, be given reasonable access to, and copies of, all documents, records, and other information relevant to your *claim* for benefits, including your *claim* file. You will also have the opportunity to submit to the *Medical Claims Administrator* written comments, documents, records and other information relating to your *claim* for benefits. You may also present evidence and testimony should you choose to do so however, a formal hearing may not be allowed. The medical *Claims Administrator* will take into account all this information regardless of whether it was considered in the adverse *benefit determination*.

A document, record, or other information shall be considered relevant to a *claim* if any of the following apply:

1. it was relied upon in making the *benefit determination*
2. it was submitted, considered, or generated in the course of making the *benefit determination*, without regard to whether it was relied upon in making the *benefit determination*
3. it demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all *claimants*
4. it constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit

The period of time within which a *benefit determination* on *appeal* is required to be made shall begin at the time an *Appeal* is filed in writing in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

Before the medical *Claims Administrator* issues its *final adverse benefit determination* based on a new or additional rationale or evidence, the *claimant* must be provided, free of charge, with a copy of the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the time within which a final determination on *appeal* is required to allow the *claimant* time to respond.

If the adverse *benefit determination* was based, in whole or in part, on a medical judgment, including determinations that treatments, drugs, or other services are *experimental/investigational*, or not *medically necessary* or appropriate, the medical *Claims Administrator* will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted in connection with the adverse *benefit determination* nor is a subordinate of any such individual.

Upon request, you will be provided the identification of the medical or vocational expert(s) whose advice was obtained on behalf of the Plan in connection with the adverse *benefit determination*, whether or not the advice was relied upon to make the adverse *benefit determination*.

Form and Timing

All requests for a review of a denied *pre-service claim* (other than *urgent care claim*) must be in writing and should include a copy of the *adverse benefit determination*, if applicable, and any other pertinent information that you wish the medical *Claims Administrator* to review in conjunction with your *appeal*. Send all information to:

AmeriBen
Attn: Customer Relations Representative/Request for Review
P.O. Box 7186
Boise, ID 83707
E-mail: custserv@ameriben.com
Customer Service: 1-866-955-1482 Fax: 1-208-424-0595

You may *appeal* an adverse *benefit determination* of an **urgent care claim** on an expedited basis, either orally or in writing. You may *appeal* orally by calling the *Claims Administrator*. All necessary information, including the medical *Claims Administrator's benefit determination* on review, will be transmitted between the *Claims Administrator* and you by telephone, facsimile, or other available similarly expeditious method.

All requests for a review of a denied **post-service claim** must be in writing and should include a copy of the adverse *benefit determination* and any other pertinent information that you wish the *Claims Administrator* to review in conjunction with your *appeal*. Send all information to:

AmeriBen
Attn: Customer Relations Representative/Request for Review
P.O. Box 7186
Boise, ID 83707
E-mail: custserv@ameriben.com
Customer Service: 1-866-955-1482 Fax: 1-208-424-0595

You or your *authorized representative* must file any appeal of an adverse *benefit determination* within one hundred eighty (180) days after receiving notification of the adverse *benefit determination*.

Requests for *appeal* which do not comply with the above requirements will not be considered.

K. Time Period for Deciding Appeals

Urgent care claims:

Appeals of *urgent care claims* will be decided by the medical *Claims Administrator* as soon as possible, taking into account the medical exigencies, but no later than seventy-two (72) hours after the medical *Claims Administrator* receives the *appeal*. A decision communicated orally will be followed-up in writing.

Other pre-service claims:

Appeals of *pre-service claims* will be decided by the medical *Claims Administrator* within a reasonable period of time appropriate to the medical circumstances, but no later than thirty (30) days after the medical *Claims Administrator* receives the *appeal*. The medical *Claims Administrator's* decision will be provided to you in writing.

Post-service claims:

Appeals of *post-service claims* will be decided by the medical *Claims Administrator* within a reasonable period of time, but no later than thirty (30) days after the medical *Claims Administrator* receives the *appeal*. The medical *Claims Administrator's* decision will be provided to you in writing.

L. Notification of Appeal Denials

If your *appeal* is denied, the *Claims Administrator* will provide written *notification* of the *adverse benefit determination* on *appeal*. The *notice* will state, in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the *claimant*:

1. Identification of the *claim*, including date of service, name of *provider*, *claim* amount (if applicable), and a statement that the diagnosis code and treatment code and their corresponding meanings will be provided to the *claimant* as soon as feasible upon request.
2. the specific reason(s) for the adverse *benefit determination*; including the denial codes and its corresponding meaning, and the Plan's standard, if any, used in denying the *claim*
3. reference to the specific Plan provisions on which the adverse *benefit determination* was based

4. a statement regarding your right, upon request and free of charge, to access and receive copies of documents, records and other information that are relevant to the *claim*

You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office.

5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in denying the *appeal*, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline protocol, or other similar criterion was relied upon in denying the *appeal* and that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge to you upon request
6. If the denied *appeal* was based on a *medical necessity, experimental/investigational* or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the denial, applying the terms of the Plan to your medical circumstances, or a statement that such an explanation will be provided free of charge upon request.
7. a statement describing any additional *appeal* procedures offered by the Plan and your right to obtain information about such procedures

Notification of the decision on an *urgent care claim* may be provided orally, but a follow-up written *notification* will be provided no later than three (3) days after the oral notice.

M. Second Level Appeal of Post-Service Claims

If on *appeal* the denial of your *claim* is upheld, or if you are still dissatisfied with the results of the *appeal*, you may submit a **final written request** to *appeal* to review within thirty (30) days of the first *appeal* decision to the medical *Claims Administrator*. Final requests for *appeal* must be made in writing and addressed to:

AmeriBen
Attn: Customer Relations Representative/Final Request for Review
P.O. Box 7186
Boise, Idaho 83707-1186
E-mail: custserv@ameriben.com
Customer Service: 1-866-955-1482
Fax: 1-208-424-0595

The *Claims Administrator* will promptly conduct a full and fair review of your *appeal*, independently from the individual(s) who considered your first level *appeal* or anyone who reports to such individual(s) and without affording deference to the initial denial. You will again have access to all relevant records and other information and the opportunity to submit written comments and other information, as described in more detail under the subsection entitled General Procedures above.

If the adverse *benefit determination* was based, in whole or in part, on a medical judgment, including determinations that treatments, drugs, or other services are *experimental/investigational*, or not *medically necessary* or appropriate, the *Claims Administrator* will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was consulted neither in connection with the adverse *benefit determination* nor the initial *appeal* denial and who is not a subordinate of any such individuals.

Second-level *appeals* of *post-service claims* will be decided by the medical *Claims Administrator* within a reasonable period of time, but not later than thirty (30) days after the medical *Claims Administrator* receives the *appeal*. The *Medical Claims Administrator's* decision will be provided to you in writing, and if the decision is a second denial, the *notification* will include all of the information described in the subsection entitled Notification of Appeal Denials above.

N. External Review Rights

On August 23, 2010, the U.S. Departments of Labor (DOL), Health and Human Services (HHS), and the U.S. Treasury Department collectively released interim guidance to establish procedures for the Federal *external review* process required by healthcare reform.

Until the final procedure becomes available, the *Plan* will make every effort to comply with the limited- enforcement safe harbor provisions established by DOL Technical Release 2010-01 which provides guidance on the interim review process for self-funded group health plans.

If your final *appeal* for a *claim* is denied, you will be *notified* in writing that your *claim* is eligible for an *external review* and you will be informed of the time frames and the steps necessary to request an *external review*. You must complete all levels of the internal *claims* and *appeal* procedure before you can request a voluntary *external review*.

If you decide to seek *external review*, an *independent review organization* (an *IRO*) will be assigned your *claim*, and the *IRO* will work with a neutral, independent clinical reviewer with appropriate medical expertise. The *IRO* does not have to give deference to any earlier claims and *appeals* decisions, but it must observe the written terms of the *Plan* document. In other words, the *IRO* is not bound by any previous decision made on your *claim*. The ultimate decision of the *IRO* will be binding on you, the medical *Claims Administrator*, and the *Plan*.

O. External Review of Claims

The *external review* process is available only where the *final adverse benefit determination* is denied on the basis of (1) a medical judgment (which includes but is not limited to, *Plan* requirements for *medical necessity*, appropriateness, health care setting, level of care, or effectiveness of a covered benefit), (2) a determination that a treatment is *experimental* or *investigational*, or (3) a rescission of coverage. If your *appeal* is denied, you or your *authorized representative* may request further review by an *independent review organization* (*IRO*). This request for *external review* must be made, in writing, within four (4) months of the date you are notified of an adverse *benefit determination* or *final adverse benefit determination*.

Within five (5) business days following the date of receipt of the *external review* request, the *Plan* will complete a preliminary review of the request to determine whether:

- a. The *claimant* is or was covered under the *Plan* at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the *Plan* at the time the health care item or service was provided.
- b. The adverse *benefit determination* or the final adverse *benefit determination* does not relate to the *claimant's* failure to meet the requirements for eligibility under the terms of the group health plan (e.g., worker classification or similar determination).
- c. The *claimant* has exhausted the *Plan's* internal *appeal* process.
- d. The *claimant* has provided all the information and forms required to process an *external review*.

The *Plan* will *notify* the *claimant* within **one (1) business day** of completion of its preliminary review if:

- a. the request is complete but not eligible for *external review*, in which case the *notice* will include the reasons for its ineligibility, and contact information for the Employee Benefits Security Administration [toll-free number 1-866-444-EBSA (3272)].
- b. The request is not complete, in which case the *notice* will describe the information or materials needed to make the request complete, and allow the *claimant* to perfect the request for *external review* within the four (4) month filing period, or within the forty-eight (48) hour period following receipt of the *notification*, whichever is later.

NOTE: If the adverse *benefit determination* or *final internal adverse benefit determination* relates to a *plan participant's* or beneficiary's failure to meet the requirements for eligibility under the terms of the *Plan*, it is not within the scope of the *external review process*, and no *external review* may be taken.

If the request is complete and eligible, the *Plan Administrator* will assign the request to an *IRO*. Once that assignment is made, the following procedure will apply:

- a. The assigned *IRO* will utilize legal experts where appropriate to make coverage determinations under the *Plan*.
- b. The assigned *IRO* will timely *notify* the *claimant* in writing of the request's eligibility and acceptance for external review. This *notice* will include a statement that the *claimant* may submit in writing to the assigned *IRO* within ten (10) business days following the date of receipt of the *notice* additional information that the *IRO* must consider when conducting the *external review*. The *IRO* is not required to, but may, accept and consider additional information submitted after ten (10) business days.
- c. Within five (5) business days after the date of assignment of the *IRO*, the *Plan* must provide to the assigned *IRO* the documents and any information considered in making the adverse *benefit determination* or *final internal adverse benefit determination*. Failure by the *Plan* to timely provide the documents and information must not

delay the conduct of the *external review*. If the Plan fails to timely provide the documents and information, the assigned *IRO* may terminate the *external review* and make a decision to the adverse *benefit determination* or *final internal adverse benefit determination*. Within one (1) business day after making the decision, the *IRO* must notify the *claimant* and the Plan.

