Plan Document and
Summary Plan Description
for

GROUP HEALTH PLAN

January 1, 2015

TABLE OF CONTENTS

INTRODUCTION 1
IMPORTANT PLAN INFORMATION 2
ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS 3
SCHEDULE OF BENEFITS 14
SCHEDULE OF BENEFITS (CHART) 17
MEDICAL BENEFITS 21
COST MANAGEMENT SERVICES 38
LARGE CLAIMS MANAGEMENT PROGRAM 42
DEFINED TERMS 43
PLAN EXCLUSIONS 53
PRESCRIPTION DRUG BENEFITS 57
PROCESSING CLAIMS FOR BENEFITS 60
CLAIM REVIEW AND APPEAL PROCEDURES 62
COORDINATION OF BENEFITS 72
RIGHT OF SUBROGATION 76
RESPONSIBILITIES FOR PLAN ADMINISTRATION 77
FUNDING THE PLAN AND PAYMENT OF BENEFITS 78
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT 80
GENERAL PLAN INFORMATION 84

INTRODUCTION

This document is a description of the City of Springfield Group Health Plan (the Plan). No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain catastrophic health expenses.

Coverage under the Plan will take effect for an eligible Employee and designated Dependents when the Employee and such Dependents satisfy the Waiting Period and all the eligibility requirements of the Plan.

The City of Springfield fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason. No Covered Person under the Plan shall have a vested right to any benefits provided under the Plan.

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, maximums, copayments, exclusions, limitations, definitions, eligibility and the like.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, utilization review or other cost management requirements, lack of Medical Necessity, lack of timely filing of claims or lack of coverage. These provisions are explained in this document.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated. An expense for a service or supply is incurred on the date the service or supply is furnished.

If the Plan is terminated, amended, or benefits are eliminated, the rights of Covered Persons are limited to Covered Charges incurred before termination, amendment or elimination.

This document summarizes the Plan rights and benefits for covered Employees and their Dependents and is divided into the following parts:

- **Eligibility, Funding, Effective Date and Termination.** Explains eligibility for coverage under the Plan, funding of the Plan and when the coverage takes effect and terminates.
- **Schedule of Benefits.** Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services.
- **Benefit Descriptions.** Explains when the benefit applies and the types of charges covered.
- **Cost Management Services.** Explains the methods used to manage charges that are determined to be excessive, not Medically Necessary, or otherwise ineligible for payment by the Plan.

This part should be read carefully since each Participant is required to take action to assure that the maximum payment levels under the Plan are paid.

- **Defined Terms.** Defines those Plan terms that have a specific meaning.
- **Plan Exclusions.** Shows what charges are **not** covered.
- **Claim Provisions.** Explains the rules for filing claims.
- **Coordination of Benefits.** Shows the Plan payment order when a person is covered under more than one plan.
- **Continuation Coverage Rights Under COBRA.** Explains when a person's coverage under the Plan ceases and the continuation options, which are available.
- **HIPAA Security.** Explains the Plan's compliance with the Health Insurance Portability and Accountability Act (HIPAA) Electronic Security Standards.
- **HIPAA Privacy Policies and Procedures Notice.** Explains the Plan's obligations with respect to Participants' privacy rights under the Health Insurance Portability and Accountability Act (HIPAA).

IMPORTANT PLAN INFORMATION

Third Party Administrator (TPA)/Claims Administrator:

Med Pay, Inc.
P.O. Box 10909
Springfield, MO 65808

1.800.777.9087 or 417.886.6886

To obtain benefits see the Payment of Claims provision of this plan document.

All claims must be submitted to the Third Party Administrator (TPA) as listed above.

If you need assistance with filing your claim or an explanation of how your claim was paid, contact the TPA as listed above.

If you have any questions or problems arise regarding this coverage, you may contact the Third Party Administrator at the telephone number and address shown above. Please have your identification number available.

Utilization Review Coordinator:

MPI Care
P.O. Box 10909
Springfield, MO 65808

1.800.777.9087 or 417.886.6886

Call the number listed above for utilization review including precertification and preauthorization.

Preferred Provider Organization (PPO) is listed below. See the Medical Benefits section of this document for information about coverage when using In and Out-of-Network providers.

Mercy

417.888.8888

http://www.mercy.net/springfieldmo/ (myMercy link and other general information)

http://www.mercy.net/springfieldmo/mercy-springfield-provider-network
(Search for in-network providers)

Important Notices:

This booklet contains certain Cost Containment provisions. These provisions affect the way benefits are paid to you. It is important that you refer to the SCHEDULE for the details. For Precertification of Inpatient Hospitalizations, call the Third Party Administrator (TPA) or the Utilization Coordinator at the numbers listed above.

Precertification Penalty - Elective Hospital stays must be precertified prior to date of admission. Emergency Hospitalizations do not have to be pre-certified but must be certified within seventy-two (72) hours of admission. See the Schedule of Benefits and Cost Management Sections of this document for more details about the Plan's precertification requirements.

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

ELIGIBILITY

Eligibility Requirements for Employee Coverage

An Employee is eligible for coverage under this Plan if he or she meets the eligibility requirements:

1. The Employee holds a regular or written contract status position with the City of Springfield, as defined in City of Springfield Merit System (Merit Rule 1(p)(1) and 1(p)(2));

2. The Employee must be regularly scheduled to work at least 30 hours per week; and

3. The Employee may not be an independent contractor or in an emergency, temporary, seasonal or provisional appointment as defined in the City's Merit Rules.

In the case of Employees married to one another without Dependents, the Employees will be covered as separate plan members.

Eligibility Requirements for Dependent Coverage

A family member of an eligible Employee will be eligible for Dependent coverage if he or she satisfies the definition of a Dependent, as described below.

If a spouse loses coverage due to the death of the Employee, the spouse may elect to continue coverage for himself or herself and/or his or her Dependent children.

In the event a Dependent child loses coverage due to the Employee's the death of the Employee, the Dependent child may elect to continue coverage even if his or her parent who is the Dependent spouse elects not to continue such coverage. A parent or guardian may make such election on behalf of a Dependent child.

At any time, the Plan may require proof that a spouse or a child qualifies or continues to qualify as a Dependent as defined by this Plan.

Definition of Dependent

A Dependent is any one of the following persons:

1. An eligible Employee's spouse.

2. A child of an eligible Employee under age 26.

3. A child under age 26 named in a Qualified Medical Child Support Order (QMCSO) will be considered an eligible Dependent under the Plan as long as the child otherwise meets the definition of a dependent child.

4. An unmarried child (as defined below) age 26 or older who is Totally and Permanently Disabled with a disability that existed prior to the attainment of the Plan's age limit and who will be claimed as a dependent on the employee's federal income tax return for each plan year for which coverage is provided. The Plan will require initial and periodic proof of disability. The employee will have 31 days from the date of the request to provide this proof before the child is determined to be ineligible.

   The Plan Administrator reserves the right to have such child examined by a physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

The term "Spouse" shall mean the person recognized as the covered employee's husband or wife. The Plan Administrator may require documentation proving legal marital relationship.

In the cases where Employees are married to one another without Dependents, the Employees will be covered as separate plan members.

The term “child” means an employee’s natural child, adopted child, child placed with an Eligible Employee in anticipation of adoption. A step-child is included in the definition of “child” as long as a natural parent remains married to the employee.

- If an eligible Employee is the Legal Guardian of a child, the child may be enrolled in this Plan as a covered Dependent only if the Employee has legal guardianship under a court order and is under age 26 (proof of guardianship and age will be required);

The Plan will not provide coverage to a child under legal guardianship who is age 26 or older regardless of whether such child is Totally and Permanently Disabled.

Guardianship and adoption must be established by valid court order or decree entered after the petition for same has been filed.

The phrase "child placed with a covered Employee in anticipation of adoption" refers to a child whom the Employee intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

Pursuant to Missouri SB264, any eligible Dependent of a deceased, active or retired employee may elect to continue coverage if the survivor is eligible for a retirement benefit, elects the group coverage, and pays any required Plan contributions in a timely manner.

If both of a Dependent child’s parents are Employees, the child will be covered as a Dependent of the mother or father, but not of both.

If a Dependent Child of an Employee is also an eligible Employee, the Dependent Child will only be eligible as an Employee. Such Dependent Child’s effective date as an Employee will immediately follow their Waiting Period. The (Dependent Child) Employee will no longer be eligible as a Dependent of the parent who is an Employee.

In cases where Employees are married to one another with Dependents, one of the Employees must be covered as a Dependent of the other Employee along with the Dependent Children.

In the case of a family with eligibility for both the City of Springfield Group Health Plan and the City of Springfield Retiree Health Plan (Non-Medicare), all eligible dependents who request coverage must be enrolled in the City of Springfield Group Health Plan unless the dependent is a spouse who is retiring or has retired from the City of Springfield. At the time of retirement, the dependent spouse who is retiring may elect to remain covered under the City of Springfield Employee Health Care Plan or to be covered in the City of Springfield Non-Medicare Retiree Health Plan.

Retirees who are the spouse of a current employee covered in the City of Springfield Employee Group Health Plan may elect to change coverage from the City of Springfield Employee Group Health Plan to the City of Springfield Retiree Plan (Non-Medicare) or from the City of Springfield Retiree Plan (Non-Medicare) to the City of Springfield Employee Group Health Plan, effective January 1 of the following calendar year, by completing a change of coverage form prior to January 1 of the plan year, and filing this form with the Human Resources Department no later than the last business day of the plan year. Upon acceptance of a completed form, the coverage in the Plan being changed from shall cease at midnight on December 31 of the year the form is filed with the Director, and coverage in the Plan selected shall begin at 12:00 a.m. on January 1 of the following calendar year. This election between plans may only be made once each calendar year the coverage for a plan is in place. In no event shall coverage be changed between the plans once a calendar year has begun.

If a person covered under this Plan changes status from Employee to Dependent or Dependent to Employee, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for all amounts applied to maximums (as well as the application of the Pre-existing Condition provision at the same point prior to the change) depending upon the coverages elected and which Covered Persons elect those coverages.

In the event there is a change in status of any Employee's Dependent covered under the Plan following the initial eligibility determination, the Employee must inform the Plan Administrator of the change in status.

The Plan Administrator may require documentation proving dependency, which may include, but not be limited to, birth certificates, tax records or initiation of legal proceedings severing parental rights.

These persons are excluded as Dependents: other individuals living in the Covered Employee's home, but who are not eligible as defined; the legally separated or divorced former Spouse of the Employee.

Eligibility Requirements for Retirees with Medicare and a Serious Health Condition

If continuously enrolled in a City of Springfield Health Plan, a retiree who becomes Medicare eligible but is ineligible for enrollment in the City sponsored Medicare supplement or Advantage Plan (according to Medicare rules and regulations) due to a serious health condition may be reinstated in the City of Springfield Group Health Plan. The City may require documentation from Medicare to verify the ineligibility to enroll in the secondary plan.

COBRA CONTINUATION COVERAGE

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event, known as a qualifying event. Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage is offered to each Covered Person who is a "qualified beneficiary." An Employee, his or her spouse, and his or her Dependent children could become qualified beneficiaries if coverage under the Plan is lost because of a qualifying event.

Type of Coverage

If an Employee or his or her Dependents choose COBRA continuation coverage, the Plan is required to provide health coverage that is basically the same coverage that you had before the event that triggered COBRA.

Cost of Coverage

Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. The Plan is permitted to charge the full cost of coverage for similarly situated Employees and Dependents (including both the Plan's share and the Employee's share, if any) plus an additional 2%. If the 18-month period of COBRA continuation is extended because of disability, the Plan is permitted to charge the full cost for similarly situated Employees and Dependents (including both the Plan's share and the Employee's share, if any) plus an additional 50% for members of a COBRA family unit that includes the disabled person for the 11-month disability extension period.

QUALIFYING EVENTS

An **Eligible Employee** becomes a qualified beneficiary if he or she loses coverage under the Plan because either one of the following qualifying events occur:

- His or her hours of employment are reduced; or
- His or her employment ends for any reason.

The **Spouse of an Employee** becomes a qualified beneficiary if he or she loses coverage under the Plan because any of the following qualifying events occur:

- The Employee dies;
- The Employee's hours of employment are reduced;
- The Employee's employment ends for any reason other than his or her gross misconduct;
- The Employee becomes entitled to Medicare benefits (under Part A, Part B, or both). The Employee becoming entitled to Medicare means that he or she:
  - Was eligible for Medicare benefits; and
  - Enrolled in Medicare and the entitlement date is the date of enrollment; or
- The spouse becomes divorced or legally separated from the Employee.

Dependent Children become qualified beneficiaries if they lose coverage under the Plan because of any of the following qualifying events occur:

- The Employee dies;
- The Employee's hours of employment are reduced;
- The Employee's employment ends for any reason other than his or her gross misconduct;
- The Employee becomes entitled to Medicare benefits (under Part A, Part B, or both). The Employee becoming entitled to Medicare means that the Employee:
  - Was eligible for Medicare benefits; and
  - Enrolled in Medicare and the entitlement date is the date of enrollment; or
- The Employee and Dependent Spouse become divorced or legally separated; or
- A child is no longer eligible for coverage under the Plan as a Dependent.

ADDITIONAL COBRA QUALIFIED BENEFICIARIES

If the Employee has a newborn Child, adopts a Child, or has a Child placed with him or her for adoption while COBRA continuation coverage is in effect, the Employee may add the child to his or her coverage. The Employee must notify the Plan Administrator in writing of the birth, adoption, or placement and provide all of the documentation (i.e., birth certificates, legal documents) to have the child added to his or her coverage. Children born, adopted, or placed for adoption as described above, have the same COBRA rights as a spouse or Dependent children who were covered by the Plan before the event that triggered COBRA continuation coverage. Like all qualified beneficiaries with COBRA continuation coverage, their continued coverage depends on timely and uninterrupted payments on their behalf.

EMPLOYER MUST GIVE NOTICE OF CERTAIN QUALIFYING EVENTS

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The Employer must notify the Plan Administrator of the qualifying event within 30 days from the date coverage ends when the qualifying event is the end of employment or reduction of hours of employment, death of the Employee, or the Employee's becoming entitled to Medicare benefits.

