COLORADO EMPLOYER BENEFIT TRUST
ANNUAL NOTICES
2015 - 2016 PLAN YEAR

ANNUAL NOTICES – 2015-2016 PLAN YEAR

PATIENT PROTECTION MODEL DISCLOSURE

Colorado Employer Benefit Trust Benefits Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Colorado Employee Benefit Trust (CEBT) at (303) 773-1373 or 1-800-332-1168 or www.cebt.org. For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology contact CEBT at (303) 773-1373 or 1-800-332-1168 or www.cebt.org.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

The Women's Health and Cancer Rights Act of 1998 requires group health plans to make certain benefits available to participants who have undergone a mastectomy. In particular, a plan must offer mastectomy patients benefits 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
- Treatment of physical complications of the mastectomy, including lymphedema

Our plan complies with these requirements. Benefits for these items generally are comparable to those provided under our plan for similar types of medical services and supplies. Of course, the extent to which any of these items is appropriate following mastectomy is a matter to be determined by consultation between the attending physician and the patient. Our plan neither imposes penalties (for example, reducing or limiting reimbursements) nor provides incentives to induce attending providers to provide care inconsistent with these requirements. If you would like more information about WHCRA required coverage, you can contact Anthem at the number listed on the back of your ID card.

THE NEWBORNS' AND MOTHERS' HEATH PROTECTION ACT OF 1996

The Newborns' and Mothers' Health Protection Act of 1996 prohibits group and individual health insurance policies from restricting benefits for any hospital length of stay for the mother or newborn child in connection with childbirth; (1) following a normal vaginal delivery to less than 48 hours; and (2) following a cesarean section, to less than 96 hours. Health insurance policies may not require that a provider obtain authorization from the health insurance plan or the issuer for prescribing any such length of stay. Regardless of these standards, an attending health care provider may, in consultation with the mother, discharge the mother or newborn child prior to the expiration of such minimum length of stay.

Further, a health insurer or health maintenance organization may not:

- Deny to the mother or newborn child eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan, solely to avoid providing such length of stay coverage
- Provide monetary payments or rebates to mothers to encourage such mothers to accept less than the minimum coverage
- Provide monetary incentives to an attending medical provider to induce such provider to provide care inconsistent with such length of stay coverage
- Require a mother to give birth in a hospital
- Restrict benefits for any portion of a period within a hospital length of stay described in this notice

These benefits are subject to the plan's regular deductible and co-pay. For further details, refer to your SPD.

GENETIC INFORMATION NONDISCRIMINATION ACT 2008

Title II of the Genetic Information Nondiscrimination Act of 2008 protects applicants and employees from discrimination based on genetic information in hiring, promotion, discharge, pay, fringe benefits, job training, classification, referral, and other aspects of employment. GINA also restricts employers' acquisition of genetic information and strictly limits disclosure of genetic information. Genetic information includes information about genetic tests of applicants, employees, or their family members; the manifestation of diseases or disorders in family members (family medical history); and requests for or receipt of genetic services by applicants, employees, or their family members. Our Plan complies with these requirements.

NOTICE OF ADVERSE BENEFIT DETERMINATION

Employer-sponsored group health plans are required to provide notice of an adverse benefit determination when a claim is first denied.

- In the case of a claim filed after medical services are provided, notice of the adverse benefit determination is required within 30 days of filing, except that one 15-day extension is allowed if proper notice of the need for extension is provided.
- In the case of a claim filed before medical services are provided (e.g., if pre-authorization is required to obtain full benefits) the notice of adverse benefit determination with respect to a non-urgent claim is required within 15 days of filing, except that one 15-day extension is allowed if proper notice of the need for extension is provided.
- If the pre-service claim is for urgent care, the notice of adverse benefit determination generally is required within 24 hours of filing.

These timing rules are currently in effect for ERISA plans, except that the 24-hour deadline for urgent pre-service claims will become effective for plan years starting on or after September 23, 2010 (currently the requirement generally is to provide the notice within 72 hours). Available at: http://www.dol.gov/ebsa/IABDModelNotice2.doc. Spanish language version available at: http://www.dol.gov/ebsa/IABDModelNotice2sp.doc.

NOTICE OF FINAL INTERNAL ADVERSE BENEFIT DETERMINATION

For plan years starting on or after September 23, 2010, employer-sponsored group health plans are required to provide notice of a final internal adverse benefit determination when internal appeals procedures have been completed. This notice is similar to the notice of decision on appeal that is currently required of ERISA plans under DOL regulations. If a plan has only one level of appeal, the final internal adverse benefit determination is the only notice of the decision on appeal that is required (provided it also meets applicable ERISA requirements). Plans may have one or two levels of internal appeals and, if a plan has two appeal levels, this model notice is intended for use only after the second internal appeal if it results in an adverse benefit determination.

