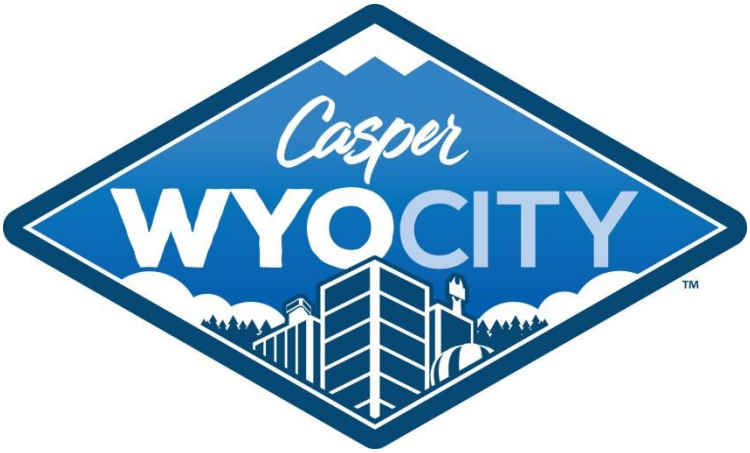
Casper WYOCITY™

2015 EMPLOYEE BENEFITS GUIDE

RETIREE



2015 Employee Benefits Guide

City of Casper is pleased to make available to its employees a wide array of group insurance benefits. It is important to remind employees that the first line of resource to answering questions on benefits and claims payment is directly with the insurance carriers.

When you have a question on a benefit or a problem with a claim, we would encourage you to contact the insurance carriers who have your claims information and are very knowledgeable on the City of Casper insurance benefits.

Listed are the insurance carriers and contact telephone numbers.

Cigna	**Medical** **Pharmacy**	(800) 244-6224 www.mycigna.com
Delta Dental of Wyoming	**Dental**	(800) 735-3379 www.deltadentalwy.org
VSP	**Vision**	(800) 877-7195 www.vsp.com
Cigna	**Life and AD&D** **Disability**	(800) 362-4462 www.cigna.com
GBS Benefits, Inc.	**Marcie Gentry** *Senior Account Manager*	(801) 933-2612 (800) 427-6586 x1112 marcie.gentry@gbsbenefits.com

In an effort to make your benefits more understandable, this brief summary of your benefits has been prepared. The benefit booklet is provided as a summary of your employee benefits only. While the benefits listed are considered accurate, they are not a guarantee of service, or payment by the insurance company. For complete details regarding any of your employee benefits, please see plan summaries.

This summary of benefits is a cursory description of your employee benefits and should be considered such.

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MEDICAL & PHARMACY

Cigna

City of Casper

Cigna Medical Comparison 2015 Plan Design

Illustrative Purposes Only

		Buy Down Plan	Mid Option Plan	Buy Up Plan
		In-Network	In-Network	In-Network
	Deductible	$2500/$5000	$1500/$3000	$750/$1500
	Out of Pocket Maximum	$5000/$10000	$3000/$6000	$2000/4000
	Deductible Included in OOP Maximum	Yes	Yes	Yes
	Professional Services	Network Providers Only - Non contracted provider visits are subject to deductible + coinsurance	Network Providers Only - Non contracted provider visits are subject to deductible + coinsurance	Network Providers Only - Non contracted provider visits are subject to deductible + coinsurance
Office Visits	Primary Care Physicians	$50	$35	$20
Office Visits	Labwork (performed in physician's office)	$50	$35	$20
Office Visits	Specialists	$50	$35	$20
Office Visits	Mental Health & Chemical Dependency	$50	$35	$20
Office Visits	Substance Abuse	$50	$35	$20
Office Visits	Urgent Care	$50	$35	$20
Office Visits	Accupuncture	$50/10 visits maximum	$35/10 visits maximum	$20/10 visits maximum
Office Visits	Physical, Speech, Occupational Therapy	$50 (Unlimited with no RX)	$35 (Unlimited with no RX)	$20 (Unlimited with no RX)
Office Visits	Chiropractic	$50/10 visits maximum	$35/10 visits maximum	$20/10 visits maximum
	Emergency Room	80% AD	80% AD	80% AD
	Extended Care Facility	80% AD, 90 Day Calendar Year Maximum	80% AD, 90 Day Calendar Year Maximum	80% AD, 90 Day Calendar Year Maximum
	Newborn Nursery Care	80% DW	80% DW	80% DW
	Preadmission Testing	100% DW	100% DW	100% DW
	Pregnancy	80% AD	80% AD	80% AD
	Private Duty Nursing (Inpatient Only)	80% AD	80% AD	80% AD
	Ambulance Service			
	Ground Transportation	80% AD	80% AD	80% AD
	Air Ambulance	80% AD	80% AD	80% AD
	Diagnostic X-ray and Lab Expenses			
	Minor Lab / X-Ray	$50	$35	$20
	Major Lab / X-Ray	80% AD	80% AD	80% AD
	Outpatient Lab	80% AD	80% AD	80% AD
	Imaging Charges (MRI, etc.)	80% AD	80% AD	80% AD
	Hospital Outpatient Surgery	80% AD	80% AD	80% AD
	Durable Medical Equipment	80% AD	80% AD	80% AD
	Preventive Care			
	Preventive Care	100% DW	100% DW	100% DW
	Hospice Care			
	In-Home Care	100% AD	100% AD	100% AD
	Inpatient Care	100% AD	100% AD	100% AD
	Acute Inpatient	100% AD	100% AD	100% AD
	Bereavement Counseling	80% AD	80% AD	80% AD
	Home Health Care	100% AD, 60 visit Calendar Year maximum	100% AD, 60 visit Calendar Year maximum	100% AD, 60 visit Calendar Year maximum
	Inpatient Services			
	Hospital / Physicians	80% AD	80% AD	80% AD
	Mental Health & Chemical Dependency	80% AD	80% AD	80% AD
	Substance Abuse	80% AD	80% AD	80% AD
	Cardiac Rehabilitation			
		80% AD	80% AD	80% AD
		36 days maximum	36 days maximum	36 days maximum
	Additional Benefits			
	Employee Assistance Program	Available with Three Trails	Available with Three Trails	Available with Three Trails
	Prescription Drugs			
Retail	Deductible	None	None	None
Retail	Tier 1	$5 + 20% Co-Insurance	$5 + 20% Co-Insurance	$5 + 20% Co-Insurance
Retail	Tier 2	$20 + 20% Co-Insurance	$20 + 20% Co-Insurance	$20 + 20% Co-Insurance
Retail	Tier 3	$30 + 50% Co-Insurance	$30 + 50% Co-Insurance	$30 + 50% Co-Insurance
Retail	Mail Order	$5+20% / $20+20% / $30+50%	$5+20% / $20+20% / $30+50%	$5+20% ? $20+20% / $30+50%

**For detailed information on these benefits - please refer to the plan document and summary plan description booklet.*

Customer reference guide

Understanding your PREVENTIVE CARE HEALTH COVERAGE

Getting the right preventive care services at the right time can help you stay healthier by:

- Preventing certain illnesses and health conditions from happening; or
- Detecting a health problem at a stage that may be easier to treat.