EMPLOYEE MUST GIVE NOTICE OF CERTAIN QUALIFYING EVENTS

For other qualifying events (divorce or legal separation of the Employee and a spouse or a Dependent child's losing Dependent status), the Employee or Dependent must notify the Plan Administrator within 60 days of the date he or she would lose coverage due to the qualifying event.

HOW COBRA CONTINUATION COVERAGE IS PROVIDED

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

LENGTH OF COBRA CONTINUATION COVERAGE

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the eligible Employee, the Employee's entitlement to Medicare benefits, divorce or legal separation, or a Dependent child's losing eligibility as a Dependent child, COBRA continuation coverage lasts for up to a total of 36 months.

When the qualifying event is the end of employment or reduction of the eligible Employee's hours of employment, and the Employee became entitled to (qualified for and enrolled in) Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the Employee lasts until 36 months after the date of Medicare entitlement. However, the eligible Employee's maximum coverage period will be 18 months. For example, if an eligible Employee becomes entitled to Medicare eight months before the date on which his or her employment ends, COBRA continuation coverage for his or her spouse and children can last up to 36 months after the date of Medicare entitlement, which is

equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the Employee's hours of employment, COBRA continuation coverage lasts for up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended, as explained in the next two sections.

DISABILITY EXTENSION OF 18-MONTH PERIOD OF COBRA CONTINUATION COVERAGE

If an Employee or anyone in his or her family covered under the Plan is determined by the Social Security Administration to be disabled and the Employee or covered Dependent notifies the Fund Office in a timely fashion, the Employee and his or her entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month COBRA continuation period. The Employee or covered family member must notify the Plan Administrator of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage.

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF COBRA CONTINUATION COVERAGE

If an Employee's covered family member(s) experiences another qualifying event while receiving COBRA continuation coverage during a maximum period of 18-months, the spouse and Dependent Children in the covered family can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan Administrator. This extension is available to the spouse and any Dependent children receiving COBRA continuation coverage if:

- The Employee dies;
- The Employee becomes entitled to Medicare benefits (qualified for and enrolled in coverage under Part A, Part B, or both);
- The Employee gets divorced or legally separated; or
- The Dependent child stops being eligible under the Plan as a Dependent child.

The extension is available only if the event would have caused the spouse or Dependent child to lose coverage under the Plan had the first qualifying event not occurred. In all of these cases, you must make sure to notify the Plan within 60 days after the second qualifying event occurs.

ELECTING COBRA CONTINUATION COVERAGE

Each qualified beneficiary has an independent right to elect COBRA continuation coverage. For example, both the Employee and the Employee's spouse may elect COBRA continuation coverage, or only one of them. Parents may elect to continue coverage on behalf of their Dependent children only. A qualified beneficiary must elect coverage by the date specified on the COBRA election form. Failure to do so will result in loss of the right to elect COBRA continuation coverage under the Plan. A qualified beneficiary may change a prior rejection of COBRA continuation coverage any time until that date.

In determining whether to elect COBRA continuation coverage, a qualified beneficiary should consider the following consequences if he or she fails to continue his or her group health coverage through COBRA:

- First, he or she may have pre-existing condition exclusions applied to him or her by other group health plans if he or she has more than a 63-day gap in health coverage, and election of COBRA continuation coverage may help him or her avoid such a gap.
- Second, he or she will lose the guaranteed right to purchase individual health insurance policies that do not impose pre-existing condition exclusions if he or she does not elect COBRA continuation coverage for the maximum time available to him or her.
- Finally, he or she should take into account that he or she has special enrollment rights under federal law. A qualified beneficiary has the right to request special enrollment in another group health plan for which he or she is otherwise eligible (such as a plan sponsored by his or her spouse's employer) within 30 days after his or her group health coverage ends because of the qualifying event listed above. A qualified beneficiary will also have the same special enrollment right at the end of COBRA continuation coverage if he or she elects this coverage for the maximum time available to him or her.

To elect COBRA continuation coverage, a qualified beneficiary must complete an election form provided by the Plan Administrator. Under federal law, a qualified beneficiary must have 60 days from the later of the date of the notice is mailed by the Plan to decide whether he or she wants to elect COBRA continuation coverage under the Plan. To elect COBRA continuation coverage, the qualified beneficiary must send the completed election form to the Plan Administrator. Each qualified beneficiary has the right and must be offered the opportunity to elect COBRA continuation coverage. However, an Employee, or the spouse of an Employee can elect COBRA continuation coverage on behalf of all other qualified beneficiaries. Also, a parent (or legal guardian) can make an election on behalf of a minor child. An election is considered to be made on the date that the completed election form is mailed (as evidenced by the postmark) or delivered in person to the Plan Administrator.

An Employee may not decline COBRA continuation coverage on behalf of his or her eligible Dependents. If an Employee does not elect COBRA continuation coverage on behalf of his or her Dependents who are entitled to COBRA continuation coverage, Dependents are entitled to make a separate and independent election of COBRA continuation coverage within the period of time during which the Employee could have elected COBRA continuation coverage.

COBRA continuation coverage may be elected for an individual who, as of the individual's election date, is already covered under another group health care plan (including Medicare), provided however, that if an individual becomes covered, after the date of the election of COBRA continuation coverage, under another group health care plan, COBRA continuation coverage will terminate unless the individual has a pre-existing medical condition that would cause benefits to be excluded or limited under the other group health care plan, in which case this exclusion will not apply.

Neither an Employee nor his or her Dependents are required to prove that they are insurable in order to be entitled to COBRA continuation coverage.

If a qualified beneficiary does not submit a completed election form by the date shown on the form, he or she will be deemed to have declined COBRA continuation coverage and will lose his or her right to elect COBRA continuation coverage. If a qualified beneficiary rejects COBRA continuation coverage before the due date, he or she may change his or her mind as long as he or she furnishes a completed election form before the due date. However, if a qualified beneficiary changes his or her mind after first rejecting COBRA continuation coverage, his or her COBRA continuation coverage will begin on the date he or she furnishes the completed election form.

MAKING PAYMENTS FOR COBRA CONTINUATION COVERAGE

If a qualified beneficiary elects COBRA continuation coverage, he or she does not have to send any payment for COBRA continuation coverage with the election form. However, a qualified beneficiary must make his or her first payment for COBRA continuation coverage within 45 days after the date the election form is returned to the Plan Administrator. If a qualified beneficiary does not make his or her first payment for COBRA continuation coverage within those 45 days, he or she will lose all COBRA continuation coverage rights under the Plan.

The first payment must cover the cost of COBRA continuation coverage from the time a qualified beneficiary's coverage under the Plan would have otherwise ended, up to the time he or she makes the first payment. Qualified beneficiaries are responsible for making sure that the amount of his or her first payment is enough to cover this entire period. A qualified beneficiary may contact the Plan Administrator to confirm the correct amount of his or her first payment.

After a qualified beneficiary makes his or her first payment for COBRA continuation coverage, he or she will be required to pay for COBRA continuation coverage for each subsequent month of coverage. Under the Plan, these periodic payments for COBRA continuation coverage are due on the first day of the month for which payment is made. A payment is considered to be made on the date that the payment is mailed or delivered in person to the Plan Administrator. The Plan will not send periodic notices of payments due for these coverage periods. A COBRA payment will be considered on time if it is received within 30 days of the due date. A COBRA payment is considered made when it is mailed (postmarked) or personally delivered.

GRACE PERIODS FOR COBRA PAYMENTS

Although COBRA payments are due on the dates previously noted, a qualified beneficiary will be given a grace period of 30 days to make each COBRA payment. A qualified beneficiary should note that the grace period does not apply to the first COBRA payment, which is due within 45 days of election of COBRA continuation

coverage, as previously described. COBRA continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if a qualified beneficiary pays a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage and the qualified beneficiary submits a claim within that period, he or she may receive an explanation of benefits that a benefit determination cannot be made due to a pending COBRA payment. If a qualified beneficiary fails to make a COBRA payment before the end of the grace period for that payment, he or she will lose all rights to COBRA continuation coverage under the Plan.

WHEN COBRA CONTINUATION COVERAGE ENDS

COBRA continuation coverage will be terminated before the end of the maximum period if:

- Any required premium is not paid on time;
- A qualified beneficiary becomes covered, after electing COBRA continuation coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary;
- A qualified beneficiary becomes entitled to Medicare benefits (qualified for and enrolled in coverage under Part A, Part B or both); or
- The Employer ceases to provide any group health plan for its Employees.

COBRA continuation coverage may also be terminated for any reason the Plan would terminate any other Covered Person's coverage (such as fraud). When COBRA continuation coverage ends, a qualified beneficiary will be provided with a Notice of Credible Coverage, which may reduce any pre-existing condition limitations under another health plan.

IF YOU ENTER ACTIVE MILITARY SERVICE

If an Employee is on active duty in the military for 31 days or less, he or she will continue to receive health care coverage under the Plan for up to 31 days, according to the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

If an Employee is on duty in the military for more than 31 days, his or her coverage under this Plan will normally end. However, USERRA permits an Employee to continue Plan coverage for himself or herself and his or her Dependents at his or her own expense until the earlier of 24 consecutive months after Plan coverage ends or the end of the period during which the Employee is eligible to apply for re-employment in accordance with USERRA.

An Employee must elect continuation coverage under USERRA for himself or herself and any of his or her Dependents who are covered by the Plan on the date coverage ends due to the Employee's active duty in the military. An Employee's election for USERRA continuation coverage must be made within 60 days after the date eligibility for Plan coverage terminates due to his or her active service in the U.S. military. If an Employee does not elect USERRA continuation coverage within the 60-day timeframe, the Employee (and his or her Dependents) will no longer be eligible for such continuation coverage.

If an Employee's coverage under the Plan is continued under any other continuation of coverage provision of this Plan, (such as COBRA Continuation Coverage) the periods of USERRA continuation coverage and the other contribution coverage will run concurrently.

Coverage under this Plan will not be offered for any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services. The uniformed services and the Department of Veterans Affairs will provide care for service-connected disabilities.

An Employee's USERRA continuation coverage may be terminated if:

- He or she does not pay the required premium;
- The Employee exhausts the 24-month coverage period;
- The Plan ceases to provide group health coverage;
- The Employee loses his or her rights under USERRA (for instance, for a dishonorable discharge); or

- The Employee fails to return to work or applies for reemployment within the time required under USERRA.

Following discharge from military service, an Employee may be eligible to apply for reemployment with the City of Springfield in accordance with USERRA. Such reemployment rights include the right to elect immediate reinstatement of the Employee's health benefits under the Plan.

FUNDING

Cost of the Plan

The cost of the Plan is funded as follows:

(a) For Employee Coverage, the City pays 100% of the full cost of coverage for eligible Employees as long as they are actively working, on an approved paid leave of absence or on an FMLA approved leave of absence (as required by law and regardless of pay status). Should the Employee not meet the above criteria for City paid premium, the Employee must make the monthly contribution for their coverage.

(b) For Dependent Coverage, when elected, payment for the cost of dependent coverage is the responsibility of the covered employee. Employees are required to pay the premium for dependent coverage to the City of Springfield to maintain their dependents' coverage during any type of leave absence. Contributions shall be deducted from an Employee's paycheck during the month preceding the coverage period, for example deductions from paychecks in May provide funding for June dependent coverage. If payment cannot be deducted from the employee's pay check due to insufficient earnings or lack of paid leave time to cover the monthly premium, the employee will be responsible for remitting the premium due to the City of Springfield by the first of the month that coverage is provided.

(c) Medicare Eligible Retirees who have been approved for coverage due to a serious health condition that makes them ineligible for a Medicare secondary plan will contribute the employee premium less the current Medicare Part B premium rate.
COBRA Plan participants must pay a premium in accordance with the terms described in the COBRA provisions of the Plan.

The amount of City and Employee contributions is recommended by the Health Insurance Committee and/or the City Manager and as required, approved by City Council. The Health Insurance Committee shall from time to time evaluate the costs of the Plan and recommend the amount to be contributed by the Employee and Dependents.

In the event that the City of Springfield terminates this Plan, then as of the termination date, the Employees and Dependents, and the City of Springfield shall have no further obligation to make additional contributions to the Plan.

ENROLLMENT

Enrollment Requirements

Before Plan coverage can begin, an Employee must enroll for Employee coverage (and for Dependent coverage if so elected) by filling out and signing an enrollment application.

Minimum Dependent Enrollment Period

Dependents, once enrolled, shall remain enrolled for a minimum period of 6 months from the effective date of dependent coverage.

Dependent Coverage

Dependent coverage is not automatic. Their coverage is elective.

OPEN ENROLLMENT

An annual Open Enrollment period will be held prior to the beginning of each Plan year to allow employees to enroll eligible dependents for coverage. The Employer will announce in advance the specific dates for the Open Enrollment period. Plan participants will receive detailed information regarding Open Enrollment from their Employer.

Eligible dependents who were not enrolled when initially eligible or due to a qualifying event, may enroll during the Open Enrollment Period.

Benefit choices made during the Open Enrollment period will become effective 12:01 a.m. the following January 1.

Plan Participants who fail to make an election during Open Enrollment will automatically retain his or her present coverages or lack thereof.

TIMELY AND LATE ENROLLMENT

Timely Enrollment

The enrollment will be "timely" for Employees and Dependents if the completed enrollment form is received and approved by the Plan Administrator:

(a) No later than 31 days after the initial date the Employee meets the eligibility requirements;

(b) No later than 31 days after the following events:

  i. The effective date of marriage;

  ii. The date of birth of a child, the adoption of a child, or the placement of a child with the Employee for adoption;

(c) No later than 31 days following the loss of other health care coverage. In all such prior coverage situations, the request for enrollment in the Plan of a Dependent must be submitted within thirty-one days of the discontinuance of prior health coverage. The Plan shall require that evidence satisfactory to the Plan Administrator regarding prior health coverage be provided as a condition of enrollment.

(d) In regard to eligible dependent children born or adopted on or after July 1, 2001, to or by current employees who at the time of the birth or adoption already had dependent coverage in force under this Plan and have maintained such coverage in force on a continuous uninterrupted basis following said birth or adoption and through the time of request for enrollment of such dependent child, said dependent children shall be initially enrolled by this plan upon request by the employee.

(e) No later than 60 days following the loss of coverage through Medicaid or CHIP or within 60 days of eligibility for premium assistance under Medicaid or CHIP.