- d. Upon receipt of any information submitted by the *claimant*, the assigned *IRO* must within one (1) business day forward the information to the Plan. Upon receipt of any such information, the Plan may reconsider its adverse *benefit determination* or *final internal adverse benefit determination* that is the subject of the *external review*. Reconsideration by the Plan must not delay the *external review*. The *external review* terminated as a result of the reconsideration only if the Plan decides, upon completion of its reconsideration, to reverse its adverse *benefit determination* or *final internal adverse benefit determination* and provide coverage or payment. Within one (1) business day after making such a decision, the Plan must provide written *notice* of its decision to the *claimant* and the assigned *IRO*. The assigned *IRO* must terminate the *external review* upon receipt of the *notice* from the Plan.
- e. The *IRO* will review all of the information and documents timely received. In reaching a decision, the assigned *IRO* will review the *claim* de novo and not be bound by any decisions or conclusions reached during the Plan's internal *claims* and *appeals* process. In addition to the documents and information provided, the assigned *IRO*, to the extent the information or documents are available and the *IRO* considers them appropriate, will consider all of the following in reaching a decision:
 - i. the *claimant's* medical records
 - ii. the attending health care professional's recommendation
 - iii. reports from appropriate health care professionals and other documents submitted by the Plan, *claimant*, or the *claimant's* treating *provider*
 - iv. the terms of the *claimant's* plan to ensure that the *IRO's* decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law
 - v. appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, boards, and associations
 - vi. any applicable clinical review criteria developed and used by the *Plan*, unless the criteria are inconsistent with the terms of the Plan or with applicable law
 - vii. the opinion of the *IRO's* clinical reviewer or reviewers after considering the information described in this notice to the extent the information or documents are available
- f. The assigned *IRO* must provide written *notice* of the final *external review* decision within forty-five (45) days after the *IRO* receives the request for the *external review*. The *IRO* must deliver the notice of final *external review* decision to the *claimant* and the Plan.
- g. The assigned *IRO's* decision *notice* will contain:
 - i. a general description of the reason for the request for *external review*, including information sufficient to identify the *claim* (including the date or dates of service, the *health care provider*, the *claim* amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, and the reason for the previous denial)
 - ii. the date the *IRO* received the assignment to conduct the *external review* and the date of the *IRO* decision
 - iii. the references to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision
 - iv. a discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision
 - v. a statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the group health plan or to the *claimant*
 - vi. a statement that judicial review may be available to the *claimant*
 - vii. current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman

Generally, a claimant must exhaust the Plan's Claims and Procedures in order to be eligible for the External Review process. However, in some cases the Plan provides for an expedited External Review if:

1. The *claimant* receives an *adverse benefit determination* that involves a medical condition for which the time for completion of the *Plan's* internal *claims* and *appeal* procedures would seriously jeopardize the *claimant's* life or health or ability to regain maximum function and the claimant has filed a request for an expedited internal review; or
2. The *claimant* receives a *final adverse benefit determination* that involves a medical condition where the time for completion of a standard *external review* process would seriously jeopardize the *claimant's* life or health or the *claimant's* ability to regain maximum function, or if the *final adverse benefit determination* concerns an admission, availability of care, continued stay, or health care item or service for which the *claimant* received emergency services, but has not been discharged from a facility.

Immediately upon receipt of a request for expedited *external review*, the Plan must determine and notify the *claimant* whether the request satisfies the requirements for expedited review, including the eligibility requirements for *external review* listed above. If the request qualifies for expedited review, it will be assigned to an *IRO*. The *IRO* must make its determination and provide a notice of the decision as expeditiously as the *claimant's* medical condition or circumstances require, but in no event more than seventy-two (72) hours after the *IRO* receives the request for an expedited *external review*. If the original notice of its decision is not in writing, the *IRO* must provide written confirmation of the decision within forty-eight (48) hours to both the *claimant* and the Plan.

P. Limitation on When a Lawsuit May Be Started

You may not start a lawsuit to obtain benefits until after you have requested an *appeal* and a final decision has been reached on the *appeal*, or until ninety (90) days have elapsed since you filed a request for *appeal* if you have not received a final decision or notice that an additional sixty (60) days will be necessary to reach a final decision. **Any lawsuit must be started within the applicable statute of limitations for the State of Colorado.**

Q. Workers' Compensation

If the *employer* contests the *claim* filed for a workers' compensation law for the *illness* or *injury* for which expenses are *incurred*, this Plan will pay benefits, subject to its right to recover those payments if and when it is determined that they are covered under a workers' compensation or occupational disease law. However, before such payment will be made, you and/or your covered dependent must execute a subrogation and reimbursement agreement acceptable to the *Plan Administrator* or its designee.

SECTION XII—COORDINATION OF BENEFITS

A. Coordination of the Benefit Plans

Coordination of benefits sets out rules for the order of payment of *covered expenses* when two (2) or more plans, including *Medicare*, are paying. When a *participant* is covered by this Plan and another plan, or the *employee's spouse* is covered by this Plan and by another plan or the *employee's* covered children are covered under two (2) or more plans, the plans will coordinate benefits when a *claim* is received.

Non-Dupe/Maintenance of Benefits/Benefit-less-Benefit

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary will pay up to its own plan formula minus whatever the primary plan paid.

B. Benefit Plan

This provision will coordinate the medical and dental benefits of a benefit plan. The term benefit plan means this Plan or any one (1) of the following plans:

1. group or group-type plans, including franchise or blanket benefit plans
2. group practice and other group prepayment plans
3. federal government plans or programs

This includes *Medicare* and Tricare.

4. other plans required or provided by law

This does not include *Medicaid* or any benefit plan like it that, by its terms, does not allow coordination.

5. no fault auto insurance, by whatever name it is called, when not prohibited by law

C. Allowable Charge

For a charge to be allowable it must be a *reasonable and customary amount* and at least part of it must be covered under this Plan.

In the case of HMO (Health Maintenance Organization) or other *network* only plans: This Plan will not consider any charges in excess of what an HMO or *network provider* has agreed to accept as payment in full. Also, when an HMO or *network* plan is primary and the *participant* does not use an HMO or *network provider*, this Plan will not consider as an *allowable charge* any charge that would have been covered by the HMO or *network* plan had the *participant* used the services of an HMO or *network provider*.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the *allowable charge*.

D. General Limitations

When medical payments are available under any other insurance source, the Plan shall always be considered the secondary carrier.

E. Automobile Limitations

When medical payments are available under vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan *deductibles*. This Plan shall always be considered the secondary carrier regardless of the individual's election under PIP (personal injury protection) coverage with the auto carrier.

F. Benefit Plan Payment Order

When two (2) or more plans provide benefits for the same *allowable charge*, benefit payment will follow these rules.

1. Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.
2. Plans with a coordination provision will pay their benefits up to the allowable charge:
 - a. The benefits of the plan which covers the person directly (that is, as an *employee, participant, or subscriber*) (Plan A) are determined before those of the plan which covers the person as a dependent (Plan B).
 - b. The benefits of a benefit plan which covers a person as an *employee* who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or retired *employee*. The benefits of a benefit plan which covers a person as a dependent of an *employee* who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a dependent of a laid off or retired *employee*. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.
 - c. The benefits of a benefit plan which covers a person as an *employee* who is neither laid off nor retired or a dependent of an *employee* who is neither laid off nor retired are determined before those of a plan which covers the person as a *COBRA* beneficiary.
 - d. When a child is covered as a dependent and the parents are not separated or divorced, these rules will apply:
 - 1) The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;
 - 2) If both parents have the same birthday, the benefits of the benefit plan which has covered the patient for the longer time are determined before those of the benefit plan which covers the other parent.
 - e. When a child's parents are divorced or legally separated, these rules will apply:
 - 1) This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.
 - 2) This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the step-parent that covers the child as a dependent will be considered next. The benefit plan of the parent without custody will be considered last.
 - 3) This rule will be in place of items (1) and (2) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a dependent.
 - 4) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a dependent and the parents are not separated or divorced.
 - 5) For parents who were never married to each other, the rules apply as set out above as long as paternity has been established.
 - f. If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. When there is a conflict in *coordination of benefit* rules, the Plan will never pay more than 50% of *allowable charges* when paying secondary.
3. *Medicare* will pay primary, secondary or last to the extent stated in federal law. When *Medicare* is to be the primary payer if the person has enrolled in *Medicare*, this Plan will base its payment upon benefits that would have been paid by *Medicare* under Parts A and B, regardless of whether or not the person was enrolled under both of these parts. The Plan reserves the right to coordinate benefits with respect to *Medicare* Part D.
4. If a *participant* is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.
5. When an adult dependent is covered by his/her *spouse's* plan and is also covered by his/her parent's plan, the benefits of the benefit plan which has covered the patient for the longest time are determined before those of the other plan.

6. When an adult dependent is covered by multiple parents' plans, the benefits of the benefit plan of the parent whose birthday falls earlier in the year are determined before those of the benefit plan of the parent whose birthday falls later in that year. Should both/all parents have the same birthday, the benefits of the benefit plan which has covered the patient the longest shall be determined first.
7. The Plan will pay primary to Tricare and a state child health plan to the extent required by federal law.

G. Claims Determination Period

Benefits will be coordinated on a *benefit year* basis. This is called the claims determination period.

H. Right to Receive or Release Necessary Information

To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A *participant* will give this Plan the information it asks for about other plans and their payment of *allowable charges*.

I. Facility of Payment

This Plan may repay other plans for benefits paid that the *Plan Administrator* determines it should have paid. That repayment will count as a valid payment under this Plan.

J. Right of Recovery

This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the *participant*. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the *allowable charge*. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

SECTION XIII—REIMBURSEMENT AND RECOVERY PROVISION

A. Right of Subrogation and Refund

WHEN THIS PROVISION APPLIES:

The *plan participant* may incur medical or dental charges due to *injuries* that may be caused by the act or omission of a third party or a third party may be responsible for payment. In such circumstances, the *plan participant* may have a claim against that third party, or insurer, for payment of the medical or dental charges, except as provided by Colorado Subrogation statute.

The payment for benefits received by a covered person under the Plan shall be made in accordance with the assignment of rights by or on behalf of the covered person as required by Medicaid.

The *plan participant*, to the extent permitted by law, must repay to the *Plan* the benefits paid on his or her behalf out of the *recovery* made from the third party or insurer.

B. Amount Subject to Subrogation or Refund

When a right of *recovery* exists, the *participant* will execute and deliver all required instruments and papers as well as doing whatever else is needed to secure the Plan's right of *subrogation*.

C. Recovery from Another Plan

To the extent permitted by law, *recovery* from another plan under which the *participant* is covered. This right of refund also applies when a *participant recovers* under an uninsured or underinsured motorist plan (which will be treated as third party coverage when reimbursement or *subrogation* is in order), homeowner's plan, renter's plan, medical malpractice plan or any liability plan.

D. Rights of Plan Administrator

The *Plan Administrator* has a right to request reports on and approve of all settlements.

SECTION XII – CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (*COBRA*), certain *employees* and their families covered under The City of Colorado Springs Medical Benefit Plan (the Plan) will be entitled to the opportunity to elect a temporary extension of health coverage (called *COBRA* continuation coverage) where coverage under the Plan would otherwise end. This notice is intended to inform *participants* and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of *COBRA*, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

The *Plan Administrator* is The City of Colorado Springs, 30 S. Nevada Avenue, P.O. Box 1575, Mail Code 722, Colorado Springs, CO 80903-1575, 1-719-385-5125. The *Plan Administrator* is responsible for administering *COBRA* continuation coverage. Complete instructions on *COBRA*, as well as election forms and other information, will be provided by the *Plan Administrator* to *participants* who become qualified beneficiaries under *COBRA*.

COBRA continuation coverage does not run concurrent with the coverage under the terms of the Plan.

