EL PASO COUNTY

EMPLOYEE BENEFITS GUIDEBOOK

A comprehensive guide to your
EMPLOYEE BENEFITS

IMPORTANT

- **New full-time employees have 31 days from their date of hire to enroll in (or waive) their benefits. This process must be completed by following the directions emailed to you from Employee Benefits soon after your start date.**
- **Social Security numbers are required for all dependents enrolled in your health coverage. Be sure to have this information available for entry when enrolling.**
- **Documentation is required within 30 days of enrollment for any dependents that are enrolled on your medical, dental or vision plans. A copy of the marriage or civil union certificate or common law affidavit is required for a spouse and copies of birth certificates are required for children. Failure to submit the documents will result in cancellation of dependent benefits.**

Table of Contents

Table of Contents

About the Guidebook

Your Benefits Guidebook is intended to provide information you need to assist with your employee benefit selections.

The types of questions you can ask yourself to help you decide which plan(s) are best for you and your family:

- What benefits are available for the plan year
- What administrative steps you must take to enroll
- How to access your benefits
- Where you can go to get more information or assistance regarding any of the plans offered by El Paso County

To take full advantage of the benefits, please take the time to fully consider each of the available benefit plan options explained in the guidebook.

We have included a benefits contact list beginning on the following page for your convenience when you have benefit questions. We recommend starting with Quantum Health, as they are able to consult on and support inquiries regardling El Paso County benefits. Please also feel free to contact any of the plan carriers directly for any plan-related questions you may have now and throughout the year.

If you have a general question regarding any of the benefit plans, please do not hesitate to call the Employee Benefits Division at (719) 520-7486 or employeebenefits@elpasoco.com, Monday-Friday, 8:00 a.m. to 4:30 p.m.

This Guidebook is intended to provide a general overview of all the insurance benefit plans, including eligibility, cost, contact information and how to use your benefits. Should there be an inconsistency with any communications regarding these plans the actual Master Plan Documents will govern. Any information contained herein may be subject to change.

Contact List

Human Resources Department – Employee Benefits Division

Employee Benefits Division ..... (719) 520-7486
E-Mail ..... employeebenefits@elpasoco.com
HIPAA Compliance ..... (719) 520-7486

Payroll

E-Mail ..... finpayroll@elpasoco.com
Payroll Fax ..... (719) 520-6469

El Paso County Health Centers

Regional Development Center (RDC) ..... (719) 520-7080
Citizens Service Center (CSC) ..... (719) 520-7600
24/7 Telehealth 1-877-272-0813
Premise Health Patient Portal ..... mypremisehealth.com

Medical Plan – UMR (UnitedHealthcare Choice Plus Network)

(Group #76-414547)
Use **Quantum Health** for Medical and Rx Questions, Claims, ID Cards and Pre-Authorizations
Quantum Health 1-866-885-1484
Website ..... elpasocobenefits.com
SurgeryPlus Phone/Website ..... 1-833-814-5702 / epcepo.surgeryplus.com
SleepCharge Phone/Website ..... 1-877-615-7257 / sleepcharge.com/epcmed

Prescription Plan – Express Scripts

(RxBIN #003858 / RxPCN #A4 / RxGRP #ELPASO16)
Member Services 1-855-738-1153
Website ..... express-scripts.com
Accredo Specialty Rx 1-800-803-2523
Accredo Specialty Rx Website ..... accredo.com

Dental Plans – Delta Dental of Colorado

(Group #12104)
Member Services 1-800-610-0201
Website ..... deltadentalco.com

Vision Plan – EyeMed Vision Care

(Access Plan H / Group #9728999)
Member Services 1-866-723-0596
Website ..... eyemed.com

Contact List

Flexible Spending Accounts – Employee Benefits Corporation (EBC)

Customer Service 1-800-346-2126
Claim Fax Number..... (608) 831-4790
Website .....ebcflex.com

Wellness Program – Reach Your Peak

E-Mail..... reachyourpeakepc@elpasoco.com
WebsiteVirgin Pulse Registration Website: join.virginpulse.com/reachyourpeakepc
Program Website: iam.virginpulse.com

Health Reimbursement Account (HRA), Employee Benefits Corporation (EBC) Customer Service…..…….1-800-346-2126
HRA, EBC Website.....ebcflex.com

Employee Assistance Program – Lyra

Phone 1-877-207-9553
Website .....epc.lyrahealth.com

Life, Supplemental, and Disability Plans – Unum

Life Insurance (Basic Life Policy #907338 / Voluntary Life Policy #907339) 1-800-421-0344
Supplemental Benefits (Accident, Critical Illness, Hospital Indemnity)..... 1-800-635-5597
Short Term Disability (Policy #907374) - to file a claim 1-888-673-9940
Short Term Disability Fax..... 1-800-447-2498

El Paso County Retirement Plan

Retirement Office ..... (719) 520-7490
E-mail..... epcrpsupport@elpasoco.com
Website .....retirement.elpasoco.com

Deferred Compensation (457 Plan) – Empower Retirement

(Group #98722-01)
Empower Retirement 1-800-701-8255
Key-Talk 1-800-701-8255
Website ..... empower-retirement.com

Chapter 1

Enrollment and Eligibility Information

Summary of Benefits & Coverage and Summary Plan Documents

For the Summaries of Benefits and Coverage (SBC) or a copy of the Summary Plan Documents (SPD) for El Paso County health plans contact the Employee Benefits Division at (719) 520-7486. SBCs and SPDs can be found at elpasoco.com under the Human Resources – Employee Benefits section and on the Employee Portal.

Benefit Enrollment

Eligible employees must complete the enrollment process – even if waiving coverage – through the Employee Benefits Portal. Enrollment must be completed within 31 days of your full-time hire date. If you do not enroll within this 31-day period, you will not be eligible to enroll until the next Open Enrollment period, unless you have a Qualifying Life Event. Employees enrolling for coverage agree to pay the required contributions.

Dependents of an eligible employee may not be enrolled in the medical, dental or vision plans unless the employee is also enrolled for coverage under the plan.

If spouses are both employees of El Paso County and both are eligible for benefits, you should carefully review the contribution rates and out-of-pocket maximums and select the option that best meets your and your family's needs. If both parents of an eligible dependent child are enrolled as a subscriber, only one parent may enroll the child as a dependent.

When Coverage is Effective

Coverage for you and your eligible enrolled dependents is effective on the 1st of the month following your full-time date of hire.

> Example: First day of full-time employment is in January (1st through 31st), coverage is effective February 1st.

In no event will health services be rendered or delivered before the effective date of coverage.

When Coverage Ends

Coverage ends on the last day of the month that you separate employment, the last day premiums are paid through, or when you no longer meet the eligibility requirements.

Plan Year

El Paso County's "Plan Year" begins January 1st and ends December 31st.

Employee Contributions

Benefit premium contributions are deducted the first and second pay period of each month through payroll deductions. Deductions will not apply to a third pay period in a month.

Premium contributions will begin on the first paycheck of the month that your benefits become effective. If you have not completed your enrollment prior to that pay period, your "missed" premium contributions will be added to your next paycheck.

El Paso County health plans are premium only plans (POP)* allowing deductions to be taken on a pre-tax basis. With pre-tax deductions, you will not pay federal, state or Social Security taxes on these monies, but you may not claim your premiums as a deduction on your Federal Income Tax Return. Because your taxable income will be smaller under the pre-tax method, your tax withholding will be less, and your take home pay may be higher. A lower Social Security reportable income may lower your potential income from Social Security upon retirement. Unless you submit a written request for your contributions to be taken on after-tax basis, contributions for health plan premiums will automatically be deducted on a pre-tax basis.

*Voluntary Life, Voluntary Accidental Death and Dismemberment, Accident, Critical Illness and Hospital Indemnity plans are deducted after-tax.

Benefits may be terminated for non-payment of benefit premiums. Arrangements must be made in advance with the Employee Benefits Division if benefit contributions are not deducted through payroll (such as when an employee is off work due to workers' compensation, FMLA or other unpaid leave of absence).

Eligible Dependents

Eligible dependents include your lawful spouse and children who are less than 26 years old. Dependent children that are age 26 or more years old and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical handicap that are enrolled on the plan before age 26, may continue coverage after age 26. You may be required to provide proof of the child's dependent status to the health care plan carrier or to the Employee Benefits Division.

You must provide the Social Security number (SSN) for any dependent(s) enrolled on our medical plan. Federal law requires group health plans and claim administrators to provide reports to the Centers for Medicare and Medicaid Services (CMS). We understand that you may have concerns with sharing your SSN. However, federal law requires that we collect this information so accurate reports can be provided to CMS. This information will be shared only for reporting directly to CMS. The medical administrator sends the reports to CMS using a secure data transmission method to ensure the privacy and security of your information.

Documentation for any covered dependents is also a requirement. If an employee enrolls a spouse, a copy of the marriage certificate, civil union certificate or common law affidavit must be provided. If enrolling children, copies of birth certificates or adoption certificates must be provided.

These persons are excluded as dependents: other individuals living in the covered employee's home, but who are not eligible as defined in the Summary Plan Document (SPD); the divorced former spouse of the employee; or any person who is covered under the plan as an employee.

Enrollment and Eligibility Information

See the SPD for additional information on eligible classes of dependents.

Provider and Facility Contracts

Although most physicians or providers and facilities that contract with our insurance plans remain with those networks year after year, you should always contact the plan carrier to verify that they are still participating in the plan network(s) and to verify if they are accepting new patients to ensure coverage.

Annual Open Enrollment

Every year each eligible employee is given an opportunity to change their benefit elections for the upcoming benefit plan year. Benefit elections made during the Open Enrollment period take effect January 1st of the following calendar year. Changes to Open Enrollment elections will only be accepted if received by the Employee Benefits Division in writing by the stated deadline. After this date, changes can only be made during the plan year if you have a Qualifying Life Event (please see the Special Enrollment and Making Changes section below).

Special Enrollment and Making Changes (Qualifying Life Events)

Federal law provides Special Enrollment provisions under some circumstances. If you decline enrollment for yourself or your dependents because of other group health plan coverage, there may be a right to enroll in this plan if there is a loss of eligibility for that other coverage (or if the employer stops contributing towards the other coverage or coinciding with an Open Enrollment period specific to the other coverage). However, a request for enrollment must be made **within 31 days** after the coverage ends.

Note: A pre-Medicare eligible retiree who declines continued coverage at retirement and later loses other coverage will not be entitled to a Special Enrollment right, nor will their dependent spouse or children.

In addition, in the case of a birth, marriage, adoption or placement for adoption, there may be a right to enroll in this plan. However, a request for enrollment must be made **within 31 days** after birth, marriage, adoption, or placement for adoption.