That's why your Cigna plan covers designated preventive care services. When you receive care in-network, it generally is at a lower cost to you. Depending on your plan, in-network preventive care services may be covered at 100% – but be sure to check your plan materials for details about your specific medical plan.

To make sure you get the care you need – without any unexpected out-of-pocket costs – it's important for you to understand the following:

- What a preventive care service is; and
- Which services your health plan will cover.

What is a preventive care service?

Preventive care services are provided when you don't have any symptoms and haven't been diagnosed with the health issue connected with the preventive service. For example, a flu vaccination is given to prevent the flu before you get it. Other preventive care services like mammograms can help detect an illness when there aren't any symptoms. Even if you're in the best shape of your life, a serious condition with no signs or symptoms may put your health at risk. During a wellness exam, you and your doctor will determine what tests and health screenings are right for you based on your age, gender, personal health history and current health.

Even when your appointment is for a preventive exam, you may receive other services during that exam that are not preventive care services. For example, your doctor may check on a chronic condition such as heart disease. When your doctor determines that you have a medical issue present, the additional screenings and tests after this diagnosis are no longer considered preventive. These services are covered under your plan's medical benefits, not your preventive care benefits. This means you may be responsible for paying a different share of the cost than you do for preventive care services.

The charts on the following pages outline the various services and supplies considered as preventive care under your plan. If you have additional questions about preventive care services, talk to your doctor or call Cigna at the toll-free number on the back of your ID card.

Offered by: Connecticut General Life Insurance Company, Cigna Health and Life Insurance Company, and their affiliates.

HP-POL38 03-11
GM6000 C1 et al
GM5800 OR POL1 ED. 1/2001

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Wellness exams

SERVICE	GROUP	AGE, FREQUENCY
Well-baby/well-child/well-person exams, including annual well-woman exam (includes height, weight, head circumference, BMI, blood pressure, history, anticipatory guidance, education regarding risk reduction, psychosocial/behavioral assessment)		• Birth, 1, 2, 4, 6, 9, 12, 15, 18, 24 and 30 months • Additional visit at 2-4 days for infants discharged less than 48 hours after delivery • Ages 3 to 21 once a year • Ages 22 and older periodic visits, as doctor advises

The following routine immunizations are currently designated preventive services:

SERVICE	SERVICE
Diphtheria, Tetanus Toxoids and Acellular Pertussis (DTaP, Tdap, Td)	Meningococcal (MCV)
Haemophilus influenzae type b conjugate (Hib)	Pneumococcal (pneumonia)
Hepatitis A (HepA)	Poliovirus (IPV)
Hepatitis B (HepB)	Rotavirus (RV)
Human papillomavirus (HPV) (age and gender criteria apply depending on vaccine brand)	Varicella (chickenpox)
Influenza vaccine	Zoster (shingles)
Measles, mumps and rubella (MMR)	

You may view the three immunization schedules on the CDC website: **cdc.gov/vaccines/schedules/**.

Health screenings and interventions

SERVICE	GROUP	AGE, FREQUENCY
Alcohol misuse screening		All adults
Anemia screening		Pregnant women
Aspirin to prevent cardiovascular disease[1]		Men ages 45-79; women ages 55-79
Autism screening		18, 24 months
Bacteriuria screening		Pregnant women
Breast cancer screening (mammogram)		Women ages 40 and older, every 1–2 years
Breast-feeding support/counseling, supplies[2]		During pregnancy and after birth
Cervical cancer screening (pap test) HPV DNA test with pap test		Women ages 21–65, every 3 years Women ages 30-65, every 5 years
Chlamydia screening		Sexually active women ages 24 and under and older women at risk
Cholesterol/lipid disorders screening		• Screening of children and adolescents (after age 2, but by age 10) at risk due to known family history; when family history is unknown; or with personal risk factors (obesity, high blood pressure, diabetes) • All men ages 35 and older, or ages 20-35 if risk factors • All women ages 45 and older, or ages 20-45 if risk factors
Colon cancer screening		The following tests will be covered for colorectal cancer screening, ages 50 and older: • Fecal occult blood test (FOBT) or fecal immunochemical test (FIT) annually • Flexible sigmoidoscopy every 5 years • Double-contrast barium enema (DCBE) every 5 years • Colonoscopy every 10 years • Computed tomographic colonography (CTC)/virtual colonoscopy every 5 years - Requires precertification

= Men, = Women, = Children/Adolescents

Health screenings and interventions

SERVICE	GROUP	AGE, FREQUENCY
Congenital hypothyroidism screening		Newborns
Contraception counseling/education. Contraceptive products and services[1,3,4]		Women with reproductive capacity
Depression screening		Ages 12-18, All adults
Developmental screening		9, 18, 30 months
Developmental surveillance		Newborn 1, 2, 4, 6, 12, 15, 24 months. At each visit ages 3 to 21
Diabetes screening		Adults with sustained blood pressure greater than 135/80
Discussion about potential benefits/risk of breast cancer preventive medication		Women at risk
Dental caries prevention (Evaluate water source for sufficient fluoride; if deficient prescribe oral fluoride[1])		Children older than 6 months
Domestic and interpersonal violence screening		All women
Fall prevention in older adults (physical therapy, vitamin D supplementation[1])		Community-dwelling adults ages 65 and older with risk factors (coverage effective upon your plan's start or anniversary date on or after 5/1/13)
Folic acid supplementation[1]		Women planning or capable of pregnancy
Genetic counseling/evaluation and BRCA1/BRCA2 testing		Women at risk • Genetic counseling must be provided by an independent board-certified genetic counselor or clinical geneticist prior to BRCA1/BRCA2 genetic testing • BRCA1/BRCA2 testing requires precertification
Gestational diabetes screening		Pregnant women
Gonorrhea screening		Sexually active women at risk
Hearing screening (not complete hearing examination)		All newborns by 1 month. Ages 4, 5, 6, 8, and 10 or as doctor advises
Healthy diet/nutrition counseling		Ages 6 and older - to promote improvement in weight status. Adults with hyperlipidermia, those at risk for cardiovascular disease or diet-related chronic disease
Hemoglobin or hematocrit		12 months
Hepatitis B screening		Pregnant women
HIV screening and counseling		Pregnant women; adolescents and adults 15 to 65 years; younger adolescents and older adults at risk; sexually active women, annually
Iron supplementation[1]		6-12 months for children at risk
Lead screening		12, 24 months
Metabolic/hemoglobinopathies (according to state law)		Newborns
Obesity screening		Ages 6 and older. All adults
Oral health evaluation/assess for dental referral		12, 18, 24, 30 months. Ages 3 and 6
Osteoporosis screening		Age 65 or older (or under age 65 for women at risk). Computed tomographic bone density study requires precertification
PKU screening		Newborns
Ocular (eye) medication to prevent blindness		Newborns
Prostate cancer screening (PSA)		Men ages 50 and older or age 40 with risk factors
Rh incompatibility test		Pregnant women
Sexually transmitted diseases counseling		Sexually active women, annually

