Summary of Benefits and Coverage

What this Plan Covers & What You Pay For Covered Services
Coverage Period: 01/01/2025 – 12/31/2025
Coverage for: Individual and Family
Plan Type: CHDP

The City of Colorado Springs: Advantage Medical Benefit Plan

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, contact AmeriBen at 1-866-955-1482. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.MyAmeriBen.com or call 1-866-955-1482 to request a copy.

What is the overall deductible?

Per Participant:

Network: $1,900
Non-Network: $4,500

Per Family

Network: $3,800
Non-Network: $9,000

Why this Matters?

Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.

Are there services covered before you meet your deductible?

Yes. Acupuncture, alternative medicine, ambulance services, bone density screenings, breast feeding pump and supplies, chiropractic care, City Employee Medical Clinic services, network colonoscopies, network diabetic insulin pumps and supplies, dietician, drug screenings, emergency physician services, emergency room services, network primary care physicians and specialists, Health Management programs, network hearing aids, mammograms, network medicine monitoring, nutritionist, network outpatient mental health and substance abuse/chemical dependency, network oxygen equipment and supplies, prescription drugs, routine wellness, network preventive care, and network urgent care.

Why this Matters?

This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.

Are there other deductibles for specific services?

No.

Why this Matters?

You don't have to meet deductibles for specific services.

What is the out-of-pocket limit for this plan?

Per Participant:

Network: $3,500

Non-Network: $9,000

Per Family

Network: $8,000

Non-Network: $18,000

Why this Matters?

The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.

What is not included in the out-of-pocket limit?

Premiums, balance-billed charges, health care this Plan doesn't cover, charges in excess of maximum allowed amounts, and penalties.

Why this Matters?

Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Will you pay less if you use a network provider?

Yes, for medical: Anthem. For a list of network providers, call Anthem, at 1-800-676 BLUE or visit www.anthem.com

Yes, for prescription drugs**:** MaxorPlus. For a list of retail and mail pharmacies, log on to www.maxor.com.

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Why this Matters?

This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

Do you need a referral to see a specialist?

No.

Why this Matters?

You can see the specialist you choose without a referral.

*All copayment and co-insurance costs shown in this chart are after your deductible has been met, if a deductible applies.

If you visit a health care provider's office or clinic?

Services You May Need

Primary care visit to treat an injury or illness

What will you pay for the Network Provider (you will pay the least)

City Employee Medical Clinic: $20 co-payment/visit
Primary Care Providers: $35 co-payment/visit

What will you pay for the Non-Network Provider (you will pay the most)

50% co-insurance

Limitations, Exceptions, & Other Important Information

None

Services You May Need

Specialist Visit

What will you pay for the Network Provider (you will pay the least)

Specialist Providers: $60 co-payment/visit

What will you pay for the Non-Network Provider (you will pay the most)

50% co-insurance

Limitations, Exceptions, & Other Important Information

None

Services You May Need

Preventive care/screening/immunization

What will you pay for the Network Provider (you will pay the least)

No Charge

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What will you pay for the Non-Network Provider (you will pay the most)

50% co-insurance

Limitations, Exceptions, & Other Important Information

You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.

If you have a test?

Services You May Need

Diagnostic test (x-ray, blood work)

What will you pay for the Network Provider (you will pay the least)

20% co-insurance

What will you pay for the Non-Network Provider (you will pay the most)

50% co-insurance

Limitations, Exceptions, & Other Important Information

None

Services You May Need

Imaging (CT/PET scans, MRIs)

What will you pay for the Network Provider (you will pay the least)

20% co-insurance

What will you pay for the Non-Network Provider (you will pay the most)

50% co-insurance

Limitations, Exceptions, & Other Important Information

None

If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at www.cityemployeepharmacy.com OR www.maxor.com.