The following is a list of Qualifying Life Events and the required documentation:

- Marriage: Marriage or Civil Union Certificate
- Divorce or Dissolution of Marriage/Common Law: Divorce Decree
- Legal Separation: Court Decree
- Annulment: Court Decree
- Birth or Adoption of Dependent: Birth Certificate or Final Court Decree
- Death of a Dependent: Death Certificate
- Loss/Gain of Spousal Group Medical, Dental and/or Vision Coverage: Letter from Spouse's Former Employer or Insurance Company
- Ineligible Dependent: Proof of Age
- Medicare Eligibility: Proof of Medicare Eligibility (i.e., Medicare ID card)
- Medicaid Eligibility: Proof of Medicaid Eligibility*

*Medicaid eligibility as a Qualifying Life Event allows for a 60-day period for enrollment changes.

If you do not submit the benefit change request within the 31-day period, you will not be allowed to make a change until the next Open Enrollment period or your next Qualifying Life Event. El Paso County requires you to provide documentation of your Qualifying Life Event whenever you request changes.

Contact the Employee Benefits Division with questions regarding documentation.

Failure to remove a dependent within 31 days of when the dependent is no longer eligible (i.e., divorce) will result in immediate cancellation of coverage and additional premiums may be due based on the COBRA rates and may be deducted through payroll.

Qualifying Life Event Effective Date

The coverage of the dependent and/or employee or pre-Medicare eligible retiree enrolled based on a Qualifying Life Event will be as follows:

- Marriage: as of the date of marriage or beginning the first day of the calendar month following the date of marriage
- Birth of a Dependent: as of the date of birth
- Adoption of a Dependent: the date of the adoption or placement for adoption

Military Leave

Military leave will be assessed and granted in accordance with the provisions of the Uniformed Services Employment and Reemployment Rights Act (USERRA). For more information about what additional leave benefits may be offered please contact the Benefits Division.

COBRA Coverage

The Consolidated Omnibus Budget Reconciliation Act (COBRA) health benefit provisions require group health plans to provide a temporary continuation of group health coverage that otherwise might be terminated.

In the event of a loss of coverage, you and/or your eligible dependents may be eligible to continue medical, dental and vision insurance for a period of up to 18 months, or 29 months for disabled individuals. Please contact the Employee Benefits Division for more information.

Wellness Program – Reach Your Peak

Reach Your Peak (RYP) is a wellness program designed to assist you by promoting and maintaining your good health. All full-time employees are eligible to participate Employees and spouses enrolled in the El Paso County EPO Medical Plan can enroll in the RYP+ program to earn additional benefits.

If you believe you are unable to meet a standard for a reward under this wellness program, you may qualify for an opportunity to earn the same reward by different means. Contact the Employee Benefits Division at (719) 520-7420 and we will work with you and your doctor to find a reasonable alternative, with the same reward, that is right for you.

Please call (719) 520-7486 with any questions and for information on the enrollment period.

Workers' Compensation

Employees who sustain a work-related illness or injury may be eligible for statutory benefits pursuant to the Colorado Workers' Compensation Act, C.R.S. § 8-40-101, *et seq.*

For any **personal health** (non-work related) problems, please seek the advice of your family physician. Workers' compensation does not cover expenses for non-work-related accidents, injuries, or illnesses (for example, a private automobile accident). Your health insurance coverage would apply.

For questions regarding workers' compensation, call the Human Resources Risk Management Workers' Compensation Division at (719) 520-7486.

Chapter 2

Insurance Plan Premiums

Please see current Benefits Brochure for premium information

Medical Plan

El Paso County EPO Medical Plan

You have one medical plan option – the El Paso County Exclusive Provider Organization (EPO) Medical Plan administered by UMR. With this plan you have access to the County Employee Health Centers and the UnitedHealthcare Choice Plus Network providers.

This plan does not have a deductible. See the benefits summaries on the following pages for additional information on deductibles, copayments, and coinsurance.

Once you make your elections you may not change or cancel your benefits or change enrolled dependents until the next Open Enrollment period unless you have a Qualifying Life Event.

Provider Network

You may find out if a provider is in the UnitedHealthcare Choice Plus Network by contacting Quantum Health at 866-855-1484 and at elpasocobenefits.com

Plan Summary

A medical plan summary is listed on the following pages.

Plan Year

El Paso County's plan year begins January 1st and ends December 31st.

SleepCharge Program

The El Paso County EPO Medical Plan has partnered with NoxHealth to bring you the SleepCharge Program for Sleep Health.

This benefit provides:

- Medical experts who will help you assess your sleep health
- A personalized treatment plan, including all equipment and supplies
- Dedicated Care Managers, always available to support you
- The latest sleep health education and advice

All employees and their adult dependents enrolled on the El Paso County EPO Medical Plan are eligible. All costs for the program are covered by the plan.

For more information go to sleepcharge.com/epcmed, call 1-877-615-7257 or e-mail sleep@noxhealth.com.

SurgeryPlus

SurgeryPlus is a free supplemental benefit that offers higher quality, a great experience and waived copays and coinsurance for non-emergent surgical procedures for you and your enrolled dependents.

The benefits of using SurgeryPlus include:

- High-Quality: SurgeryPlus has already located and rigorously screened the area's top-quality surgeons. Before being allowed into the network, surgeons are required to meet various qualifications including board certification, fellowship training, minimum volume thresholds, background checks and more.
- A Better Experience: A dedicated Care Advocate will manage the entire procedure process for you, including locating a surgeon, scheduling appointments, transferring medical records, and arranging all logistics. You will work with the same Care Advocate through the entire process, so they will know all the details of your case and ensure your top satisfaction.
- Lower Costs: Because of lower contracted rates, El Paso County will waive your patient surgery coinsurance when you use SurgeryPlus. You could save thousands on your procedure!

Hundreds of procedures are covered. Below is a list of commonly covered procedure categories; however, call SurgeryPlus to inquire about a specific procedure and a Care Advocate will assist you with your needs and questions.

- Cardiac
- Ear, Nose, & Throat (ENT)
- General Surgery
- Gynecology (GYN)
- Orthopedics
- Pain Management
- Spine

For more information go to epcepo.surgeryplus.com, call 1-833-814-5702, or e-mail epcepo@surgeryplus.com.

Women's Health and Cancer Rights Act of 1998

Important information about your rights under your group health plan:

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same coinsurance applicable to other medical and surgical benefits provided under this plan
Call Quantum Health at 1-866-885-1484 if you would like more information about these benefits.

Medical Plan

Medical Plan

Grandfathered Health Plan

El Paso County believes this medical health plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at Employee Benefits Division (719) 520-7486. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov. .

Contact Information

Medical Plan Benefits and Claim Questions:
UMR (UnitedHealthcare Choice Plus Network)
Group #76-414547
Quantum Health: 1-866-855-1484
Website: elpasocobenefits.com

SurgeryPlus
Phone: 1-833-814-5702
E-mail: epcepo@surgeryplus.com
Website: epcepo.surgeryplus.com

SleepCharge Program
Phone: 1-877-615-7257
E-mail: sleep@noxhealth.com
Website: sleepcharge.com/epcmed

Medical Plan

El Paso County UMR EPO Medical Plan Benefits Summary

Please see Current Benefits Brochure and Summary Plan Description on the Employee Benefits Website at https://admin.elpasoco.com/human-resources/employeebenefits/

Medical Plan

Health Insurance Marketplace

The federal government requires all employers provide the "New Health Insurance Marketplace Coverage Options and Your Health Coverage" notice (on the following pages) to all employees. The mandatory notice briefly explains what public Marketplaces are and how to access them.

For individuals needing to purchase health insurance on their own, each State in the U.S. must have a public Marketplace website and call center where individuals may shop for private health insurance. States are also integrating enrollment for Medicaid and the Children's Health Insurance Program (CHIP) into the public Marketplace to direct people into those programs if they qualify instead of purchasing private coverage.

Please note that insurance companies are not required to participate in the State's public Marketplace, so individuals are probably still not going to see all plans available in their community when shopping the public Marketplace.

As part of the public Marketplaces, the Health Care Reform law also created federal tax credits to help pay for coverage. There are several requirements an individual must satisfy to qualify for these tax credits. One of those requirements is the individual cannot have access to employer-sponsored health insurance that meets the qualifying standards of the Health Care Reform law.

The El Paso County medical plan will meet the government's qualifying standards. As a result, if you are eligible for the El Paso County medical plan and you or someone in your family wanted to compare your health insurance options in the public Marketplace to the insurance offered through us, you'll need to remember that:

- You would pay full retail price for public Marketplace insurance (without the tax credits)
  - You would no longer be paying for insurance on a pre-tax basis
  - You would no longer have an employer contribution toward your insurance
- You would navigate any questions you have directly with the insurance company you choose. We will not be able to assist you with your public Marketplace plan
- Should you desire to come back to the El Paso County medical plan in the future, you will either need to experience a federally recognized "qualifying event" that allows a mid-year election change or wait until our next annual Open Enrollment

If you or someone in your household are not eligible for our plan and wish to apply for a public Marketplace tax credit, your household income must be within certain limits. When you apply for the tax credit, you will estimate your household income. If your household income ends up higher than you estimated, you may owe some or all of the tax credits back on your personal tax return.

Premium Assistance under Medicaid and CHIP

If you or your children are eligible for Medicaid or the Children's Health Insurance Program (CHIP) and you are eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS-NOW (1-877-543-7669) or go online to insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at askebsa.dol.gov or call 1-866-444-EBSA (3272).

State Contact Information

Contact your state for more information on eligibility:

Colorado – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)

Health First Colorado Website: healthfirstcolorado.com
Health First Colorado Member Contact Center:
1-800-221-3943 / State Relay 711
CHP+ Website:
colorado.gov/pacific/hcpf/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991 / State Relay 711
Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program
HIBI Customer Service: 1-855-692-6442

Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[1][2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.
[2] An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

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Prescription Plan

General Information

The prescription plan, administered by Express Scripts, is included with your medical plan enrollment. Plan members may fill their prescriptions through retail pharmacies participating in the Express Scripts network for a 30 and/or 90-day supply. You can also obtain a 90-day supply of maintenance medications through the Express Scripts Pharmacy Home Delivery service.

Pharmacy Network

The prescription plan provides you with convenient access to a nationwide network of pharmacies. You can obtain a complete listing of pharmacies in your network by logging onto express-scripts.com. Click on the "Prescriptions" menu and select "Find a Pharmacy" enter your zip code and click "Search."

Smart90

Smart90 is a feature of your prescription plan. With it, you have two ways to get up to a 90-day supply of your long-term medications (those drugs you take regularly for ongoing conditions). You can conveniently fill those prescriptions either at a **Walgreens** retail pharmacy or through the **Express Scripts Pharmacy Home Delivery**.

By getting up to a 90-day supply, you will make fewer trips to the pharmacy, and you will only need to make one payment every three months. In addition, there is a savings for getting one 90-day supply versus three 30-day supplies.

Home Delivery Pharmacy

Through the Express Scripts Pharmacy Home Delivery service, you can take advantage of convenient delivery of your covered maintenance medications to your home or other specified address. Maintenance medications are defined as medications that are used for chronic, long-term conditions such as high blood pressure, high cholesterol, etc. Specialty pharmacy medications are not considered to be maintenance medications.

