



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.MyAmeriBen.com or by calling 1-866-955-1482.

Important Questions	Answers	Why this Matters:
<p>What is the overall deductible?</p>	<p>NETWORK Individual-\$1,500 Family-\$3,000</p> <p>NON-NETWORK Individual -\$4,500 Family-\$9,000</p> <p>The following charges do not apply to the Plan Year deductible: Alternative Medicine, Ambulance, Urgent Care, Health Management Programs, Hearing Aids (pediatric), Preventive Care Services, Oxygen Equipment and Supplies, Substance Abuse Drug Screenings, Diabetics Care Management Program</p>	<p>You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 3 for how much you pay for covered services after you meet the deductible.</p>
<p>Are there other deductibles for specific services?</p>	<p>No</p>	<p>You don't have to meet deductibles for specific services, but see the chart starting on page 3 for other costs for services this plan covers.</p>
<p>Is there an out-of-pocket limit on my expenses?</p>	<p>Yes. NETWORK Individual - \$3,500 Family - \$8,000</p> <p>NON-NETWORK Individual - \$9,000 Family - \$18,000</p> <p>Prescription Annual Out of Pocket Limit Chronic Injectables and Specialty Drugs: \$2,500 out-of-pocket maximum per member, per year. Health Reimbursement Account: Access to an HRA is available for eligible participants when enrolled on this plan. Funding may be used for reimbursements of eligible health expenses. Employee Only level coverage has \$500/annual HRA funding. All other coverage tiers have access to \$750/annual funding.</p>	<p>The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.</p>
<p>What is not included in the out-of-pocket limit?</p>	<p>Charges in excess of Usual & Customary, Premiums, Balance-billed charges, and Health care this plan doesn't cover</p>	<p>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</p>
<p>Is there an overall annual limit on what the plan pays?</p>	<p>No</p>	<p>The chart starting on page 3 describes any limits on what the plan will pay for specific covered services, such as office visits.</p>
<p>Does this plan use a network of providers?</p>	<p>Yes, Anthem Blue Cross Blue Shield. For a list of preferred providers, call 866-810-2583 or 866-955-1482 Or visit www.anthem.com For a list of network retail and mail pharmacies, log on to www.maxor.com or call MAXORPLUS Customer Service at 800-687-0707. For a list of EAP providers, visit www.profileeap.com or call 719-634-1825 or 800-645-6571.</p>	<p>If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 3 for how this plan pays different kinds of providers.</p>

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If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.MyAmeriBen.com or www.dol.gov/ebsa/healthreform or call 1-866-4-USA-DOL to request a copy.

Important Questions	Answers	Why this Matters:
Do I need a referral to see a specialist?	No	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about excluded services .



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% co-insurance, after deductible	40% co-insurance, after deductible	_____none_____
	Specialist visit	20% co-insurance, after deductible	40% co-insurance, after deductible	_____none_____
	Other practitioner office visit	<p>Acupuncture; massage therapy; dietician; nutritionist, chiropractic, homeopathic and naturopathic services</p> <p>50% co-insurance</p> <p>Spinal Manipulation</p> <p>20% co-insurance, after deductible</p>	50% co-insurance	The Plan pays up to \$1,000 per family per plan year.
	Preventive care/screening/immunization	No Charge	40% co-insurance, deductible waived	Refer to the Summary Plan Description, Section II (F), Schedule of Benefits, for specific age and frequency limits (if applicable).
If you have a test	Diagnostic test (x-ray, blood work)	20% co-insurance, after deductible	40% co-insurance, after deductible	Labs in conjunction to preventive care service are covered at 100% in-network, deductible waived.
	Imaging (CT/PET scans, MRIs)	20% co-insurance, after deductible	40% co-insurance, after deductible	_____none_____