Services You May Need

Generic drugs

What will you pay for the Network Provider (you will pay the least)

Thirty (30) Day Supply: $6 co-payment

Ninety (90) Day Supply:$15 co-payment

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What will you pay for the Non-Network Provider (you will pay the most)

Thirty (30) Day Supply: $25 co-payment

Ninety (90) Day Supply: Not Covered

Limitations, Exceptions, & Other Important Information

Any amounts in the form of coupons used for brand name drugs when there is a generic equivalent available, unless the brand name is medically necessary, does not apply to the out-of-pocket limit.

Plan participants will progressively pay higher co-payments for maintenance prescriptions that are filled at a MaxorPlus Retail Network Pharmacy versus the City Employee Pharmacy.

Some medications may be subject to quantity limitations and/or pre-certification.

Not all prescription drugs are covered. To determine if a specific drug is covered under your plan, log into your account at www.cityemployeepharmacy.com OR www.maxor.com.

If you obtain prescription drugs from a non-network pharmacy, you will be required to pay the full cost of the prescription.

Services You May Need

Preferred brand drugs

What you will pay Network Provider (you will pay the least)

Thirty (30) Day Supply: $35 co-payment

Ninety (90) Day Supply:$70 co-payment

What you will pay Non-Network Provider (you will pay the most)

Thirty (30) Day Supply: $55 co-payment

Ninety (90) Day Supply: Not Covered

Limitations, Exceptions, & Other Important Information

Any amounts in the form of coupons used for brand name drugs when there is a generic equivalent available, unless the brand name is medically necessary, does not apply to the out-of-pocket limit.

Plan participants will progressively pay higher co-payments for maintenance prescriptions that are filled at a MaxorPlus Retail Network Pharmacy versus the City Employee Pharmacy.

Some medications may be subject to quantity limitations and/or pre-certification.

Not all prescription drugs are covered. To determine if a specific drug is covered under your plan, log into your account at www.cityemployeepharmacy.com OR www.maxor.com.

If you obtain prescription drugs from a non-network pharmacy, you will be required to pay the full cost of the prescription.

Services You May Need

Non-preferred brand drugs

What you will pay Network Provider (you will pay the least)

Thirty (30) Day Supply: $60 co-payment

Ninety (90) Day Supply:$120 co-payment

What you will pay Non-Network Provider (you will pay the most)

Thirty (30) Day Supply: $75 co-payment

Ninety (90) Day Supply: Not Covered

Limitations, Exceptions, & Other Important Information

Any amounts in the form of coupons used for brand name drugs when there is a generic equivalent available, unless the brand name is medically necessary, does not apply to the out-of-pocket limit.

Plan participants will progressively pay higher co-payments for maintenance prescriptions that are filled at a MaxorPlus Retail Network Pharmacy versus the City Employee Pharmacy.

Some medications may be subject to quantity limitations and/or pre-certification.

Not all prescription drugs are covered. To determine if a specific drug is covered under your plan, log into your account at www.cityemployeepharmacy.com OR www.maxor.com.

If you obtain prescription drugs from a non-network pharmacy, you will be required to pay the full cost of the prescription.

Services You May Need

Specialty drugs

What you will pay Network Provider (you will pay the least)

Preferred/Tier 4: *20% co-insurance up to a $100 co-payment

Non-Preferred/Tier 5: *20% co-insurance up to a $150 co-payment

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* For more information about limitations and exceptions, see the plan or policy document at www.MyAmeriBen.com.

What you will pay Non-Network Provider (you will pay the most)

Not Covered

Limitations, Exceptions, & Other Important Information

*Co-insurance is waived, and the full co-payment is applied for specialty drugs bought without co-payment assistance.

Specialty drugs are covered only up to a thirty (30) day supply.

Specialty drugs are only covered at City Employee Pharmacy or Maxor Specialty Pharmacy.

Maxor Specialty Pharmacy Patient Care Advocates will assist members with enrollment with manufacturer copay assistance programs if available (*Please note that not all specialty medications will have copay assistance available; those medications that do have assistance available are subject to availability and may be discontinued at any time*). Any portion known to have been paid by a secondary payer (*i.e. patient assistance, copay cards, or other insurance*) will not be considered as true member out-of-pocket and will not apply to deductible and out-of-pocket maximums.