If two Employees (husband and wife) (or Employee and Retiree) are covered under the Plan and the Employee who is covering the Dependent children terminates coverage or retires, the Dependent coverage may be continued by the other covered Employee with no Waiting Period and no pre-existing condition exclusions as long as coverage has been continuous.

Late Enrollment Dependents

An enrollment is "late" if it is not made on a "timely basis" or during the Open Enrollment Period unless otherwise defined by Federal and State law.

EFFECTIVE DATE

Effective Date of Employee Coverage

An Employee's coverage under the Plan will become effective as of 12:01 a.m. the first day of the month following the date he or she initially meets the eligibility requirements. The waiting period is no more than 31 days.

If coverage of an eligible Employee would otherwise begin on a date that the Employee is absent from work because of Illness or Injury, coverage will not begin until the date the Employee returns to work.

Effective Date of Dependent Coverage

When enrollment is due to initial eligibility or a qualifying event, a Dependent's coverage under the Plan will become effective as of 12:01 a.m. the first day of the month following the date on which he or she meets the definition of a Dependent or the date he or she meets the eligibility requirements.

Dependent(s) covered under the Plan who are enrolled during the Open Enrollment period will become effective 12:01 a.m. on the first day of the next Plan year.

For newborn children, adopted children or children placed with a child with an employee in anticipation of adoption, coverage is effective the date of birth, date of adoption or date of placement when the parent elects coverage within 31 days said event.

If coverage for a Dependent would otherwise begin while the Dependent is confined in a Hospital, except for a newborn child confined in a hospital at birth, coverage will not begin until the date immediately following the date the Dependent is discharged from the Hospital.

RECISSION

Under no circumstances will coverage be terminated retroactively except in the case of fraud, material misrepresentation or nonpayment of premiums.

TERMINATION OF COVERAGE

When coverage under this Plan stops, Covered Persons will receive a Certificate of Creditable Coverage from the Claims Administrator that will verify their period of coverage under this Plan. Please contact the Claims Administrator or the Plan Administrator for further details.

When Employee Coverage Terminates

Employee coverage will terminate at midnight on the earliest of these dates unless termination is due to retirement (except in certain circumstances, a covered Employee may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled COBRA Continuation Coverage Rights):

1. The date the Plan is terminated.

2. The date the covered Employee no longer meets the Eligibility requirements.

3. The date that any contribution required by you or on your behalf is due and unpaid.

4. The date of the Employee's death.

5. The end of the period for which the required contribution has been paid if the Employee is on non-FMLA leave without pay.

6. Midnight of the last day of the calendar month in which an Employee ceases to be an eligible Employee with the exception of employees who retire. When the employee retires, coverage in the employee plan terminates the last day of the month following the final employee pay check date (see definition of Retired Employee).

7. If you are a surviving spouse, the date on which you became remarried, eligible for any other group medical plan because of employment, or become eligible for any other federal or state medical plan (except Medicare).

8. In accordance with the requirements in the Affordable Care Act, the Plan will not retroactively cancel coverage except when contributions are not timely paid, or in cases of fraud or intentional misrepresentation of material fact.

9. If an employee terminates employment and is reinstated to employment within the same calendar month and same calendar year, coverage will **not** be terminated. Therefore, there shall be no break in coverage for this employee.

When Dependent Coverage Terminates

A Dependent's coverage will terminate at midnight on the earliest of these dates:

1. The date the Plan or Dependent coverage is terminated.

2. Midnight of the last day of the calendar month in which a covered spouse or Dependent child loses Dependent status, provided that such spouse or Dependent child does not elect to continue coverage under the circumstances described under the Section entitled "Eligibility Requirements for Dependent Coverage" Section.

3. On midnight of the last day of the calendar month that a Dependent child ceases to be an eligible Dependent as defined by the Plan.

4. Midnight of the last day of the calendar month in which the Employee requests that a Dependent's coverage be terminated. Voluntary termination may or may not be allowed in certain situations and time of the plan year due to State and Federal law.

5. The date that any contribution required by an Employee is due and unpaid.

6. If you are a surviving spouse, the date on which you became remarried, eligible for any other group medical plan because of employment, or become eligible for any other federal or state medical plan.

7. Coverage for dependents of an employee, who is retiring, ends midnight of the last day of the month following the employee's final pay check date.

8. If an employee terminates employment and is reinstated to employment within the same calendar month and same calendar year, a covered spouse or Dependent Child will **not** be terminated. Therefore, there shall be no break in coverage for the covered spouse or Dependent Child.

The Employee shall be responsible for notifying the Plan Administrator of new Dependents and of any changes in the eligibility status of a Dependent. Benefits provided to an ineligible Dependent will be recouped by the Plan in accordance with its rights for reimbursement. Employee contributions paid for a period when the Employee knew or should have known the Dependent was ineligible may not be reimbursed to the Employee.

The City of Springfield reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust agreement (if any). Any such amendment or termination shall be recommended by the City of Springfield's Health Insurance Committee and formally adopted by the City Council, unless otherwise authorized.

SCHEDULE OF BENEFITS

VERIFICATION OF ELIGIBLITY

Contact the Third Party Administrator/Claims Administrator as listed on Page 2 of the Plan Document to verify eligibility for Plan benefits **before** the charge is incurred.

PREADMISSION CERTIFICATION

(Also referred to as **PRECERTIFICATION**) means the review of all Hospital admissions prior to the admission date. This program is designed to help ensure that all Covered Persons receive necessary and appropriate health care while avoiding unnecessary expenses when a Hospital stay is proposed. For example, based on the information provided by the Physician, the Pre-certification Nurse will make an initial assessment of the condition to determine, among other things: if a second surgical opinion is required or recommended; if the admission is to an In-Network facility; if concurrent review by Utilization Review Coordinator is to be initiated; and if Medical Case Management is applicable.

PRECERTIFICATION REQUIREMENT

If any part of a Hospital or other inpatient stay is not precertified per the instructions in the Cost Management Section, the benefit payment will be reduced by $100.

Release from a Hospital and readmission to the same or different Hospital within 96 hours due to the same medical condition shall count as one admission as far as penalty assessment is concerned. Treatment for Substance Abuse will not be subject to Utilization Review. No penalty will be assessed for treatment for Substance Abuse, regardless of whether treatment occurs in a general Hospital, emergency care facility or accredited and approved alcohol and Substance Abuse center.

The attending Physician does not have to obtain precertification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery. (The Hospital stay begins at the time of delivery, or admission if the delivery occurred outside the Hospital.) The Covered Person is still required to precertify the Hospital stay.

If the stay is not precertified, the individual is responsible for the penalty amount indicated above. (Refer to the Cost Management Services Section for complete details.)

PREAUTHORIZATION

Preauthorization of certain services is requested and may expedite the adjudication of the claim. (For items marked with * in the Schedule of Benefits table, refer to the Cost Management Services Section for complete details.)

All organ transplant services, including evaluation, must be preauthorized or benefits may otherwise be reduced or denied. The Covered Person or his/her physician must call the Third Party Administrator as listed on page 2 when the Physician first indicates a transplant is recommended. Retransplantation procedures must also have preauthorization.

TIMELY FILING OF CLAIMS

Claims must be filed with the Claims Administrator within fifteen (15) months of the date charges for the service was incurred. If the Plan should terminate, all claims must be filed within 90 days of the Plan's termination date. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date may be declined. (Refer to the section entitled "How to File a Claim".)

MEDICAL BENEFITS

To be considered an Eligible Benefit under this Plan, treatment, services and/or supplies must meet all of the following criteria:

- Be Medically Necessary;
- Be ordered by an appropriate Physician;

- Not be excluded under the Plan; and
- Meet the standards of care for the diagnosis.

All benefits described in this Schedule are subject to the exclusions and limitations described more fully herein including, but not limited to the above.

Allowable Charges will be determined as follows:

- Charges for Network Providers that are considered under the Out-of-Network benefit, will be allowed up to the contracted rate/negotiated rate or billed amount, whichever is less unless specifically stated otherwise in the contract with that provider.

- Charges for Non-Network Providers that are considered under the In-Network benefit will be allowed at the Usual and Customary Allowance unless other negotiations are made with that provider.

- Charges for Non-Network Providers will be allowed up to the lesser of the rates contracted with Mercy Hospital and Physicians (as defined in the Mercy contract), the Usual and Customary Allowance, or the billed amount unless other negotiations are made with that provider. Notwithstanding the foregoing, parenteral medications administered by a provider in an outpatient setting will be allowed at the lesser of the provider's billed charge or the current Average Wholesale Price (AWP). The AWP will also be applied to parenteral medications administered during an inpatient hospitalization in which the total billed charges exceed the contracted outlier limit for Mercy Hospital.

The Covered Person will be responsible for the amount in excess of the Allowable Charge. This excess amount will not apply to Deductible or Coinsurance maximums.

The Plan has a (PPO) Preferred Provider Organization as identified on page 2 of this document.

This Plan has entered into an agreement with certain Hospitals, Physicians and other health care providers, which are called In-Network Providers. Because these In-Network Providers have agreed to charge reduced fees to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees.

Therefore, when a Covered Person uses an In-Network Provider, that Covered Person will receive a higher payment from the Plan than when an Out-of-Network Provider is used. It is the Covered Person's choice as to which Provider to use.

Additional information about this network is available in the Human Resources Department. A list of In-Network Providers is available by calling the PPO's number listed on page 2 of this document or searching for a provider on their web site. The PPO's home page is listed on page 2 of this document. In order to obtain benefits at the higher level, it is the Covered Person's responsibility to make sure the provider is participating in the network prior to seeking services. Call the provider to verify their current status before each visit.

The Claims Administrator may also contract directly with certain Hospitals and Physicians. These providers will be considered Participating Providers.

Under the following circumstances, the higher In-Network Provider benefit will be applied for certain Out-of-Network Provider services:

SERVICES WITHIN OR OUTSIDE THE NETWORK AREA

1. If a Covered Person has no choice of Network Providers in the specialty required to treat the illness or injury within the PPO service area because the network does not have that type of provider available. Verification of the availability, or lack thereof, of a Network Provider must be submitted to the Claim Administrator by the Covered Person or the Physician to review for authorization of payment at the Network Provider benefit level prior to seeking services.

   Though not a specialty as defined by this Plan, midwife services will be paid as in-network if no in-network provider (midwife) is available.

2. If a Covered Person has an Emergency Medical Condition (on an inpatient or outpatient basis) that is a Life-threatening situation when the Covered Person had no control regarding the Hospital to which they were taken. This applies to ambulance transport, facility and Physician charges. For an inpatient admission, in order to continue to receive the higher benefit once the Covered Person's condition has been stabilized following admission to a Non-Participating facility, the Covered Person must be transferred to a Participating facility.

3. If a Covered Person receives Physician, diagnostic or anesthesia services by an Out-of-Network Provider when the Covered Person did not have a choice of In-Network Providers or they were not available while admitted inpatient or outpatient at an In-Network facility.

4. If a Covered Person has a specimen for a lab test drawn or an x-ray taken by an In-Network Provider but an Out-of-Network Provider performs the lab test or reads the x-ray.

5. If a Covered Person receives treatment, services or supplies by an Out-of-Network Provider and the charges for the services were negotiated and/or approved by the Utilization Review Coordinator as listed on Page 2 of this document. (Pre-certification is not an approval of the services or a guarantee of payment for the services.) *However, charges for services with discounts accessed through a repricing network in absence of any other exception listed above will be considered at the Out-of-Network Provider benefit level.*

DEDUCTIBLES PAYABLE BY PLAN PARTICIPANTS

Deductibles are dollar amounts that the Covered Person must pay before the Plan pays.

A deductible is an amount of money that is paid by the Covered Person once a Calendar Year. It must be paid before any money is paid by the Plan for any Covered Charges. Each January 1st, a new deductible amount is required. Deductibles accrue toward the 100% maximum out-of-pocket payment.

Any expenses applied against the deductible in the last three (3) months of a calendar year may also be applied against the deductible for the next year.

When an Employee retires mid-plan year, claims that have been accumulated toward the annual deductible in the employee plan do not carry over to the annual deductible in the Non-Medicare Retiree Health Plan.

EMERGENCY ROOM PENALTY

The emergency room Penalty of $100 is not applied to any deductible or out of pocket maximum. It is imposed even if the Covered Person has met his or her total out-of-pocket maximum. It is waived if the Covered Person is admitted to the Hospital on an emergency basis directly from the emergency room, if treatment is substantiated by severity of the sickness or injury or if a Physician provides a referral within the time period as follows: the Utilization Review Coordinator or the Claims Administrator must be notified within 48 hours of a weekday admission and within 72 hours after an admission on a weekend or legal holiday. This notification requirement applies even if the patient is discharged within the 48/72 hour period.

SCHEDULE OF BENEFITS (CHART)

(Refer to the Cost Management Services Section for Preauthorization on Items Marked with *.)