A. What is COBRA Continuation Coverage?

COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain *participants* and their eligible family members (called qualified beneficiaries) at group rates. The right to *COBRA* continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the qualifying event). As a result of a qualifying event a member can elect the same Plan coverage that was in effect prior to the loss of coverage or a lesser plan provided the change meets the consistency rule.

B. Who Can Become a Qualified Beneficiary?

In general, a Qualified Beneficiary can be:

1. Any individual who, on the day before a qualifying event, is covered under a Plan by virtue of being on that day either a covered *employee*, the spouse, or civil union partner of a covered *employee*, or a dependent child of a covered *employee*. If, however, an individual who otherwise qualifies as a qualified beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a qualified beneficiary if that individual experiences a qualifying event.
2. Any child who is born to or placed for adoption with a covered *employee* during a period of *COBRA* continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a qualified beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a qualifying event.
3. A covered *employee* who retired on or before the date of substantial elimination of Plan coverage which is the result of a bankruptcy proceeding under Title 11 of the U.S. Code with respect to the *employer*, as is the spouse, surviving spouse or dependent child of such a covered *employee* if, on the day before the bankruptcy qualifying event, the spouse, surviving Spouse or dependent child was a beneficiary under the Plan.

The term covered *employee* includes not only common-law *employees* (whether part-time or full-time) but also any individual who is provided coverage under the Plan due to his or her performance of services for The City of Colorado Springs who sponsors the Plan (e.g., self-employed individuals, independent contractor, or corporate director). However, this provision does not establish eligibility of these individuals. Eligibility for Plan coverage shall be determined in accordance with Plan eligibility provisions.

An individual is not a qualified beneficiary if the individual's status as a covered *employee* is attributable to a period in which the individual was a nonresident alien who received from the individual's *employer* no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a qualified beneficiary, then a spouse or dependent child of the individual will also not be considered a qualified beneficiary by virtue of the relationship to the individual.

Each qualified beneficiary (including a child who is born to or placed for adoption with a covered *employee* during a period of *COBRA* continuation coverage) must be offered the opportunity to make an independent election to receive *COBRA* continuation coverage.

C. What is a Qualifying Event?

A qualifying event is any of the following if the Plan provided that the *participant* would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the qualifying event) in the absence of *COBRA* continuation coverage:

1. The death of a covered *employee*.
2. The termination (other than by reason of the *employee's* gross misconduct), or reduction of hours, of a covered *employee's* employment.
3. The divorce or legal separation of a covered *employee* from the *employee's* spouse or legal dissolution of the Civil Union license or legal separation from Civil Union Partner. If the *employee* reduces or eliminates the *employee's* spouse's Plan coverage in anticipation of a divorce, dissolution, or legal separation, and a divorce, dissolution, or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event even though the spouse's coverage was reduced or eliminated before the divorce or legal separation.
4. A covered *employee's* enrollment in any part of the *Medicare* program.
5. A dependent child's ceasing to satisfy the Plan's requirements for a dependent child (for example, attainment of the maximum age for dependency under the Plan).
6. A proceeding in bankruptcy under Title 11 of the U.S. Code with respect to an *employer* from whose employment a covered *employee* retired at any time.

If the qualifying event causes the covered *employee*, or the covered spouse or a dependent child of the covered *employee*, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the qualifying event (or in the case of the bankruptcy of The City of Colorado Springs, any substantial elimination of coverage under the Plan occurring within twelve (12) months before or after the date the bankruptcy proceeding commences), the persons losing such coverage become qualified beneficiaries under *COBRA* if all the other conditions of the *COBRA* are also met. For example, any increase in contribution that must be paid by a covered *employee*, or the *spouse*, or a dependent child of the covered *employee*, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993 (FMLA) does not constitute a qualifying event. A Qualifying Event will occur, however, if an *employee* does not return to employment at the end of the FMLA leave and all other *COBRA* continuation coverage conditions are present. If a qualifying event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost). Note that the covered *employee* and family members will be entitled to *COBRA* continuation coverage even if they failed to pay the *employee* portion of premiums for coverage under the Plan during the FMLA leave.

D. What Factors Should be Considered when Determining to Elect COBRA Continuation Coverage?

You should take into account that a failure to continue your group health coverage will affect your rights under federal law. If you do not elect *COBRA* continuation coverage and pay the appropriate premiums for the maximum time available to you, you will lose the right to convert to an individual health insurance policy. You should take into account that you have special enrollment rights under federal law (HIPAA). You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within thirty (30) days after *Plan* coverage ends due to a qualifying event listed above. You will also have the same special right at the end of *COBRA* continuation coverage if you get *COBRA* continuation coverage for the maximum time available to you.

E. What is the Procedure for Obtaining COBRA Continuation Coverage?

The Plan has conditioned the availability of *COBRA* continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

F. What is the Election Period and How Long Must it Last?

The election period is the time period within which the qualified beneficiary must elect *COBRA* continuation coverage under the Plan. The election period must begin no later than the date the qualified beneficiary would lose coverage on account of the qualifying event and ends sixty (60) days after the later of the date the qualified beneficiary would lose coverage on account of the qualifying event or the date notice is provided to the qualified beneficiary of her or his right to elect *COBRA* continuation coverage. If coverage is not elected within the sixty (60) day period, all rights to elect *COBRA* continuation coverage are forfeited.

Note: If a covered *employee* who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, and the *employee* and his or her covered *dependents* have not elected *COBRA* coverage within the normal election period, a second opportunity to elect *COBRA* coverage will be made available for themselves and certain family members, but only within a limited period of sixty (60) days or less and only during the six (6) months immediately after their group health plan coverage ended. Any person who qualifies or thinks that he and/or his family members may qualify for assistance under this special provision should contact the *Plan Administrator* for further information.

G. Is a Covered Employee or Qualified Beneficiary Responsible for Informing the Plan Administrator of the Occurrence of a Qualifying Event?

The Plan will offer *COBRA* continuation coverage to qualified beneficiaries only after the *Plan Administrator* or its designee has been timely notified that a qualifying event has occurred. The City of Colorado Springs (if The City of Colorado Springs is not the *Plan Administrator*) will notify the *Plan Administrator* of the qualifying event within thirty (30) days following the date coverage ends when the qualifying event is:

1. the end of employment or reduction of hours of employment
2. death of the *employee*
3. commencement of a proceeding in bankruptcy with respect to The City of Colorado Springs
4. enrollment of the *employee* in any part of *Medicare*

IMPORTANT:

For the other qualifying events (divorce or legal separation of the employee and spouse or dissolution or legal separation of Civil Union Partner, or a dependent child's losing eligibility for coverage as a dependent child), you or someone on your behalf must notify the Plan Administrator or its designee in writing within sixty (60) days after the qualifying event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the sixty (60) day notice period, any spouse or dependent child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the plan sponsor.

NOTICE PROCEDURES:

Any notice that you provide must be **in writing**. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the person, department or firm listed below, at the following address:

The City of Colorado Springs
30 S. Nevada Avenue
P.O. Box 1575, Mail Code 722
Colorado Springs, CO 80903-1575
1-719-385-5125

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

the **name of the plan or plans** under which you lost or are losing coverage

the name and address of the *employee* covered under the plan

the name(s) and address(es) of the qualified beneficiary(ies)

the **qualifying event** and the **date** it happened

If the qualifying event is a divorce or legal separation, your notice must include a copy of the divorce decree or the legal separation agreement.

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the *Plan Administrator* or its designee receives timely notice that a qualifying event has occurred, *COBRA* continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect *COBRA* continuation coverage. Covered *employees* may elect *COBRA* continuation coverage for their spouses, and parents may elect *COBRA* continuation coverage on behalf of their children. For each qualified beneficiary who elects *COBRA* continuation coverage, *COBRA* continuation coverage will begin on the date that plan coverage would otherwise have been lost. If you or your spouse or dependent children do not elect continuation coverage within the sixty (60) day election period described above, the right to elect continuation coverage will be lost.

H. What is a Notice of Unavailability of COBRA Continuation Coverage?

If the *Plan Administrator* receives notice of a qualifying event from a qualified beneficiary and determines that the individual is not entitled to *COBRA* continuation coverage, the *Plan Administrator* or its designee will provide to such individual an explanation as to why the individual is not entitled to *COBRA* continuation coverage. The notice will be provided within the same time frame that the *Plan Administrator* or its designee would have provided the notice of right to elect *COBRA* continuation coverage.

I. Is a Waiver Before the End of the Election Period Effective to End a Qualified Beneficiary's Election Rights?

If, during the election period, a qualified beneficiary waives *COBRA* continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of *COBRA* continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the *Plan Administrator* or its designee, as applicable.

J. Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare?

Qualified beneficiaries who are entitled to elect *COBRA* continuation coverage may do so even if they are covered under another group health plan or are entitled to *Medicare* benefits on or before the date on which *COBRA* is elected. However, a qualified beneficiary's *COBRA* coverage will terminate automatically if, after electing *COBRA*, he or she becomes entitled to *Medicare* or becomes covered under other group health plan coverage.

K. When May a Qualified Beneficiary's COBRA Continuation Coverage be Terminated?

During the election period, a qualified beneficiary may waive *COBRA* continuation coverage. Except for an interruption of coverage in connection with a waiver, *COBRA* continuation coverage that has been elected for a qualified beneficiary must extend for at least the period beginning on the date of the qualifying event and ending not before the earliest of the following dates:

1. the last day of the applicable maximum coverage period
2. the first day for which timely payment is not made to the Plan with respect to the qualified beneficiary
3. the date upon which The City of Colorado Springs ceases to provide any group health plan (including a successor plan) to any *employee*
4. the date, after the date of the election, that the qualified beneficiary first becomes covered under any other Plan
5. the date, after the date of the election, that the qualified beneficiary first enrolls in the *Medicare* program (either part A or part B, whichever occurs earlier)

In the case of a qualified beneficiary entitled to a disability extension, the later of:

1. twenty-nine (29) months after the date of the qualifying event, or (ii) the first day of the month that is more than thirty (30) days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled qualified beneficiary whose disability resulted in the qualified beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier
2. the end of the maximum coverage period that applies to the qualified beneficiary without regard to the disability extension

The Plan can terminate for cause the coverage of a qualified beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a qualified beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a qualified beneficiary, if the Plan's obligation to make *COBRA* continuation coverage available to the qualified beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a qualified beneficiary.

If *COBRA* continuation coverage for a qualified beneficiary terminates before the expiration of the maximum coverage period, the *Plan Administrator* or its designee will provide notice to the qualified beneficiary of the reason that the continuation coverage terminated, and the date of termination. The notice will be provided as soon as practicable following the determination regarding termination of the continuation coverage.

L. What are the Maximum Coverage Periods for COBRA Continuation Coverage?

The maximum coverage periods are based on the type of the qualifying event and the status of the qualified beneficiary, as shown below.

1. In the case of a qualifying event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends eighteen (18) months after the loss of coverage if there is not a disability extension and twenty-nine (29) months after the loss of coverage if there is a disability extension.
2. In the case of a covered *employee's* enrollment in the *Medicare* program before experiencing a qualifying event that is a termination of employment or reduction of hours of employment, the maximum coverage period for qualified beneficiaries other than the covered *employee* ends on the later of:
 - a. thirty-six (36) months after the date the covered *employee* becomes enrolled in the *Medicare* program
 - b. eighteen (18) months [or twenty-nine (29) months, if there is a disability extension] after the date of the covered *employee's* termination of employment or reduction of hours of employment
3. In the case of a qualified beneficiary who is a child born to or placed for adoption with a covered *employee* during a period of *COBRA* continuation coverage, the maximum coverage period is the maximum coverage period applicable to the qualifying event giving rise to the period of *COBRA* continuation coverage during which the child was born or placed for adoption.
4. In the case of any other qualifying event than that described above, the maximum coverage period ends thirty-six (36) months after the qualifying event.