If you have outpatient surgery

Services You May Need

Facility fee (e.g., ambulatory surgery center) & Physician/surgeon fees

What you will pay Network Provider (you will pay the least)

UCHealth Memorial Facility 15% co-insurance, all other 20% co-insurance

What you will pay Non-Network Provider (you will pay the most)

50% co-insurance

Limitations, Exceptions, & Other Important Information

None

Services You May Need

Emergency Room Care

What you will pay Network Provider (you will pay the least)

20% co-insurance

What you will pay Non-Network Provider (you will pay the most)

20% co-insurance

Limitations, Exceptions, & Other Important Information

Pre-certification is required for all hospital admissions. Failure to obtain pre-certification within forty-eight (48) hours of admission may result in your claim being denied.

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Services You May Need

Emergency medical transportation

What you will pay Network Provider (you will pay the least)

20% co-insurance

What you will pay Non-Network Provider (you will pay the most)

20% co-insurance

Limitations, Exceptions, & Other Important Information

None

Services You May Need

Emergency medical transportation

What you will pay Network Provider (you will pay the least)

20% co-insurance

What you will pay Non-Network Provider (you will pay the most)

50% co-insurance

Limitations, Exceptions, & Other Important Information

None

If you have a hospital stay?

Services You May Need

Facility fee (e.g., ambulatory surgery center) & Physician/surgeon fees

What you will pay Network Provider (you will pay the least)

UCHealth Memorial Facility 15% co-insurance, all other 20% co-insurance

What you will pay Non-Network Provider (you will pay the most)

50% co-insurance

Limitations, Exceptions, & Other Important Information

Pre-certification is required. Failure to obtain pre-certification may result in your claim being denied.

If you need mental health, behavioral health, or substance abuse services?

Services You May Need

Outpatient services

What you will pay Network Provider (you will pay the least)

$35 co-payment

What you will pay Non-Network Provider (you will pay the most)

50% co-insurance

Limitations, Exceptions, & Other Important Information

One (1) annual mental health wellness exam is covered at no charge.

Services You May Need

Inpatient services

What you will pay Network Provider (you will pay the least)

UCHealth Memorial Facility 15% co-insurance, all other 20% co-insurance

What you will pay Non-Network Provider (you will pay the most)

50% co-insurance

Limitations, Exceptions, & Other Important Information

Pre-certification is required. Failure to obtain pre-certification may result in your claim being denied.

If you are pregnant?

Services You May Need

Office Visits

What you will pay Network Provider (you will pay the least)

Primary Care Provider: $35 co-payment
Specialist: $60 co-payment

What you will pay Non-Network Provider (you will pay the most)

50% co-insurance

Limitations, Exceptions, & Other Important Information

Co-payment applies to the first office visit only.

Services You May Need

Childbirth/delivery professional services & Childbirth/delivery facility services

What you will pay Network Provider (you will pay the least)

UCHealth Memorial Facility 15% co-insurance, all other 20% co-insurance

What you will pay Non-Network Provider (you will pay the most)

50% co-insurance

Limitations, Exceptions, & Other Important Information

None

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If you need help recovering or have other special needs?

Services You May Need

Home health care

What you will pay Network Provider (you will pay the least)

20% co-insurance

What you will pay Non-Network Provider (you will pay the most)

50% co-insurance

Limitations, Exceptions, & Other Important Information

It covers up to two (2) hours in a twenty-four (24) hour period.

Services You May Need

Rehabilitation services and/or Habilitation services

What you will pay Network Provider (you will pay the least)

UCHealth Memorial Facility 15% co-insurance, all other 20% co-insurance

What you will pay Non-Network Provider (you will pay the most)

50% co-insurance

Limitations, Exceptions, & Other Important Information

Outpatient Rehabilitation Services Maximum: one hundred eighty (180) days per illness/injury

Benefit Year Maximum (Other): sixty (60) visits, combined

Pre-certification is required for outpatient pediatric rehabilitation therapy up to age ten (10) and hospital admissions. Failure to obtain pre-certification may result in your claim being denied.