To use the Express Scripts Pharmacy Home Delivery service, you will need to ask your doctor to write a prescription for up to a 90-day supply, plus refills for up to one year (as appropriate). Note: If you need your medicine right away, ask your doctor to write two prescriptions. Fill the first one at your local drug store. Mail the second one to Express Scripts Pharmacy Home Delivery.

To fill the prescription, you may:

- Mail your prescription(s) along with the required copayment in the envelope provided with your Welcome Package.
- Call Express Scripts toll-free at 1-855-738-1153. You will need to have your prescription number handy when you call.
- Order through the Express Scripts website after registering at express-scripts.com.

Orders are usually processed and mailed within 48 hours of receipt. Please allow 8 days from the day you mail in your prescription. You can check on the status of your order by logging on to express-scripts.com or by calling customer service and using the automated system. Have your member ID number handy.

Medications are shipped via standard service at no cost to you. Express shipping is also available for an additional fee.

You can pay for Home Delivery prescriptions by check, e-check, money order or credit card. If you prefer to use a credit card, you have the option of joining Express Scripts' automatic payment program by calling 1-800-948-8779 or by enrolling online.

Specialty Pharmacy

Express Script's Specialty Pharmacy administered by Accredo provides convenient, dependable access to medications for people living with complex health conditions. Specialty medications are used to treat complex, chronic health conditions like Multiple Sclerosis or Rheumatoid Arthritis. These medications usually must be stored or handled in special ways. **Drugs that fall under this program are dispensed via a home delivery method. These drugs will be limited to a 30-day supply whether dispensed at a retail pharmacy or at a mail service pharmacy.** Specialty pharmacy copayments will apply.

Please call toll-free at 1-800-803-2523 to pre-enroll in the Accredo Specialty Rx program.

Prior Authorization

El Paso County uses coverage management programs to help ensure you receive the prescription drugs you need at a reasonable cost. Coverage management programs include prior authorization, step therapy and quantity duration. Each program is administered by Express Scripts to determine whether your use of certain medications meets your plan's conditions of coverage. In some cases, a coverage review may be necessary to determine whether a prescription can be covered under your plan.

If your prescription requires prior authorization, you or your doctor can initiate the prior authorization review by calling Express Scripts at 1-800-753-2851. Express Scripts will inform you and your doctor in writing of the coverage decision.

If you would like to find out ahead of time if a medication may need coverage review, you can log on to express-scripts.com and use the "Price a medication" feature. After you look up a medication's name, click "View coverage notes" or you can call customer service at 1-855-738-1153.

Step Therapy

Step Therapy is a program especially for people who take prescription drugs regularly to treat an ongoing medical condition, such as arthritis, asthma, or high blood pressure. The program helps you get the prescription drugs you need, with safety, cost and – most importantly – your health in mind.

Prescription Plan

In Step Therapy, prescription drugs are grouped in categories, based on cost:

- Front-line drugs – the first step – are lower cost drugs that are proven safe, effective, and affordable. These medications should be tried first because they can provide the same health benefit as more expensive medications, at a lower cost.
- Back-up drugs – Step 2 and Step 3 drugs – are brand-name drugs such as those you see advertised on TV. There are lower-cost brand drugs (Step 2) and higher-cost brand drugs (Step 3). Back-up drugs almost always cost more than lower cost alternatives.

Quantity Limits

Drug Quantity Management (DQM) is a program in your pharmacy benefit that's designed to make the use of prescription drugs safer and more affordable. It provides you with medications you need for your good health while making sure you receive them in the quantity considered safe.

Certain medications are included in this program. For these medications, you can receive an amount to last you a certain number of days: for instance, the program could provide a maximum of 30 pills for a medication you take once a day. This gives you the right amount to take the daily dose considered safe and effective, according to guidelines from the FDA.

Your Cost

When covered prescriptions are filled under this program, you will share a portion of the cost; the plan pays for the remainder. The Express Scripts formulary (a list of preferred medications) is available at express-scripts.com. Your prescription drug program provides you with five (5) tier options. These formulary medications have received FDA approval as safe and effective. Please note that although a drug is on a formulary, it does not necessarily mean that it is a covered drug under your plan. Refer to your Summary Plan Document for a list of coverage/exclusions.

The following will help to maximize your prescription drug coverage benefits:

- Use generic drugs whenever possible.
- If you are taking a brand-name drug that is not on your formulary, ask your doctor if a formulary drug or a generic would be right for you. You can review your medication for formulary status by visiting express-scripts.com.
- Use participating local pharmacies to fill your prescriptions.

Contact Information

Member Services: 1-855-738-1153
Website: express-scripts.com
Accredo Specialty Rx: 1-800-803-2523
For Prescriptions:
RxBIN #003858
RxPCN #A4
RxGRP #ELPASO16

Express Scripts Prescription Copayment Schedule

	Retail 30 Day Supply	Retail or Mail Order Up to 90 Day Supply	Accredo Specialty 30 Day Supply
First Tier (Generic)	$ 6.00	$ 15.00	
Second Tier (Preferred Brand)	$ 30.00	$ 75.00	
Third Tier (Non-Preferred Brand)	$ 50.00	$ 125.00	
Fourth Tier (Preferred Specialty)*		N/A	$ 150.00
Fifth Tier (Non-Preferred Specialty)*		N/A	$ 250.00
*Covered Specialty Pharmacy medications are limited to a 30-day supply. For Specialty Pharmacy medications, a Patient Maximum Out-of-Pocket (MOOP) of $2,500.00 applies per individual, per calendar year. Once the MOOP is met, the member's copayment is zero for the remainder of the calendar year.			

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Prescription Plan

Notice of Creditable Coverage

Important Notice from El Paso County about Your Prescription Drug Coverage and Medicare

This notice of Creditable Coverage is mailed to plan participants annually by the medical plan administrator, UMR. Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with El Paso County and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. El Paso County has determined that the prescription drug coverage offered by the El Paso County plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage If You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current El Paso County coverage will not be affected. You can keep your coverage if you elect Part D, and this plan will coordinate with Part D

If you do decide to join a Medicare drug plan and drop your current El Paso County coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with El Paso County and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information about This Notice or Your Current Prescription Drug Coverage

Contact the Employee Benefits Division for further information.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through El Paso County changes. You also may request a copy of this notice at any time.

For More Information about Your Options under Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778)

Remember: Keep the Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of the notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Premise Health Center Clinics

General Information

Employees, retirees, spouses, and children **enrolled in the County's medical plan** can receive high quality health care services through the El Paso County Employee Health Centers (Clinics), operated by Premise Health.

El Paso County Employee Health Centers complement your medical insurance benefits, providing you with comprehensive, affordable, convenient, and excellent health care. Board certified staff, including two family physicians, two nurse practitioners and a clinical psychologist, provide service at both Health Center locations.

The Health Centers offer acute care as well as a variety of preventive health and wellness services. When appropriate, the Health Center can also make referrals to specialists. The Health Center physicians and nurse practitioners can also write prescriptions.

Services Offered

Health Center copayments are only $10.00 for physician, nurse practitioner or psychologist visits. There is no copayment for preventive care visits or RYP+ Health Consultations. Other medical services, such as immunizations and vaccinations, may carry an additional cost.

Following are just a few examples of the many services offered:*

- Comprehensive individual/family primary care
- Urgent and acute care (flu, fever, viral infections, nausea, cuts, sprains/strains)
- Preventive health (annual adult and children physicals)
- Clinical psychology
- Disease management
- Stress management counseling
- Smoking cessation counseling
- Wellness education/support
- Referrals to specialists
- Vaccinations, injections, and laboratory services

*All services are by appointment only.

Wellness Exams

The Health Centers offer physicals for employees, retirees, and dependents.

Well Woman Physicals

Well Woman physicals are also offered. The physical includes a Pap smear, breast exam and consultation on specific concerns or questions. Pregnancy can be confirmed by the Health Centers. Prenatal care is not offered at the Health Centers; pregnant women should see their obstetrician for care.

Adolescent Physicals

School and sports physicals are offered. The physicals include a comprehensive examination, risk appraisal, vision screen and appropriate vaccinations. Health and wellness advice will also be provided. Please bring record of immunizations and required school forms.

On-site Psychologist

Our clinical psychologist is here to help identify problems in your life – emotional, mental, and behavioral. Through observation, interviews and tests, the psychologist will diagnose any existing or potential disorders. Then, together with you, formulate a program of treatment according to your needs. Your progress can be monitored on a regular basis to ensure that your needs are met by the course of action and adjust it if necessary.

Disease Management Program

Disease management is an approach to health care that can help a patient learn how to manage a chronic disease. It is the concept of integrating care, minimizing the effects of a disease or chronic condition, and ultimately improving the lives of those being treated.

Disease Management at the Health Centers is a confidential, on-site health improvement program. You will have the opportunity to work one-on-one with the Health Centers' medical teams in lowering your health risks such as type 2 diabetes, coronary heart disease, high blood pressure, heart failure, asthma, emphysema, and lower back pain.

The Disease Management Program at the Health Centers is designed to help you and your doctor work together in managing your chronic health condition – whether you have been diagnosed by your own primary care physician or a provider at one of the Health Centers.

24/7 National Virtual Visits

While we encourage you to contact and utilize the El Paso County Employee Health Centers and onsite medical providers during regular business hours, El Paso County Medical Plan participants have 24/7 after-hours access to visit with a Board-Certified provider using a telephone, tablet, or computer.

Premise National Virtual Health visits (also known as "telehealth") can be performed by phone or video and are available anywhere in the United States. No appointment is needed. National Virtual Visits will be accessed by the My Premise Health app (available on Apple Store and Google Play), at mypremisehealth.com.

Telehealth visits are ideal for after-hours non-emergency medical issues and conditions such as cold, cough, flu, earache, sinus infection, sore throat, fever, headache, backache, allergies, and nausea. In addition to Virtual Primary/Acute Care services, you can also schedule convenient Virtual Behavioral Health visit.

Confidentiality

Ensuring your privacy and maintaining confidentiality is assured – strict adherence to HIPAA (the Health Insurance Portability and Accountability Act of 1996) guidelines ensures all personal medical information obtained by the Health Centers is protected and kept completely confidential.

Premise Health Center Clinics

Locations and Contact Information

Regional Development Center (RDC) Health Center
2880 International Circle, Suite N010 – Lower Level
Colorado Springs, CO 80910
Phone: **(719) 520-7080**
Monday-Friday 8:00 a.m. to 5:00 p.m.

Citizens Service Center (CSC) Health Center
1675 W. Garden of the Gods Road, Suite 1053
Colorado Springs, CO 80907
Phone: **(719) 520-7600**
Monday-Friday 8:00 a.m. to 5:00 p.m.

Premise Health Patient Portal: mypremisehealth.com

Dental Plans

General Information

El Paso County offers two Preferred Provider Organization (PPO) options with Delta Dental: a Low Option PPO and a High Option PPO plus Premier. A comparison of the two plans is shown below.