M. Under What Circumstances Can the Maximum Coverage Period be Expanded?

If a qualifying event that gives rise to an eighteen (18) month or twenty-nine (29) month maximum coverage period is followed, within that eighteen (18) or twenty-nine (29) month period, by a second Qualifying Event that gives rise to a thirty-six (36) months maximum coverage period, the original period is expanded to thirty-six (36) months, but only for individuals who are qualified beneficiaries at the time of both qualifying events. In no circumstance can the *COBRA* maximum coverage period be expanded to more than thirty-six (36) months after the date of the first qualifying event. The *Plan Administrator* must be notified of the second qualifying event within sixty (60) days of the second qualifying event. This notice must be sent to the *plan sponsor*.

N. How Does a Qualified Beneficiary Become Entitled to a Disability Extension?

A disability extension will be granted if an individual (whether or not the covered *employee*) who is a qualified beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered *employee's* employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first sixty (60) days of *COBRA* continuation coverage. To qualify for the disability extension, the qualified beneficiary must also provide the *Plan Administrator* with notice of the disability determination on a date that is both within sixty (60) days after the date of the determination and before the end of the original eighteen (18) month maximum coverage. This notice should be sent to the *plan sponsor*.

O. Does the Plan Require Payment for COBRA Continuation Coverage?

For any period of *COBRA* continuation coverage under the Plan, qualified beneficiaries who elect *COBRA* continuation coverage must pay for *COBRA* continuation coverage. Qualified beneficiaries will pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of *COBRA* continuation coverage covering a disabled qualified beneficiary due to a disability extension. The Plan will terminate a qualified beneficiary's *COBRA* continuation coverage as of the first day of any period for which timely payment is not made.

P. Must the Plan Allow Payment for COBRA Continuation Coverage to be Made in Monthly Installments?

Yes. The Plan is also permitted to allow for payment at other intervals.

Q. What is Timely Payment for Payment for COBRA Continuation Coverage?

Timely payment means a payment made no later than thirty (30) days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered timely payment if either under the terms of the Plan, covered *employees* or qualified beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between The City of Colorado Springs and the entity that provides Plan benefits on The City of Colorado Springs behalf, The City of Colorado Springs is allowed until that later date to pay for coverage of similarly situated non-*COBRA* beneficiaries for the period.

Notwithstanding the above paragraph, the Plan does not require payment for any period of *COBRA* continuation coverage for a Qualified Beneficiary earlier than forty-five (45) days after the date on which the election of *COBRA* continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

If timely payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the qualified beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A reasonable period of time is thirty (30) days after the notice is provided. A shortfall in a timely payment is not significant if it is no greater than the lesser of \$50 or 10% of the required amount.

R. Must a Qualified Beneficiary be Given the Right to Enroll in a Conversion Health Plan at the End of the Maximum Coverage Period for COBRA Continuation Coverage?

If a qualified beneficiary's *COBRA* continuation coverage under a group health plan ends as a result of the expiration of the applicable maximum coverage period, the Plan will, during the 180-day period that ends on that expiration date, provide the qualified beneficiary with the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated non-COBRA beneficiaries under the Plan. If such a conversion option is not otherwise generally available, it need not be made available to qualified beneficiaries.

S. If You Have Questions

If you have questions about your *COBRA* continuation coverage, you should contact the *Plan Administrator* or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

T. Keep Your Plan Administrator Informed of Address Changes

In order to protect your family's rights, you should keep the *Plan Administrator* informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the *Plan Administrator*.

U. If You Wish to Appeal

In general, COBRA-related claims are not governed by ERISA and the related federal regulations. In an effort to provide all qualified beneficiaries with a fair and thorough review process for COBRA-related claims, all determinations regarding *COBRA* eligibility and coverage will be made in accordance with the **Continuation Coverage Rights Under COBRA** section of this governing Plan document. Accordingly, if a qualified beneficiary wishes to *appeal* a *COBRA* eligibility or coverage determination made by the Plan, such claims must be submitted consistent with the *appeals* procedure set forth in the **Claims and Appeals** section of this document. The Plan will respond to all complete *appeals* in accordance with the appeals procedure set forth in Paragraph J of the **Claims and Appeals** section of this document. A qualified beneficiary who files an appeal with the plan must exhaust the administrative remedies afforded by the Plan prior to pursuing civil action in federal court under *COBRA*.

SECTION XIV—RESPONSIBILITIES FOR PLAN ADMINISTRATION

A. Plan Administrator

The City of Colorado Springs Employee Benefit Plan is the benefit plan of The City of Colorado Springs, the *Plan Administrator*, also called the *plan sponsor*. An individual may be appointed by The City of Colorado Springs to be *Plan Administrator* and serve at the convenience of The City of Colorado Springs. If the *Plan Administrator* resigns, dies or is otherwise removed from the position, The City of Colorado Springs shall appoint a new *Plan Administrator* as soon as reasonably possible.

The *Plan Administrator* shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the *Plan Administrator* shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a *participant's* rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the *Plan Administrator* will be final and binding on all interested parties.

B. Duties of the Plan Administrator

1. To administer the Plan in accordance with its terms.
2. To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.
3. To decide disputes that may arise relative to a *participant's* rights.
4. To prescribe procedures for filing a *claim* for benefits and to review *claim* denials.
5. To keep and maintain the Plan documents and all other records pertaining to the Plan.
6. To appoint a *third party administrator* to pay *claims*.
7. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

C. Plan Administrator Compensation

The *Plan Administrator* serves **without** compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

D. Third Party Administrator is Not a Fiduciary

A *Third Party Administrator* is not a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the *Plan Administrator*.

E. Discretionary Authority of Medical Claims Administrator and Designees

In carrying out their respective responsibilities under the Plan, the *Plan Administrator* and individuals to whom responsibility for the administration of the Plan has been delegated have discretionary authority to interpret the terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made under that discretionary authority would be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

F. Fiduciary

A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.

G. Fiduciary Duties

A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the *employees* and their dependent(s), and defraying reasonable expenses of administering the Plan. These are duties which must be carried out:

1. with care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation
2. by diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so;
3. in accordance with the Plan documents

H. The Named Fiduciary

A named fiduciary is the one named in the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

1. the named fiduciary has violated its stated duties in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures
2. the named fiduciary breached its fiduciary responsibility

I. Facility of Payment

If the *Plan Administrator* or its designee determines that you cannot submit a *claim* or prove that you or your covered dependent paid any or all of the charges for health care services that are covered by the Plan because you are incompetent, incapacitated or in a coma, the Plan may, at its discretion, pay Plan Benefits directly to the *health care provider(s)* who provided the health care services or supplies, or to any other individual who is providing for your care and support. Any such payment of Plan Benefits will completely discharge the Plan's obligations to the extent of that payment. Neither the Plan, *Plan Administrator*, nor any other designee of the *employer* will be required to see to the application of the money so paid.

SECTION XV—ADDITIONAL PLAN INFORMATION

A. Funding the Plan and Payment of Benefits

The cost of the Plan is funded as follows:

For Employee and Dependent Coverage: Funding is derived from the funds of The City of Colorado Springs and contributions made by the covered *employees*.

The level of any *employee* contributions will be set by the *Plan Administrator*. These *employee* contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the *employee* or withheld from the *employee's* pay through payroll deduction.

Benefits are paid directly from the Plan through the *Third Party Administrator*.

B. Plan is Not an Employment Contract

The Plan is not to be construed as a contract for or of employment.

C. Clerical Error

Any clerical error by the *Plan Administrator* or an agent of the *Plan Administrator* in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a *participant*, the amount of overpayment may be deducted from future benefits payable.

D. Amending and Terminating the Plan

If the Plan is terminated, the rights of the *participants* are limited to expenses incurred before termination.

The City of Colorado Springs intends to maintain this Plan indefinitely; however, it reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust agreement (if any).

E. Your IMPORTANT Notice Obligations (When COBRA is available)

The Plan provides that your *spouse's* coverage terminates (thus, is lost) as of the last day of the month in which a divorce or legal separation occurs. A dependent's coverage terminates the last day of the month in which he or she ceases to be an eligible dependent under the Plan.

If your spouse or dependent loses coverage under the Plan because of divorce, legal separation or the child losing dependent status under the Plan, then under the *COBRA* statute, you (the *employee*) or your *spouse* or dependent has the responsibility to notify the *Plan Administrator* upon a divorce, legal separation, or a child losing dependent status.

You (the *employee*) or your spouse or dependent must provide written notice to the Plan no later than sixty (60) days after the last day of the month of the divorce, legal separation, or a child losing dependent status. If you or your *spouse* or dependent fails to notify the *Plan Administrator* during the sixty (60)-day notice period, any *spouse* or dependent that loses coverage will NOT be offered the option to elect continuation coverage. Furthermore, if you or your spouse or dependent fails to provide this notice to the *Plan Administrator*, and if any claims are mistakenly paid for expenses incurred after the date coverage is supposed to terminate upon the divorce, legal separation, or a child losing dependent status, then you will be required to reimburse the Plan for any *claims* so paid and may be subject to charges of insurance fraud.

If the *Plan Administrator* is provided timely notice of a divorce, legal separation, or a child losing dependent status that has caused a loss of coverage, the *Plan Administrator* will notify the affected family member of the right to elect continuation coverage.

You (the *employee*) and your *spouse* and dependent will be notified of the right to elect continuation coverage automatically (i.e., without any action required by you or a family member) upon the following events that result in a loss in coverage: the *employee's* termination of employment (other than for gross misconduct), reduction in hours or death.

F. Death or Incompetence

Any benefits otherwise payable to a *participant* following his or her death shall be paid to his or her surviving *spouse* or to his or her estate if there is no surviving spouse. If the *Plan Administrator* determines that any *participant* is incompetent by reason of physical or mental disability, the Plan may cause all benefit payments that thereafter become due to be made to another person for the *participant's* benefit. Payments made to another party because of the *participant's* death or incompetence shall completely discharge any obligation of the Plan and The City of Colorado Springs.

SECTION XVI—DEFINED TERMS

The following terms have special meanings and when used in this Plan will be italicized. The failure of a term to appear in italics, does not waive the special meaning given to that term, unless the context requires otherwise.

Accident

A sudden and unforeseen event as a result of an external or extrinsic source, that is not work-related, and that occurred while the *participant* was covered under the Plan.

Accidental Injury (Accidental Injuries)

An objectively demonstrable impairment of bodily function caused by trauma from a sudden, unforeseen outside force or object, occurring at an identifiable time and place, and without the *participant's* foresight or expectation.

Active Employee

An *employee* who is on the regular payroll of The City of Colorado Springs and who has begun to perform the duties of his or her job with The City of Colorado Springs.

Activities of Daily Living

Activities performed as part of a person's daily routine, such as getting in and out of bed, bathing, dressing, feeding or eating, use of the toilet, ambulating, taking drugs or medicines that can be self-administered.