= Men, = Women, = Children/Adolescents

Health screenings and interventions

SERVICE	GROUP	AGE, FREQUENCY
Sexually transmitted infections (STI) screening		All sexually active adolescents. All adults at risk
Sickle cell disease screening		Newborns
Skin cancer prevention counseling to minimize exposure to ultraviolet radiation		Ages 10-24
Syphilis screening		Individuals at risk; Pregnant women
Tobacco use/cessation interventions		All adults; Pregnant women
Tuberculin test		Children and adolescents at risk
Ultrasound aortic abdominal aneurysm screening		Men ages 65-75 who have ever smoked
Vision screening (not complete eye examination)		Ages 3, 4, 5, 6, 8, 10, 12, 15 and 18 or as doctor advises

= Men, = Women, = Children/Adolescents

Other coverage: Your plan supplements the preventive care services listed above with additional services that are commonly ordered by primary care physicians during preventive care visits. These include services such as urinalysis, EKG, thyroid screening, electrolyte panel, Vitamin D measurement, bilirubin, iron and metabolic panels.

1 Subject to the terms of your plan's pharmacy coverage, certain drugs and products may be covered at 100%. Your doctor is required to give you a prescription, including for those that are available over-the-counter, for them to be covered under your Pharmacy benefit. Cost sharing may be applied for brand name products where generic alternatives are available. Please refer to Cigna's "No Cost Preventive Medications by Drug Category" Guide for information on drugs and products with no out-of-pocket cost..

2 Subject to the terms of your plan's medical coverage, breast-feeding equipment rental and supplies may be covered at the preventive level. Your doctor is required to provide a prescription, and the equipment and supplies must be ordered through CareCentrix, Cigna's national durable medical equipment vendor. Precertification is required for some types of breast pump equipment.

3 Examples include oral contraceptives; diaphragms; hormonal injections and contraceptive supplies (spermicide, female condoms); emergency contraception.

4 Subject to the terms of your plan's medical coverage, contraceptive products and services such as some types of IUD's, implants and sterilization procedures may be covered at the preventive level. Check your plan materials for details about your specific medical plan.

These preventive health services are based on recommendations from the U.S. Preventive Services Task Force (A and B recommendations), the Advisory Committee on Immunization Practices (ACIP) for immunizations, the American Academy of Pediatrics' Periodicity Schedule of the Bright Futures Recommendations for Pediatric Preventive Health Care, the Uniform Panel of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children and, with respect to women, evidence-informed preventive care and screening guidelines supported by the Health Resources and Services Administration. For additional information on immunizations, visit the immunization schedule section of www.cdc.gov. This document is a general guide. Always discuss your particular preventive care needs with your doctor.

Exclusions

This document provides highlights of preventive care coverage generally. Some preventive services may not be covered under your plan. For example, immunizations for travel are generally not covered. Other non-covered services/supplies may include any service or device that is not medically necessary or services/supplies that are unproven (experimental or investigational). For the specific coverage terms of your plan, refer to the Evidence of Coverage, Summary Plan Description or Insurance Certificate.

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Click with a site that CLICKS WITH YOU

myCigna.com is completely personalized, so it's easy to quickly find *exactly* what you're looking for.

- **Find** doctors and medical services
- **Manage** and track claims
- **See** cost estimates for medical procedures
- **Compare** quality of care ratings for doctors and hospitals
- **Access** a variety of health and wellness tools and resources

Manage your health and health care expenses with ease. It's all waiting for you on **myCigna.com**.

Connect with better health. Here's how:

Health and wellness

- ***My health assessment.*** In just twenty minutes, this confidential, online questionnaire will give you a better understanding of your health today – and teach you simple steps for improving your health in the future.
- **Condition and wellness resources.** Using our interactive medical library, find information on health conditions, first aid, medical exams, wellness and more.

Cost estimates and quality of care ratings

- **Find a doctor.** Personalized search results make it easy to find the right doctor for you. Search by name, specialty, procedure, location and other criteria.
- **Estimate medical costs.** Review estimated costs for specific, in-network procedures, treatments and facilities so there aren't any surprises.
- **Compare hospitals and doctors.** See how they compare by cost, patient outcomes and more.
- **Quality of care.** Quality distinctions and cost-efficiency ratings for doctors appear with every search result, with quality-designated doctors appearing at the top of your list.
- **Prescription drug price quote tool.** Compare prices between Cigna Home Delivery Pharmacy℠ and our network of retail pharmacies to help ensure you're getting the best price possible.
- **Manage and track claims.** Quickly search and sort claims, as well as track account balances, like deductibles and out-of-pocket maximums.

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Prescription services

- **Live pharmacists 24/7** to help answer all your prescription drug-related questions and put you at ease.
- **Refill prescriptions with Cigna Home Delivery Pharmacy.** Save time and money by reordering prescriptions online and getting up to a 90-day supply delivered right to your mailbox.
- **Manage your Cigna Home Delivery Pharmacy prescription orders.** You can easily place a new order, track shipments and view how many refills you have left on your prescription.
- **Sign up for QuickFill.** This refill reminder service lets you know when your prescription is about to run out – and fill it at the same time.
- **Instant access to Cigna Home Delivery Pharmacy and retail prescription information.** View your pharmacy claim history, plan details and account balances.

It's all designed to click with you.

For a quick tour on how to get the most out of myCigna.com, go to:
myCigna.com > Site Benefits

To register:
myCigna.com > Learn How to Register

You can access myCigna.com from any smartphone or web-enabled mobile device.*
With the myCigna Mobile App, it's never been easier to be on the go and in the know.

Your health has met its App.℠
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Web-enabled device with the internet or other online connectivity is required. myCigna features and functionality may vary between myCigna.com, myCigna Mobile and the myCigna Mobile App. Actual features may also vary depending on your specific plan and mobile device. The downloading and use of the myCigna Mobile App is subject to the terms and conditions of the App and the online stores from which it is downloaded. Standard mobile phone carrier and data usage charges apply. The listing of a doctor or facility in the health care professional directory does not guarantee that the services rendered by that doctor or facility are covered under your specific medical plan. Check your official plan documents, or call the number listed on your ID card, for more information about the services covered under your plan benefits.

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GUIDE TO YOUR EXPLANATION OF BENEFITS

Simple format.

See how your benefits are working for you with this easy-to-understand document. It shows you the costs associated with the medical care you've received. When a claim is filed under your Cigna benefits plan, you get an Explanation of benefits (EOB). Because we know health care expenses can be confusing, we've simplified the language and summarized the most important information about the claim.

The choice is yours: online, paper or both.