	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
MAXIMUM LIFETIME BENEFIT AMOUNT	No lifetime maximum	
DEDUCTIBLE, PER CALENDAR YEAR		
Per Covered Person Per Family Unit	$500 $1,000	$1,000 $2,000
Note: The Calendar Year deductible is waived for certain services. Refer to the benefits below for further information. In addition, the maximum amounts an individual can contribute to the family In-Network deductible and coinsurance maximums are the amounts up to the In-Network "Per Covered Person" maximums. Therefore, if the individual has out-of-network services, only the amount up to the In-Network maximum will be counted toward reaching the family's In-Network maximum. For example, an individual has Out-of-Network Covered Charges of $1,200. $1,000 will be applied to the Out-of-Network deductible. The individual In-Network deductible amount will be credited $500 for calculating their In-Network deductible and the family unit maximum.		
CO-INSURANCE	80%	60%
MAXIMUM COINSURANCE AMOUNT, PER CALENDAR YEAR		
Per Covered Person Per Family Unit	$2,000 $4,000	$6,000 $12,000
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR (deductible plus coinsurance)		
Per Covered Person Per Family Unit	$2,500 $5,000	$7,000 $14,000
Note: The Plan will pay the designated percentage of Covered Charges until out-of-pocket (deductible plus coinsurance) amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise. The following charges do not apply toward the coinsurance maximum: • Cost containment penalties • Charges above usual and reasonable charges • Ineligible or excluded expenses • Out-of-Network prescription co-pay and coinsurance charges Note: The maximum amounts an individual can contribute to the family In-Network deductible and coinsurance maximums are the amounts up to the In-Network "Per Covered Person" maximums. Therefore, if the individual has Out-of-Network services, only the amount up to the In-Network maximum will be counted toward reaching the family's In-Network maximum. For example, an individual has Out-of-Network Covered Charges of $1,200. $1,000 will be applied to the Out-of-Network deductible The individual In-Network deductible amount will be credited $500 for calculating their In-Network deductible and the family unit maximum.		
COVERED SERVICES		
AMBULANCE SERVICE	80% after deductible	For emergent: 80% after deductible For non-emergent: 60% after deductible
Note: For Out-of-Network services to qualify as emergent, they must meet the criteria outlined prior to this table.		
***Applied Behavior Analysis for Autisum Spectrum Disorders**	80% after deductible	60% after deductible
***CARDIC/PULMONARY THERAPY**	80% after deductible	60% after deductible
CONTRACEPTIVE DEVICES (Must be prescribed by a Physician)	100%, deductible waived	60% after deductible
DIAGNOSTIC TESTS & X-RAYS (including Pre-admission Testing)	80% after deductible	60% after deductible
***DURABLE MEDICAL EQUIPMENT**	80% after deductible	60% after deductible
***HOME HEALTH CARE**	80% after deductible 60 visits Calendar Year maximum	60% after deductible 60 visits Calendar Year maximum

	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
HOSPICE CARE	80% after deductible 90 days maximum (Combined inpatient days and outpatient per diem)	60% after deductible 90 days maximum (Combined inpatient days and outpatient per diem)
HOSPITAL SERVICES		
Emergency Room	80% after deductible	For emergent: 80% after deductible For non-emergent: 60% after deductible.
Note: For services to qualify as emergent, they must meet the criteria outlined prior to this table. Refer to "Emergency Room Penalty" section preceding the "Schedule of Benefits (Chart)" for penalties that may apply.		
Room and Board	80% after deductible At the semiprivate room rate	60% after deductible At the semiprivate room rate
Note: Precertification Penalty: A $100 penalty will be charged for failure to precertify scheduled inpatient Hospitalizations. The precertification penalty will not count toward the Out-of-Pocket Limit (including the Deductible and Coinsurance Limit).		
Other Outpatient Services not listed herein	80% after deductible	60% after deductible
Intensive Care Unit	80% after deductible At Hospital's ICU rate	60% after deductibles At Hospital's ICU rate
JAW JOINT/TMJ (Non-surgical treatment requires predetermination – Note: Orthodontia is excluded)	80% after deductible	60% after deductible
MENTAL DISORDERS		
Inpatient	80% after deductible	60% after deductible
Outpatient & office visits	80% after deductible	60% after deductible
***OCCUPATIONAL THERAPY**	80% after deductible	60% after deductible
***ORGAN TRANSPLANTS**	Designated Transplant Facility: 80% after deductible	Non-Designated Transplant Facility: 60% after deductible
Note: Organ and tissue transplants are covered except those which are classified as "Experimental and/or Investigational". All Organ Transplant services, including evaluation, **must** be preauthorized or benefits may otherwise be reduced or denied. Therefore, the Covered Person or his/her physician must call the Third Party Administrator (as listed on page 2) when the Physician first indicates a transplant is recommended. Retransplantation procedures must also have preauthorization. Non-authorized services rendered by a non-designated transplant facility will be excluded by this Plan.		
***ORTHOTICS**	80% after deductible	60% after deductible
***OUTPATIENT PRIVATE DUTY NURSING**	80% after deductible	60% after deductible
***PHYSICAL THERAPY**	80% after deductible	60% after deductible
PHYSICIAN SERVICES		
Inpatient visits	80% after deductible	60% after deductible
Office visit charges	80% after deductible	60% after deductible
Surgery	80% after deductible	60% after deductible
All other services:	80% after deductible	60% after deductible
PREGNANCY	80% after deductible	60% after deductible
Note: Two ultrasounds will be considered an eligible expense for a routine Pregnancy to determine gestational age and for routine screening. Services listed as preventive under the Affordable Care Act will be considered under the Preventive Care benefit.		

	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
PRESCRIPTION DRUGS (Administered Inpatient, Outpatient, or Physician's Office)	80% after deductible	60% after deductible
Pharmacy Retail (see Prescription Drug Benefits section for exclusions and other plan provisions)	$5.00 co-pay per 30-day fill plus 20% of the remainder of the cost per Prescription 90 day fill only allowed at preferred retail pharmacies Maximum fill: 90 days	Subject to Out-of-Network deductible and coinsurance
Mail Order (see Prescription Drug Benefits section for exclusions and other plan provisions)	20% of total cost per Prescription Maximum Fill: 90 days	Subject to Out-of-Network deductible and coinsurance; Claim must be filed by the Plan Participant with the Health Plan Third Party Administrator.
In-Network Pharmacy Retail and Mail Order: Maximum Out-of-Pocket, per calendar year: Per Covered Person: $4,100; Per Covered Family: $8,200. Out-of-Pocket maximums adjust annually as permitted by the Affordable Care Act.		
Mandatory Generic: If the plan participant elects a brand name drug when a generic drug is available, the cost is $5 co-pay (co-pay waived if using mail order) plus 20% of the total cost per prescription plus the difference in cost between the generic and brand name drug.		
Specialty Drugs must be obtained through the Preferred Provider Specialty Drug Provider of the Plan. Plan participants pay 20% of the total prescription cost. Specialty Drugs shall have an individual out-of-pocket maximum of $1,500 per plan year. See the Prescription Section of the Plan for exclusions and other specialty drug plan provisions.		
Costs incurred for Prescriptions filled through pharmacy retail and mail order do not apply toward medical deductible and coinsurance amounts.		
PREVENTATIVE CARE		
Preventive Care is limited to reimbursement for the following routine services:		
PREVENTIVE WELL ADULT AND WELL CHILD CARE	100%, deductible waived	Subject to Out-of-Network deductible and coinsurance
Benefit restricted to services performed in conjunction with preventive examinations such as a physical examination, laboratory tests, mammograms, gynecologic exams, prostate screening, colonoscopy, immunizations (including immunizations required for travel outside the United States) and other preventive or screening exams per the standard criteria for the plan member's age. Benefit also includes recommended preventive services under the Affordable Care Act (ACA). The ACA follows services recommended by the United States Preventive Services Task Force (categories A and B), as well as recommendations and guidelines of the Advisory Committee on Immunization Practices (ACIP),and the Health Resources and Services Administration (HRSA). A current listing of recommended preventive care services under the Affordable Care Act can be accessed at www.HealthCare.gov/center/regulations/prevention.html		
ROUTINE WELL NEWBORN CARE NURSERY/PHYSICIAN CARE (Initial Hospital confinement)	80% after deductible	Subject to Out-of-Network deductible and coinsurance
***PROSTHETICS**	80% after deductible	60% after deductible
SECOND SURGICAL OPINION, VOLUNTARY Note: Refer to Cost Management Services section.	80% after deductible	60% after deductible
SKILLED NURSING FACILITY	80% after deductible At the facility's semiprivate room rate 60 days Calendar Year maximum	60% after deductible At the facility's semiprivate room rate 60 days Calendar Year maximum
SMOKING CESSATION	100% deductible waived	60% after deductible
***SPEECH THERAPY**	80% after deductible	60% after deductible

SPINAL MANIPULATION Note: Must be performed by an M.D. orD.O.	80% after deductible	60% after deductible
SUBSTANCE ABUSE, INCLUDING ALCOHOL ABUSE AND OTHER CHEMICAL DEPENDENCY		
Inpatient	80% after deductible Unlimited Days	60% after deductible Unlimited Days
Outpatient	80% after deductible Unlimited Visits	60% after deductible Unlimited Visits
	IN-NETWORK PROVIDERS	**OUT-OF-NETWORK PROVIDERS**
WEIGHT MANAGEMENT	80% after deductible	60% after deductible
Note: Coverage only when medically necessary and requires utilization review (see obesity description in exclusions section).		
ALL OTHER COVERED CHARGES not excluded or limited in this Plan Document.	80% after deductible	60% after deductible

MEDICAL BENEFITS

Medical Benefits apply when Covered Charges are incurred by a Covered Person for care of an Injury or Illness and while the person is covered for these benefits under the Plan.

DEDUCTIBLE

Deductible Amount

This is an amount of Covered Charges for which a Covered Person is responsible before the Plan begins to pay benefits. Before benefits can be paid in a Calendar Year a Covered Person must meet the individual and/or the family unit deductible shown in the Schedule of Benefits.

This amount will accrue toward the 100% maximum out-of-pocket payment. It does not count toward the coinsurance maximum.

Family Unit Limit

When the maximum amount shown in the Schedule of Benefits has been incurred by members of a Family Unit toward their Calendar Year deductibles, the deductibles of all members of that Family Unit will be considered satisfied for that year. One person can only contribute up to the individual person amount toward the family unit. The Family Unit maximum is calculated by adding together the individual amounts satisfied by all Covered Person in the family covered under the same ID number.

Deductible For A Common Accident

This provision applies when two or more Covered Persons in a Family Unit are injured in the same accident.

These persons need not meet separate deductibles for treatment of injuries incurred in this accident; instead, only one deductible for the Calendar Year in which the accident occurred will be required for them as a unit for expenses arising from the accident.

BENEFIT PAYMENT

Each Calendar Year, benefits will be paid for the Covered Charges of a Covered Person that are in excess of the deductible. Payment will be made at the rate shown in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount or any listed limit of the Plan. The Covered Person must satisfy the deductible, coinsurance and benefit limits as stated in the Schedule of Benefits.

OUT-OF-POCKET LIMIT

Out-of-pocket equals deductible plus coinsurance. Covered Charges are payable at the percentages shown each Calendar Year until the out-of-pocket limit shown in the Schedule of Benefits is reached. Then, Covered Charges incurred by a Covered Person will be payable as shown in the Schedule of Benefits (except for the charges excluded) for the rest of the Calendar Year.

When a Family Unit reaches the out-of-pocket limit, Covered Charges for that Family Unit will be payable as shown in the Schedule of Benefits (except for the charges excluded) for the rest of the Calendar Year.
When a Covered Person elects COBRA, he/she will only receive credit for any individual deductible and coinsurance amounts applied on services incurred prior to the COBRA coverage date. Individual deductible and/or coinsurance amounts applied to claims with dates of service incurred after the COBRA coverage date will not apply toward the prior active family accumulated totals. Covered Persons in a Family Unit on COBRA will accrue their individual totals toward the Family Unit totals. Dependent Children who elect COBRA without a parent will be covered as separate individuals. Covered Persons in a Family Unit on COBRA will accrue their individual totals toward the Family Unit totals.

MAXIMUM BENEFIT AMOUNT

The Maximum Benefit Amount, if any, is shown in the Schedule of Benefits. It is the total amount of benefits that will be paid under the Plan for all Covered Charges incurred by a Covered Person.

COVERED CHARGES

Covered charges are the Usual and Reasonable Charges that are incurred for the following items of service and supply. These charges are subject to the benefit limits, exclusions and other provisions of this Plan. A charge is incurred on the date that the service or supply is performed or furnished.

1. Hospital Care

The medical services and supplies furnished by a Hospital or Ambulatory Surgical Center or a Birthing Center. Covered charges for room and board will be payable as shown in the Schedule of Benefits. After 23 observation hours, a confinement will be considered an inpatient confinement. Claims submitted for longer than 23 hours will be pended for a corrected inpatient claim.

Room charges made by a Hospital for a semi-private room with general nursing care shall be paid in accordance with the Schedule of Benefits and charges for private rooms will not be paid unless it is Medically Necessary or if the facility does not provide semi-private rooms and charges for a private room will be paid in accordance with the semi-private room rates as shown in the Schedule of Benefits.

Charges for an Intensive Care Unit stay are payable as described in the Schedule of Benefits.

2. Provider Nondiscrimination

The Plan will cover covered charges without regard to the type of health care provider as long as that individual is licensed under State law, and performing within the scope of their practice, as defined under State law. A “health care provider” shall include:

a. doctors of medicine or osteopathy authorized to practice medicine or surgery by the State in which the doctor practices; and
b. podiatrists, dentists, clinical psychologists, optometrists and chiropractors (limited to manual manipulation of the spine to correct subluxation as demonstrated by X-ray to exist), authorized to practice and performing within the scope of their practice, as defined under State law.

Notwithstanding the foregoing, the Plan shall not be required to contract with any health care provider willing to abide by the terms and conditions for participation established by the Plan.

3. Coverage for Pregnancy

The Usual and Reasonable Charges for the care and treatment of Pregnancy are covered the same as any other Sickness for a covered Employee or covered Spouse. Services listed as preventive under the Affordable Care Act will be considered under the Preventive Care benefit.

Group health plans generally may not, under Federal law, 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 cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). The Covered Person is still responsible for the Precertification process. (Refer to the Cost Management Section.) The 48- or 96-hour inpatient stay begins at the time the delivery occurs in the Hospital. For deliveries occurring outside of the Hospital, the stay begins at the time the mother and/or newborn are admitted as an inpatient to a Hospital.

4. Skilled Nursing Facility Care

The room and board and nursing care furnished by a Skilled Nursing Facility will be payable if and when:

a. the patient is confined as a bed patient in the facility;

b. the attending Physician certifies that the confinement is needed for further care of the condition that caused the Hospital confinement;

c. the attending Physician completes a treatment plan, which includes a diagnosis, a proposed course of treatment, and a projected date of discharge from the Skilled Nursing Facility. The care must be likely to result in a significant improvement in the Covered Person's condition; and

d. the degree of care must be more than can be given in the Covered Person's home, but not so much as to require acute hospitalization;

e. the confinement starts immediately following a Hospital confinement of at least 3 days.

In lieu of the above criteria, services will be covered if they are pre-certified as Medically Necessary through the Utilization Review program.

Covered charges for a Covered Person's care in a Skilled Nursing Facility are limited to the covered daily maximum shown in the Schedule of Benefits.