On the Low and High Delta Dental options, dental procedures are covered through any licensed dentist. You will benefit from contracted rates by accessing care through a PPO or Premier provider. **The greatest discount and least out-of-pocket to you will be with a PPO provider.**

Provider Networks

A listing of network providers can be found on the Delta Dental website at deltadentalco.com. Click "Find a Dentist" on the main page. Enter your search parameters by selecting "Your Plan" (Delta Dental PPO or Delta Dental PPO Plus Premier), entering your location (address or zip code) and/or other criteria you wish to include, then click "Find dentists." The list of providers will indicate how the provider is contracted – PPO and/or Premier.

Contact Information

Member Services: 1-800-610-0201
Website: deltadentalco.com
Group #12104

Delta Dental Plan Comparison

	LOW OPTION		HIGH OPTION	
Dental Services	**In Network**	**Premier/ Out-of-Network**	**In Network**	**Premier/ Out-of-Network**
Teeth Cleaning – 2 per calendar year	100%	80%	100%	100%
Oral Evaluations (Diagnostic)	100%	80%	100%	100%
X Rays (Diagnostic)	100%	80%	100%	100%
Lab and Other Diagnostic Tests	100%	80%	100%	100%
Prophylaxis (Preventive)	100%	80%	100%	100%
Fluoride Treatment (Preventive) under age 19	100%	80%	100%	100%
Fillings (Amalgam & Anterior Composites)	80%	60%	90%	70%
Crowns: Stainless Steel	80%	60%	90%	70%
Simple Extractions/Oral Surgery	80%	60%	90%	70%
Endodontic Services – Root Canal Therapy	50%	30%	90%	70%
Periodontal Services	50%	30%	90%	70%
Inlays/Onlays	50%	30%	60%	30%
Dentures/Bridges (once ever 60 months)I'm re	50%	30%	60%	30%
Fixed Prosthetics	50%	30%	60%	30%
Crowns: Resin, Metal	50%	30%	60%	30%
Implants	50%	30%	60%	30%
Orthodontia	N/A		50%	50%
Individual Deductible/Family Deductible	$50/$150		$25/$75	$50/$150
Deductible applies to Preventive & Diagnostic	No		No	
Ortho Lifetime Maximum	N/A		$1500	
Calendar Maximum includes In and Out of Network	$1,000		$1,500	
Out-of-Network Basis	MAC*		Proprietary Fee Schedule**	

*This is a Maximum Allowable Charge (MAC) PPO plan.

- PPO Dentist: Payment is based on the PPO dentist's Allowable Fee, or the actual fee charged, whichever is less.
- Premier Dentist: The member will be responsible for the difference between the PPO dentist's Allowable Fee and the fee from the Premier Maximum Plan Allowance (MPA).
- Out-of-Network Dentist: The member will be responsible for the difference between the PPO dentist's Allowable Fee and the full fee charged by the dentist.

**This is a Delta Dental PPO plus Premier plan.

- PPO Dentist: Payment is based on the PPO dentist's Allowable Fee, or the actual fee charged, whichever is less.
- Premier Dentist: Payment is based on the Premier MPA, or the actual fee charged, whichever is less.
- Out-of-Network Dentist: Payment is based on the Out-of-Network MPA; members are responsible for the difference between the out-of-network MPA, and the full fee charged by the dentist.

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Vision Plan

General Information

El Paso County's vision plan is administered by EyeMed.

Provider Network

A listing of network providers can be found on the EyeMed website at eyemed.com. Click "Find an eye doctor" on the main page. Enter your search parameters by entering your zip code, choosing your network (Access) and other criteria you wish to include, then click "Get Results."

Contact Information

Member Services: 1-866-723-0596
Website: eyemed.com
Access Plan H
Group #9728999

EyeMed Vision Plan Summary

Frequency of Services		
Exam	Once every 12 months	
Lenses	Once every 12 months	
Contact Lenses	Once every 12 months	
Frame	Once every 24 months	
Services	**In-Network**	**Out-of-Network Reimbursement**
Exam with Dilation as Necessary	$10 copayment	Up to $35
Retinal Imaging	Up to $39	N/A
Exam Options		
Standard Contact Lens Fit and Follow-Up	Up to $55	N/A
Premium Contact Lens Fit and Follow-Up	10% off Retail Price	N/A
Frames Any available frame at provider location	$0 copayment; $150 allowance, 20% off balance over $150	Up to $45
Standard Plastic Lenses		
Single Vision	$25 copayment	Up to $40
Bifocal	$25 copayment	Up to $60
Trifocal	$25 copayment	Up to $80
Lenticular	$25 copayment	Up to $80
Standard Progressive Lens	$25 copayment	Up to $60
Premium Progressive Lens	$25 copayment, 80% of charge less $120 allowance	Up to $60
Lens Options		
UV Treatment	$15	N/A
Tint (Solid and Gradient)	$15	N/A
Standard Plastic Scratch Coating	$0 copayment	Up to $5
Standard Polycarbonate – Adults	$40	N/A
Standard Polycarbonate – Kids under 19	$40	N/A
Standard Anti-Reflective Coating	$45	N/A
Polarized	20% off retail price	N/A
Other Add-Ons	20% off retail price	N/A
Contact Lenses (*allowance includes materials only*)		
Conventional	$0 copayment; $150 allowance 15% off balance over $150	Up to $105
Disposable	$0 copayment; $150 allowance, plus balance over $150	Up to $105
Medically Necessary	$0 copayment, paid in full	Up to $200

Vision Plan

Services	In-Network	Out-of-Network Reimbursement
Additional Benefits:		
Lasik or PRK from U.S. Laser Network	15% off retail price or 5% off promotional price	N/A
Additional Pairs	40% discount off complete pair of eyeglass purchases and 15% discount off conventional contact lenses once the funded benefit has been used	N/A
Additional Discounts: Member receives a 20% discount on items not covered by the plan at network providers. Discount does not apply to EyeMed's provider's professional services or contact lenses. Plan discounts cannot be combined with any other discounts or promotional offers. Services or materials provided by any other group benefit plan providing vision care may not be covered. After initial purchase, replacement contact lenses may be obtained via the Internet at substantial savings and mailed directly to the member. Details are available at eyemed.com. The contact lens benefit allowance is not applicable to this service. Benefit Allowances provide no remaining balance for future use within the same Benefit Frequency. Certain brand name Vision Materials in which the manufacturer imposes a no-discount practice.		
Plan Exclusions: 1) Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; 2) Medical and/or surgical treatment of the eye, eyes or supporting structures; 3) Any eye or Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; Safety eyewear 4) Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; 5) Plano (non-prescription) lenses and/or contact lenses; 6) Non-prescription sunglasses; 7) Two pair of glasses in lieu of bifocals; 8) Services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order; 9) Services or materials provided by any other group benefit plan providing vision care; 10) Lost or broken lenses, frames, glasses or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available.		

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Flexible Spending Accounts

What is a Flexible Spending Account (FSA)?

The BESTflex Plan from Employee Benefits Corporation (EBC) is a Flexible Spending Account (FSA) which allows you to set aside money for eligible expenses on a pre-tax basis. There are two types of FSAs available – a health care account and a dependent day care account.

When you enroll in an FSA, you set aside the portion of your pay you will spend annually on eligible health and dependent care expenses. Throughout the year, these elections are deducted bit by bit from your paychecks and placed in FSAs. The usual payroll taxes do not apply to your FSA contributions, saving you from paying approximately 30 percent* in taxes on each dollar you contribute to the FSA.

*These tax examples are broad approximations of tax liability. You should consult a tax advisor for help with your own situation. Current IRS tax laws control all FSA matters.

What you need to know about FSAs:

- You determine your contribution in an FSA during Open Enrollment or when you first become eligible.
- Contributions are deducted from 24 pay periods or, when you are first eligible, on each of the remaining pay periods in the plan year (twice monthly).
- You do not need to be covered by your employer's health plan to participate in an FSA.
- Expenses must be for services received, not for services to be provided in the future.
- Once you establish your plan year contribution, you may only change it if you experience a Qualifying Life Event.
- Any claims that were incurred during the plan year must be submitted for reimbursement by the end of your run out period. The run-out date is 3 months after the end of your plan year. (If terminated, there is a 3-month runout period after the termination date in which claims incurred through the last day of work may be submitted.)
- You must re-enroll each year.

Getting Started

Getting started is as easy as 1-2-3!

1. Estimate the amount you will spend on out-of-pocket health care expenses and/or dependent day care expenses during the plan year.
   - Review expenses from prior plan year.
2. Decide how much you wish to set aside in your health care FSA and/or dependent day care FSA.
   - Divide your annual contribution by 24 pay periods or the remaining pay periods in your plan year to determine the amount that will be deducted from your paycheck each pay period.
3. As you incur eligible health care and dependent day care expenses throughout the year, you can access your funds by:
   - Using your EBC Benefits Card (for health care expenses) or
   - Submitting a claim for reimbursement.

Health Care FSA

The Health Care FSA is used for out-of-pocket medical, dental and vision expenses that are not covered by another health plan and that are incurred by you, your spouse, or your child(ren) who has not attained age 27 as of the end of the calendar year.

- The annual contribution amount may not exceed the amount listed in the current Benefits Brochure.
- Your entire contribution is available at the beginning of the plan year or when you first become eligible.
- View a detailed listing of eligible expenses at ebcflex.com.

Rollover

You are allowed to rollover a minimum of $50 and up to $610 of unused Health Care FSA dollars into the following plan year. Money left in your account under $50 or in excess of $610 at the end of the plan year is forfeited.

Dependent Day Care FSA

The Dependent Day Care FSA is used for day care expenses incurred for the care of a child under age 13 or for the care of a dependent who is physically or mentally incapable of taking care of themselves.

- The annual contribution amount may not exceed:
  - the lesser of your earned income;
  - if married, your spouse's earned income;
  - the annual maximums listed in the current Benefits Brochure.
- You can only be reimbursed up to the amount that is available in your account.
- You and your spouse, if married, must be actively working, seeking employment or a full-time student, in order to get reimbursed.

Eligible Expenses

- Licensed day care provider
- In-home provider, as long as the care provider is not your child under age 19 or someone you claim as a tax dependent
- Summer camps (not overnight)
- Tuition through preschool
- Before and after school care (under age 13)

Ineligible Expenses

- Tuition expenses for kindergarten and beyond
- Overnight camps
- Childcare expenses for a child 13 or older (unless disabled)
- Childcare expenses for night-time babysitting
- Childcare expenses while you are on an extended leave of absence
- Care provided by an older dependent or sibling

Reimbursement Methods

Submitting a Claim for Reimbursement

Online:

- Go to ebcflex.com.
- Log into My Account Assistant.

- Complete the short web form and upload the scanned documentation.
- Review, submit and print your confirmation.

Smart Phone:

- Available for iPhone and Android.
- Download the EBC Mobile app if you haven't already.
- Simply complete the Claim Screen, attach the receipt, and submit.

Manual Submission:

- Download the Claim Form at ebcflex.com.
- Attach supporting documentation.
- E-mail, fax or mail the Claim Form and supporting documents to Employee Benefits Corporation.