Services You May Need

Skilled nursing care

What you will pay Network Provider (you will pay the least)

20% co-insurance

What you will pay Non-Network Provider (you will pay the most)

50% co-insurance

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Limitations, Exceptions, & Other Important Information

Benefit Year Maximum: one hundred (100) days

Pre-certification is required. Failure to obtain pre-certification may result in your claim being denied.

Services You May Need

Durable medical equipment

What you will pay Network Provider (you will pay the least)

0% co-insurance

What you will pay Non-Network Provider (you will pay the most)

50% co-insurance

Limitations, Exceptions, & Other Important Information

None

Services You May Need

Hospice services

What you will pay Network Provider (you will pay the least)

20% co-insurance

What you will pay Non-Network Provider (you will pay the most)

50% co-insurance

Limitations, Exceptions, & Other Important Information

none

If your child needs dental or eye care?

Services You May Need

Children's eye exam

What you will pay Network Provider (you will pay the least)

No Charge

What you will pay Non-Network Provider (you will pay the most)

50% co-insurance

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Limitations, Exceptions, & Other Important Information

Covered only for plan participants up to age eighteen (18) who are not enrolled in The City of Colorado Springs' VSP.

Routine only.

Services You May Need

Children's glasses and dental check-up

What you will pay Network Provider (you will pay the least)

Not Covered

What you will pay Non-Network Provider (you will pay the most)

Not Covered

Limitations, Exceptions, & Other Important Information

None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Abortion (except in cases of rape, incest, or when the mother's life is in danger)
- Cosmetic Surgery
- Dental Care (Adult)
- Non-Emergency care when traveling outside the U.S.
- Private-Duty Nursing
- Routine Eye Care (Adult)
- Routine Foot Care (except when medically necessary)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture: Calendar Year Maximum: twenty (20) visits
- Bariatric Surgery
- Chiropractic Care: Calendar Year Maximum: twenty (20) visits
- Hearing Aids
- Infertility Treatment

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- Long-Term Care
- Weight Loss Programs

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: You may also contact the Plan at The City of Colorado Springs, 30 S. Nevada Avenue, P.O. Box 1575, Mail Code 322, Colorado Springs, CO 80901-1575, 719-385-5125. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

AmeriBen

Attention: Appeals Coordination

P.O. Box 7186
Boise, ID 83707
1-866-504-6814

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

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

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

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

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

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

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This is not a cost estimator. The treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, co-payment and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and hospital delivery)

- **The plan's overall deductible $1900**
- **Specialist co-payment $60**
- **Hospital (facility) cost sharing 15%**
- **Other cost sharing 20%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost $12,700
In this example, Peg would pay:

Cost Sharing

Deductibles $1,900
Co-payments $0
Co-insurance $1,600

What isn't covered

Limits or exclusions $20
Total Peg would pay $3,520
Out-of-pocket has been met

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Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible $1900**
- **Specialist co-payment $60**
- **Hospital (facility) cost sharing 15%**
- **Other cost sharing 20%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost $5,600
In this example, Joe would pay:

Cost Sharing

Deductibles $900
Co-payments $900
Co-insurance $0

What isn't covered

Limits or exclusions $0
Total Joe would pay $1,800

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- **The plan's overall deductible $1900**
- **Specialist co-payment $60**
- **Hospital (facility) cost sharing 15%**
- **Other cost sharing 20%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy*

Total Example Cost $2,800
In this example, Mia would pay:

Cost Sharing

Deductibles $1,900
Co-payments $200
Co-insurance $300
What isn't covered
Limits or exclusions $0
Total Mia would pay $2,400

The plan would be responsible for the other costs of these EXAMPLE covered services.

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