In the case of a claim filed after medical services are provided, this notice is required within 60 days after the appeal is first filed (even if the plan has two appeal levels) and no extensions are allowed.

- In the case of a claim filed before medical services are provided (e.g., if pre-authorization is required to obtain full benefits), the notice of final internal adverse benefit determination with respect to a non-urgent claim is required within 30 days after the appeal is first filed (even if the plan has two appeal levels) and no extensions are allowed.
- If the pre-service claim is for urgent care, the notice of final internal adverse benefit determination generally is required within 72 hours after the appeal is first filed (even if the plan has two appeal levels) and no extensions are allowed.

These timing rules are the same as those currently in effect for ERISA plans. Available at: http://www.dol.gov/ebsa/IABDModelNotice1.doc. Spanish language version available at: http://www.dol.gov/ebsa/IABDModelNotice1sp.doc.

NOTICE OF FINAL EXTERNAL REVIEW DECISION

For plan years starting on or after September 23, 2010, employer-sponsored group health plans are required to maintain an external review procedure that meets certain requirements, including a notice of final decision. The agencies have provided a model notice for that purpose. Available at: http://www.dol.gov/ebsa/IABDModelNotice3.doc. Spanish language version available at: http://www.dol.gov/ebsa/IABDModelNotice3sp.doc.

SPECIAL ENROLLMENT NOTICE

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Effective April 1, 2009 special enrollment rights also exist in the following circumstances:

- If you or your dependents experience a loss of eligibility for Medicaid or your State Children's Health Insurance Program (SCHIP) coverage; or
- If you or your dependents become eligible for premium assistance under an optional state Medicaid or SCHIP program that would pay the employee's portion of the health insurance premium.

Note: In the two above listed circumstances only, you or your dependents will have 60 days to request special enrollment in the group health plan coverage.

As stated earlier in this notice, a special enrollment opportunity may be available in the future if you or your dependents lose other coverage. This special enrollment opportunity will not be available when other coverage ends, however, unless you provide a written statement now explaining the reason that you are declining coverage for yourself or your dependent(s). Failing to accurately complete and return this form for each person for whom you are declining coverage will eliminate this special enrollment opportunity for the person(s) for whom a statement is not completed, even if other coverage is currently in effect and is later lost. In addition, unless you indicate in the statement that you are declining coverage because other coverage is in effect, you will not have this special enrollment opportunity for the person(s) covered by the statement. (See the paragraph above, however, regarding enrollment in the event of marriage, birth, adoption or placement for adoption.)

To request special enrollment or obtain more information, contact Colorado Employer Benefit Trust.

MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) OFFER FREE OR LOW-COST HEALTH COVERAGE TO CHILDREN AND FAMILIES

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can 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, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**.

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of January 31, 2012. You should contact your State for further information on eligibility –

ALASKA – Medicaid	**COLORADO** – Medicaid and CHIP
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Medicaid Website: http://www.colorado.gov/ Medicaid Phone (In state): 1-800-866-3513 Medicaid Phone(Out of state): 1-800-221-3943
ARIZONA – CHIP	
Website: http://www.azahcccs.gov/applicants Phone(Outside of Maricopa County): 1-877-764-5437 Phone(Maricopa County): 602-417-5437	
FLORIDA – Medicaid	**GEORGIA** – Medicaid
Website: http://www.flmedicaidtplrecovery.com/ Phone: 1-877-357-3268	Website: http://dch.georgia.gov/ Click on Programs, then Medicaid Phone: 1-800-869-1150
IDAHO – Medicaid and CHIP	**INDIANA** – Medicaid
Medicaid Website: www.accesstohealthinsurance.idaho.gov Medicaid Phone: 1-800-926-2588 CHIP Website: www.medicaid.idaho.gov CHIP Phone: 1-800-926-2588	Website: http://www.in.gov/fssa Phone: 1-800-889-9948
IOWA – Medicaid	**MONTANA**– Medicaid
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Phone: 1-800-694-3084
KANSAS – Medicaid	**NEBRASKA** – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884	Website: http://dhhs.ne.gov/medicaid/Pages/med_kidsconx.aspx Phone: 1-877-255-3092
KENTUCKY – Medicaid	**NEVADA** – Medicaid and CHIP
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900
LOUISIANA – Medicaid	**NEW HAMPSHIRE** – Medicaid
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447	Website: http://www.dhhs.nh.gov/ombp/index.htm Phone: 603-271-5218
MAINE – Medicaid	**NEW JERSEY** – Medicaid and CHIP
Website: http://www.maine.gov/dhhs/OIAS/public-assistance/index.html Phone: 1-800-572-3839	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicard/ Medicaid Phone: 1-800-356-1561 Chip Website: http://www.njfamilycare.org/index.html Chip Phone: 1-800-701-0710
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK** – Medicaid
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA** – Medicaid and CHIP

Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone: 1-8000-657-3629	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MISSOURI – Medicaid	**NORTH DAKOTA** – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604
OKLAHOMA- Medicaid and CHIP	**UTAH** – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://health.utah.gov/upp Phone: 1-866-435-7414
OREGON- Medicaid and CHIP	**VERMONT** – Medicaid
Website: http://www.oregonhealthykids.gov http://hijossaludablesoregon.gov Phone: 1-888-314-5678	Website: http://www.greenmoutaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA- Medicaid	**VIRGINIA** – Medicaid and CHIP
Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462	Medicaid Website: http://www.dmas.virginia.gov/rep-HIPP.htm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647
RHODE ISLAND- Medicaid	**WASHINGTON** – Medicaid
Website: www.ohhs.ri.gov Phone: 401-462-0820	Website: http://hrsa.dsha.wa.gov/premiumpymt/Apply.shtm Phone: 1-800-562-3022 ext. 15473
SOUTH CAROLINA- Medicaid	**WEST VIRGINIA** – Medicaid
Website: http://www/schhs.gov Phone: 1-888-549-0820	Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability
SOUTH DAKOTA- Medicaid	**WISCONSIN** – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002
TEXAS- Medicaid	**WYOMING** – Medicaid
Website: http://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: http://health.wyo.gov/healthcarefin/equalitycare Phone: 307-777-7531

To see if any more States have added a premium assistance program since January 31, 2012, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.gov
1-877-267-2323, Ext. 61565

COBRA CONTINUATION OF COVERAGE RIGHTS

Under the federal law, known as COBRA, you and your dependents generally may continue medical, dental, and vision if coverage ends due to either:

- A reduction in the number of hours you work or
- Termination of your employment for any reason other than gross misconduct.

Your dependents may continue their medical, dental and vision coverage under this plan if their coverage ends for any of the following reasons:

- Your death
- You become entitled to Medicare
- Your divorce, annulment, or legal separation, provided the company is notified within 60 days
- Your dependent loses dependent status, provided the company is notified within 60 days

This is not a complete description of all COBRA-related provisions. You should consult your SPD for more details.

The following chart shows how long you can continue your COBRA coverage:

If you lose coverage because . . .	Then you can continue coverage for . . .
You are no longer eligible	18 months
You are no longer eligible and either you or your dependent is disabled (according to the Social Security Administration) within 60 days of your loss of eligibility	29 months

If your dependent loses coverage because . . .	Then your dependent can continue coverage for . . .
Of your death	36 months
You become eligible for Medicare after your COBRA election begins	36 months
You and your spouse divorce	36 months
He or she is no longer a dependent (because of age or divorce)	36 months

Notice of Availability
Special Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW YOU MAY OBTAIN A COPY OF THE PLAN'S NOTICE OF PRIVACY PRACTICES, WHICH DESCRIBES THE WAYS THAT THE PLAN USES AND DISCLOSES YOUR PROTECTED HEALTH INFORMATION.

Colorado Employer Benefit Trust (the "Plan") provides health benefits to eligible employees of City Of Gunnison (the "Company") and their eligible dependents as described in the summary plan description(s) for the Plan. The Plan creates, receives, uses, maintains and discloses health information about participating employees and dependents in the course of providing these health benefits. The Plan is required by law to provide notice to participants of the Plan's duties and privacy practices with respect to covered individuals' protected health information, and has done so by providing to Plan participants a Notice of Privacy Practices, which describes the ways that the Plan uses and discloses protected health information. To receive a copy of the Plan's Notice of Privacy Practices you should contact Colorado Employer Benefit Trust, who has been designated as the Plan's contact person for all issues regarding the Plan's privacy practices and covered individuals' privacy rights. You can reach customer service at: *Colorado Employer Benefit Trust, 2000 South Colorado Blvd, Tower II, Suite 900, Denver, CO 80222 or 303-773-1373 / 1-800-332-1168*

Colorado Employer Benefit Trust	
Date:	October 2015
Name of Entity/Sender:	Colorado Employer Benefit Trust
Contact-Position/Office:	Customer Service
Address:	2000 South Colorado Blvd., Tower II, Suite 900 Denver, CO 80222
Phone Number:	(303) 773-1373 or 1-800-332-1168

Important Notice From City Of Gunnison
About Your Prescription Drug Coverage and Medicare Creditable Coverage

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with City Of Gunnison 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. City Of Gunnison has determined that the prescription drug coverage offered by CEBT 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 to 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 City Of Gunnison coverage will not be affected. You can keep this coverage if you elect Part D and this plan will coordinate with Part D coverage; [See pages 7-9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.]

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 City Of Gunnison 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...

For further information call (970) 641-8070. **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 City Of Gunnison changes. You may also 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 www.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 www.socialsecurity.gov. , or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this 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).

Date:	8/24/2015
Name of Entity/Sender:	City Of Gunnison
Address:	201 West Virginia Avenue Gunnison, CO 81230
Phone Number:	(970) 641-8070