5. Physician Care

The professional services of a Physician for surgical or medical services. Charges for the following services will be a Covered Charge subject to the following provisions:

If a physician's assistant or nurse practitioner bills for covered services other than as an assistant surgeon, the covered charge will not exceed 75% of the MD or DO's contract rate, Usual and Reasonable allowance or billed charges, whichever is less.

Charges for multiple surgical procedures will be a Covered Charge subject to the following provisions:

a. If Bilateral or Multiple Surgical Procedures are performed by one (1) surgeon, benefits will be determined based on the Usual and Reasonable Charge that is allowed for the primary procedures; 50% of the Usual and Reasonable Charge will be allowed for each additional procedure performed through the same incision; and 70% of the Usual and Reasonable Charge will be allowed for each additional procedure performed through a separate incision. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures;

b. If multiple unrelated surgical procedures are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the Usual and Reasonable Charge for each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed the Usual and Reasonable percentage allowed for that procedure;

c. If an assistant surgeon (another Physician or Certified First Assistant) is required (according to Medicare guidelines), the assistant surgeon's covered charge will not exceed 20% of the surgeon's contract rate, Usual and Reasonable allowance, or billed charges, whichever is less. If the acting assistant surgeon is a physician's assistant or nurse practitioner, the covered charge will not exceed 15% of the surgeon's contract rate, the network rate established in the contract, Usual and Reasonable allowance or billed charges, whichever is less.

6. Private Duty Nursing Care

The private duty nursing care by a licensed nurse (R.N., L.P.N. or L.V.N.). Covered charges for this service will be included to this extent:

a. Inpatient Nursing Care. Charges are covered only when care is Medically Necessary or not custodial in nature and the Hospital's Intensive Care Unit is filled or the Hospital has no Intensive Care Unit.

b. Outpatient Nursing Care. Charges are covered only when care is Medically Necessary not Custodial in nature and is in lieu of Inpatient acute care. Outpatient private duty nursing care must be authorized by the Utilization Review Coordinator.

7. Home Health Care Services and Supplies

Charges for home health care services and supplies are covered only for care and treatment of an Injury or Sickness when Hospital or Skilled Nursing Facility confinement would otherwise be required. The diagnosis, care and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan.

Benefit payment for nursing, home health aide and therapy services is subject to the Home Health Care limit shown in the Schedule of Benefits. Services provided by a home health aide are covered if in conjunction with Home Health Care provided by a nurse or therapist and the services provided support skilled nursing services. The following services are considered Covered Expenses under this benefit:

a. Part-time or intermittent nursing care by or under the supervision of a registered nurse (RN);

b. Part-time or intermittent home health aide services which consist primarily of caring for the patient;

c. Physical therapy, occupational therapy and speech therapy provided by a Home Health Care Agency;

d. Medical supplies, laboratory services, drugs and medications prescribed by a Physician.

A home health care visit will be considered a periodic visit by either a nurse or therapist, as the case may be, or four hours of home health aide services.

Expenses incurred in connection with home health care visits are covered under the Plan provided:

a. the services are preauthorized as Medically Necessary through the Utilization Review Program,

b. the services are rendered in accordance with a treatment plan submitted by the attending physician, and

c. in-patient confinement in a Hospital or Skilled Nursing Facility would be required in absence of Home Health Care.

8. Hospice Care Services and Supplies

Charges for hospice care services and supplies are covered only when the attending Physician has diagnosed the Covered Person's condition as being terminal, determined that the person is not expected to live more than six months and placed the person under a Hospice Care Plan.

Covered charges for Hospice Care Services and Supplies are payable in accordance with the Schedule of Benefits.

Covered Expenses for in-patient Hospice Care include room and board and other services and supplies furnished for pain control and other acute and chronic symptom management.

Bereavement counseling services, by a licensed social worker or licensed pastoral counselor, for the patient's immediate family (covered Spouse and/or covered Dependent Children). Bereavement services must be furnished within six (6) months after the patient's death.

Covered Expenses for out-patient Hospice Care include charges for:

a. part-time or intermittent nursing care by an R.N. or L.P.N. as needed to meet the person's assessed needs;

b. psychological and dietary counseling;

c. consultation or case management services by a Physician;

d. physical therapy;

e. part-time or intermittent home health aide services; and

f. medical supplies, drugs, and medicines prescribed by a physician.

9. Other Medical Services and Supplies

These services and supplies not otherwise included in the items above are covered as follows:

a. **Allergy Treatment.** Evaluation, diagnosis and treatment of allergies (immunotherapy).

b. **Local Medically Necessary professional ground or air ambulance service**. A charge for this item will be a Covered Charge only if the service is to transport a person from the place where he/she is injured or stricken by Illness to the first Hospital where treatment is given. Ground transportation is covered only to the nearest Hospital or Skilled Nursing Facility where necessary treatment can be provided unless the Plan Administrator finds a longer trip was Medically Necessary.

   Ground ambulance is also covered in the following circumstances:

   i. To transport a patient from one Hospital to another nearby Hospital when the first Hospital does not have the required services and/or facilities to treat the patient;

   ii. To transport a patient from Hospital to Skilled Nursing Facility when the patient cannot be safely or adequately transported in another way without endangering the individual's health, whether or not such other transportation is actually available;

   iii. To transport a patient from Skilled Nursing Facility to Hospital for Medically necessary inpatient or outpatient treatment when an ambulance is required to safely and adequately transport the patient; or

   iv. To transport a patient from an Out-of-Network Provider to an In-Network Provider.

   Ambulette Service or other forms of passenger transportation that are available to the public (e.g., buses, taxis or airplanes) are not covered because they do not meet the definition of a professional ambulance. An ambulette is usually a van equipped with a wheelchair lift and other safety equipment. It is used in non-emergency transportation for wheelchair bound, physically challenged, or elderly patients. They are often used to transport dialysis, radiation, and chemotherapy patients to and from treatment or to transfer patients to and from Hospital, home or nursing facilities.

Air Ambulance is a covered expense in the following circumstances:

i. When a patient requires transport to a Hospital or from one Hospital to another because the first Hospital does not have the required services and/or facilities to treatment the patient; and

ii. Ground ambulance transportation is not medically appropriate because of the distance involved or because the patient has an unstable condition requiring medical supervision and rapid transport.

Except in Life-threatening emergencies, coverage of air ambulance transport requires preauthorization.

Transportation by ground or air for patient convenience or for nonclinical (social) reasons is not covered.

c. **Anesthetic**; oxygen; blood and blood derivatives that are not donated or replaced; intravenous injections and solutions. Administration of these items is included.

d. **Applied Behavior Analysis (ABA)** for **Autism Spectrum Disorders (ASD).** ABA intervention shall produce socially significant improvements in human behavior through skill acquisition, increase or decrease in behaviors under specific environmental conditions and the reduction of problematic behavior. The services must be Medically Necessary treatment ordered by the treating Physician or psychologist in accordance with a treatment plan. An ASD treatment plan must include all elements necessary for this Plan to pay the claim. The Plan has the right to review the treatment plan once every six months unless the treating Physician or psychologist agrees that more frequently is necessary. For purposes of this benefit, educational and habilitative therapies are covered when part of the treatment plan. Payments and reimbursements for ABA therapies can only be made to the ASD service provider or the entity or group for whom the supervising board certified behavior analyst works or is associated. ABA services provided by a line therapist under the supervision of a state-licensed ASD provider must be reimbursed to the provider if the services are included in the treatment plan and are deemed Medically Necessary. ABA services provided by any Part C Early Intervention Program (i.e., First Steps) or any school district to an individual diagnosed with ASD is not covered under this Plan. The benefit limit stated in the Schedule of Benefits may be exceeded upon prior approval by the Claim Supervisor and/or the Plan Administrator after Medical Necessity has been established. This limit will be reviewed and adjusted every three years beginning January 1, 2012, based upon the increase in the federal Consumer Price Index as calculated by the applicable federal department.

e. **Blood sugar kits (glucometers)** are a covered expense when Medically Necessary.

f. **Breast Pumps.** Purchase or rental of a breast pump will be covered according to the Affordable Care Act and per current guidelines and is payable at the level shown in the schedule of benefits under Preventive Care. Eligibility for coverage begins from the date of the baby's birth. Rental or purchase of a breast pump prior to that date are not eligible. Contact the Third Party Administrator for specific guidelines and eligibility.

g. **Cardiac rehabilitation** as deemed Medically Necessary provided services are rendered (i.) under the supervision of a Physician; (ii.) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; and (iii.) in a Medical Care Facility as defined by this Plan.

h. Radiation or **chemotherapy** and treatment with radioactive substances. The materials and services of technicians are included.

i. **Childhood Immunization** charges (deductible waived) for immunizations of children from birth up to six years of age for poliomyelitis, rubella, rubeola, mumps, tetanus, pertussis, diphtheria, hepatitis B, Haemophilus influenza type H (HIB) and varicella. Administration of these immunizations shall be provided in accordance with the

standards established by the American Medical Association. Any related office visits, laboratory work, X-rays, etc. are subject to other applicable provisions of the Plan.

j. Approved Clinical Trial

Charges incurred due to participation in either a Phase I, II, III, or IV Approved Clinical Trial conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition will be covered, provided the charges are those that are:

A. Ancillary to participation in the Approved Clinical Trial and would otherwise be covered under this Plan if the individual were not participating in the Approved Clinical Trial; and
B. Not attributable to any device, item, service, or drug that is being studied as part of the Approved Clinical Trial or is directly supplied, provided, or dispensed by the provider of the Approved Clinical Trial.

A Covered Person is eligible for payment of charges related to participation in an Approved Clinical Trial if he or she:

1. Satisfies the protocol prescribed by the Approved Clinical Trial provider; and
2. Either:
   a. The individual's network participating provider determines that the individual's participation in the Approved Clinical Trial would be medically appropriate; or
   b. The individual provides the Plan with medical and scientific information establishing that participation in the Approved Clinical Trial would be medically appropriate.

For the purposes of this provision, an Approved Clinical Trial means a Phase I, II, III, or IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition. The Approved Clinical Trial's study or investigation must be (1) approved or funded by one or more of: (a) the National Institutes of Health (NIH), (b) the Centers for Disease Control and Prevention (CDC), (c) the Agency for Health Care Research and Quality (AHCRQ), (d) the Centers for Medicare and Medicaid Services (CMS), (e) a cooperative group or center of the NIH, CDC, AHCRQ, CMS, the Department of Defense (DOD), or the Department of Veterans Affairs (VA), (f) a qualified non-governmental research entity identified by NIH guidelines for grants; or (g) the VA, DOD, or Department of Energy (DOE) if the study has been reviewed and approved through a system of peer review that the Secretary of HHS determines is comparable to the system used by NIH and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review; (2) a study or trial conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or (3) a drug trial that is exempt from investigational new drug application requirements.

Excluded expenses include:

- Expenses incurred due to participation in an Approved Clinical Trial that are: (1) the investigational items, devices, services, or drugs being studied as part of the Approved Clinical Trial; (2) items, devices, services, and drugs that are provided solely for data collection and analysis purposes and not for direct clinical management of the patient; or (3) items, devices, services, or drugs inconsistent with widely accepted and established standards of care for a patient's particular diagnosis.
- Expenses incurred at a non-network provider if a network participating provider will accept the patient in an Approved Clinical Trial.

k. Initial **contact lenses or glasses** required following eye surgery, except surgeries to correct refractive disorders. In this case, rose-tinting, scratch-resistant coating and the additional charge for progressive lenses are considered cosmetic and not covered. However basic tinting, frames and up to tri-focal lenses are covered. If surgery is performed on one eye and then the second eye within 2 years, only the second lenses will be covered and not a new pair of glasses. If later than that time period, a full pair of glasses will be covered. Accommodating Intra-Ocular Lenses

used to replace the lens of the eye following cataract surgery are not covered under this Plan.

l. Rental of **durable medical or surgical equipment** if deemed Medically Necessary. These items may be bought rather than rented, with the cost not to exceed the fair market value of the equipment at the time of purchase, but only if agreed to in advance by the Claims Administrator. Sales tax and shipping charges on covered equipment are covered expenses. Shipping charges solely for the patient's convenience will not be covered. DME includes, but is not limited to, crutches, trusses, catheters/ostomy supplies, self-injection supplies for covered medications, wheelchairs, Hospital beds, oxygen/administration equipment, etc.

Rental fees, but not to exceed, in aggregate, the purchase price, for Durable Medical Equipment made and used only for treatment of Injury.

Replacement of durable medical equipment will be considered a Covered Expense when Medically Necessary and appropriate and when repairs are cost prohibitive. Replacement due to improper use or care (according to the manufacturer's guide on proper use) will not be covered. Repairs not covered under the warranty or required after the warranty expires will be covered, unless cost-prohibitive. Power-operated vehicles may be replaced no more often than once every five years and if repair is cost-prohibitive or is Medically Necessary due to a change in the Covered Person's physical condition.

m.. **Educational training.** One Medically Necessary unit of educational training is allowed per Illness per lifetime or as prescribed by applicable state or Federal law.

n. **Genetic testing** is covered if it aids diagnosing of a Covered Person with functional abnormalities or an Illness which may be inheritable and the results of the test will impact the treatment being delivered.

o. **Hearing Aid/amplification device** will be covered as follows: The initial purchase of a hearing aid if the loss of hearing is a result of a covered surgical procedure performed while coverage is in effect; or the initial amplification device for a Newborn. Refer to Well Newborn Nursery/Physician Care claims for coverage of hearing screening/necessary rescreening and audiological assessment/follow-up.

p. Medically Necessary services for care and treatment of **jaw joint conditions, including Temporomandibular Joint Syndrome but** excluding orthodontia in cases of TMJ. Orthodontia is excluded by this Plan.

q. **Laboratory studies.** Covered Charges for diagnostic and preventive lab testing and services.

.r. Treatment of **Mental Disorders and Substance Abuse.** Covered Charges for services, supplies and treatment of Mental Disorders and Substance Abuse will be limited as follows:

All treatment is subject to the benefit payment maximums shown in the Schedule of Benefits.

Psychiatrists (M.D.), psychologists (Ph.D.), counselors (Ph.D. or L.P.C.) or Licensed Clinical Social Work (L.C.S.W.) may bill the Plan directly. Other licensed mental health practitioners must be under the direction of these professionals.