Acupuncture

A technique for treating disorders of the body by passing long thin needles through the skin. This technique is based on the belief that physical *illness* and disorders are caused by imbalances in the life force, called Qi, which flows through the body along meridians or channels, and that the needles stimulate the natural healing energy flow. When the services of an Acupuncturist are payable by this Plan, the Acupuncturist must be properly licensed by the state in which he or she is practicing and must be performing services within the scope of that license, or, where licensing is not required be certified by the National Certification Commission for Acupuncturists (NCCA).

Adverse Benefit Determination

The term adverse *benefit determination* means any of the following: a denial, reduction, rescission, or termination of a *claim* for benefits, or a failure to provide or make payment for such a *claim* (in whole or in part) including determinations of a *claimant's* eligibility, the application of any review under the **Health Care Management Program**, and determinations that an item or service is *experimental/investigational* or not *medically necessary* or appropriate.

Allowable Expense / Allowable Charge(s)

A health care service or expense, including *deductibles*, *co-insurance*, or *co-payments*, that is covered in full or in part by any of the Plans covering a *plan participant*, except as otherwise provided by the terms of this Plan or where a statute applicable to this Plan requires a different definition. This means that an expense or service (or any portion of an expense or service) that is not covered by any of the Plans is not an allowable expense.

Alternative Medicine

Health care services outside the traditional medical practice. This type of care can include such therapies as: *acupuncture*, massage therapy, nutritionist, chiropractic, foot care, homeopathic and *naturopathic services*. Covered services for the Alternative Medicine benefit are set forth under Alternative Medicine in the **Schedule of Medical Benefits** and, where licensing is required, must be performed by a licensed health care practitioner. Refer to the Alternative Medicine benefit under the **Schedule of Medical Benefits**.

Ambulance

A legally licensed vehicle, helicopter, or airplane certified for emergency patient transportation.

Ambulatory Surgical Center

A licensed facility that is used mainly for performing *outpatient surgery*, has a staff of *physicians*, has continuous *physician* and nursing care by Registered Nurses (R.N.s) and does not provide for overnight stays. An ambulatory surgical center that is part of a *hospital*, as defined in this Section, will be considered an Ambulatory Surgical Center for the purposes of this Plan.

Ancillary Services

Services provided by a *hospital* or other specialized health care facility other than room and board, including but not limited to, use of the operating room, recovery room, intensive care unit, etc., and laboratory and x-ray services, drugs and medicines, and medical supplies provided during confinement.

Anesthesia

The condition produced by the administration of specific agents (anesthetics) to render the patient unconscious and without conscious pain response (general anesthesia), or to achieve the loss of conscious pain response and/or sensation in a specific location or area of the body (local anesthesia). Anesthetics are commonly administered by injection or inhalation either by a *physician* (anesthesiologist) or Nurse Anesthetist.

Appeal

A review by the *Plan* of an *adverse benefit determination*, as required under the *Plan's* internal *claims* and appeals procedures.

Assignment of Benefits

An assignment of benefits is an arrangement by which a patient requests that their health benefit payments under this *Plan* be made directly to a designated medical provider or facility. By completing an assignment of benefits, the participant authorizes the *Plan Administrator* to forward payment for a covered procedure directly to the treating medical provider or facility. The *Plan Administrator* expects that an assignment of benefits form to be completed, as between the *plan participant* and the provider.

Authorized Representative

To designate an authorized representative a *claimant* must provide written authorization on a form provided by the *Plan*, and clearly indicate on the form the nature and extent of the authorization. However, where an *urgent care claim* is involved, a health care professional with knowledge of the medical condition will be permitted to act as a *claimant's* authorized representative without a prior written authorization.

Benefit Determination

A benefit determination is the *Plan's* decision regarding the acceptance or denial of a *claim* for benefits under the *Plan*.

Benefit Payment

Each benefit year, benefits will be paid for the covered expenses of a participant that are in excess of the deductible. Payment will be made at the rate shown under the reimbursement rate in the Schedule of Medical Benefits. No benefits will be paid in excess of the maximum benefit amount or any listed limit of the Plan.

Benefit Year

The twelve (12) month period beginning January 1 and ending December 31. All annual *deductibles* and benefit maximums accumulate during the benefit year.

Birthing Center

Any freestanding health facility, place, professional office or institution which is not a *hospital* or in a *hospital*, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to birthing centers in the jurisdiction where the facility is located.

The birthing center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a *physician* and either a Registered Nurse (R.N.) or a Licensed Nurse-Midwife; and have a written agreement with a *hospital* in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

Brand Name Drug

Means a drug produced and marketed exclusively by a particular manufacturer. The name is usually a registered trademark with the patent office and confers upon the registrant certain legal rights with respect to its use.

Cafeteria Plan

A plan described under Section 125 of the Internal Revenue Code which is maintained by the *employer* and permits *employees* to elect between taxable and non-taxable benefits.

Case Management

A process, administered by the Utilization/Medical Management vendor, in which its medical professionals work with the patient, family, care-givers, *health care providers*, medical *Claims Administrator* and the *employer* to coordinate a timely and cost-effective treatment program.

Change in Status

The following qualifying changes are the only ones permitted under the Plan:

1. change in legal marital status, including marriage by civil union, approved common law declaration, divorce, legal separation, annulment, or death of a *spouse*
2. change in number of dependents, including birth, adoption (other than an adoption of an adult), placement for adoption, or death of a dependent child
3. change in employment status or work schedule, including the start or termination of employment by you, your *spouse* or any dependent child, or an increase or decrease in hours of employment by you, your *spouse*, or any dependent child, including a switch between part-time and full-time employment, a strike or lock-out, or the start of or return from an unpaid leave of absence
4. change in dependent status under the terms of this Plan, including changes due to attainment of age, or any other reason provided under the definition of dependent in the **Defined Terms** section of this document
5. change of residence or worksite by you, your spouse, or any dependent child, whereby the change moves you in or out of the PPO network's area
6. change required under the terms of a National Medical Support Notice (NMSN), including a change in your election to provide coverage for the child specified in the order, or to cancel coverage for the child if the order requires your former spouse to provide coverage
7. change consistent with your right to special enrollment as described in the paragraph dealing with when you, your *spouse*, or dependent child(ren) Lose other coverage in the section dealing with special enrollment when you declined coverage under this Plan for yourself and/or any of your eligible dependents in the manner described in that paragraph
8. cancellation of your coverage or coverage of your *spouse*, or any dependent child who becomes entitled and enrolled under *Medicaid* or *Medicare*
9. curing a period of coverage, corresponding with an open enrollment period change made by a *spouse*, or dependent when the plan of that individual's employer has a different period of coverage
10. any other event or status that is permissible under IRS Code 125, as determined by the *Plan Administrator*

Chiropractic Care

Skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a *physician* to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

City

The City of Colorado Springs, and its unincorporated enterprises, other than Memorial Hospital.

Claim

A claim is defined as any request for a *Plan* benefit, made by a *claimant* or by a representative of a *claimant*, which complies with the *Plan's* reasonable procedure for filing claims and making benefit claims determinations.

A claim does not include a request for a determination of an individual's eligibility to participate in the *Plan*.

Claimant

A claimant is any *plan participant* or beneficiary making a claim for benefits. Claimants may file *claims* themselves or may act through an *authorized representative*. In this document, the words you and your are used interchangeably with claimant.

Claims Administrator

See *Third Party Administrator*.

Clinical Prior Authorization

The Clinical Prior Authorization program through the Pharmacy Benefit Manager that promotes quality utilization of potentially expensive, misprescribed, or abused medications. The Clinical Prior Authorization program allows a Plan to continue covering medications, when appropriate, that may otherwise be excluded. Clinically trained pharmacists handle the process from start to finish. Protocols are established based on numerous compendia of literature. Pharmacists work with *physicians* to ensure the highest level of overall care for patients.

COBRA

Consolidated Omnibus Reconciliation Act of 1985 is a federal law creating the right of *employees* to continue coverage after a separation of service and certain other events.

Co-Insurance

The portion of medical expenses (after the *deductible* has been satisfied) for which a *plan participant* is responsible.

Concurrent Review

A managed care program designed to assure that hospitalization and specialized health care facility admissions and length of stay, *surgery* and other health care services are *medically necessary* by having the Utilization/Medical Management vendor conduct an ongoing assessment of the health care as it is being provided, especially (but not limited to) *inpatient* confinement in a *hospital* or specialized health care facility.

Coordination of Benefits (COB)

The rules and procedures applicable to determination of how Plan benefits are payable when a person is covered by two (2) or more employer-sponsored health care plans.

Co-Payment, Co-Pay

A co-payment is a specific dollar amount a participant is required to pay and is typically payable to *the health care provider* at the time services or supplies are rendered.

Corrective Appliances

General term for appliances or devices that support a weakened body part (Orthotic) or replace a missing body part (Prosthetic).

Cosmetic Surgery or Treatment

Surgery or medical treatment to improve or preserve physical appearance, but not physical function. Cosmetic surgery or treatment includes, but is not limited to, removal of tattoos, breast augmentation, or other medical or

surgical treatment intended to restore or improve physical appearance, as determined by the medical *Claims Administrator* or its designee.

Covered Charges

Those *medically necessary* services or supplies that are covered under the plan.

Covered Person

Any *employee*, FPPA Retiree, and that person's *spouse* or dependent child who has completed all required formalities for enrollment for coverage under the Plan and is actually covered by the Plan.

Creditable Coverage

Includes most health coverage, such as coverage under a group health plan (including *COBRA* continuation coverage), HMO membership, an individual health insurance policy, *Medicaid* or *Medicare*.

Creditable coverage does not include coverage consisting solely of dental or vision benefits.

Custodial Care

Care (including room and board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of custodial care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication which could normally be self-administered.

Deductible

A specified portion of the *eligible expenses* that must be *incurred* by a *participant* before the Plan has any liability.

Dentist

A person who is properly trained and licensed to practice dentistry and who is practicing within the scope of such license.

Dietician

A qualified person who specializes in the art and science of dietetics - the study of food and its nutritional properties. Dieticians give advice on the design of special diets for well and ill patients.

Disability or Disabled

For purposes of this Plan, for determining whether a child is disabled, disability means the inability of a person to be self-sufficient as the result of a physical impairment or a condition such as mental retardation, cerebral palsy, epilepsy or another neurological disorder, psychosis, or is otherwise *totally disabled*, provided the condition is diagnosed by a *physician*, and accepted by the medical *Claims Administrator* or its designee, as a permanent and continuing condition.

Durable Medical Equipment

Equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an *illness* or *injury*, (d) is not disposable or non-durable and (e) is appropriate for use in the home.

Durable medical equipment includes, but is not limited to, apnea monitors, blood sugar monitors, blood pressure monitors, breast pump and supplies, commodes, electric hospital beds (with safety rails) electric and manual wheelchairs, nebulizers, oximeters, enteral feeding supply kit, infusion pump, ventilators, and for the purpose of this Plan, oxygen and oxygen equipment and related oxygen supplies.

Employee

A person who is an active employee of The City of Colorado Springs, regularly scheduled to work for The City of Colorado Springs in an employee/*employer* relationship.

Employer

Employer means the City of Colorado Springs, including its unincorporated enterprises other than Memorial Hospital (who is not a participating employer in this Plan).

Enrollment Date

The first day of coverage or, if there is a waiting period, the first day of the waiting period.