  E-mail: participantservices@ebcflex.com
  Fax: (608) 831-4790
  Mail: Employee Benefits Corporation
  PO Box 44347
  Madison, WI 53744-4347

Direct Deposit

When you enroll in the BESTflex Plan, you have the option of having EBC deposit your reimbursements directly into your financial institution checking or savings account. Direct Deposit saves you time and makes paying providers easier. It also eliminates the possibility of losing a reimbursement check and having to pay a stop-payment fee for a new check.

Benefits Card

The EBC Benefits Card can be used to pay for eligible health care expenses instead of using cash or submitting a claim for reimbursement. The benefits card debits your BESTflex Plan Health Care FSA and makes the FSA even more convenient to use.

Contact Information

Customer Service: 1-800-346-2126
Website: ebcflex.com

Chapter 3

Life Insurance Plans

Basic Life Insurance

Basic Life Insurance Coverage Amounts

	Life Benefit	AD&D Benefit
Employee	$ 40,000	$ 40,000
Spouse	$ 2,000	$ 0
Child(ren)	$ 1,000 first 6 months $ 2,000 thereafter, until age 26	$ 0

Term Life

This coverage is Term Life Insurance. The Life Insurance benefit is payable to the designated beneficiary upon the death of the insured. Coverage is provided for the time period that you are eligible, and premium is paid. There is no cash value associated with this product. A beneficiary designation form can be found on page 63 of this guidebook.

AD&D

Accidental Death and Dismemberment (AD&D) Insurance provides specified benefits for a covered accidental bodily injury that directly causes dismemberment (i.e., the loss of a hand, foot, or eye). In the event that death occurs to an employee from a covered accident, both the Life and the AD&D benefit would be payable.

Eligibility

Coverage is available to all full-time employees in active employment in the U.S. with the employer and their eligible spouses and children (up to age 26). A delayed effective date will apply if the employee is not actively at work on the date the insurance would otherwise take effect.

Note: All District Attorneys, full-time means 37.5 hours each week. All Non District Attorneys, full-time means 40 hours each week.

Cost

If you are eligible, El Paso County pays for this coverage.

Benefit Reduction

Coverage amount(s) will reduce according to the following: at age 70 benefits reduce to 65% of original amount and at age 75 benefits reduce to 50% of original amount. Coverage may not be increased after a reduction.

Living Benefit

A living benefit (or accelerated death benefit) is available to employees who have satisfied the "active work" rule. If you become terminally ill and are not expected to live beyond a certain time period as stated in your certificate booklet, you may request up to 75% of your life insurance amount up to $500,000, without fees or present value adjustments. A doctor must certify your condition in order to qualify for this benefit. Upon your death, the remaining benefit will be paid to your designated beneficiary. This feature also applies to your covered dependents.

Portability/Conversion

If your employment ends or you retire from the County or you are working less than the minimum number of hours as described under the Eligibility section, you may elect to port or convert coverage for yourself and your dependents. You must apply for portable or convertible coverage for yourself and your dependents and pay the first premium within 31 days from the date of the loss of coverage.

Voluntary Life Insurance

General Information

Voluntary Term Life insurance is an **optional** benefit. An enrollment form can be found on page 65 of this guidebook.

For more information on this Voluntary Life Insurance plan, please see Basic Life Insurance sections Term Life, AD&D, Eligibility, Benefit Reduction, Living Benefit and Portability/Conversion.

Coverage Amounts

Coverage is available in $10,000 units. For the employee: starting at $10,000 up to the lesser of seven (7) times your salary rounded to the next highest $10,000 or $500,000. For the employee's spouse*: up to the lesser of 100% of the employee's elected amount or $250,000. You may also elect a flat $10,000 of coverage for dependent child(ren)*.

*You must elect coverage in order to elect coverage for your spouse or child(ren).

Cost

Term Life Insurance Rates

See current Benefits Brochure for Rates.

Insurance Age: Your rate is based on your insurance age. To calculate your insurance age, subtract your year of birth from the year your coverage becomes effective. Your rate will increase as you age and move to the next age band. *When porting coverage, rates are based on your actual age.*

Child Life Monthly Rate: $10,000 = $2.00
AD&D Rates: Employee/Spouse/Child Monthly Rate per $10,000 = $0.20

Monthly premiums are divided in half and deducted on the first and second pay period of each month.

Guarantee Issue

For timely entrants enrolled within 31 days of becoming eligible, up to $200,000 in coverage is guaranteed for you the employee and up to $30,000 for your spouse without any evidence of insurability requirement.

Evidence of Insurability

Any coverage applied for above the guarantee issue or new coverage applied for after the initial enrollment period require an Evidence of Insurability (EOI) form to be completed. The EOI form can be completed at securehealth.unum.com/eoiaccess, using access code 3JW6WUS.

Enrolling After Initial Date of Eligibility

If you do not elect the minimum coverage when first eligible, you will only be eligible again at the next annual enrollment period and evidence of insurability will be required to obtain this coverage.

Increasing Coverage

Life Insurance Plans

Increases to your coverage can be made during the annual enrollment period. If you already have the minimum amount of Life Insurance ($10,000) for yourself and your dependents, you can purchase additional insurance up to the Guaranteed Issue (GI) amount without any evidence of insurability requirement, as long as you remain eligible and actively at work. For amounts over the GI you will need to submit evidence of insurability.

An increase in coverage that is made during an annual enrollment period will begin at 12:01 a.m. on:

- the first day of the next plan year for any amount of insurance that is not subject to evidence of insurability requirements; and
- the first of the month coincident with or next following the date Unum approves your evidence of insurability form for any amount of insurance that is subject to evidence of insurability requirements.

Contact Information

Phone: 1-800-421-0344
Basic Life Policy #907338
Voluntary Life Policy #907339

Supplemental Benefit Plans

Accident Insurance

Designed to help employees meet the out-of-pocket expenses and extra bills that can follow an accidental injury, whether minor or catastrophic.

Indemnity lump sum benefits are paid directly to the employee based on the amount of coverage listed in the schedule of benefits.

Critical Illness Insurance

Designed to help employees offset the financial effects of a catastrophic illness with a lump sum benefit if an insured is diagnosed with a covered critical illness. The Critical Illness benefit is based on the amount of coverage in effect on the date of diagnosis of a critical illness or the date treatment is received according to the terms and provisions of the policy.

You may choose $10,000 or $20,000 of coverage for yourself and $5,000 or $10,000 of coverage for your spouse (employee must be covered). This plan includes a Wellness Benefit: every year, each family member who has Critical Illness coverage can receive $50 for getting a health screening test.

Hospital Indemnity Insurance

Designed to help provide financial protection for covered individuals by paying a benefit due to a hospitalization and in some cases, for treatment received for an accident or sickness, even if that treatment occurs outside the hospital.

Employees can use the benefit to meet the out-of-pocket expenses and extra bills that can occur. Indemnity lump sum benefits are paid directly to the employee based on the amount of coverage listed, regardless of the actual cost of treatment.

Claim Submission Instructions

There are three easy ways to file a claim:

- On the Unum Customer App for Apple and Android devices (you need an account, so if it's your first time filing a claim, register on unum.com first). Once you're registered you can use the app to submit claims and check claims status.
- Online at unum.com.
- By calling 1-800-635-5597.

To file a claim for the Wellness or Health Screening Benefit:

- Call 1-800-635-5597.
- Request to submit a wellness/health screening claim.
- Be prepared to provide:
  - First and last name of the policy holder
  - Policy holder's Social Security Number and/or policy number
  - First and last name of the claimant (may or may not be the policy holder)
  - Name and date of the wellness test
- You can call 1-800-635-5597 to request a paper claim form if you do not want to file a claim over the phone.

Contact Information

Phone: 1-800-635-5597

Disability Insurance Plans

Short Term Disability (STD)

Enrollment and Eligibility Date

All full-time employees are eligible for STD benefits and will be automatically enrolled, and are given the option to opt out during the new hire enrollment period and during Open Enrollment. Coverage is effective on the 1st of the month following your full-time date of hire.

Who Pays for STD Coverage?

Enrolled employees will contribute $6.50 per pay period twice monthly for their STD coverage.

Reporting a Claim

How to report a claim:

1. Contact the Employee Benefits Division at FMLAAdmin@elpasoco.com or call (719) 520-7486.
2. Advise your supervisor or manager as soon as possible, preferably on or before your first absence.
3. Call the Unum hotline at 1-888-673-9940 as soon as possible.

Notification of Claim Decision

The insurance company will notify both the employee and the Employee Benefits Division of their claim decision. Claims can take a few weeks or even longer to be processed so employees are encouraged to submit their paperwork as soon as possible.

Elimination Period

Benefits begin following 14 continuous days of disability. Employees may use available accrued sick, vacation leave and personal days (in this order), during the elimination period, unless the employee submits a written request for leave without pay. The days you are not disabled will not count toward your elimination period.

Weekly Benefit

If you are totally disabled beyond the elimination period due to a covered sickness or injury, you may be eligible to receive a weekly benefit of 60% of your basic weekly earnings to a maximum benefit of $1,500. This benefit may be reduced by income or benefits from certain other income sources listed in the short term disability plan document.

Definition of Disabled or Disability

Disabled or disability means totally disabled and/or partially disabled. Partial disability means you do not need to be continuously disabled through your elimination period as long as you satisfy the elimination period within the 31-day accumulation.

Recurring Disability

If your benefit ceased because the disability ended and you become eligible again, the new period of disability will be considered a recurring disability if you return to active, full-time employment immediately following the initial disability, your disability recurs due to the same sickness or injury and your disability recurs within 31 successive continuous days after the end of the initial disability period. If the disability is deemed a recurring disability, you will not be required to satisfy a new elimination period before benefits will be payable under the plan. The coverage level and maximum benefit period will continue as an extension of the first period of disability.

Pre-existing Condition Clause.

Benefits will not be paid for a disability considered to be a pre-existing condition. You have a pre-existing condition if:

- you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines in the 3 months just prior to your effective date of coverage; and
- the disability begins in the first 12 months after your effective date of coverage.

Disability Insurance Plans

Long Term Disability (LTD)

Eligibility Date
All full-time active employees are eligible for coverage on the policy effective date. A delayed effective date will apply if the employee is not actively at work on the date the insurance would otherwise take effect.

Who Pays for LTD Coverage?
El Paso County pays the full cost for LTD coverage.

Elimination Period
You need to satisfy a 180-day elimination period before benefits would begin.

Monthly Benefit
If you are disabled beyond the elimination period due to a covered sickness or injury, you will be eligible to receive a weekly benefit of 60% of monthly earnings to a maximum benefit of $6,500 per month or 70% of monthly earnings less any deductible sources of income.

Definition of Disability
Disabled means you are limited from performing the material and substantial duties of your regular occupation due to your sickness or injury and you have a 20% or more loss in your indexed monthly earnings due to the same sickness or injury. After 24 months of payments, you are disabled when due to the same sickness or injury, you are unable to perform the duties of any gainful occupation for which you are reasonably fitted by education, training, or experience.