Your EOB is now online at **myCigna.com**. You can choose to go paperless, continue getting paper EOBs by mail or opt for both.

Online EOBs are:

- Safely stored on **myCigna.com**.
- Easy to access anywhere, 24 hours a day.
- Printable from your computer if you need a paper copy.

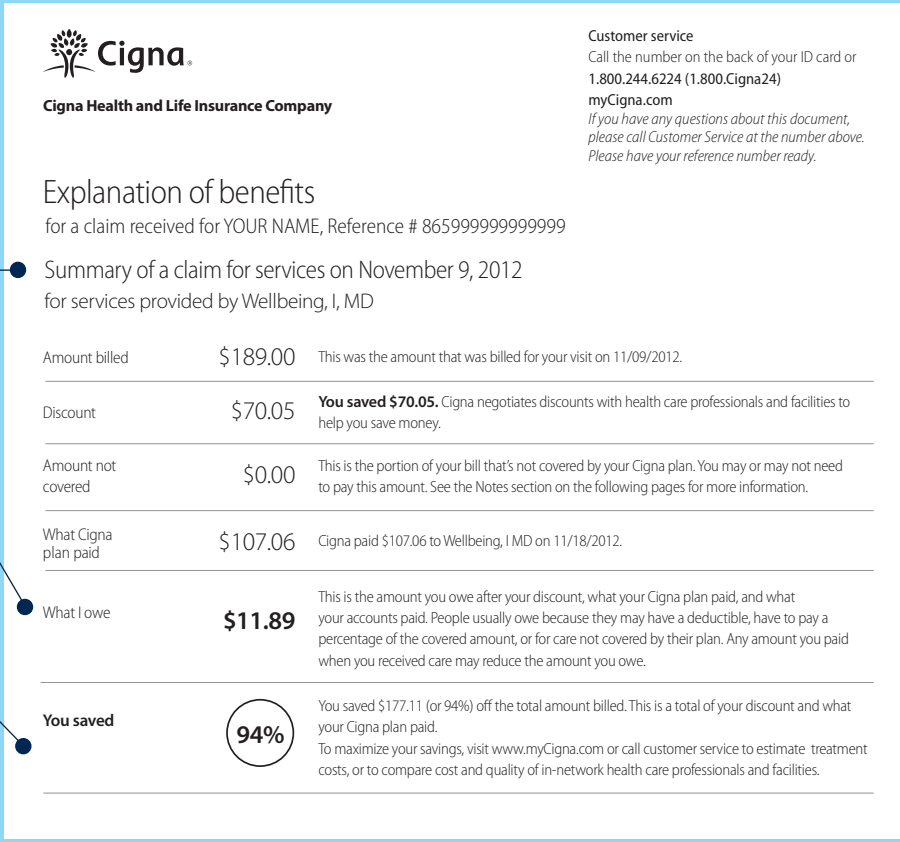
PAGE 1 SUMMARY

The Summary page gives an overview of the ways your benefits are working for you – quickly see what was submitted, what's been paid and what you owe.

Date of service and health care professional are both listed for easier reference.

The amount you owe does not reflect any amount you may have already paid.

This reflects the total value of your plan – the amount you saved by visiting an in-network health care professional or facility, and the amount paid by your plan.



Cigna.

Cigna Health and Life Insurance Company

Customer service
Call the number on the back of your ID card or
1.800.244.6224 (1.800.Cigna24)
myCigna.com
If you have any questions about this document, please call Customer Service at the number above. Please have your reference number ready.

Explanation of benefits
for a claim received for YOUR NAME, Reference # 865999999999999

Summary of a claim for services on November 9, 2012
for services provided by Wellbeing, I, MD

Amount billed	$189.00	This was the amount that was billed for your visit on 11/09/2012.
Discount	$70.05	**You saved $70.05.** Cigna negotiates discounts with health care professionals and facilities to help you save money.
Amount not covered	$0.00	This is the portion of your bill that's not covered by your Cigna plan. You may or may not need to pay this amount. See the Notes section on the following pages for more information.
What Cigna plan paid	$107.06	Cigna paid $107.06 to Wellbeing, I MD on 11/18/2012.
What I owe	**$11.89**	This is the amount you owe after your discount, what your Cigna plan paid, and what your accounts paid. People usually owe because they may have a deductible, have to pay a percentage of the covered amount, or for care not covered by their plan. Any amount you paid when you received care may reduce the amount you owe.
You saved	94%	You saved $177.11 (or 94%) off the total amount billed. This is a total of your discount and what your Cigna plan paid. To maximize your savings, visit www.myCigna.com or call customer service to estimate treatment costs, or to compare cost and quality of in-network health care professionals and facilities.

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Offered by: Connecticut General Life Insurance Company or Cigna Health and Life Insurance Company.

PAGE 2 GLOSSARY

If you're unsure of words or terms, look them up in the Glossary.

Glossary

Amount billed: The amount charged by the health c
covered dependents.

Amount not covered: The portion of the amount bil

Your Rights of review and appeal will help you figure out what to do if you disagree with any of the benefits decisions made on this claim.

Rights of review and appeal

If you have any questions about this explanation of b

If you're not satisfied with this decision, you can start

PAGE 3 CLAIMS

The Claims detail page follows the Glossary page. Here, you'll find:

The dollar amount and percentage Cigna paid toward the covered amount, minus any copay/deductible you're responsible for.

The portion of covered expenses you're responsible for paying. For example, if your Cigna plan covers 90% of the covered amount, you pay the remaining 10%.

What you have left in your plan deductibles and out-of-pocket expenses.

Help with making an appeal if you're unsatisfied with part or all of your claim being denied. The information is state-specific.

★ If your "Covered amount" is less than your "Amount billed," it could be due to Cigna discounts (a portion you don't have to pay) or amounts not covered (a portion you might have to pay). The Notes section will tell you specific details.

Cigna.

Claim received for Your Name
Reference # 865999999999999
ID U99999999

THIS IS NOT A BILL

Claim detail

Cigna received this claim on November 15, 2012 and processed it on November 18, 2012.

Service dates	Type of service	Amount billed	Discount	Amount not covered	Covered amount	Copay/ Deductible	What Cigna plan paid	% paid	Coinsurance	See notes
Dr. John Wellbeing Reference # 865999999999999										
11/09/12	PHYSICIAN	189.00	70.05	0.00	118.95	0.00	107.06	90	11.89	A
Total		**$189.00** ★	**$70.05**	**$0.00**	**$118.95** ★	**$0.00**	**$107.06**		**$11.89**	

**After you have met your deductible, the cost of the covered expenses are shared by you and your health plan. The percentage of covered expenses you are responsible for is called coinsurance.*

What I need to know for my next claim

You've now paid a total of $1,000 toward your $1,000 in-network deductible for this plan year.
You've now paid a total of $1,500 toward your $1,500 out-of-network deductible for this plan year.
You've now paid a total of $1,500 toward your $4,000 in-network out-of-pocket expenses for this plan year.
You've now paid a total of $1,500 toward your $5,500 out-of-network out-of-pocket expenses for this plan year.