Benefits are payable under this provision for Mental Disorders and Substance Abuse upon the diagnosis and recommendation of a Physician. Such effective treatment must meet all of the following tests.

i. The treatment facility, either inpatient, outpatient or at a residential treatment center, is appropriate for the diagnosis;

ii. Treatment is prescribed and supervised by a Physician within the scope of his or her license; and

iii. Treatment includes patient attendance, as appropriate, at meetings of organizations devoted to the therapeutic treatment of the illness.

Treatment solely for detoxification or maintenance care is not considered effective treatment and is not covered under this provision. "Detoxification" means care is aimed primarily at overcoming the after-effects of a specific drinking or drug episode and "maintenance care" means providing an environment free of alcohol or drugs.

Evidence to document attendance/participation in the follow-up therapy and/or meeting sessions appropriate to the treatment of the Illness may be required for consideration of claims.

s. **Treatment of mouth, teeth and gums.**

i. **Care of mouth, teeth and gums**. Charges for care of the mouth, teeth, gums and alveolar processes will be Covered Charges under Medical Benefits only if that care is for the following oral surgical procedures:

A. Excision of bony growths of the jaw and hard palate.

B. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, hard palate and floor of the mouth.

C. Incision and drainage of cellulitis.

D. Incision of sensory sinuses, salivary glands or ducts.

E. Reduction of dislocations and excision of temporomandibular joints (TMJs).

F. Osteotomy (jaw surgery) which is Medically Necessary and not cosmetic in nature.

G. Removal of teeth for the medical management of a hazardous medical condition to include but not limited to the following: anticoagulation, valvular heart disease, hemophilia, preparation for cancer treatment in the neck/head region. Initial office visit and diagnostic services will be covered when connected to the services to remove the teeth. Documentation of the Illness should be submitted with the charges.

This Plan will cover the replacement of any teeth that were required to be removed for this treatment. The Usual and Reasonable Charge for the replacement is calculated at the 90th percentile for the geographic area. This amount will also be applied to the cost of dental implants if the person chooses to have dental implants instead of dentures.

H. Hospital and anesthesia charges for Medically Necessary pediatric or adult dental procedures that require the use of anesthesia in a Hospital setting. Physician's charges for the dental procedure are not eligible under this Medical Plan. Documentation of the Medical Necessity should be submitted with the charges.

ii. **Injury to or care of mouth, teeth and gums**. Charges for repairs to the mouth, teeth, gums and alveolar processes due to an Injury will be covered charges under Medical Benefits only if that care is for the following oral procedures:

A. Repair due to Injury to the mouth, teeth or gums or to any appliance or previously repaired/replaced teeth required for an Injury that occurred while covered under the Plan. Teeth must be without impairment or periodontal disease and not in need of the treatment provided for reasons other than dental Injury. Dental Injury means an Injury by an external force such as a blow or fall. It does not include tooth breakage while chewing.

B. Surgery needed to correct accidental Injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth required for an Injury that occurred while covered under the Plan.

C. Treatment plan must begin within 90 days of the Injury. Medically Necessary services will be covered up to one year following the date of Injury, unless approved by the Utilization Review Coordinator or Plan Administrator.

No charge will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease, dental implants or preparing the mouth for the fitting of or continued use of dentures unless specifically addressed in the benefit.

t. Coverage of **Newborn Nursery/Physician Care**.

Charges for Routine Nursery Care. Routine well newborn nursery care is care while the newborn is Hospital-confined after birth and includes room, board and other normal care for which a Hospital makes a charge.

This coverage is only provided if a parent is a Covered Person and the newborn child is an eligible and enrolled Dependent who is neither injured nor ill.

The benefit is limited to Usual and Reasonable Charges for nursery care for the newborn child while Hospital confined as a result of the child's birth.

Charges for covered routine nursery care will be applied toward the Plan of the newborn child.

Charges for Routine Physician Care. The benefit is limited to the Usual and Reasonable Charges made by a Physician for the newborn child while Hospital confined as a result of the child's birth.

Circumcision is considered under this benefit if performed during the initial Hospital confinement. Otherwise, it will be considered an eligible expense under Physician Services (refer to Schedule of Benefits) up to the second birthday of the Dependent Child or within 2 years of legal adoption or placement for adoption. Thereafter, it will *not* be considered an eligible charge unless Medically Necessary (refer to Physician Service in the Schedule of Benefits for Benefits.

Charges for covered routine Physician care will be applied toward the Plan of the newborn child.

u**.** **Occupational therapy** by a licensed occupational therapist. Preauthorization of therapy is recommended. Therapy must be ordered by a Physician, result from an Injury or Sickness, improve a body function and treat conditions which are subject to significant improvement through short-term therapy. Covered expenses do not include recreational programs, maintenance therapy or supplies used in occupational therapy. The therapy must be expected to produce a significant improvement of the Covered Person's condition within a two (2) month period. The need for the therapy, the care and the regimen established must be documented in writing for each two (2) month period. This therapy is subject to the Reasonable and Necessary, Restorative Therapy and Maintenance provisions as found in the Defined Terms section of the Plan.

v. **Organ transplant** limits. All Organ Transplant services, including evaluation, must be preauthorized or benefits may otherwise be reduced or denied. Therefore, the Covered Person or his/her physician must call the Third Party Administrator (as listed on page 2) when the Physician first indicates a transplant is recommended. Retransplantation procedures must also have preauthorization. Charges otherwise covered under the Plan that are incurred for the care and treatment due to an organ or tissue transplant are subject to these limits:

i. **Definitions:** For purposes of this section, the following definitions apply.

Approved Transplant: A human organ or bone marrow transplant procedure currently performed at a Designated Transplant Facility.

Approved Transplant Services: Medically Necessary services and supplies which are related to an Approved Transplant procedure; are approved in writing under the precertification and/or preauthorization process; and include but are not limited to:

A. Pre-transplant patient evaluation for the Medical Necessity of the transplant.

B. Hospital charges.

C. Physician charges.

D. Tissue typing and ancillary services.

E. Organ procurement or acquisition.

Center of Excellence: A Designated Transplant Facility that has a Medicare-approved transplant program and is recognized by the United Network for Organ Sharing (UNOS) and the National Marrow Donor Program (NMDP) (non-profit organizations under contract with the United States Department of Health and Human Services to coordinate organ and bone marrow donation and distribution). These organizations have set standards for physical facilities, laboratory capabilities for organ and tissue matching, the recipient selection process and the availability of specialized services. The criteria used for selection of a Designated Transplant Facility are intended to ensure that approval is given only to facilities with the necessary experience and expertise to perform these complex surgeries successfully.

Medicare-approved medical centers must meet extensive criteria set out by CMS (the Centers for Medicare and Medicaid Services) and a review board comprised of transplant surgeons, specialists, and other clinicians and scientists. A facility must have Medicare-approval status before it can receive payment for transplantation services provided to Covered Persons.

All Designated Transplant Facilities must offer comprehensive services that include experts in many medical specialties, such as radiology, infectious disease and pathology, as well as a range of allied health services that may include physical therapy, rehabilitation and social services.

Clinical Practice Guidelines: Reports written by experts who have carefully studied whether a treatment works and which patients are most likely to be helped by it.

Designated Transplant Facility: A Center of Excellence facility which has an agreement with the Plan Administrator or Claims Administrator to render Approved Transplant Services to Covered Persons. This agreement will be made through a national organ transplant network and may not be located in the person's geographic area. Contact the Utilization Review Coordinator for a list of facilities.

Non-designated Transplant Facility: A facility which does not have an agreement with the Plan Administrator or Claims Administrator to render approved Transplant Services to Covered Persons.

Transplant Benefit Period: The period of time from the date the Covered Person receives preauthorization and has an initial evaluation for the transplant procedure until the earliest of:

A. one year from the date the transplant procedure was performed;

B. the date coverage under the Plan terminates; or

C. the date of the Covered Person's death.

If, during the same admission as the initial transplant a retransplant occurs, the period of time is one year from the date of the initial transplant. If a retransplant will be done during a subsequent admission, a new Transplant Benefit Period starts from the date the person receives preauthorization for the retransplant.

ii. **Designated Facilities for Approved Transplant Services**

This provision only applies to transplant procedures listed in the definition of Approved Transplant.

Transplant procedures must have preauthorization. The Covered Person or his/her Physician must call the toll free number provided for this purpose. Retransplantation procedures must also have preauthorization.

If the Physician and the Plan Administrator and/or Claims Administrator in consultation with the UR provider do not agree that the transplant procedure is Medically Necessary and appropriate, the Covered Person will be informed in writing of the right to a second opinion. A Board Certified Specialist must be utilized for this second opinion.

A person who will be undergoing a transplant procedure will be referred to a Designated Transplant Facility. This referral and authorization for services at a Designated Transplant Facility shall continue to be appropriate through the Transplant Benefit Period.

If the Covered Person is denied the procedure by the Designated Transplant Facility, he/she may be referred to a second such facility for evaluation. If the second facility determines, for any reason, that the person is not an acceptable candidate for the procedure, no benefits will be paid for any services or supplies related to that procedure. This applies regardless of whether the services or supplies are provided at a third Designated Transplant Facility or at a Non-designated Transplant Facility.

iii. **Benefits**

Benefits for Approved Transplant Services provided during a Transplant Benefit Period will be paid as shown in the Schedule of Benefits. Benefits will be different for services provided at a Designated Transplant Facility than services provided at a Non-designated Transplant Facility. Other transplant procedures will be considered for benefit payment according to the provisions of the Plan.

Benefits will be paid for expenses incurred for Approved Transplant Services done at a Designated Transplant Facility as follows:

- The transplant must be performed to replace an organ or tissue.

Donor charges:

A. Charges for obtaining donor organs or tissue for a covered recipient are considered Covered Charges under this Plan. The donor's

expenses will be applied toward the benefits of the covered recipient.

Donor charges include those for:

- evaluating the organ or tissue;
- removing the organ or tissue from the donor;
- transporting the organ within the United States and Canada to the place in the US where the transplant is to take place.

B. If the organ donor is a Covered Person and the recipient is not, then this Plan will always pay secondary to any other coverage. This Plan will cover donor charges for:

- evaluating the organ or tissue;
- removing the organ or tissue from the donor.
- No transportation charges will be considered.

For procedures done at a Non-designated Transplant Facility, the benefits listed above will be paid as shown in the Schedule of Benefits. The organ transplant limitations will apply.

iv. **Exclusions**

No benefits will be paid for any service:

A. related to the transplantation of any non-human organ or tissue;

B. for a facility or Physician outside the United States of America;

C. which are eligible to be repaid under any private or public research fund.

w. The initial purchase (of a single unit per body part), fitting, repair and replacement of **orthotic appliances** such as braces, splints or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Sickness. Preauthorization of services and/or treatment recommended.

Charges for the purchase of orthopedic shoes or devices for the support of flat feet will not be considered a covered expense. Orthopedic shoes that are Medically Necessary for treatment of other conditions will be covered. Preauthorization of services and/or treatment recommended.

Replacement of orthotics will not be covered unless 1) there is sufficient change in the Covered Person's physical condition to make the original device no longer functional or 2) the device has reached its life expectancy and needs to be replaced (but no more frequently than every 3 years). Replacement of the appliance should be pre-authorized. (Refer to Cost Management Services.). The benefit payment will be based on the cost of the treatment which provides professionally satisfactory results at the most cost-effective level. (Refer to Plan Exclusions items Foot and Hand Care and Orthotics for further information.)

x. **Physical therapy** by a licensed physical therapist. Preauthorization of services and/or treatment recommended.

The therapy must be in accord with a Physician's exact orders as to type, frequency and duration, to improve a body function and to treat conditions which are subject to

significant improvement through short-term therapy. The therapy must be expected to produce a significant improvement of the Covered Person's condition within a two (2) month period. The need for the therapy, the care and the regimen established must be documented in writing for each two (2) month period. This therapy is subject to the Reasonable and Necessary, Restorative Therapy and Maintenance provisions as found in the Defined Terms section of the Plan.

y. **Pre-Existing Conditions.** A condition that was present before the date of enrollment in the Plan, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that date. Effective January 1, 2011, the Plan will not exclude coverage of specific benefits associated with a preexisting condition in the case of an enrollee or exclude an enrollee from such plan or coverage based on a preexisting condition.

z. **Prescription Drugs** (as defined) and supplies. Refer to the Prescription Drug Benefit section for further details on covered and excluded drugs dispensed at a retail or mail order pharmacy or through the Specialty Pharmacy program. Call the pharmacy benefit manager (PBM) at the number on your health insurance ID card for complete information about covered and excluded Prescription Drugs and supplies purchased at the Pharmacy.

   Prescription Drugs and supplies dispensed at a Pharmacy and drugs consumed on the premises of a Physician or facility (such as a Hospital or urgent care facility) or if dispensed for take-home use upon release from such facility are covered as stated in the Schedule of Benefits.

   All Contraceptive Prescription Drugs through the Pharmacy or supplies through the Physician's Office are covered by the Medical Plan either under regular medical benefits or Prescription Drug Benefits, except for over the counter (OTC – non-legend) drugs and devices.

   Prescription Drug use does not have unlimited coverage. As with all medical and Hospital services, Prescription Drug utilization is subject to determinations of Medical Necessity and appropriate use. Drug utilization review (DUR) by the Prescription Benefit Manager (PBM) may be retrospective, concurrent or prospective. Retrospective DUR generally involves claim review and may include communication by the PBM with prescribers to coordinate care and verify diagnoses and Medical Necessity. Concurrent DUR generally occurs at the point of service and may include electronic claim edits to protect patients from potential drug interactions, drug-therapy conflicts or overuse or underdose of medications. Prospective DUR may include, among other things, therapy guidelines or Physician or Pharmacy assignment in which one Physician or Pharmacy is selected to serve as the coordinator or Prescription Drug services and benefits for the eligible Covered Person.

aa. **Preventive Care.** Covered charges under Medical Benefits are payable for Preventive Care for adults and children as described in the Schedule of Benefits. Preventive well adult and well child care is care by a Physician that is not for an Injury or Sickness. Preventive care includes services as defined under the Affordable Care Act.