Benefit Duration
Benefits may continue to be paid until you reach age 65/Social Security Normal Retirement Age (SSNRA), as long as you meet the definition of disability. Please note that certain conditions may be limited benefit durations. Review your employee certificate of coverage for clarification.

Pre-Existing Condition
Benefits will not be paid for a disability considered to be a pre-existing condition. You have a pre-existing condition if you received medical treatment, consultation, care, or services including diagnostic measures or took prescribed drugs or medicines in the 3 months just prior to your effective date of coverage and the disability begins in the first 12 months after your effective date of coverage.

Contact Information

Employee Benefits Division Phone: (719) 520-7420
STD Unum Phone: 1-888-673-9940
STD Policy #907374
LTD Policy #907338

Employee Assistance Program

General Information

Lyra provides confidential mental health support to you and your dependents, at no cost to you, regardless of your/their enrollment on the County health plan. With highly-trained coaches, therapists, and easy-to-use digital lessons and tools, you and your dependents can tap into support right away.

Confidential Counseling

No matter what you're going through, Lyra can help. Get matched to confidential mental health support today. Each employee and their dependents are eligible for up to 8 no-cost visits. After 8-visits, if enrolled in the El Paso Count EPC medical plan, additional visits will be billed through the plan as an in-network mental health visit.

Parent and Caregiver Stress
Anger Management
Anxiety and Depression
Alcohol Use
Work Stress and Burnout
Relationship Challenges

Work Life Services:

Lyra also offers additional work life services. Receive expert advice to help you stay on top of your busy life, including legal financial, identify theft, and dependent care services.

Getting started is easy. Share what you're dealing with, get care recommendations and book an appointment. Lyra members waste less time looking for care and spend more time feeling better. Lyra providers are ready to meet you where you are – via live video, live messaging or even in-person. Many use digital lessons and exercises to enhance your care experience between sessions.

Website: epc.lyrahealth.com | Phone: (877) 207-9553 | E-mail: care@lyrahealth.com

El Paso County Retirement Plan

General Information

The El Paso County Retirement Plan is a Defined Benefit Plan as stated under section 401(a) of the IRS Code. Participation is mandatory.

Contribution Level

The contribution amount is 8% of your pre-tax salary. By having the contributions withheld on a pre-tax basis, the amount of your taxable income is lowered. No additional contributions can be made to this Plan. You cannot borrow or withdraw your money from the plan while you are an active employee.

Vesting

If hired after January 1, 2013, the vesting period under this Plan is 8 years. If hired prior to January 1, 2013, the vesting period is 5 years. This means after you have 5 or 8 years of full-time creditable service, depending on your hire date and once you reach the age requirements, you could be eligible for a lifetime retirement benefit.

Retirement Eligibility

Normal retirement age is 62. You can retire under the Rule of 75 or Rule of 80 with a full benefit. The Rule of 75 & 80: your age and service total the number 75 or 80. If hired after December 31, 2015, you must be at least age 50 to qualify for this retirement. Early retirement is age 55 at a reduced rate of 3% for each year you are under 62. All benefits are lifetime benefits.

Board of Retirement

The Board of Retirement consists of seven members. Two are elected by the participants, two are appointed by the Board of County Commissioners, one is the County Treasurer who is mandated by State Statute to be on the Board and up to four associate members.

Disclaimer

This summary information is intended to provide general information about the El Paso County Retirement Plan. The El Paso County Retirement Plan Document is the governing authority. **Should there be differences between this summary and the plan documents, contracts or policies, the plan documents, contract and/or policies will govern.**

Contact Information

Phone: (719) 520-7490
Fax: (719) 520-7495
Website: retirement.elpasoco.com

A Website has been established to provide more current and detailed information. Information provided:

- Benefit calculator (calculate your own benefit)
- Investment performance
- Financial statements
- Actuarial report
- El Paso County Retirement Plan Document
- Minutes of meetings

Retiree Health Plan Benefits

Benefit Enrollment

Retiree and dependent(s) of the retiree may be eligible for continuation of health benefits (medical, dental and vision). The retiring employee and dependent(s) must be currently enrolled and elect to continue the coverage at the time of retirement from El Paso County. **If the retiring employee does not elect continuation of the benefit as a retiree at the time of retirement from El Paso County, the benefit is forfeited for both the retiree and dependent(s) of the retiree.**

If the retiree elects to waive a health benefit(s) during Open Enrollment or due to Special Enrollment, the benefit is forfeited for both the retiree and dependent(s) of the retiree.

If the retiree is married to another El Paso County employee, the retiring employee may elect to be covered under the active married employee.

If at the time of retirement from El Paso County, the retiree is covered as an eligible dependent of another El Paso County employee or retiree, the retiring employee qualifies as being currently enrolled in the plan and may elect to continue coverage at the time of retirement.

Enrollment is coordinated through the Employee Benefits Division and Retirement Office.

An individual's eligibility for and enrollment in Medicare may be a factor in eligibility for enrollment in an El Paso County Plan. Please contact the Employee Benefits Division for more information.

Monthly Premiums

The cost for continuation of health benefits for retirees and dependents of retirees will be subject to the premium rate for the benefit plan(s) elected.

The County may provide a medical plan retirement subsidy depending upon the number of years of creditable service the retiree had at the time of retirement. If the premium rate of the medical plan selected is more than the provided subsidy, the balance due will be deducted from the retiree's pension benefit payment. If the premium rate of the health plan(s) exceeds the retiree pension benefit payment, the retiree is responsible for making payments for the health benefits directly to the Employee Benefits Division by the 1st day of each month.

The Health Plan Trust Board will determine the subsidy amounts. The retiree subsidy rates may be re-evaluated and may be adjusted each year. Retiree costs will be based on the benefit rates and subsidies approved by the Health Plan Trust Board.

In the event of late or non-payment of health premiums, coverage will be terminated retroactively to the last day coverage was paid in full. You will be given 30 days' notice except in cases of fraud or intentional misrepresentation. Health benefits will not be reinstated if payment has not been received in full by the end of the 30-day grace period.

Eligible Dependents
Eligible dependents include your lawful spouse and children who are less than 26 years old who meet all other applicable plan eligibility requirements. A lawful spouse may include unions created by common law marriage or civil union. Dependent children aged 26 or more years old, who meet all other applicable plan eligibility requirements, and primarily supported by you and incapable of self-sustaining employment by reason of mental or physical handicap that are enrolled on the plan before age 26, may continue coverage after age 26. You may be required to provide proof of the child's dependent status to the health care plan carrier or to the Employee Benefits Division.

These persons are excluded as dependents: other individuals living in the covered retiree's home, but who are not eligible as defined in the Summary Plan Document (SPD); the divorced former spouse of the retiree; or any person who is covered under the plan as an employee. Additional individuals may be excluded under the terms of the applicable plan.

See the applicable SPD for additional information on eligible classes of dependents.

Medical Plan

El Paso County UMR EPO Medical Plan (Pre-Medicare Eligible)
If you are not eligible for Medicare, you have one medical plan option – the El Paso County EPO Medical Plan administered by UMR. With this plan you have access to the County Employee Health Centers and the UnitedHealthcare Choice Plus Network Providers.

Retiree First Humana Medicare Advantage Prescription Drug Plan (Medicare Eligible)
If you are eligible for Medicare, you have one medical plan option - the Humana Medicare Advantage Prescription Drug (MAPD) plan administered by Retiree First. **Medicare eligible retirees must also be enrolled in Medicare Part A and Part B at the time of enrollment in the Humana MAPD. It is the retiree's responsibility to complete the Medicare A and B enrollment process directly with Medicare and to ensure they are enrolled as of the required effective date. This process is NOT administered by El Paso County.**

Eligibility
Retirees and eligible dependents of retirees may continue coverage on the County's medical plans if the retiree and dependent(s) is currently enrolled and elects such coverage at the time of retirement. (Retirement is not a Qualifying Life Event.)

Spouses may continue to receive medical coverage under their own identity after the retiree has become entitled to Medicare, reached age 65 or death. The spouse is eligible to remain on the EPO plan until age 65 or Medicare entitlement, whichever may occur first, at which time they can enroll in the Humana MAPD plan (if enrolled on Medicare parts A and B on the required effective date), or their EPO coverage will be cancelled.

Dependent child(ren) of a retiree that is no longer eligible for the EPO medical plan may be allowed to continue coverage as a dependent on the EPO plan until the retiree's spouse reaches the age of sixty-five (65) or Medicare entitlement, provided the dependent child meets the eligibility requirements. Once the retiree's spouse reaches the age of sixty-five (65) or Medicare entitlement, the dependent child is no longer eligible for the EPO plan.

If the retiree has coverage for eligible dependent child(ren) and no spouse coverage and the retiree becomes entitled to Medicare, reaches age 65 or dies, the dependent child is eligible to remain on the EPO plan until they no longer meet the definition of an eligible dependent.

When enrolled retirees and spouses of retirees become Medicare eligible, they are no longer eligible for the EPO plan but can enroll at that time in the Humana MAPD plan, provided the member is also enrolled in Medicare Part A and Part B as of the required effective date.

Note: The Medicare-eligible plan will only be offered if the County meets all eligibility requirements as defined by the plan provider. If the eligibility requirements are not met, the benefit will not be offered until such eligibility is guaranteed and will begin on January 1st of the following year.

Extras

Citizens Service Center (CSC) Fitness Center

The El Paso County Citizens Service Center (CSC) Fitness Center is conveniently located on the 1st floor of the CSC in Room 1011. Memberships are available to full-time and part-time El Paso County employees at no cost.

The CSC Fitness Center is managed by nationally certified staff who instruct daily group exercise classes including, but not limited to, Boot Camp, HIIT, Yoga and Zumba, provide equipment orientations and perform confidential fitness assessments. The CSC Fitness Center is equipped with full locker rooms, cardiovascular equipment, strength machines and free weights.

Engage in a supportive environment and get inspired to live your best life at the CSC Fitness Center!

Benefits of Membership*:

- Convenient location
- Available to El Paso County employees
- No cost
- Exercise equipment orientations
- Daily group exercise classes
- Cardio equipment, strength machines and free weights
- Fully equipped locker rooms
- Confidential fitness assessments
- Fun, engaging challenges
- Nationally certified staff

*Membership is limited to only full-time and part-time El Paso County employees.

CSC Fitness Center Location and Contact Information

Citizens Service Center (CSC) Fitness Center
1675 W. Garden of the Gods Road, Suite 1011
Colorado Springs, CO 80907
Phone: (719) 520-7619
Email: epcfitness@elpasoco.com
Monday-Friday 5:00 a.m. to 8:30 p.m.

Tuition Reimbursement Program

The El Paso County Tuition Reimbursement Program is coordinated by the Employee Benefits Division.
An employee may apply for tuition reimbursement for the calendar year in which they attended a course (pre-existing student loans will not be covered under the program). Distribution of funds is not guaranteed and expressly subject to availability. Early submission is recommended.