Other important information that I need to know

Part 919 of the Rules of the Illinois Division of Insurance requires that our company advise you that if you wish to take this matter up with the Illinois Division of Insurance, it maintains an Office of Consumer Health Insurance (OCHI) in Chicago at 100 W. Randolph Street, Suite 9-301, Chicago, Illinois, 60601-3395 and in Springfield at 320 West Washington Street, Springfield, Illinois 62767-0001. The OCHI can also be reached toll free within Illinois at 877.527.9431. The main telephone number for the Chicago office is 312.814.2420 and for the Springfield office is 217.782.4515.

Notes

A. Thank you for using the CIGNA HealthCare preferred provider organization (PPO) network. This represents your savings, so you are not required to pay for this amount. This provider is prohibited from billing the patient for the difference. If you have already paid the amount in full, please request reimbursement from your provider. IN. or CA. health care professionals, for information regarding the contractual source of your discounted rate, please contact CIGNA customer service at 1.800.88cigna (882.4462)

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DENTAL

Delta Dental

DELTA DENTAL

SUMMARY OF BENEFITS

City of Casper - Group #70024

BENEFIT PERCENTAGE

- 100% Preventive and Diagnostic Services **(Not subject to deductible)**
  - Exams, bitewing x-rays, prophylaxis (cleaning), fluoride treatment, full mouth x-rays, space maintainers, sealants
- 80% Basic Services
  - Amalgam, synthetic fillings, stainless steel crowns, extractions and impacted extractions, root canal therapy, periodontal therapy, emergency treatment for relief of pain
- 60% Major Services
  - Crowns, onlays, bridges, full dentures, partial dentures, dental implants
- 60% Orthodontic Services
  - Orthodontic diagnostic services, appliance therapy, orthodontic surgical therapy
  - For dependent children to age 19 (end of month)

- Dependent children: Covered until age 26 (end of month)
- Deductible: $50 individual/$150 maximum per family
- Annual Maximum: $1,500 per person
- Orthodontic Maximum: $1,500 lifetime maximum

Predetermination or preauthorization of benefits is recommended for all dental care in the amount of $250 or more.

The Delta Difference - Network of Participating Dentists

- **The dentist office fills out the forms.**
- **The dentist office mails the forms.**
- **There is not a usual and customary chargeback.**
- **Managed dental costs.**
- **Payment directly to the dentist.**

BENEFITS

- Preventive and Diagnostic:
  - Exams and/or Prophylaxis twice per calendar year
  - Bitewing x-rays twice per calendar year
  - Full mouth x-rays once every 36 months
  - Fluoride treatment for dependent children once every twelve months to age 19 (end of month)
  - Space maintainers for dependent children to age 19 (end of month)
  - Sealants on posterior permanent teeth once every three years for dependent children to age 19 (end of month)
- Basic:
  - Amalgam restorations or synthetic restorations (white fillings on posterior teeth are a benefit)
- Major:
  - Crowns and onlays are a benefit only if teeth cannot be restored with amalgam (must be extensively decayed or fractured) and they are a benefit once in a 5 year period
  - Bridges, partial dentures and full dentures are a benefit once in a 5 year period
  - Crowns and bridges are not a benefit for children under the age of 16
  - Relines or rebases are benefits twice in a five year period
- Orthodontic:
  - For dependent children ONLY, through the end of the month age 19 is attained

EXCLUSIONS

- Before the date the Subscriber's dental coverage starts
- For procedures covered by medical policy benefits
- Developmental malformation, acquired malformation and cosmetic procedures and treatment
- Prosthetic services are not a replacement for 5 years
- Periodontal splinting
- Procedures performed to change or restore vertical dimension, lost as a result of abrasion or attrition
- Overdentures, temporary full dentures
- Cosmetic dentistry, acid etch, laminates, bite guards, athletic mouthguards and precision attachments
- Temporomandibular Joint Disturbances
- Pre-medication, analgesia or conscious sedation
- General anesthesia, except when medically necessary and when the treatment is performed by a dentist
- The removal and/or maintenance of implants

****Complete details explained in the Master Contract on file with your group. These benefits are also available in booklet form upon request.**

Delta Dental of Wyoming
P.O. Box 29 * 6234 Yellowstone Rd * Cheyenne, WY 82003-0029
307-632-3313 or 1-800-735-DDPW (3379)
Hours: 8:00 a.m. to 5:00 p.m. Monday through Thursday/8:00 a.m. to 4:00 p.m. Friday
www.deltadentalwy.org

VISION

VSP

Keep your eyes healthy with CITY OF CASPER and VSP® Vision Care.

Why enroll in VSP? Your eyes deserve the best care to keep them healthy year after year. Plus with VSP, you'll get a great value on your eyecare and eyewear.

You'll like what you see with VSP.

- **Value and Savings.** You'll get great benefits on your exam and eyewear at an affordable price.
- **Personalized Care.** You'll get quality care that focuses on your eyes and overall wellness through a WellVision Exam® from a VSP doctor. When you see a VSP doctor, you'll get the most out of your benefit and have lower out-of-pocket costs. Plus, with a VSP doctor your satisfaction is guaranteed—if you're not 100% happy, we'll make it right.
- **Great Eyewear.** Choose the eyewear that's right for you and your budget.
- **Choice of Providers.** With open access to see any eyecare provider, you can see the one who's right for you. Choose a VSP doctor or any other provider.

Using your VSP benefit is easy.

- **Find an eyecare provider who's right for you.**
  To find a VSP doctor, visit **vsp.com** or call **800.877.7195**.
- **Review your benefit information.**
  Visit **vsp.com** to review your plan coverage before your appointment.
- **At your appointment, tell them you have VSP.**
  There's no ID card necessary.

That's it! We'll handle the rest—there are no claim forms to complete when you see a VSP doctor.

Choice in Eyewear

From classic styles to the latest designer frames, you'll find hundreds of options for you and your family. Choose from great brands, like bebe®, Calvin Klein, Disney, FENDI, Nike, and Tommy Bahama®.

Enroll in VSP today. You'll be glad you did.

Contact us.
vsp.com
800.877.7195

Your VSP Vision Benefits Summary

CITY OF CASPER and VSP provide you with an affordable eyecare plan.

Visit **vsp.com** for more details on your vision benefit and for exclusive savings and promotions for VSP members.