Common Medical Event	Services You May Need		Your Cost If You Use a Network Provider	Your Cost If You Use a Non-network Provider	Limitations & Exceptions
<p>If you need drugs to treat your illness or condition</p> <p>More information about prescription drug coverage is available at www.cityemployeepharmacy.com OR www.maxor.com.</p>	Generic drugs	<p>(30 Day Supply)</p> <p>City Employee Pharmacy \$6.00 co-pay</p> <p>MaxorPlus Pharmacy \$25.00 co-pay</p>	<p>(90 Day Supply)</p> <p>City Employee Pharmacy \$15.00 co-pay</p> <p>MaxorPlus Pharmacy Not Covered</p>	<p>Non-Network</p> <p>Non-Network prescription medications are only available in Emergency/After Hours situations. Refer to the Medical Plan Document for further details.</p>	<p>Diabetic Supplies (Maximum 90-day Supply) - Covered at 100% (no co-pay) if obtained through the City Employee Diabetes Ten City Challenge Pharmacy Program.</p> <p>Chronic Condition Management — The co-payment is waived for generic maintenance prescriptions used to treat chronic conditions such as Asthma, Coronary Artery Disease, COPD, Diabetes, Hypertension, and GERD if filled at the City Employee Pharmacy while enrolled in the disease management program.</p> <p>Some medications may be subject to quantity limitations and/or Prior Authorization (PA). Refer to the Summary Plan Description, SECTION VIII, Pharmacy Benefit Management Program for specific limits (if applicable).</p> <p>Certain preventive medications (including contraceptives) received by a network pharmacy are covered at 100% and the deductible/co-payment (if applicable) is waived. This does not include non-preferred preventive medications,</p>
	Preferred brand drugs	<p>City Employee Pharmacy \$35.00 co-pay</p> <p>MaxorPlus Pharmacy \$55.00 co-pay</p>	<p>City Employee Pharmacy \$70.00 co-pay</p> <p>MaxorPlus Pharmacy Not Covered</p>		
	Non-preferred brand drugs	<p>City Employee Pharmacy \$60.00 co-pay</p> <p>MaxorPlus Pharmacy \$75.00 co-pay</p>	<p>City Employee Pharmacy \$120.00 co-pay</p> <p>MaxorPlus Pharmacy Not Covered</p>		
<p>If you need drugs to treat your illness or condition</p> <p>More information about prescription drug coverage is available at www.maxor.com.</p>	Specialty drugs	<p>(30 Day Supply)</p> <p>Preferred</p> <p>Maxor Solutions Pharmacy \$100.00 co-pay</p> <p>Non-Preferred</p> <p>Maxor Solutions Pharmacy \$150.00 co-pay</p>	<p>(90 Day Supply)</p> <p>Preferred</p> <p>Maxor Solutions Pharmacy \$200.00 co-pay</p> <p>Non-Preferred</p> <p>Maxor Solutions Pharmacy \$300.00 co-pay</p>	Not Covered	<p>\$2,500 out-of-pocket maximum per member, per year.</p> <p>Includes injectable prescription medications.</p> <p>Specialty drugs and injectables are only available through Maxor Solutions.</p> <p>Not all prescription drugs are covered. To determine if a specific drug is covered under your plan, log into your account at www.cityemployeepharmacy.com OR www.maxor.com.</p>
<p>If you have outpatient surgery</p>	Facility fee (e.g., ambulatory surgery center)		20% co-insurance, after deductible	40% co-insurance, after deductible	_____none_____
	Physician/surgeon fees		20% co-insurance, after deductible	40% co-insurance, after deductible	_____none_____
<p>If you need immediate medical attention</p>	Emergency room services		20% co-insurance, after deductible	20% co-insurance, after deductible	Diagnostic and surgical co-insurance applies.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-network Provider	Limitations & Exceptions
	Emergency medical transportation	20% co-insurance deductible waived	20% co-insurance deductible waived	—————none—————
	Urgent care	20% co-insurance deductible waived	40% co-insurance, after deductible	Diagnostic and surgical co-insurance applies.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance, after deductible	40% co-insurance, after deductible	Pre-certification is required.
	Physician/surgeon fee	20% co-insurance, after deductible	40% co-insurance, after deductible	—————none—————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% co-insurance, after deductible	40% co-insurance, after deductible	Medicine Monitoring is paid at no charge for in-network and 40% co-insurance, after deductible for non-network.
	Mental/Behavioral health inpatient services	20% co-insurance, after deductible	40% co-insurance, after deductible	Pre-certification is required.
If you have mental health, behavioral health, or substance abuse needs	Substance use disorder outpatient services	20% co-insurance, after deductible	40% co-insurance, after deductible	Drug screenings administered in connection with a Substance Abuse Treatment Program — No Charge after deductible. Medicine Monitoring is paid at No charge for in-network and 40% co-insurance, after deductible for non-network. Pre-certification is required.
	Substance use disorder inpatient services	20% co-insurance, after deductible	40% co-insurance, after deductible	
If you are pregnant	Prenatal and postnatal care	20% co-insurance, after deductible	40% co-insurance, after deductible	—————none—————
	Delivery and all inpatient services	20% co-insurance, after deductible	40% co-insurance, after deductible	—————none—————
If you need help recovering or have other special health needs	Home health care	20% co-insurance, after deductible	40% co-insurance, after deductible	—————none—————
	Rehabilitation services	Outpatient 20% co-insurance, after deductible	Outpatient 40% co-insurance, after deductible	Outpatient Rehabilitation Services Annual Maximum: limited to 180 annual days per injury and illness combined with cardiac and pulmonary therapy. Inpatient Rehabilitation Services Annual Maximum: sixty (60) visits combined per participant.
		Inpatient 20% co-insurance, after deductible	Inpatient 40% co-insurance, after deductible	