Experimental/Investigational

The service or supply is described as an alternative to more conventional therapies in the protocols (the plan for the course of medical treatment that is under investigation) or consent document (the consent form signed by or on behalf of the patient) of the *health care provider* that performs the service or prescribes the supply which meets the requirements of subparagraphs a, b, c, or d:

- a. The prescribed service or supply may be given only with the approval of an Institutional Review Board as defined by federal law.
- b. In the opinion of the *Plan Administrator* or its designee, there is either an absence of authoritative medical or scientific literature on the subject, or a preponderance of such literature that is published in the United States, **and** is written by experts in the field, **and**
 - i. shows that recognized medical or scientific experts classify the service or supply as experimental and/or investigational, **or**
 - ii. indicates that more research is required before the service or supply could be classified as equally or more effective than conventional therapies.
- c. With respect to services or supplies regulated by the Food and Drug Administration (FDA):
 - i. FDA approval is required in order for the service and supply to be lawfully marketed, and it has not been granted at the time the service or supply is prescribed or provided; **or**
 - ii. a current investigational new drug or new device application has been submitted and filed with the FDA.

However, a drug will not be considered experimental and/or investigational under this subparagraph c if it is:

- i. approved by the FDA as an investigational new drug for treatment use; **or**
- ii. classified by the National Cancer Institute as a Group C cancer drug when used for treatment of a life threatening disease as that term is defined in FDA regulations; **or**
- iii. approved by the FDA for the treatment of cancer and has been prescribed for the treatment of a type of cancer for which the drug was not approved for general use, and the FDA has not determined that such drug should not be prescribed for a given type of cancer.

In determining if a service or supply is or should be classified as experimental and/or investigational, the medical *Claims Administrator* or its designee will rely only on the following specific information and resources **that are available at the time the service or supply was performed, or provided:**

- a. medical records of the *participant*
- b. the consent document signed, or required to be signed, in order to receive the prescribed service or supply
- c. protocols of the *health care provider* that renders the prescribed service or prescribes or dispenses the supply;
- d. Authoritative peer reviewed medical or scientific writings that are published in the United States regarding the prescribed service or supply for the treatment of the *participant's* diagnosis, including, but not limited to:
 - i. United States Pharmacopeia Dispensing Information
 - ii. American Hospital Formulary Service
- e. The published opinions of either:
 - i. the American Medical Association (AMA), such as The AMA Drug Evaluations and The Diagnostic and Therapeutic Technology Assessment (DATTA) Program, etc.

- ii. specialty organizations recognized by the AMA
- iii. the National Institutes of Health (NIH)
- iv. the Center for Disease Control (CDC)
- v. the Office of Technology Assessment
- f. Federal laws or final regulations that are issued by or applied to the FDA or Department of Health and Human Services regarding the prescribed service or supply.
- g. The latest edition of The Medicare Coverage Issues Manual.

To determine how to obtain a *pre-certification* of any procedure that might be deemed to be Experimental and/or Investigational, see the subchapter on *pre-certification* review in the **Health Care Management** section of this document.

Benefits covered under the **Clinical Trials** sections are not considered experimental or investigational.

The *Plan Administrator* has the discretion to determine which drugs, services, supplies, care and/or treatments are considered experimental, investigative or unproven.

Explanation of Benefits (EOB)

A document sent to the participant by the *Third Party Administrator* after a *claim* for reimbursement has been processed. It includes the patient's name, claim number, type of service, provider, date of service, charges submitted for the services, amounts covered by this *Plan*, non-covered services, *cost sharing amounts*, and the amount of the charges that are the *plan participant's* responsibility. This form should be carefully reviewed and kept with other important records.

External Review

A review of an *adverse benefit determination*, including a *final internal adverse benefit determination* under applicable state or federal external review procedures.

Final Internal Adverse Benefit Determination

An *adverse benefit determination* that has been upheld by the *Plan* at completion of the *Plan's* internal *appeals* procedures; or an *adverse benefit determination* for which the internal *appeals* procedures have been exhausted under the deemed exhausted rule contained in the *appeals* regulations. For plans with two levels of *appeals*, the second-level *appeal* results in a final internal adverse benefit determination that triggers the right to *external review*.

Food and Drug Administration (FDA)

The U.S. government agency responsible for administration of the Food, Drug and Cosmetic Act and whose approval is required for certain *prescription drugs* and other medical services and supplies to be lawfully marketed.

Formulary

Means a listing of prescription drugs recommended by the MaxorPlus Pharmacy & Therapeutics Committee for use by participating *physicians/practitioners* and pharmacists.

FPPA

Fire and Police Pension Association.

FPPA Retiree

An Employee who retires from active FPPA service with the Employer and immediately begins receiving Retiree pension benefit payments and meets the eligibility requirements for Retirees. See the **Eligibility** section for more information concerning FPPA retiree eligibility for coverage.

FPPA Retiree Medical Plan Subsidy

The subsidy provided by the City of Colorado Springs pursuant to Section 2-1.4.204 of the Colorado Springs City Code for certain members of FPPA who were eligible to retire on or after January 1, 1979, and who were hired prior to August 1, 1988, in an amount not to exceed ninety-one dollars and forty cents (\$91.40) per month.

Genetic Information

Genetic Information means information about the genetic tests of an individual or his or her family members, and information about the manifestations of disease or disorder in family members of the individual. A genetic test means an analysis of human DNA, RNA, chromosomes, proteins or metabolites, which detects genotypes, mutations or chromosomal changes. It does not mean an analysis of proteins or metabolites that is directly related to a manifested disease, disorder or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved. Genetic information does not include information about the age or gender of an individual.

Genetic Information Nondiscrimination Act of 2008 (GINA)

GINA Title I applies to group health plans sponsored by local government employers; Title I generally prohibits discrimination in group premiums based on genetic information and the use of genetic information as a basis for determining eligibility or setting premiums, and places limitations on genetic testing and the collection of genetic information in group health plan coverage. Title I provides a clarification with respect to the treatment of genetic information under privacy regulations promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Health Care Provider

A physician, nurse, hospital or specialized treatment facility as those terms are specifically defined in this section.

Health Education

Educational activities including publications, which contain instructions on achieving and maintaining physical and mental health preventing *illness or injury*.

Health Management Program

The Health Management Program is an educational program designed to teach individuals the care and management of chronic diseases (such as diabetes, asthma, hyperlipidemia, hypertension, etc.), designed to improve patient knowledge of the disease and techniques for self-management and compliance with proper health care procedures required for the patient's well-being.

Home Health Care Agency

An agency or organization that provides a program of home health care and meets one of the following three tests:

1. It is approved by Medicare; **or**
2. It is licensed as a Behavioral Health Treatment Facility by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; **or**
3. If licensing is not required, it meets all of the following requirements:
 - a. It has the primary purpose of providing a home health care delivery system bringing supportive skilled nursing and other therapeutic services under the supervision of a *physician* or Registered Nurse (RN) to the home.
 - b. It has a full-time administrator.
 - c. It is run according to rules established by a group of professional *health care providers* including *physicians* and Registered Nurses (RNs).
 - d. It maintains written clinical records of services provided to all patients.

- e. Its staff includes at least one Registered Nurse (RN) or it has nursing care by a Registered Nurse (RN) available.
- f. Its employees are bonded.
- g. It maintains malpractice insurance coverage.
- h. It is established and operated in accordance with applicable licensing and other laws.

Homeopathy Services

An *alternative medicine* service that treats a disease especially by the administration of minute doses of a remedy that would in healthy persons produce symptoms similar to those of the disease.

Hospice

An agency or organization that administers a program of Palliative and supportive health care services providing physical, psychological, social and spiritual care for terminally ill persons assessed to have a life expectancy of 6 months or less. Hospice care is intended to let the terminally ill spend their last days with their families at home (home hospice services) or in a home-like setting (inpatient hospice), with emphasis on keeping the patient as comfortable and free from pain as possible, and providing emotional support to the patient and his or her family. The agency must meet one of the following three tests:

1. It is approved by Medicare; **or**
2. It is licensed as a Hospice by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; **or**
3. If licensing is not required, it meets all of the following requirements:
 - a. It provides twenty-four (24) hour-a-day, seven (7) day-a-week service.
 - b. It is under the direct supervision of a duly qualified *physician*.
 - c. It has a full-time administrator.
 - d. It has a nurse coordinator who is a Registered Nurse (RN) with four (4) years of full-time clinical experience. Two of these years must involve caring for terminally ill patients.
 - e. The main purpose of the agency is to provide hospice services.
 - f. It maintains written records of services provided to the patient.
 - g. It maintains malpractice insurance coverage.

A hospice that is part of a *hospital*, as defined in this section, will be considered a hospice for purposes of this Plan.

Hospital

A public or private facility, licensed and operated according to the law, which provides care and treatment by physicians and nurses at the patient's expense of an *illness* or *injury* through medical, surgical and diagnostic facilities on its premises.

A hospital does not include a facility or any part thereof which is, other than by coincidence, a place for rest, the aged or convalescent care.

Illness

Any bodily sickness or disease, including any congenital abnormality of a newborn child, as diagnosed by a *physician* and as compared to the person's previous condition. Pregnancy of a covered *employee* or covered *spouse* will be considered to be an illness only for the purpose of coverage under this Plan.

Incurred

An expense for a service or supply is incurred on the date the service or supply is furnished.

Independent Review Organization (IRO)

An Independent Review Organization is an entity that performs independent *external reviews* of *adverse benefit determinations* and *final internal adverse benefit determinations*.

In-Network Services

Services provided by (or treated as provided by) a *health care provider* that is a member of the Plan's Preferred Provider Organization (PPO), as distinguished from *out-of-network* services that are provided by a *health care provider* that is not a member of the PPO network.

Injury

An accidental physical injury to the body caused by unexpected external means.

Inpatient

Treatment in an approved facility during the period when charges are made for room and board.

Intensive Care Unit

A separate, clearly designated service area which is maintained within a hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a coronary care unit or an acute care unit. It has: facilities for special nursing care not available in regular rooms and wards of the *hospital*; special life-saving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one (1) Registered Nurse (R.N.) in continuous and constant attendance twenty-four (24) hours a day.

Investigational

See *Experimental/Investigational*.

Legal Guardian

A person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

Lifetime

The period of time you or your eligible dependents participate in this Plan or any other plan sponsored by The City of Colorado Springs.

Maintenance Care

Services and supplies provided primarily to maintain, support and/or preserve a level of physical or mental function rather than to improve such function.

Maintenance Medication

Any prescription drug covered under this rider and listed on the MaxorPlus maintenance drug list used to treat chronic conditions.

Managed Care

Procedures designed to help control health care costs by avoiding unnecessary services or services that are more costly than others that can achieve the same result.

Massage Therapy

Services provided by a licensed Massage Therapist who manipulates the body tissues by rubbing, stroking, kneading or tapping with the hand or an instrument for therapeutic purposes. When the services of an Massage Therapist are

payable by this Plan, the Massage Therapist must be properly licensed by the state in which he or she is practicing and must be performing services within the scope of that license.

Medicaid

Title XIX (Grants to states for Medical Assistance Programs) of the United States Social Security Act as amended.

Medical Care Facility

A hospital, a facility that treats one or more specific ailments or any type of *skilled nursing facility*.

Medical Emergency

A sudden unexpected onset of a medical condition, which manifests itself by such acute symptoms of sufficient severity that requires urgent and immediate medical attention (without regard to the hour of day or night) to prevent significant impairment in bodily functions or serious and/or permanent dysfunction of any bodily organ or part and is not normally treatable in the *provider's* office.