VSP Doctor Network: VSP Signature

Benefit	Description	Copay	Frequency
	Your Coverage with a VSP Doctor		
WellVision Exam	• Focuses on your eyes and overall wellness	$10	Every 12 months
Prescription Glasses		$25	See frame and lenses
Frame	• $130 allowance for a wide selection of frames • 20% off amount over your allowance	Included in Prescription Glasses	Every 24 months
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children	Included in Prescription Glasses	Every 12 months
Lens Options	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average 35-40% off other lens options	$50 $80 - $90 $120 - $160	Every 12 months
Contacts (instead of glasses)	• $130 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation)	Up to $60	Every 12 months
Extra Savings and Discounts	**Glasses and Sunglasses** • 30% off additional glasses and sunglasses, including lens options, from the same VSP doctor on the same day as your WellVision Exam. Or get 20% off from any VSP doctor within 12 months of your last WellVision Exam. **Retinal Screening** • Guaranteed pricing on retinal screening as an enhancement to your WellVision Exam. **Laser Vision Correction** • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities • After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor		

Your Coverage with Other Providers

Visit vsp.com for details, if you plan to see a provider other than a VSP doctor.

Exam.....up to $50
Single Vision Lenses.....up to $50
Lined Trifocal Lenses.....up to $100
Contacts.....up to $105
Frame.....up to $70
Lined Bifocal Lenses.....up to $75
Progressive Lenses.....up to $75

VSP guarantees coverage from VSP doctors only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail.

Enroll in VSP today.
You'll be glad you did.
Contact us. **vsp.com**
800.877.7195

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LIFE

Cigna

Basic Term Life, Basic Personal Accident Insurance Overview

Prepared for the employees of the City of Casper

What would happen to your family if you and your income were gone?

- Could they maintain their standard of living?
- Pay for college tuition?
- Household bills?
- What about monthly mortgage or rent?

Three in 10 households carry no life insurance on anyone in the household.

Household Trends in U.S. Life Insurance Ownership. LIMRA, 2010

Half of U.S. households now believe they are underinsured.

Household Trends in U.S. Life Insurance Ownership. LIMRA, 2010

Basic Term Life Insurance Coverage

Employee – Retirees of the Employer

- Benefit Amount and Maximum –$10,000
- Benefit Reduction Schedule – Benefits will reduce to 10% at age 70

Your Spouse —

- Benefit Amount – $1,000
- Benefit Reduction Schedule – Benefits will reduce to $500 at age 70

Your Unmarried, Dependent Children — Under age 26

- Benefit Amount – Birth to 14 days $500, 15 days to 26 years $1,000

No one may be covered more than once under this plan.

Other Coverage Features

Accelerated Death Benefit — Terminal Illness

If you are diagnosed by two unaffiliated physicians as terminally ill with a life expectancy of 12 months or less, the benefit for terminal illness provides for up to 75% of the Basic and Voluntary Term Life Insurance combined coverage amount inforce or $7,500, whichever is less, to be paid to the insured. This benefit is payable only once in the insured's lifetime, and will reduce the life insurance death benefit.

Conversion

If group life insurance coverage is reduced or ends for any reason except nonpayment of premiums, you can convert to an individual policy. To convert, you must apply for the conversion policy and pay the first premium payment within 31 days after your group coverage ends. Converted policies are subject to certain benefits and limits as outlined in the conversion brochure which may be requested as needed. Premiums may change at this time.

This information is a brief description of the important features of the plan. It is not a contract. Terms and conditions of life coverage are set forth in Group Policy No.FLX-965049 issued in Wyoming. The group policy is subject to the laws of the jurisdiction in which it is issued. The availability of this offer may change. Please keep this material as a reference. Coverage is underwritten by Life Insurance Company of North America. As used in this brochure, the term Cigna and Cigna Group Insurance are registered service marks of Life Insurance Company of North America, a CIGNA company, which is the insurer of the Group Policy. Insurance products and services are provided by the individual CIGNA companies and not by the Corporation itself. © Cigna 2012

10/2012

Cigna.

ADDITIONAL INFORMATION

City of Casper 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.

THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Our Legal Duty

We are required by applicable federal and state laws to maintain the privacy of your medical information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your medical information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect **September 15, 2013**, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided that applicable law permits such changes. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all medical information that we maintain, including medical information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and send the new notice to our health plan subscribers at the time of the change.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

Uses and Disclosures of Medical Information

Under the HIPAA Privacy Rule, we may use or disclose your protected health information for certain purposes without your permission. This section describes the ways we can use and disclose your protected health information.

Treatment: We may disclose your medical information to a doctor or a hospital which asks us for it to assist in your treatment.

Payment: We use or disclose your protected health information without your written authorization in order to determine eligibility for benefits, seek reimbursement from a third party, or coordinate benefits with another health plan under which you are covered. For example, a health care provider that provided treatment to you will provide us with your health information. We use that information in order to determine whether those services are eligible for payment under our group health plan.

Health Care Operations: We use and disclose your protected health information in order to perform plan administration functions such as quality assurance activities, resolution of internal grievances, and evaluating plan performance. For example, we review claims experience in order to understand participant utilization and to make plan design changes that are intended to control health care costs.

However, we are prohibited from using or disclosing protected health information that is genetic information for underwriting purposes.

You and Your Authorization: We must disclose your medical information to you, as described below in the Individual Rights section of this notice. You may give us written authorization to use your medical information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect.

Without your written authorization, we may not use or disclose your medical information for any reason except those described in this notice.

member, friend or other person to the extent necessary to help with your health care or with payment for your health care.

To Plan Sponsors: We may disclose your medical information and the medical information of others enrolled in your group health plan to the plan sponsor to permit it to perform plan administration functions. Please see your plan documents for a full explanation of the limited uses and disclosures that the plan sponsor may make of your medical information in providing plan administration functions for your group health plan.

To Business Associates*:* We may enter into contracts with entities known as Business Associates that provide services to or perform functions on behalf of the Plan. We may disclose protected health information to Business Associates once they have agreed in writing to safeguard the protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims. Business Associates are also required by law to protect protected health information.

Underwriting: We may use and disclose your medical information for underwriting, premium rating or other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits. We will not use or further disclose this medical information for any other purpose, except as required by law, unless the contract of health insurance or health benefits is placed with us. In that case, our use and disclosure of your medical information will only be as described in this notice

Research; Death; Organ Donation: We may use or disclose your medical information for research purposes in limited circumstances. We may disclose the medical information of a deceased person to a coroner, medical examiner, funeral director, or organ procurement organization for certain purposes.

Public Health and Safety: We may disclose your medical information to the extent necessary to avert a serious and imminent threat to your health or safety or the health or safety of others. We may disclose your medical information to a government agency authorized to oversee the health care system or government programs or its contractors, and to public health authorities for public health purposes. We may disclose your medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence or other crimes.

As permitted or required by law. We may also use or disclose your protected health information without your written authorization for other reasons as *permitted* by law. We are *permitted* by law to share information, subject to certain requirements, in order to communicate information on health-related benefits or services that may be of interest to you, respond to a court order, or provide information to further public health activities (e.g., preventing the spread of disease) without your written authorization. We are also permitted to share protected health information during a corporate restructuring such as a merger, sale, or acquisition. We will also disclose health information about you when *required* by law, for example, in order to prevent serious harm to you or others.

Process and Proceedings: We may disclose your medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may disclose your medical information to law enforcement officials.