   In-network preventive services as described above and in the Schedule of Benefits will be covered with no cost-sharing by the plan member or dependent. This means that the service will be covered at 100% of the Plan's allowable charge, with no coinsurance, copayment, or deductible.

   Preventive services are covered when performed for preventive screening reasons and billed under the appropriate preventive services codes. Service for diagnostic reasons may be covered under other applicable plan benefits, not the Preventive Care benefit.

The Plan will use reasonable medical management techniques to control costs of the Preventive Care benefit. The Plan will establish treatment, setting, frequency, and medical management standards for specific Preventive Care services, which must be satisfied in order to obtain payment under the Preventive Care benefit.

Examinations, screenings, tests, items or services are not covered under the Preventive Care benefit when such services are diagnostic, investigational or experimental, as determined by the Plan.

bb. **Prosthetic devices.** The initial purchase, fitting, repair and replacement of fitted **prosthetic devices** which replace body parts. Replacement of prostheses will not be covered unless 1) there is sufficient change in the Covered Person's physical condition to make the original device no longer functional or 2) the device has reached its life expectancy and needs to be replaced (but no more frequently than every 5 years). Replacement of the device must be pre-authorized. (Refer to Cost Management Services.). Replacement due to improper use or care (according to the manufacturer's guide on proper use) will not be covered. Repairs not covered under the warranty or required after the warranty expires will be covered, unless cost-prohibitive. The benefit payment will be based on the cost of the treatment which provides professionally satisfactory results at the most cost-effective level. (Refer to Plan Exclusions for further information.) Preauthorization of services and/or treatment recommended.

Two mastectomy bras are covered every six months; one prosthetic every Calendar Year. Compression stockings are covered with a prescription or Physician's orders. The prescription must require measurement of the patient for proper fitting. Limit two (2) pair per Calendar Year.

cc. **Pulmonary rehabilitation** as deemed Medically Necessary, Reasonable and Necessary, and Restorative. These services must be rendered: (i) under the supervision of a Physician; (ii.) for chronic pulmonary disability with reduction of exercise tolerance which restricts the abilities of the Covered Person to perform daily activities and/or work; and (iii.) in a Medical Care Facility as defined by this Plan. Pulmonary Function Test must show FEV1 of less than 60% predicted. Maintenance programs are <u>not</u> covered.

dd. **Reconstructive or Cosmetic Surgery.** The following will be considered Covered Charges

i. correction of abnormal congenital conditions in a child born while the parent of such covered child is enrolled under this Plan;

ii. repair of damage from an Injury that occurred while covered under this Plan;

iii. repair following Medically Necessary surgery for an Illness that occurred while covered under this Plan;

iv. reconstructive mammoplasties if the mastectomy was performed while covered under this Plan. The Plan also follows the guidelines set forth in the Women's Health and Cancer Rights Act of 1998 (WHCRA).The Plan will also provide coverage for the following in a manner determined in consultation with the attending Physician and the patient:

- surgery and reconstruction of the other breast to produce a symmetrical appearance, and
- coverage of initial and replacement prostheses (two mastectomy bras are covered every six months; one prosthesis every Calendar Year) and physical complications during all stages of mastectomy, including lymphedemas.

ee. **Smoking Cessation**: Smoking cessation programs will be covered as stated in the Schedule of Benefits. Refer to the Prescription Drug Benefits section for coverage of prescription drugs.

ff. **Speech therapy** by a licensed speech therapist. Therapy must be ordered by a Physician and follow either: (i.) surgery for correction of a congenital condition of the oral cavity, throat or nasal complex; or (ii.) an Injury or Sickness that results in loss of previously acquired speech, including normal swallowing mechanics or physiologic abnormalities of the throat and larynx. Maintenance programs are not covered.

gg. **Spinal Manipulation** by a licensed M.D. or D.O. (Refer to the Schedule of Benefits for benefit maximum.) Chiropractic care is not covered.

hh. **Sterilization** procedures.

ii. **Surgical dressings**, splints, casts and other devices used in the reduction of fractures and dislocations.

jj. **Vision therapy.** Charges incurred in connection with vision therapy for rehabilitative therapy after brain injury, including stroke, that are Medically Necessary, Reasonable and Necessary, and Restorative. Maintenance programs are not covered.

kk. **Weight Management/Control**.

Weight-loss programs: Charges for weight-loss programs will be covered if the program is necessary to treat a medical condition by decreasing the patient's weight. This program must be designed to treat health problems associated with high-risk Morbid Obesity/Severe Clinical Obesity (as defined by the National Institute of Health or other standard as identified by the Utilization Review Coordinator) and be administered and supervised by a Hospital or Physician's clinic. These health conditions may include hypertension, diabetes, cardiovascular disease and sleep apnea. The Covered Person must have demonstrated unsuccessful results in a weight-loss program. This weight-loss program must include diet, exercise and behavioral components. Documentation of the Covered Person's participation in qualifying programs must be submitted to the Utilization Review Coordinator for approval. Coverage is limited to Medically Necessary charges for treatment of Morbid Obesity/Severe Clinical Obesity. The weight management must be expected to produce a significant improvement of the Covered Person's condition within a six (6) month period. For the purposes of this provision, "significant improvement" means a reduction of weight by 10% the first 6 months, with a continued 10% reduction every 6 months from the adjusted baseline weight or a minimum of 1 to 2 pounds per week. The need to continue the care and regimen established must be documented in writing by the Physician for each six (6) month period. Benefits will terminate when the Covered Person's body mass index (BMI) has decreased below 30.

Bariatric surgery: Charges must be preauthorized by the Utilization Review Coordinator and meet Medically Necessary criteria. The Covered Person must have failed previous attempts to reduce weight under a Physician-monitored weight-loss program as described above for a minimum of one year in the two-year period immediately preceding the date the Physician requests benefit authorization. The Covered Person's BMI must be 40 or greater in conjunction with at least 1 of the following co-morbidities: hypertension uncontrolled by medical treatment, sleep apnea, coronary artery disease and diabetes mellitus. Physician documentation is required which indicates the Covered Person has been Morbidly Obese (as defined by the plan) for a minimum of 5 years immediately preceding surgery.

Panniculectomy surgery: Surgical removal of redundant skin folds is generally considered a cosmetic procedure. However, in order to be eligible for this surgery post weight-loss, the Covered Person must meet Medically Necessary criteria utilized by the Utilization Review Coordinator and must participate in the follow-up program,

as appropriate, which may include an aftercare support group and Physician visits.

ll. Diagnostic **x-rays,** electrocardiograms, electroencephalograms, pneumoencephalograms, basal metabolism tests, or similar well-established diagnostic tests generally approved by Physicians throughout the United States.

COST MANAGEMENT SERVICES

PREADMISSION CERTIFICATION

AUTHORIZATION IS NOT A GUARANTEE THAT ALL CHARGES ARE COVERED.

Preadmission Certification (also referred to as Precertification) means the review of all Hospital admissions prior to the admission date. This program is designed to help ensure that all Covered Persons receive necessary and appropriate health care while avoiding unnecessary expenses when a Hospital stay is proposed. For example, based on the information provided by the Physician, the Pre-certification Nurse will make an initial assessment of the condition to determine, among other things: if a second surgical opinion is required or recommended; if the admission is to an In-Network facility; if concurrent review by Utilization Review Coordinator is to be initiated; and if Medical Case Management is applicable.

Precertification Procedures

The Covered Person or the Physician must call **the Third Party Administrator's Utilization Review Coordinator at the number listed on page 2 of the document for precertification** as follows:

Scheduled Hospitalization

Precertification is required and should be completed prior to the Hospital stay. When the Covered Person or Physician notifies the Utilization Review (UR) Coordinator of a scheduled hospitalization, the UR Coordinator will then determine the length of stay based upon diagnosis, appropriateness of services and the Physician's plan of treatment. The UR Coordinator also assures that reasonable alternatives to inpatient care are considered, including outpatient treatment and preadmission testing. Request for second surgical opinion may also be made at that time. For every approved admission, a target length of stay will be assigned by the UR Coordinator, based upon length of stay norms for the geographical region. A preadmission certification letter will be sent to notify the Covered Person, Hospital and attending Physician of the assigned length of stay.

Unscheduled, Non-Emergent Hospitalization

Precertification is required as soon as possible but no later than 48 hours after a weekday admission or within 72 hours after an admission on a weekend or legal holiday. Unscheduled admission means an admission for treatment of an Injury or Illness that requires immediate inpatient treatment which is Medically Necessary and cannot be reasonably provided on an outpatient basis.

Emergency Hospitalization

Precertify as soon as possible but no later than 72 hours after an admission. Emergency admission means an admission for a Life-threatening medical condition or a condition for which the lack of immediate treatment would cause permanent disability.

Precertification Penalties

Failure to follow the precertification procedure as described above will reduce reimbursement received from the Plan.

If precertification is not obtained as explained in this section, a penalty may be applied in the amount shown in the Schedule of Benefits. (Refer to the first page of the Schedule of Benefits for details.) This penalty will not accrue toward the 100% maximum Out-of-Pocket payment (including the Deductible and the Coinsurance Limit) as indicated in the Schedule of Benefits.

Release from a Hospital and readmission to the same or different Hospital within 96 hours due to the same medical condition shall count as one admission as far as penalty assessment is concerned.

No penalty will be assessed for treatment for Substance Abuse, regardless of whether treatment occurs in a general Hospital, emergency care facility or accredited and approved alcohol and Substance Abuse center.

Exception: A Plan may not, under federal law, require that a Physician or other health care provider obtain precertification from the Plan for prescribing a maternity length of stay of up to 48 hours for a vaginal delivery or 96 hours for a cesarean delivery. However, to use certain providers or facilities, or to reduce the out-of-pocket costs, the Covered Person is still required to obtain precertification for the Hospital stay. If the stay is not precertified, the individual is responsible for the amount indicated in Precertification Penalties above. A Covered Person will not be denied the Hospital stay granted under Federal law (Newborns and Mothers Health Protection Act). For more information on precertification, contact the Plan Administrator or Claims Administrator as listed on Page 2 of this document.

EXTENDED HOSPITAL STAYS

Once a Hospital stay begins, whether it is a non-emergency or emergency, if the stay is expected to exceed the number of days precertified, the Covered Person or the Physician must contact the Utilization Review Coordinator to request an extension of the length of stay.

EFFECTS OF PREADMISSION CERTIFICATION ON BENEFITS

Authorization is not a guarantee that all charges are covered.

If any part of a Hospital stay is not precertified, the penalty amount shown in the Precertification Penalties section and the Schedule of Benefits may be applied. No part of the penalty will be applied towards the deductible amount shown in the Schedule of Benefits or the maximum out-of-pocket expense limitation.

A Hospital stay is not precertified if:

1. Precertification is not obtained prior to admission;

2. The type of treatment, admitting Physician or the Hospital differs from the precertified treatment, Physician or Hospital.

CONCURRENT REVIEW

The purpose of concurrent review is to continually evaluate the Covered Person's progress toward the treatment goal and the patient's ability to function in a non-acute environment and to facilitate timely discharge as appropriate.

PREAUTHORIZATION AND UTILIZATION REVIEW

Preauthorization means the review of services prior to their being rendered to determine if the services are eligible under the Plan. While not required, preauthorization is recommended to avoid the possibility of receiving services that are not covered under the Plan. If preauthorization is not obtained as described in this section, benefit reimbursement may be delayed while awaiting further information from the Physician or Covered Person. The Utilization Review Coordinator will consider the following, among other things, in making this decision: medical services, treatments and/or supplies are covered under this Plan; meet standards of care; are Medically Necessary; are ordered by a Physician; and are not Experimental/Investigational or otherwise excluded by this Plan. If the services are determined to be excluded under this Plan, the cost for those services will be the responsibility of the Covered Person.

Services Subject to Preauthorization and Utilization Review:

Preauthorization is not a guarantee that all charges are covered.

The Covered Person or the Physician should call the Utilization Review Coordinator for preauthorization of the following services (refer to the ID card or on page 2 of this book for the contact information):

- Home Health Care
- Durable Medical Equipment (greater than $200 purchase value)
- Physical, speech and occupational therapy
- Cardiac rehabilitation therapy
- Obesity Treatment
- Private Duty Nursing
- Orthotics/Prosthetics
- IV Infusion(Outpatient or Physician’s office, except for chemotherapy
- Out-of-Network Provider services when In-Network Providers are available

MEDICAL CASE MANAGEMENT

The purpose of Medical Case Management is to identify potentially high-dollar claims as a result of serious Illnesses, accidents or other circumstances and to coordinate the highest quality care in the most appropriate, cost-effective setting. The interest of the Covered Person is always primary in this program. The Covered Person receives the type of care required and the available benefits are used more effectively. Large Case Management is more than a cost containment provision. It requires in-depth involvement between the Case Manager, the provider and the Covered Person. The Covered Person and the attending Physician must be in agreement for any form of alternative medical care.

The Medical Case Management firm may recommend coverage for services or equipment that is not normally provided to the Covered Person under the Plan. In these instances, exceptions may be made by the Plan Administrator to cover these services or equipment that are recommended. The alternative benefits shall be determined on a case-by-case basis, and the Plan's determination to provide the benefits in one instance shall not obligate the Plan to provide the same or similar alternative benefits for the same or any other Covered Person, nor shall it be deemed to waive the right of the Plan to strictly enforce the provisions of the Plan.

Services provided by Medical Case Management are:

Continued Hospital Stay Review

The Covered Person may be hospitalized longer than Medically Necessary. Substantial savings can be achieved by reviewing the Covered Person's condition and treatment based on established medical criteria. Inappropriate treatment may be identified and discontinued.

Discharge Planning

Careful advance planning can ease the Covered Person's transfer from an acute-care facility to a less costly and more suitable facility such as a nursing home, rehabilitation center or the Covered Person's own home. It ensures that the benefits or early discharge are not outweighed by the need for a return to the Hospital at a later date for corrective and more costly treatment.

Home Health Care Coordination

With the right home environment and some professional coordination, many services traditionally performed on an inpatient basis may be handled in the Covered Person's home. Home health care involves coordination of required medical treatment and evaluation of the appropriate required level of care by the Medical Case Management firm. Patient/family counseling would be considered a covered expense in connection with these services, where applicable.