Please see the "Tuition Reimbursement Administrative Guidelines " document available on the Employee Portal or contact the Employee Benefits Division for more information.

457 Deferred Compensation Plan

The El Paso County 457 Deferred Compensation Plan from Empower Retirement can help you achieve the retirement you want – a future focused on what you want to do instead of what you must do. Get started today and use the tools to help you invest for the retirement income you may need.

Section 457(b) of the Internal Revenue Code; designed as a supplemental retirement account, because Social Security and your defined benefit plan might not be enough.

Note: This is an optional retirement plan; El Paso County does not match 457 Deferred Compensation Plan contributions.

457 Deferred Compensation Plan Contact Information

Member Services: 1-800-701-8255
Website: empower-retirement.com
Group #98722-01

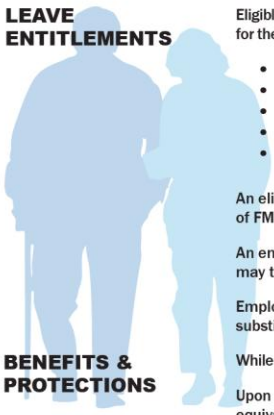
Chapter 4

Family and Medical Leave Act (FMLA)

Family and Medical Leave Act (FMLA)

EMPLOYEE RIGHTS
UNDER THE FAMILY AND MEDICAL LEAVE ACT

THE UNITED STATES DEPARTMENT OF LABOR WAGE AND HOUR DIVISION



LEAVE ENTITLEMENTS

Eligible employees who work for a covered employer can take up to 12 weeks of unpaid, job-protected leave in a 12-month period for the following reasons:

- The birth of a child or placement of a child for adoption or foster care;
- To bond with a child (leave must be taken within 1 year of the child's birth or placement);
- To care for the employee's spouse, child, or parent who has a qualifying serious health condition;
- For the employee's own qualifying serious health condition that makes the employee unable to perform the employee's job;
- For qualifying exigencies related to the foreign deployment of a military member who is the employee's spouse, child, or parent.

An eligible employee who is a covered servicemember's spouse, child, parent, or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

An employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an employer may require, use of accrued paid leave while taking FMLA leave. If an employee substitutes accrued paid leave for FMLA leave, the employee must comply with the employer's normal paid leave policies.

BENEFITS & PROTECTIONS

While employees are on FMLA leave, employers must continue health insurance coverage as if the employees were not on leave.

Upon return from FMLA leave, most employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

An employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

ELIGIBILITY REQUIREMENTS

An employee who works for a covered employer must meet three criteria in order to be eligible for FMLA leave. The employee must:

- Have worked for the employer for at least 12 months;
- Have at least 1,250 hours of service in the 12 months before taking leave;* and
- Work at a location where the employer has at least 50 employees within 75 miles of the employee's worksite.

*Special "hours of service" requirements apply to airline flight crew employees.

REQUESTING LEAVE

Generally, employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an employee must notify the employer as soon as possible and, generally, follow the employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an employer that the employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a certification or periodic recertification supporting the need for leave. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

EMPLOYER RESPONSIBILITIES

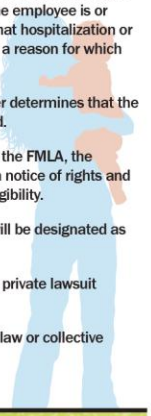
Once an employer becomes aware that an employee's need for leave is for a reason that may qualify under the FMLA, the employer must notify the employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the employee is not eligible, the employer must provide a reason for ineligibility.

Employers must notify its employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

ENFORCEMENT

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.



For additional information or to file a complaint:

1-866-4-USWAGE

(1-866-487-9243) TTY: 1-877-889-5627

www.dol.gov/whd

U.S. Department of Labor | Wage and Hour Division

WH1420 REV 04/16

Pregnant Workers' Rights Notice

NOTICE REGARDING RIGHTS OF PREGNANT WORKERS

Employees and applicants have the right to be free from discriminatory or unfair employment practices because of pregnancy, a health condition related to pregnancy, or the physical recovery from childbirth.

An employer may require an employee or applicant to provide a note stating the necessity of a reasonable accommodation from a licensed health care provider before providing such accommodation. If an applicant or an employee requests an accommodation, the employer and applicant or employee shall engage in a timely, good-faith, and interactive process to determine effective, reasonable accommodations for the applicant or employee for conditions related to pregnancy, physical recovery from childbirth, or a related condition. **If you need an accommodation, please contact the El Paso County Employee Benefits Office at 520-7402 or employeebenefits@elpasoco.com.**

Notice of Privacy Practices

Your Right to Receive a Copy of the
El Paso County Medical Plan
Notice of Privacy Practices

The Plan is required by law to maintain the privacy of your health information as described in its Notice of Privacy Practices. You have a right to request and receive a copy of that Notice at any time, even if you have received the Notice previously.

If you would like to see or obtain a copy of the Plan's HIPAA Notice of Privacy Practices, please contact the Employee Benefits Division at the address below:

El Paso County – Human Resources
Employee Benefits Division
2080 International Circle, Suite N040
Colorado Springs, CO 80910

Phone (719) 520-7486
Email employeebenefits@elpasoco.com

The Notice describes how the Plan uses and discloses Protected Health Information and it also discusses important federal rights that you have with respect to your Protected Health Information.

Notice of Privacy Practices

El Paso County
Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices ("Notice") is made in compliance with the Standards for Privacy of Individually Identifiable Health Information (the "Privacy Standards") set forth by the U.S. Department of Health and Human Services ("HHS") pursuant to the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"). The El Paso County EPO Medical Plan (the "Plan") is required by law to take reasonable steps to ensure the privacy of your Protected Health Information ("PHI"), as defined below, and to inform you about:

(1) the Plan's uses and disclosures of PHI;
(2) your privacy rights with respect to your PHI;
(3) the Plan's duties with respect to your PHI;
(4) your right to file a complaint with the Plan and with the Secretary of HHS; and
(5) the person or office to contact for further information about the Plan's privacy practices.

The term "**Protected Health Information**" (PHI) includes all "Individually Identifiable Health Information" transmitted or maintained by the Plan, regardless of form (oral, written, or electronic).

The term "**Individually Identifiable Health Information**" means information that:

- Is created or received by a health care provider, health plan, employer, or health care clearinghouse;
- Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; or genetic information of an individual; and
- Identifies the individual, or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

Section 1. Notice of PHI Uses and Disclosures

1.1 Required PHI Disclosures

Upon your request, the Plan is required to give you access to certain PHI. For further information pertaining to your rights in this regard, see Section 2 of this Notice.

The Plan must disclose your PHI when required by the Secretary of HHS to investigate or determine the Plan's compliance with the Privacy Standards.

1.2 Permitted uses and disclosures to carry out treatment, payment, and health care operations

The Plan, its business associates, and their agents/subcontractors, if any, will use or disclose PHI without your consent, authorization, or opportunity to agree or object, to carry out treatment, payment, and health care operations. The Plan will disclose PHI to a business associate only if the Plan receives satisfactory assurance that the business associate will appropriately safeguard the information.

In addition, the Plan may contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you. The Plan will disclose PHI to Barnard Construction Company, Inc. ("Plan Sponsor") for purposes related to treatment, payment, and health care operations. The Plan Sponsor has amended its plan documents to protect your PHI as required by the Privacy Standards.

Treatment is the provision, coordination or management of health care and related services by one or more health care providers. It also includes, but is not limited to, consultations and referrals between one or more of your providers.

For example, the Plan may disclose to a treating orthodontist the name of your treating dentist so that the orthodontist may ask for your dental X-rays from the treating dentist.

Payment means activities undertaken by the Plan to obtain premiums or to determine or fulfill its responsibility for coverage and provision of benefits under the Plan, or to obtain or provide reimbursement for the provision of health care. Payment includes, but is not limited to, actions to make eligibility or coverage determinations, billing, claims management, collection activities, subrogation, reviews for medical necessity and appropriateness of care, utilization review and pre-authorizations.

For example, the Plan may tell a doctor whether you are eligible for coverage or what percentage of the bill might be paid by the Plan.

Health care operations means conducting quality assessment and improvement activities, population-based activities relating to improving health or reducing health care costs, contacting health care providers and patients with information about treatment alternatives, reviewing the competence or qualifications of health care professionals, evaluating health plan performance, underwriting, premium rating and other insurance activities relating to creating, renewing or replacing health insurance contracts or health benefits. It also includes disease management, case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse detection and compliance programs, business planning and development, business management and general administrative activities.

For example, the Plan may use information about your claims to refer you to a disease management program, project future benefit costs or audit the accuracy of its claims processing functions.

1.3 Uses and disclosures that require your written authorization

Uses and disclosures not described in this notice will only be made with your authorization. The Plan will not sell your PHI or use your PHI for marketing purposes without your express written authorization. Your written authorization generally will be obtained before the Plan will use or disclose psychotherapy notes about you from your psychotherapist. Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment. The Plan may use and disclose such notes without authorization when needed by the Plan to defend against litigation filed by you.

You may revoke a written authorization by contacting the following individual: HIPAA Privacy Officer, 2880 International Circle, Colorado Springs, CO 80910.

1.4 Disclosures that require that you be given an opportunity to agree or disagree prior to the disclosure

The Plan may disclose to a family member, other relative, close personal friend of yours or any other person identified by you PHI directly relevant to such person's involvement with your care or payment for your health care when you are present for, or otherwise available prior to, a disclosure and you are able to make health care decisions, if:

- The Plan obtains your agreement;
- The Plan provides you with the opportunity to object to the disclosure and you fail to do so; or
- The Plan infers from the circumstances, based upon professional judgment, that you do not object to the disclosure.

1.5 Uses and disclosures for which authorization or opportunity to agree or object is not required

Use and disclosure of your PHI is allowed without your authorization or opportunity to agree or object under the following circumstances:

(a) When required or authorized by law, provided that the use or disclosure complies with and is limited to the relevant requirements of such law.
(b) When permitted for purposes of public health activities. The Plan may disclose your PHI to a health oversight agency for oversight activities authorized by law. The Plan may disclose your PHI in the course of a judicial or administrative proceeding in response to an order of a court or administrative tribunal, provided that the Plan discloses only the PHI expressly authorized by such order, or in response to a subpoena, discovery request, or other lawful process, that is not accompanied by an order of a court of administrative tribunal if certain conditions are met.
(c) The Plan may disclose your PHI to a law enforcement official when required for law enforcement purposes.
(d) The Plan may use or disclose PHI for research, subject to certain conditions.
(e) When consistent with applicable law and standards of ethical conduct, the Plan may use or disclose PHI if the Plan, in good faith, believes the use or disclosure: (i) is necessary to prevent or lessen a serious and imminent threat to health or safety of a person or the public and is to person(s) able to prevent or lessen the threat, including the target of the threat, or (ii) is needed for law enforcement authorities to identify or apprehend an individual, provided certain requirements are met.
(f) When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

1.6 Uses and Disclosures that are Prohibited

If the Plan uses your PHI for underwriting purposes, the Plan may not disclose PHI that is genetic information to be used for that purpose. "Genetic information" includes genetic tests and manifested diseases/disorders of family members.