Law Enforcement: We may disclose limited information to a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may disclose the medical information of an inmate or other person in lawful custody to a law enforcement official or correctional institution under certain circumstances. We may disclose medical information where necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.

Military and National Security: We may disclose to military authorities the medical information of armed forces personnel under certain circumstances. We may disclose to authorized federal officials medical information required for lawful intelligence, counterintelligence, and other national security activities.

Other Disclosures and Revocation: In addition, most uses and disclosures of psychotherapy notes, disclosures for marketing purposes, and disclosures that constitute a sale of protected health information will require an authorization from you before the information may be disclosed. Such authorization can be revoked at any time.

Individual Rights

Access: You have the right to look at or get copies of your medical information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your medical information. You may obtain a form to request access by using the contact information listed at the end of this notice. You may also request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you $0.50 for each page, $10.00 per hour for staff time to locate and copy your medical information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your medical information in that format. If you prefer, we will prepare a summary or an explanation of your medical information for a fee. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your medical information for purposes other than treatment, payment, health care operations and certain other activities, since April 14, 2003. We will provide you with the date on which we made the disclosure, the name of the person or entity to which we disclosed your medical information, a description of the medical information we disclosed, the reason for the disclosure, and certain other information. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Restriction Requests: You have the right to request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is so memorialized in writing.

Confidential Communication: You have the right to request that we communicate with you in confidence about your medical information by alternative means or to an alternative location. You must inform us that confidential communication by alternative means or to an alternative location is required to avoid endangering you. You must make your request in writing, and you must state that the information could endanger you if it is not communicated in confidence by the alternative means or to the alternative location as you want. We must accommodate your request if it is reasonable, specifies the alternative means or location, and continues to permit us to collect premiums and pay claims under your health plan.

Amendment: You have the right to request that we amend your medical information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.

Electronic Notice: If you receive this notice on our web site or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact us using the information listed at the end of this notice to obtain this notice in written form.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us using the information listed at the end of this notice.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information or in response to a request you made to amend or restrict the use or disclosure of your medical information or to have us communicate with you in confidence by alternative means or at an alternative location, you may complain to us using the contact information listed at the end of this notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to protect the privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Office: Human Resources, Becky Nelson, Privacy Officer

Telephone: (307) 235-8289

Fax: (307) 235-8273

E-mail: bnelson@cityofcasperwy.com

Address: 200 N. David, Casper, WY 82601

Effective Date

This Notice is effective September 15, 2013.

Women's Health and Cancer Rights Act Notice

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 deductibles, co-payments and coinsurance applicable to other medical and surgical benefits provided under this plan. See the Summary Plan Description.

Following the initial reconstruction, any additional modification or revision is covered only to the extent that it is not otherwise limited or excluded from coverage by your plan.

For additional information on WHCRA benefits, contact the Human Resource Department at 307-235-8344.

Newborns' and Mothers' Health Protection Act

Under Federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g. your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours).

For plan participants residing in California, the following maternity minimum stay provisions also apply: If the hospital stay is less than 48 hours after a normal vaginal delivery or less than 96 hours after a cesarean delivery, this plan will cover a follow-up visit for the mother and newborn within 48 hours of discharge, when prescribed by the treating physician. This visit shall be provided by a licensed health care provider whose scope of practice includes postpartum and newborn care. The treating physician, in consultation with the mother, shall determine whether this visit shall occur at home, in a medical facility, or at the physician's office.

Mandatory Insurer Reporting Law

Employees are required to provide Social Security numbers for all dependents enrolled in the medical plan. You will be asked to enter Social Security numbers for all dependents you enroll on your medical plan. The reason for this requirement is the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMESA). This law requires that providers of group health plans must report certain information (Social Security numbers of plan participants) to the Secretary of Health and Human Services (HHS) to determine Medicare entitlement. The reporting party will be the insurer or third-party administrator, or plan administrator or fiduciary if the plan is self-insured and self-administered. The law also provides penalties for noncompliance. This law became effective on January 1, 2009.

Mental Health Parity & Addiction Equity Act (MHPAEA) Notice

The MHPAEA imposes the following requirements on plans that provide both medical and surgical benefits as well as mental health or substance use disorder benefits:

- The financial requirements that apply to mental health or substance use disorder benefits cannot be more restrictive than the predominant financial requirements that apply to substantially all medical and surgical benefits under the Plan, and no separate cost-sharing requirements can be applied only to mental health or substance use disorder benefits.
- The treatment limitations that apply to mental health or substance use disorder benefits cannot be more restrictive than the predominant treatment limitations that apply to substantially all medical and surgical benefits under the Plan, and no separate treatment limitations can be applied only to mental health or substance use disorder benefits.

Large plans and self-insured plans are not *required* to provide coverage for mental health conditions or substance use disorders, but if they do they must comply with the MHPAEA. Small insured plans are required under the Affordable Care Act to provide coverage for mental health conditions and substance use disorders, beginning with the 2014 plan year.

Genetic Information Non-Discrimination Act (GINA)

In accordance with GINA, this Plan does not deny coverage or benefits, or charge a higher rate or premium, to an otherwise healthy individual found to have a potential genetic condition or genetic predisposition towards a disease or disorder. If PHI is used or disclosed for underwriting purposes, the Plan is prohibited from using or disclosing any of your PHI that is genetic information for such purposes. GINA defines genetic information as that obtained from an individual's genetic test results, as well as genetic test results of family members and the occurrence of a disease or disorder in family members.

Your Prescription Drug Coverage and Medicare

**** If you or your dependents are not eligible for Medicare, you may disregard this notice.***

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage and 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.

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 Casper has determined that the prescription drug coverage offered by Cigna 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.

Choosing Between Existing Coverage and Medicare Prescription Drug Coverage

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

If you do decide to enroll in a Medicare prescription drug plan and drop your prescription drug coverage provided by Cigna, be aware that you and your dependents may or may not be able to get this coverage back immediately. Please contact us for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan. You should also know that if you drop or lose your coverage with Cigna 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 Prescription Drug Coverage

You will receive this notice annually and if this coverage through City of Casper changes. You also may request a copy from the HR Department at any time.

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. Individuals eligible for Medicare will 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 whether or not you are required to pay a higher premium (a penalty).

Premium Assistance under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're 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 aren't eligible for Medicaid or CHIP, you won't 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 www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, 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 or www.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 www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

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, 2014. Contact your State for more information on eligibility.