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Habilitation services	Outpatient 20% co-insurance, after deductible Inpatient 20% co-insurance, after deductible	Outpatient 40% co-insurance, after deductible Inpatient 40% co-insurance, after deductible	Pre-Certification required for Pediatrics Rehabilitation Therapy for pediatrics (up to age ten (10); limited to sixty (60) combined visits per plan year.
	Skilled nursing care	50% co-insurance, after deductible	50% co-insurance, after deductible	Lifetime maximum: three hundred sixty-five (365) days. Pre-Certification required.
	Durable medical equipment	No charge, after deductible	40% co-insurance, after deductible	—————none—————
	Hospice service	20% co-insurance, after deductible	40% co-insurance, after deductible	—————none—————
If your child needs dental or eye care	Eye exam	No charge	40% co-insurance, after deductible	Routine eye examinations for participants to age 18, when participant is not covered by The COCS Vision Service Plan.
	Glasses	Not Covered	Not Covered	—————none—————
	Dental check-up	Not Covered	Not Covered	—————none—————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other <u>excluded services</u> .)		
<ul style="list-style-type: none"> • Cosmetic surgery • Dental care (Adult and children) • Infertility treatment 	<ul style="list-style-type: none"> • Long-term care • Non-emergency care when traveling outside the U.S. • Private-duty nursing, except when medically necessary 	<ul style="list-style-type: none"> • Routine foot care, except when medically necessary
Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
<ul style="list-style-type: none"> • Acupuncture, the Plan pays up to \$1,000 per family per plan • Bariatric surgery, when medically necessary 	<ul style="list-style-type: none"> • Chiropractic care, the Plan pays up to \$1,000 per family per plan • Hearing Aids for Pediatrics up to age 18 	<ul style="list-style-type: none"> • Routine eye care (Adult) • Weight loss programs, when medically necessary

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at The City of Colorado Springs, 30 S. Nevada Avenue, P.O. Box 1575, Mail Code 720, Colorado Springs, CO 80901-1575, 719-385-5125. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact your plan administrator or the third party administrator (TPA) to assist the plan administrator with claims adjudication. The TPA's name, address, and telephone number are:

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: 208-424-0595

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-955-1482.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-955-1482.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-866-955-1482.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijijigo holne' 1-866-955-1482.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Note: HRA reimbursements for eligible medical expenses were not included in the examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$3,110
- Patient pays \$4,430

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$3,000
Copays	\$10
Coinsurance	\$1,270
Limits or exclusions	\$150
Total	\$4,430

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$3,930
- Patient pays \$1,470

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$1,150
Copays	\$240
Coinsurance	\$0
Limits or exclusions	\$80
Total	\$1,470

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact the Plan Administrator at 719-385-5125.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

* **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

* **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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