Medically Necessary (Medical Necessity)

Care and treatment is recommended or approved by a physician or dentist; is consistent with the patient's condition or accepted standards of good medical and dental practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of medical and dental services; is not conducted for research purposes; and is the most appropriate level of services, cost efficient, and which can be safely provided to the patient.

All of these criteria must be met; merely because a physician recommends or approves certain care does not mean that it is medically necessary.

The *Plan Administrator* has the discretionary authority to decide whether care or treatment is medically necessary.

Medicare

The Health Insurance For The Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Mental Disorder

For purposes of this plan, a mental disorder is any diagnosed condition listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM, most recent edition, revised), except as specified in Medical Plan Exclusions, for which treatment is commonly sought from a psychiatrist or mental health provider. The DSM is a clinical diagnostic tool developed by the American Psychiatric Association and used by mental health professionals. Diagnoses described in the DSM will be considered mental/nervous in nature, regardless of etiology.

Midwife, Nurse Midwife

A person registered in the state of Colorado and legally licensed as a midwife or certified as a nurse midwife in the area of managing the care of mothers and babies throughout the maternity cycle, as well as providing general gynecological care, including history taking, performing physical examinations, ordering laboratory tests and x-ray procedures, managing labor, delivery and the post-delivery period, administering intravenous fluids and certain medications, providing emergency measures while awaiting aid, performing newborn evaluation, signing birth certificates, bill and be paid in his or her own name, and who acts within the scope of his or her license.

National Medical Support Notice (NMSN)

A court order that complies with requirements of federal law requiring an *employee* to provide health care coverage for a dependent child, and requiring that benefits payable on account of that dependent child be paid directly to the *health care provider* who rendered the services or to the custodial parent of the dependent child.

Naturopathic Services

Is an *alternative medicine* service that is a system of treatment of disease that avoids drugs and surgery, and emphasizes the use of natural agents (such as air, water and sunshine), and physical means (such as manipulation and electrical treatment).

Network

An arrangement under which services are provided to plan participants through a select group of *providers*.

Non-Prescription Drug

Any drug which by law does not require a prescription.

Occupational Therapy

Rehabilitation to attain the maximum level of physical and psycho-social independence following acute disease, injury or loss of body part with the expectation of significant improvement. This includes fine motor coordination, perceptual-motor skills, sensory testing, adaptive/assistive equipment, *activities of daily living*, and specialized upper extremity and hand therapies.

Office Visit

A direct personal contact between a *physician* or other health care *practitioner* and a patient in the health care practitioner's office for diagnosis or treatment associated with the use of the appropriate office visit code in the Current Procedural Terminology (CPT) manual of the American Medical Association and with documentation that meets the requirement of such CPT-4 coding. Neither a telephone discussion with a *physician* or other health care *practitioner* nor a visit to a health care *practitioner's* office solely for such services as blood drawing, leaving a specimen, or receiving a routine injection is considered to be an office visit for the purposes of this Plan.

Open Enrollment Period

The period prior to the commencement of any Plan Year during which participants in the Plan may select among the alternate health benefit programs that are offered by the Plan for such subsequent plan year. The dates of the Plan's open enrollment period will be communicated in advance by the *employer* to eligible *participants*.

Out-of-Network

See *Non-Network*.

Out-of-Network Services

Services provided by a *health care provider* that is not a member of the Plan's Preferred Provider Organization (PPO), as distinguished from *in-network* services that are provided by a *health care provider* that is a member of the PPO *network*.

Out-of-Pocket Maximum

A Plan's limit on the amount a plan participant must pay out of their own pocket for medical expenses incurred during a benefit year. Out-of-pocket maximums accumulate on an individual, family, or combined basis. After a member reaches the out-of-pocket maximum, the Plan pays benefits at a higher rate.

Outpatient

Treatment including services, supplies and medicines provided and used at a hospital under the direction of a physician to a person not admitted as a registered bed patient; or services rendered in a physician's office, laboratory or x-ray facility, an ambulatory surgical center, or the patient's home.

Participant

Any employee, retiree or dependent who is covered under this Plan.

Patient Protection and Affordable Care Act (PPACA)

In March 2010, the 111th Congress passed health reform legislation, the Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152). Jointly, these laws are referred to as PPACA.

Pharmacy

A licensed establishment where covered prescription drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Physician

A physician or person acting within the scope of applicable state licensure/certification requirements and holding the degree of Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Medicine (D.M.D), Doctor of Dental Surgery (D.D.S.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Optometrist (O.D.), Certified Nurse Midwife (C.N.M.), Certified Registered Nurse Anesthetist (C.R.N.A.), Registered Physical Therapist (R.P.T.), Psychiatrist or Psychologist (Ph.D., Ed.D., Psy.D.), Master of Social Work (M.S.W.), Licensed Professional Counselor (L.P.C.), Audiologist, Physiotherapist, Occupational Therapist, Physician's Assistant, Nurse Practitioner, or Registered Respiratory Therapist, or Speech Language Pathologist.

Plan Administrator

The City of Colorado Springs which is the named fiduciary of the Plan, and exercises all discretionary authority and control over the administration of the Plan and the management and disposition of Plan assets.

Plan Sponsor

The City of Colorado Springs.

Post-Service Claim

A post-service claim is any *claim* for a benefit under the *Plan* related to care or treatment that the *plan participant* or beneficiary has already received.

Pre-Admission Testing

Laboratory tests and x-rays and other *medically necessary* tests performed on an *outpatient* basis prior to a scheduled *hospital* admission or *outpatient surgery*.

Pre-Certification (Pre-Certified)

An evaluation conducted by a utilization review team through the Health Care Management Program to determine the medical necessity and reasonableness of a *participant's* course of treatment.

Preferred Provider Organization (PPO)

The *in-network provider of hospitals, physicians, pharmacies, medical laboratories, and/or other health care providers* who have agreed to provide *medically necessary* services.

Pre-Service Claim

A pre-service claim is any *claim* that requires *Plan* approval prior to obtaining medical care for the *claimant* to receive full benefits under the *Plan*. For example, a request for *pre-certification* under the Health Care Management Program is a pre-service claim.

Prescription Drug

Any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed *physician*. Such drug must be medically necessary in the treatment of an illness or injury.

Legend Drug means a drug which cannot be purchased without a prescription from a duly licensed *physician/practitioner*.

Preventive Care

Certain preventive care services.

This *Plan* intends to comply with the *Patient Protection and Affordable Care Act's (PPACA)* requirement to offer *network* coverage for certain preventive services without cost-sharing. To comply with *PPACA*, and in accordance with the recommendations and guidelines, the *Plan* will provide *network* coverage for:

1. evidence-based items or services rated A or B in the United States Preventive Services Task Force recommendations
2. recommendations of the Advisory Committee on Immunization Practices adopted by the Director of the Centers for Disease Control and Prevention
3. comprehensive guidelines for infants, children, and adolescents supported by the Health Resources and Services Administration (HRSA)
4. comprehensive guidelines for women supported by the Health Resources and Services Administration (HRSA)

Copies of the recommendations and guidelines may be found here: <https://www.healthcare.gov/what-are-my-preventive-care-benefits/>. For more information, you may contact the *Plan Administrator/employer*.

Primary Care Physician

Primary Care Physician (PCP) is defined as general/family practice, internal medicine, OB/GYN, Doctor of Osteopathy (D.O.), pediatrics, physician's assistant and nurse practitioner if services are provided under the supervision of a physician. Physicians in other practice specialties are considered specialists. If a Primary Care Physician also provides services as a specialist, those services will be treated as having been provided by a specialist for the purposes of this Plan.

Provider

A hospital, skilled nursing facility, urgent care facility, ambulatory surgical facility, home health care agency, physician, or other individual or organization which is duly licensed to provide medical or surgical services, supplies, and accommodations.

Reasonable and Customary Amount

A charge which is not higher than the usual charge made by the *provider* of the care or supply and does not exceed the usual charge made by most providers of like service in the same area. This test will consider the nature and severity of the condition being treated. It will also consider medical complications or unusual circumstances that require more time, skill or experience.

The Plan will reimburse the actual charge billed if it is less than the reasonable and customary amount. No more than the ninetieth (90th) percentile of the prevailing charge of most other *health care providers* in the same or similar geographic area for the same or similar health care service or supply;

or

The *Plan Administrator* has the discretionary authority to decide whether a charge is reasonable and customary.

Charges exceeding reasonable and customary amounts do not accumulate towards the plan deductibles.

The Plan will not always pay benefits equal to or based on the *health care provider's* actual charge for health care services or supplies, even after you have paid the applicable *deductible* and *co-insurance*. This is because the Plan covers only the usual and customary charge for health care services or supplies. Any amount in excess of the Usual and customary charge does not count toward the Plan's annual *out-of-pocket maximums*.

The Usual and Customary Charge is sometimes referred to as the U & C Charge, and may sometimes be called the reasonable and customary charge, the R & C charge, the usual, customary and reasonable charge, or the UCR charge.

Reasonable Charge

The prevailing charge by a group of *physicians* in the area and/or region for a particular service.

A charge is considered reasonable, if it is usual and customary or if it is justified because of special conditions.

Factors that impact how the *reasonable and customary* charge is determined:

- the complexity of the service
- the degree of skill needed
- the *provider's* specialty
- the prevailing charge in other areas

Recover / Recovered / Recovery / Recoveries

All monies paid to the *participant* by way of judgment, settlement, or otherwise to compensate for all losses caused by the *injury* or *illness*, whether or not said losses reflect medical or dental charges covered by the Plan. Recoveries further includes, but is not limited to, recoveries for medical or dental expenses, attorneys' fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, lost wages and any other recovery of any form of damages or compensation whatsoever.

Rehabilitation Therapy

Cardiac, occupational, physical, pulmonary, or speech therapy that is prescribed by a *physician* when the bodily function has been restricted or diminished as a result of *illness*, *injury* or *surgery*, with the goal of improving or restoring bodily function by a significant and measurable degree to as close as reasonably and medically possible.

Active Rehabilitation refers to therapy in which a patient, who has the ability to learn and remember, actively participates in the rehabilitation that is intended to provide significant and measurable improvement of an individual who is restricted and cannot perform normal bodily function.

Maintenance Rehabilitation refers to therapy in which a patient actively participates in and is provided after a patient has met the functional goals of Active Rehabilitation so that no continued significant and measurable improvement is reasonably and medically anticipated, but where additional therapy of a less intense nature and decreased frequency may reasonably be prescribed to maintain, support, and/or preserve the patient's functional level.

Passive Rehabilitation refers to therapy in which a patient does not actively participate because the patient does not have the ability to learn and/or remember (that is, has a cognitive deficit), or is comatose or otherwise physically or mentally incapable of active participation.

Retrospective Certification

Review of health care services after they have been provided to determine if those services were *medically necessary* and/or if the charges for them are usual and customary charges.