Section 2: Rights of Individuals

2.1 Right to Request Restrictions on PHI Uses and Disclosures

You may request the Plan to restrict uses and disclosures of your PHI to carry out treatment, payment, or health care operations, or to restrict disclosures to family members, relatives, friends, or other persons identified by you who are involved in your care or payment for your care. However, the Plan is not required to agree to your requested restriction.

If the Plan agrees to a requested restriction, the Plan may not use or disclose PHI in violation of such restriction, except that, if you requested a restriction and later are in need of emergency treatment and the restricted PHI is needed to provide the emergency treatment, the Plan may use the restricted PHI, or it may disclose such information to a health care provider, to provide such treatment to you. If restricted PHI is disclosed to a health care provider for emergency treatment, the Plan must request that such health care provider not further use or disclose the information.

You or your personal representative will be required to request restrictions on uses and disclosures of your PHI in writing. Such requests should be addressed to the following individual: HIPAA Privacy Officer, 2880 International Circle, Colorado Springs, CO 80910.

2.2 Right to Request Confidential Communications of PHI

You may request to receive communications of PHI from the Plan by alternative means or at alternative locations if you clearly state that the disclosure of all or part of the information to which the request pertains could endanger you. The Plan will accommodate all such reasonable requests. However, the Plan may condition the provision of a reasonable accommodation on:

- When appropriate, information as to how payment, if any, will be handled; and
- Specification by you of an alternative address or other method of contact.

You or your personal representative will be required to request confidential communications of your PHI in writing. Such requests should be addressed to the following individual: HIPAA Privacy Officer, 2880 International Circle, Colorado Springs, CO 80910.

2.3 Right to Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Plan maintains PHI in the designated record set. You may request an electronic copy or a paper copy of your PHI.

"**Designated Record Set**" means a group of records maintained by or for a health plan that is enrollment, payment, claims adjudication and case or medical management record systems maintained by or for a health plan; or used in whole or in part by or for the health plan to make decisions about individuals.

The Plan will act on a request for access no later than 30 days after receipt of the request. However, if the request for access is for PHI that is not maintained or accessible to the Plan on-site, the Plan must take action no later than 60 days from the receipt of such request. The Plan must take action as follows: if the Plan grants the request, in whole or in part, the Plan must inform you of the acceptance and provide the access requested. However, if the Plan denies the request, in whole or in part, the Plan must provide you with a written denial. If the Plan cannot take action within the required time, the Plan may extend the time for such action by no more than 30 days if the Plan, within the applicable time limit, provides you with a written statement of the reasons for the delay and the date by which it will complete its action on the request.

The Plan will provide you with access to the PHI in the form or format requested if it is readily producible in such form or format; or, if it is not, in a readable electronic or hard copy form or such other form or format as agreed to between you and the Plan. If you request a copy of PHI, the Plan may impose a reasonable, cost-based fee.

If the Plan does not maintain the PHI that is the subject of your request for access, and the Plan knows where the requested information is maintained, the Plan will inform you where to direct the request for access.

You or your personal representative will be required to request access to your PHI in writing. Such requests should be addressed to the following individual: HIPAA Privacy Officer, 2880 International Circle, Colorado Springs, CO 80910.

2.4 Right to Amend PHI

You have the right to request the Plan to amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set. The Plan may deny your request for amendment if it determines that the PHI or record that is the subject of the request:

- Was not created by the Plan, unless you provide a reasonable basis to believe that the originator of PHI is no longer available to act on the requested amendment;
- Is not part of the designated record set;
- Would not be available for your inspection under the Privacy Standards; or

- Is accurate and complete.

You or your personal representative will be required to request amendment to your PHI in a designated record set in writing. Such requests should be addressed to the following individual: HIPAA Privacy Officer, 2880 International Circle, Colorado Springs, CO 80910. All requests for amendment of PHI must include a reason to support the requested amendment.

2.5 Right to Receive an Accounting of PHI Disclosures

At your request, the Plan will provide you with an accounting of disclosures by the Plan of your PHI during the six years prior to the date on which the accounting is requested, including disclosures to or by business associates of the Plan. However, such accounting need not include PHI disclosures made: (a) to carry out treatment, payment or health care operations; (b) to individuals about their own PHI; (c) incident to a use or disclosure otherwise permitted or required by the Privacy Standards; (d) pursuant to an authorization; (e) to certain persons involved in your care or payment for your care; (f) to notify certain persons of your location, general condition or death; (g) as part of a "Limited Data Set" (as defined in the Privacy Standards), which largely relates to research purposes; or (h) prior to the compliance date of April 14, 2003. You may request an accounting of disclosures for a period of time less than six years from the date of the request.

You or your personal representative will be required to request an accounting of your PHI disclosures in writing. Such requests should be addressed to the following individual: HIPAA Privacy Officer, 2880 International Circle, Colorado Springs, CO 80910.

2.6 The Right to Receive a Notice of a Breach of your Unsecured PHI

A "breach" is defined as the "unauthorized acquisition, access, use or disclosure of PHI in a manner which compromises the security or privacy of such information" and which poses "a significant risk of financial, reputational, or other harm to the individual." To determine whether an impermissible use or disclosure of PHI constitutes a breach, the Plan will perform a risk assessment to determine if there is significant risk of harm to you as a result of the impermissible use or disclosure. If the Plan determines that a probability exists that your PHI may have been compromised, you will receive a notification by first-class mail regarding the breach at least sixty (60) days after the breach was discovered.

2.7 The Right To Receive a Paper Copy of This Notice Upon Request

You have a right to obtain a paper copy of this Notice upon request. To request a paper copy of this Notice, contact the following individual: HIPAA Privacy Officer, 2880 International Circle, Colorado Springs, CO 80910 (719) 520-7420.

2.8 A Note About Personal Representatives

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may include, but is not limited to, the following:

(a) a power of attorney for health care purposes, notarized by a notary public;
(b) a court order of appointment of the person as the conservator or guardian of the individual; or
(c) an individual who is the parent of a minor child.

Section 3: The Plan's Duties

3.1 Notice

The Plan is required by law to maintain the privacy of PHI and to provide individuals (participants and beneficiaries) with notice of its legal duties and privacy practices with respect to PHI.

This Notice is effective beginning on the effective date set forth on Page 1 of this Notice, and the Plan is required to comply with the terms of this Notice. However, the Plan reserves the right to change the terms of this Notice and to make the new revised notice provisions effective for all PHI that it maintains, including any PHI created, received, or maintained by the Plan prior to the date of the revised notice.

3.2 Minimum Necessary Standard

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure, or request, taking into consideration practical and technological limitations.

However, the minimum necessary standard will not apply in the following situations:

(a) disclosures to or requests by a health care provider for treatment;
(b) uses or disclosures made to the individual;
(c) disclosures made to the Secretary of HHS.
(d) uses or disclosures that are required by law;
(e) uses or disclosures that are required for the Plan's compliance with the Privacy Standards; and
(f) uses or disclosures made pursuant to an authorization.

This Notice does not apply to information that has been de-identified. De-identified information is health information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual. It is not individually identifiable health information.

In addition, the Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids or modifying, amending, or terminating the group health plan. Summary health information summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan, and from which identifying information has been deleted in accordance with the Privacy Standards.

Section 4: Your Right to File a Complaint With the Plan or the HHS Secretary

If you believe that your privacy rights have been violated, you may complain to the Plan. Any complaint must be in writing and addressed to the following individual: HIPAA Privacy Officer, Employee Benefits Division of HR, 2880 International Circle, Colorado Springs, CO 80910.

You also may file a complaint with the Secretary of the U.S. Department of Health and Human Services, by writing to him at the following address: The Hubert H. Humphrey Building, 200 Independence Avenue, S.W., Washington, D.C. 20201.

The Plan will not retaliate against you for filing a complaint.

Section 5: Whom to Contact at the Plan for More Information

If you have any questions regarding this Notice or the subjects addressed in it, you may contact the following individual: HIPAA Privacy Officer, 2880 International Circle, Colorado Springs, CO 80910 (719) 520-7420.

Conclusion

PHI use and disclosure by the Plan is regulated by a federal law known as HIPAA. You may find these rules at 45 Code of Federal Regulations Parts 160 and 164. This Notice attempts to summarize the Plan's obligations with regard to the Privacy and Security Standards. The Privacy and Security Standards will supersede any discrepancy between the information in this Notice and the law.

Chapter 5

El Paso County Retirement Plan

2880 INTERNATIONAL CR., STE. N030
COLORADO SPRINGS, CO 80910

epcrpsupport@elpasoco.com
PH (719) 520-7490
FAX (719) 520-7495

Beneficiary Designation Form

Must be typed or completed in ink

Members Name _____ Social Security Number _____ Marital Status _____

Date of Birth _____ Date of Hire _____

PRIMARY BENEFICIARY(IES):

I hereby designate the person(s) named below as my primary beneficiary(ies) to receive benefits in the event of my death. The share of any primary beneficiary who is no longer living or is otherwise disqualified by law at the time of my death, will pass to any remaining beneficiary(ies) in equal shares. Attach additional primary beneficiary information to this form if needed.

1. _____ (Name) _____ (Date of Birth) _____ (Relationship) _____ (SSN) _____%

_____ (Address) _____ (Phone Number) _____ (Email)

2. _____ (Name) _____ (Date of Birth) _____ (Relationship) _____ (SSN) _____%

_____ (Address) _____ (Phone Number) _____ (Email)

3. _____ (Name) _____ (Date of Birth) _____ (Relationship) _____ (SSN) _____%

_____ (Address) _____ (Phone Number) _____ (Email)

CONTINGENT BENEFICIARY(IES):
I hereby designate the person(s) below as my contingent beneficiary(ies) who will receive payment only if all primary beneficiary(ies) predecease me or are otherwise disqualified by law. Attach additional contingent beneficiary information to this form if needed.

1. _____ _____ _____ _____ _____%
Name Date of Birth Relationship SSN

_____ _____ _____
Address Phone Number Email

2. _____ _____ _____ _____ _____%
Name Date of Birth Relationship SSN

_____ _____ _____
Address Phone Number Email

3. _____ _____ _____ _____ _____%
Name Date of Birth Relationship SSN

_____ _____ _____
Address Phone Number Email

Member's Signature _____ Date_____

IF YOU ARE MARRIED AND NAME SOMEONE OTHER THAN YOUR SPOUSE as primary beneficiary, this form must be signed by your spouse and your spouse's signature must be notarized or, if not notarized, witnessed by a Plan representative, indicating that your spouse agrees to this beneficiary election.

Spouse's Signature _____ Date_____

Notary or Plan Representative _____ Date_____
(Seal)

My Commission Expires:_____

Retirement Office Only

Received_____

Processed_____

Confirmation_____

Scanned_____