ALABAMA – Medicaid

Website: http://www.medicaid.alabama.gov
Phone: 1-855-692-5447

ALASKA – Medicaid

Website: http://health.hss.state.ak.us/dpa/programs/medicaid/
Phone (Outside of Anchorage): 1-888-318-8890
Phone (Anchorage): 907-269-6529

ARIZONA – CHIP

Website: http://www.azahcccs.gov/applicants
Phone (Outside of Maricopa County): 1-877-764-5437
Phone (Maricopa County): 602-417-5437

COLORADO – Medicaid

Medicaid Website: http://www.colorado.gov/
Medicaid Phone (In state): 1-800-866-3513
Medicaid Phone (Out of state): 1-800-221-3943

FLORIDA – Medicaid

Website: https://www.flmedicaidtplrecovery.com/
Phone: 1-877-357-3268

GEORGIA – Medicaid

Website: http://dch.georgia.gov/ - Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP)
Phone: 1-800-869-1150

IDAHO – Medicaid

Medicaid Website: http://healthandwelfare.idaho.gov/Medical/Medicaid/PremiumAssistance/tabid/1510/Default.aspx
Medicaid Phone: 1-800-926-2588

INDIANA – Medicaid

Website: http://www.in.gov/fssa
Phone: 1-800-889-9949

IOWA – Medicaid

Website: www.dhs.state.ia.us/hipp/
Phone: 1-888-346-9562

KANSAS – Medicaid

Website: http://www.kdheks.gov/hcf/
Phone: 1-800-792-4884

KENTUCKY – Medicaid

Website: http://chfs.ky.gov/dms/default.htm
Phone: 1-800-635-2570

LOUISIANA – Medicaid

Website: http://www.lahipp.dhh.louisiana.gov
Phone: 1-888-695-2447

MAINE – Medicaid

Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 1-800-977-6740 TTY 1-800-977-6741

MASSACHUSETTS – Medicaid and CHIP

Website: http://www.mass.gov/MassHealth
Phone: 1-800-462-1120

MINNESOTA – Medicaid

Website: http://www.dhs.state.mn.us/
Click on Health Care, then Medical Assistance
Phone: 1-800-657-3629

MISSOURI - Medicaid

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid

Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml
Phone: 1-800-694-3084

NEBRASKA – Medicaid

Website: www.ACCESSNebraska.ne.gov
Phone: 1-800-383-4278

NEW HAMPSHIRE – Medicaid

Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf
Phone: 603-271-5218

NEW JERSEY – Medicaid and CHIP

Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-071

NEW YORK – Medicaid

Website: http://www.nyhealth.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: http://www.ncdhhs.gov/dma
Phone: 919-855-4100

NORTH DAKOTA - Medicaid

Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-800-755-2604

OKLAHOMA – Medicaid & CHIP

Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid

Website: http://www.oregonhealthykids.gov
http://www.hijossaludablesoregon.gov
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid

Website: http://www.dpw.state.pa.us/hipp
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid

Website: www.ohhs.ri.gov
Phone: 401-462-5300

SOUTH CAROLINA – Medicaid

Website: http://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA – Medicaid

Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid

Website: https://www.gethipptexas.com/
Phone: 1-800-440-0493

UTAH – Medicaid & CHIP

Website: http://health.utah.gov/upp
Phone: 1-866-435-7414

VERMONT - Medicaid

Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

VIRGINIA – Medicaid & CHIP

Medicaid Website:
http://www.dmas.virginia.gov/rcp-HIPP.htm
Medicaid Phone: 1-800-432-5924
CHIP Website: http://www.famis.org/
CHIP Phone: 1-866-873-2647

WASHINGTON – Medicaid

Website:
http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx
Phone: 1-800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid

Website: www.dhhr.wv.gov/bms/
Phone: 1-877-598-5820, HMS Third Party Liability

WISCONSIN – Medicaid

Website: http://www.badgercareplus.org/pubs/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid

Website:
http://health.wyo.gov/healthcarefin/equalitycare
Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2014, or for more information on special enrollment rights, 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.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 10/31/2016)

Generic Prescriptions

$4 30-Day Supply or a $10 90-Day Supply

These programs may assist you in paying a reduced amount for generic medications, as well as, reducing utilization of the medical prescription benefits.

Did You Know?

Even if the generic substitute for one of your prescription drugs is not on one of the $4 lists, generic drugs are often 80% less expensive than brand name drugs, so switching to a generic will have a large impact on your pocketbook whether you switch pharmacies or not. To see if you would benefit from a switch to a generic drug, do some comparison shopping. One of the better places to do this is at www.crbestbuydrugs.org, a Consumer Reports site.

Tips

- When you receive a prescription from your doctor, ask if a generic equivalent is available.
- The member must present the written prescription to the pharmacist and request the $4-Generic price.
- The member should not present the medical ID card. The pharmacy will not submit a claim to the insurance carrier.

How can I find out if my prescription is on the $4-Generic Drug List?

- Most of the generic programs offer approximately 150 to 300 generic drugs at a discounted price.
- The generic drugs offered cover most diseases and most chronic conditions such as arthritis, heart disease, high blood pressure, depression and diabetes.
- You may search for the generic medication on the pharmacy's website below or contact the pharmacy to inquire if the generic medication the provider prescribed is on the pharmacy's $4-Generic Drug List.

Target

http://sites.target.com/site/en/health/page.jsp?contentId=WCMP04-040590

Wal-Mart & Sam's Club

http://i.walmartimages.com/i/if/hmp/fusion/customer_list.pdf

Walgreens

https://webapp.walgreens.com/MYWCARDWeb/pdf/Value-PricedGenericsList.pdf

Smiths Pharmacy

http://www.smithsfoodanddrug.com/pharmacy/generics/Pages/alphabetical_drug_list.aspx

PREMIUMS

City of Casper

Retiree Premiums

January 1, 2015 – December 31, 2015

Medical & Pharmacy Cigna

Buy-Down Plan for Pre-65 Retirees	
Status	Total Premium Per Month
Single	$535.20
Single + Spouse	$1,212.46
Family	$1,274.90
Retiree One Under 65 & One Over 65	$844.78

Buy-Down Plan for Post-65 Retirees	
Status	Total Premium Per Month
Single	$309.65
Single + Spouse	$619.28
Family	$1, 274.90

Mid-Option (Base) Plan for Pre-65 Retirees	
Status	Total Premium Per Month
Single	$581.74
Single + Spouse	$1,317.89
Family	$1,385.76
Retiree One Under 65 & One Over 65	$918.24

Mid-Option (Base) Plan for Post-65 Retirees	
Status	Total Premium Per Month
Single	$336.58
Single + Spouse	$673.13
Family	$1,385.76

Buy-Up Plan for Pre 65 Retirees	
Status	Total Premium Per Month
Single	$628.28
Single + Spouse	$1,423.32
Family	$1,496.62
Retiree One Under 65 & One Over 65	$991.70

Buy-Up Plan for Post-65 Retirees	
Status	Total Premium Per Month
Single	$363.51
Single + Spouse	$726.98
Family	$1,496.62

Dental Delta Dental

Status	Total Premium Per Month
Single	$39.77
Single + Spouse	$79.54
Single + Child(ren)	$73.57
Family	$104.27

Vision VSP

Status	Total Premium Per Month
Single	$10.72
Single + Spouse	$15.54
Single + Child(ren)	$27.86
Family	$27.86

GBS

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