Skilled Nursing Facility

A public or private facility, licensed and operated according to law, that primarily provides skilled nursing and related services to people who require medical or nursing care and that rehabilitates *injured*, disabled or sick people, and that meets all of the following requirements:

1. It is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as a skilled nursing facility or is recognized by *Medicare* as a skilled nursing facility
2. it is regularly engaged in providing room and board and continuously provides twenty-four (24) hour-a-day skilled nursing care of sick and *injured* persons at the patient's expense during the convalescent stage of an *injury*

or illness, maintains on its premises all facilities necessary for medical care and treatment, and is authorized to administer medication to patients on the order of a licensed *physician*

3. it provides services under the supervision of *physicians*
4. it provides nursing services by or under the supervision of a licensed Registered Nurse (RN), with one licensed registered nurse on duty at all times
5. it maintains a daily medical record of each patient who is under the care of a licensed *physician*
6. it is not (other than incidentally) a home for maternity care, rest, domiciliary care, or care of people who are aged, alcoholic, blind, deaf, drug addicts, mentally deficient, mentally ill, or suffering from tuberculosis
7. it is not a hotel or motel
8. a skilled nursing facility that is part of a hospital, as defined in this document, will be considered *a skilled nursing facility* for the purposes of this plan

Special Enrollment

Under HIPAA, special mid-year enrollment rights that the Plans must offer to certain unenrolled *employees* and dependents, who experience a mid-year loss of other coverage or in the event of a mid-year adoption, birth or marriage.

Specialty Pharmacy

The specialty pharmacy is a drug management program that is provided through the Pharmacy Benefit Manager, which covers some limited expensive drugs for various chronic conditions. Specialty pharmacy also provides case management services, medication compliance, education, as well as information about health care needs related to the chronic disease for which the patient takes the medication for.

Specialized Treatment Facility

A specialized treatment facility, as the term relates to this Plan, includes birthing centers, ambulatory surgical facilities, hospice facilities, skilled nursing facilities, mental disorder treatment facilities, substance abuse treatment facilities, rehabilitation facilities, and residential treatment facilities.

Speech Therapy

Restoration of speech due to impairment following a recent physiological disturbance or injury, such as CVA, tracheotomy, swallowing disorders, laryngectomy and neuromuscular disease, with the expectation of significant improvement. See also the definition of Rehabilitation Therapy.

Spinal Manipulation

The detection and correction, by manual or mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment or dislocation of the spinal (vertebrae) column. Spinal Manipulation is commonly performed by Chiropractors, but it can be performed by a Doctor of Osteopathy (DO).

Spouse

The term spouse shall mean the employee's partner in marriage pursuant to the provisions of the Uniform Marriage Act, Part 1 of Article 2 of Title 14 or Colorado common law; or the employee's partner in a civil union pursuant to the Colorado Civil Union Act, Article 15 of Title 14. The plan administrator may require documentation proving a legal marital or civil union relationship. A common-law spouse must (a) have been living with the *employee* for at least one (1) year on a continuous basis, (b) must not be related to the *employee* by blood to a degree which would prohibit a legal marriage in the state of Colorado, (c) must be recognized as the *employee's* spouse and (d) must complete and deliver a common-law declaration (with supporting documents) in such form and satisfying such conditions as required by the *Plan Administrator* in order to permit the *Plan Administrator* to conclude the person satisfies the requirements to constitute a common law spouse. Spouse shall not include persons who are legally married, but are separated under a permanent decree of separation.

Subrogation

This is a technical legal term for the right of one party to be substituted in place of another party in a lawsuit. See the **Reimbursement and Recovery Provision** section for an explanation of how the Plan may use the right of subrogation to be substituted in place of a *participant* in that person's claim against a third party who wrongfully caused that person's injury or illness, so that the Plan may *recover* medical benefits paid if the *participant* recovers any amount from the third party either by way of a settlement or judgment in a lawsuit.

Substance Abuse

A behavioral or physical disorder manifested by repeated excessive use of a drug or alcohol to the extent that it interferes with the *participant's* health, social or economic functioning.

Surgery

Any operative or diagnostic procedure performed in the treatment of an *injury* or *illness* by instrument or cutting procedure through an incision or any natural body opening.

Temporomandibular Joint (TMJ), Temporomandibular Joint (TMJ) Dysfunction or Syndrome

The temporomandibular (or craniomandibular) joint (TMJ) connects the bone of the temple or skull (temporal bone) with the lower jawbone (the mandible). TMJ dysfunction or syndrome refers to a variety of symptoms where the cause is not clearly established, including, but not limited to, severe aching pain in and about the TMJ (sometimes made worse by chewing), limitation of the joint, clicking sounds during chewing, tinnitus (ringing, roaring or hissing in one or both ears) and/or hearing impairment, often associated with conditions such as malocclusion (failure of the biting surfaces of the teeth to meet properly) or ill-fitting dentures.

Third Party Administrator

AmeriBen has been hired as the Third Party Administrator by the *Plan Administrator* to perform *claims* processing and other specified administrative services in relation to the Plan. The Third Party Administrator is not an insurer of health benefits under this Plan, is not a fiduciary of the Plan, and does not exercise any of the discretionary authority and responsibility granted to the *Plan Administrator*. The Third Party Administrator is not responsible for Plan financing and does not guarantee the availability of benefits under this Plan.

Timely Payment

As referenced in the section entitled **Continuation Coverage Rights Under COBRA**, Timely payment means a payment made no later than thirty (30) days after the first day of the coverage period.

Total Disability (Totally Disabled)

The inability to perform all the duties of the *participant's* occupation as the result of an *illness* or *injury*. Total disability means the inability to perform the normal duties of a person of the same age.

Transplantation

The transfer of organs (such as the heart, kidney, liver) or living tissues or cells (such as bone marrow or skin) from a donor to a recipient with the intent to maintain the functional integrity of the transplanted tissue in the recipient.

1. **Autologous** refers to transplants of organs, tissues or cells from one part of the body to another. Bone marrow and skin transplants are often autologous.
2. **Allogenic** refers to transplants of organs, tissues or cells from one person to another person. Heart transplants are always allogenic.
3. **Xenographic** refers to transplants of organs, tissues or cells from one species to another (for example, the transplant of an organ from a baboon to a human). Other than with respect to heart valve transplants, Xenographic transplants are **not** covered by this Plan.

Urgent Care Facility

A free-standing facility, regardless of its name, at which a physician is in attendance at all times that the facility is open, that is engaged primarily in providing minor emergency and episodic medical care to a participant.

Urgent Service Claim

An urgent service claim is any *pre-service claim* for medical care or treatment which, if subject to the normal timeframes for Plan determination, could seriously jeopardize the *claimant's* life, health or ability to regain maximum function or which, in the opinion of a *physician* with knowledge of the *claimant's* medical condition, would subject the *claimant* to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Whether a claim is an urgent service claim will be determined by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. However, any claim that a *physician* with knowledge of the *claimant's* medical condition determines is an urgent service claim as described herein shall be treated as an urgent service claim under the *Plan*. *urgent service claims* are a subset of *pre-service claims*.

Usual and Customary Charge

Covered charges which are identified by the *Plan Administrator*, taking into consideration the fee(s) which the provider most frequently charges (or accepts for) the majority of patients for the service or supply, the cost to the provider for providing the services, the prevailing range of fees charged in the same area by providers of similar training and experience for the service or supply, and the *Medicare* reimbursement rates. The term(s) same geographic locale and/or area shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of providers, persons or organizations rendering such treatment, services, or supplies for which a specific charge is made. To be usual and customary, fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

The term usual refers to the amount of a charge made or accepted for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals with similar credentials, or health care facilities, *pharmacies*, or equipment suppliers of similar standing, which are located in the same geographic locale in which the charge was *incurred*.

The term customary refers to the form and substance of a service, supply, or treatment provided in accordance with generally accepted standards of medical practice to one individual, which is appropriate for the care or treatment of an individual of the same sex, comparable age and who has received such services or supplies within the same geographic locale.

The term usual and customary does not necessarily mean the actual charge made (or accepted) nor the specific service or supply furnished to a *plan participant* by a provider of services or supplies, such as a *physician*, therapist, nurse, *hospital*, or pharmacist. The *Plan Administrator* will determine the usual charge for any procedure, service, or supply, and whether a specific procedure, service or supply is customary.

Usual and customary charges may, at the *Plan Administrator's* discretion, alternatively be determined and established by the Plan using normative data such as, but not limited to, *Medicare* cost to charge ratios, average wholesale price (AWP) for prescriptions and/or manufacturer's retail pricing (MRP) for supplies and devices.

Utilization Review Team

A group of medical care professionals selected by the Health Care Management Program to conduct *pre-certification* review, emergency admission review, continued stay review, discharge planning, patient consultation, and individual benefits management.

SECTION XVII—COMPLIANCE WITH HIPAA PRIVACY STANDARDS

HIPAA stands for the Health Insurance Portability and Accountability Act of 1996.

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).

V. 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 whether the Protected Health Information was compromised
 - 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

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
 - 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

W. 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.

X. Breach Notification for Unsecured Protected Health Information.

Pursuant to HIPAA Omnibus Regulations effective September 23, 2013, notification is generally required 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.

SECTION XVIII— GENERAL PLAN INFORMATION

A. Type of Administration

The Plan is a self-funded group health Plan and the *claims* administration is provided through a *Third Party Administrator*. The funding for the benefits is derived from the funds of the *employer* and contributions made by covered *employees*. The Plan is not insured.

B. Employer

The *employer's* legal name, address, telephone number, and federal Employer Identification Number are:

The City of Colorado Springs, the *Plan Administrators*
30 S. Nevada Avenue
P.O. Box 1575, Mail Code 722
Colorado Springs, CO 80903-1575
1-719-385-5125
EIN# 84-6000573

C. Plan Name

The name of the plan is The Colorado Springs Medical Benefit Plan.

D. Plan Number

501

E. Plan Year

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

F. Plan Effective Date

January 1, 2014

G. Type of Plan

The Plan is commonly known as an employee welfare benefit plan. The Plan has been adopted to provide *participants* certain benefits as described in this document. The City of Colorado Springs employee Benefit Plan is structured as an ERISA exempt plan under ERISA Section 3(32) and PPA Section 906.

H. Plan Funding

The funding for this self-funded plan is derived from the funds of The City of Colorado Springs and contributions made by covered *employees*.

I. Trustees

The City of Colorado Springs, the *Plan Administrators*
30 S. Nevada Avenue
P.O. Box 1575, Mail Code 722
Colorado Springs, CO 80903-1575

1-719-385-5125

J. Plan Sponsor

The City of Colorado Springs is the *plan sponsor*.

K. Plan Administrator

The City of Colorado Springs is the *Plan Administrator*. The name, address and telephone number of the *Plan Administrator* is:

The City of Colorado Springs
City HR Benefits and Wellness
30 S. Nevada Avenue, Suite 702
P.O. Box 1575, Mail Code 722
Colorado Springs, CO 80903-1575
1-719-385-5125

L. Title and Address of HIPAA Privacy and Security Officers

The City of Colorado Springs
Human Resources Director, Suite 702
30 South Nevada Avenue
P.O. Box 1575, Mail Code 722
Colorado Springs, CO 80903
1-719-385-5904

M. Third Party Administrator

The *Plan Administrator* has contracted with a *Third Party Administrator (TPA)* to assist the *Plan Administrator* with claims adjudication. The *TPA's* name, address, and telephone number are:

AmeriBen
P.O. Box 7186
Boise, ID 83707
1-208-344-7900 or 1-800-955-1482

N. Employer's Right to Terminate

The City of Colorado Springs reserves the right to *amend* or terminate this Plan at any time. Although The City of Colorado Springs currently intends to continue this Plan, The City of Colorado Springs is under absolutely no obligation to maintain the Plan for any given length of time. If the Plan is amended or terminated, an authorized officer of The City of Colorado Springs will sign the documents with respect to such amendment or termination.

O. 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: _____

Date: _____

Title: _____

If you have questions about your plan benefits, please
contact the *Third Party Administrator* at 1-866-955-1482.



P.O. Box 7186
Boise ID 83707