The following types of claim situations may have the potential for Medical Case Management:

1. Severe trauma (head Injuries, extensive burns, spinal cord Injuries, multiple fractures, etc.);
2. Coma (any cause);
3. Neonatal (prematurity, birth Injuries, congenital deformities, profound retardation, etc.);
4. Organ transplants; or
5. Any claim where it appears that there will be extensive inpatient and/or outpatient charges, particularly for a long duration.

Note: Medical Case Management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate.
Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

SECOND AND/OR THIRD OPINION PROGRAM

Certain surgical procedures are performed either inappropriately or unnecessarily. In some cases, surgery is only one of several treatment options. In other cases, surgery will not help the condition.

In order to prevent unnecessary or potentially harmful surgical treatments, the second and/or third opinion program fulfills the dual purpose of protecting the health of the Plan's Covered Persons and protecting the financial integrity of the Plan.

Benefits will be provided for a second (and third, if necessary) opinion consultation to determine the Medical Necessity of an elective surgical procedure. An elective surgical procedure is one that can be scheduled in advance; that is, it is not an emergency or of a life-threatening nature. Refer to the Schedule of Benefits. If the second opinion is requested by the Utilization Review Coordinator, they will inform you of the benefit payable for the consultation.

The patient may choose any board-certified specialist who is not a partner of the attending Physician and who is affiliated in the appropriate specialty.

While any surgical treatment is allowed a second opinion, the following procedures are ones for which surgery is often performed when other treatments are available.

Appendectomy	Hernia surgery	Spinal surgery
Cataract surgery	Hysterectomy	Surgery to knee, shoulder, elbow or toe
Cholecystectomy (gall bladder removal)	Mastectomy surgery	Tonsillectomy and adenoidectomy
Deviated septum (nose surgery)	Prostate surgery	Tympanotomy (inner ear)
Hemorrhoidectomy	Salpingo-oophorectomy (removal of tubes/ovaries)	Varicose vein ligation

LARGE CLAIMS MANAGEMENT PROGRAM

PURPOSE

To enable the Plan to provide coverage in a cost-effective way, the Plan has adopted a Large Claims Management Program designed to help control increasing health care costs by avoiding unnecessary services or services that are more costly than others that can achieve the same result. By doing this, the Employer is better able to afford to maintain the Plan and all of its benefits.

The Program is a voluntary process whereby the patient, the patient's family, physician or other health care providers and the Employer work together under the guidance of the Plan's independent consultant to coordinate a quality, timely and cost-effective treatment plan.

Large Claims Management may be particularly helpful for patients who require complex, high-technology medical services and who may therefore benefit from professional assistance to guide them through the maze of choices of health care services, providers and practices.

In some instances, following the procedures of the Plan's Large Claims Management Program, may result in lower out-of-pocket costs for the Covered Person.

ELIGIBILITY

The Director of Human Resources or the Director's designee may refer the following categories of medical claims to the Large Claims Management program:

a. Severe trauma (head injuries, extensive burns, spinal cord injuries, multiple fractures, etc.)

b. Coma (any cause)

c. Neonatal (prematurity, birth injuries, congenital deformities, profound retardation, etc.)

d. Any claim where it appears that there will be extensive inpatient and/or outpatient charges, particularly for a long duration.

CONDITIONS

After a medical claim has been referred to the Large Claims Management program pursuant to this Article, the plan may pay medical benefits in excess of the limits provided elsewhere in this Plan, when:

a. Such additional benefits are paid pursuant to the Large Claims Management plan under the rules, procedures, and limitations approved by the City Manager; and

b. When the Director of Human Resources, or the Director's designee, has determined that payment of such additional benefits is likely to produce savings equal to or exceeding such extra benefits.

The Large Case Management Program is not intended to diagnose or treat medical conditions, validate eligibility for coverage or guarantee payment of Plan benefits. Eligibility for and actual payment of benefits are subject to the terms and conditions of the Plan as described in this document. All treatment decisions rest with the patient and the patient's physician.

ADMINISTRATIVE AUTHORITY

The City Manager or his designee is hereby authorized to do all things necessary to implement the Large Claims Management Program, to establish such rules, procedures, and limitations as are necessary to carry out the purposes of this Program and to enter into contracts with Third Party Administrator(s) or consultant(s) as he deems appropriate.

DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized.

Acupuncture Treatment - means the piercing of specific peripheral nerves with needles to relieve the discomfort of painful disorders or for therapeutic purposes.

Ambulatory Surgical Center - a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays.

Applied Behavior Analysis (ABA) is the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationships between environment and behavior. Practice of ABA is the application of the principle, methods and procedures of the experimental analysis of behavior and applied behavior analysis (including principles of operant and respondent learning) to assess and improve socially important human behaviors. It included, but is not limited to, applications of those principles, methods, and procedures to:
(1) the design, implementation, evaluation, and modification of treatment programs to change behavior of individuals;
(2) the design, implementation, evaluation, and modification of treatment programs to change behavior of groups; and
(3) Consultation to individuals and organizations.
ABA does not include physical therapy, occupational therapy, speech therapy or cognitive therapies or psychological testing, personality assessment, intellectual assessment, neuropsychological assessment, psychotherapy, sex therapy, psychoanalysis, hypnotherapy, family therapy and long-term counseling as treatment modalities.

Bilateral Surgical Procedure - shall mean any surgical procedure performed on any body part or paired organ who's right and left halves are mirror images of each other or in which a median longitudinal section divides the organ into equivalent right and left halves or on any pair of limbs. Surgery on both halves or both limbs is performed during the same operative session and may involve one (1) or two (2) surgical incisions.

Birthing Center - means any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician or a licensed nurse-midwife. The licensed nurse-midwife must have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement and a written collaborative agreement with an appropriately licensed Physician.

Brand Name - means a trade name prescription medication.

Calendar Year - means January 1st through December 31st of the same year.

Claim Administrator - means that entity or person(s) selected by the City Manager to administer the Plan.

COBRA - means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Complications of Pregnancy - means:

1. any condition resulting in hospital confinement, the diagnosis of which is distinct from pregnancy but is adversely affected or caused by pregnancy; or

2. a non-elective cesarean section, an ectopic pregnancy which is terminated, spontaneous termination of pregnancy when a viable birth is not possible, a puerperal infection, eclampsia and toxemia.

False labor, occasional spotting, physician-prescribed rest, morning sickness, hyperemesis gravidarum, preeclampsia and similar conditions associated with a difficult pregnancy are not complications of pregnancy.

Cosmetic Surgery - means surgical procedures that are generally considered not to be Medically Necessary and that is usually, but not limited to, plastic surgery directed toward preserving beauty or correcting scars, burns or disfigurements. Cosmetic Surgery is typically surgery that changes:

- The texture or appearance of the skin; or
- The relative size or position of any body part when such surgery is performed primarily for psychological purposes or is not needed to correct or improve a bodily function.

Covered Charges - means Medical services, treatments and supplies that meet standards of care, are Medically Necessary, are ordered by a Physician, are not Experimental/Investigational and not otherwise excluded by this Plan will be covered.

Covered Person - is an Employee or Dependent or COBRA Continuant who is covered under this Plan.

Custodial Care - is care (including room and board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication which could normally be self-administered.

Dependent - (Refer to the Eligibility Section of this Plan document)

Durable Medical Equipment - means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury and (d) is appropriate for use in the home.

Emergency Medical Condition - is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention will result in:

1. placing the health of the individual (or, with respect to a pregnant woman, the health of the woman and her unborn child) in serious jeopardy;

2. serious impairment to bodily functions; or

3. serious dysfunction of any bodily organ or part.

The Claims Administrator will assess emergency treatment/admissions to an Out-of-Network provider to determine if it meets the exception criteria. The exception criteria will be assessed on a case-by-case basis, taking into consideration such things as the individual's medical history, current illness/injury and the circumstances (consciousness, EMT/ambulance services, etc.) surrounding the current illness/injury in relation to the accessibility/location of other participating providers.

Employer - City of Springfield, Missouri

Experimental and/or Investigational - means services, supplies, care and treatment which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time services were rendered.

The Plan Administrator must make an independent evaluation of the experimental/nonexperimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Plan Administrator will be final and binding on the Plan. The Plan Administrator will be guided by the following principles:

1. if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or

2. if the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or

3. if Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I clinical trial, is the research, experimental, study or investigational arm of on-going phase II or III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis. *However, routine patient care costs for a phase II or III clinical trial for prevention, early detection and treatment of cancer* ***will be covered*** *according to Missouri Revised Statutes when the trial is approved or funded by one of the following entities*:

   a. One of the National Institutes of Health (NIH),

   b. An NIH cooperative group or center,

   c. The FDA in the form of an investigational new drug application,

   d. The federal Department of Veterans' Affairs or Defense,

   e. An institutional review board in that state that has an appropriate assurance approved by the Department of Health and Human Services assuring compliance with and implementation of regulations for the protection of human subjects, or

   f. A qualified research entity that meets the criteria for NIH Center support grant eligibility.

   "**Cooperative group**" - is a formal network of facilities that collaborate on research projects and have an established NIH-approved Peer Review Program operating with the group, including the NCI Clinical Cooperative Group and the NDI Community Clinical Oncology program.

   "**Routine patient care costs**" - shall include coverage for reasonable and Medically Necessary services needed to administer the drug or device under evaluation in the clinical trial. Routine patient care costs include all items and services that are otherwise generally available to a qualified individual that are provided in the clinical trial except:

   a. The investigation item or service itself;

   b. Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and

   c. Items and services customarily provided by the research sponsors free of charge for any enrollee in the trial; or

4. if Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis. Reliable Evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, service, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use.

Family Unit - is the covered Employee and the family members who are covered as Dependents under this Plan.

Generic Drug - means a Prescription Drug which has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a Generic drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

Genetic Information - means information about genes, gene products and inherited characteristics that may derive from an individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes.

Home Health Care Agency - is an organization that meets all of these tests: its main function is to provide Home Health Care Services and Supplies; it is federally certified as a Home Health Care Agency; and it is licensed by the state in which it is located, if licensing is required.

Home Health Care Plan - must meet these tests: it must be a formal written plan made by the patient's attending Physician which is reviewed at least every 30 days; it must state the diagnosis; it must certify that the Home Health Care is in place of Hospital confinement; and it must specify the type and extent of Home Health Care required for the treatment of the patient.

Home Health Care Services and Supplies – include part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and speech therapy; medical supplies; and laboratory services by or on behalf of the Hospital.

Hospice Agency - is an organization where its main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located, if licensing is required.

Hospice Care Plan - is a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

Hospice Care Services and Supplies - are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, home care, and family counseling during the bereavement period.

Hospice Unit - is a facility or separate Hospital Unit, that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

Hospital - is an institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets these tests: it is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Healthcare Facilities Accreditation Program or the Industrial Standards Organization; it is approved by Medicare as a Hospital; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians; it continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of registered nurses (R.N.s); and it is operated continuously with organized facilities for operative surgery on the premises. If the Plan has a network that credentials their providers for participation in the network, the facility will be considered eligible regardless of the accreditation or Medicare status required in this definition.

Illness - means a bodily disorder, disease, physical sickness or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage or complications of Pregnancy.

Infertility - means incapable of producing offspring.

Injury - means an accidental physical Injury to the body caused by unexpected external means.

Intensive Care Unit - is defined as a separate, clearly designated service area which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has: facilities for special nursing care not available in regular rooms and wards of the Hospital; special life saving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

Legal Guardian - means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

Life Threatening - is defined as any serious illness or injury that:

1. May result in permanent impairment of a bodily function or permanent damage to a body part.
2. May necessitate immediate medical or surgical intervention to preclude permanent impairment of a body function or permanent damage to a body structure.
3. Examples: burns, loss of organs, loss of limbs, and blindness.

Maintenance Programs - is a term used to qualify occupational, physical, speech and other rehabilitative therapy programs. These are the repetitive services required to maintain function and generally do not involve complex and sophisticated occupational/physical/speech therapy procedures; and consequently, the judgment and skill of a qualified therapist are not required for safety or effectiveness.

However, in certain instances, the specialized knowledge and judgment of a qualified physical therapist may be required to establish a maintenance program intended to prevent or minimize deterioration caused by a medical condition if the maintenance program is to be safely carried out and the treatment aims of the physician achieved. Establishing such a program is a skilled service and would be a covered expense under the Plan.

Medical Care - shall mean professional services rendered by a Physician or Other Professional Provider for the treatment of an Illness of Injury.

Medical Care Facility - means a Hospital, a facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

Medical Non-Emergency Care - means care which can safely and adequately be provided other than in a Hospital.

Medically Necessary - care and treatment is recommended or approved by a Physician; is consistent with the patient's condition or accepted standards of good medical practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of medical services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary.

The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

Medicare - is the Health Insurance For The Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Mental Disorder - means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

Morbid Obesity/Severe Clinical Obesity is a diagnosed condition in which the body weight exceeds the medically recommended weight by 100 or more pounds over normal weight (by insurance underwriting standards) or the body mass index (BMI) is 35 or greater for a person of the same height, age and mobility as the Covered Person, despite documented unsuccessful attempts to reduce weight under a Physician-monitored

diet and exercise program.

Multiple Surgical Procedures - shall mean surgical procedures which are performed during the same operative session and which are not incidental or secondary to one (1) primary procedure for which the operative session is undertaken. An “incidental procedure” is a procedure which is not Medically Necessary at the time it is performed. A “secondary procedure” is a procedure which is not part of the primary procedure for which the operative session is undertaken.

Network, or In-Network - as used in this Plan, refers to medical services or treatment provided by or through an organization designated by the City Manager as a Preferred Provider for such services or treatment.

Never Events - are occurrences that should never happen; *e.g.*, surgery on the wrong body part or death due to contaminated drugs or devices. The criteria for inclusion on the Never Events list include: i.) adverse consequence of care results in unintended injury or illness; ii.) indicative of a problem in a health facility's safety systems; and iii.) important for public credibility or public accountability. Refer to www.cms.hhs.gov for the full listing of Never Events.

Newborn – From birth through 31st day.

No-Fault Auto Insurance - is the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

Nonresidential Treatment Facility - is a facility that can provide medical and other services for the treatment of Substance Abuse to individuals who do not require inpatient status and are free from acute physical and mental complications. The facility must maintain an organized program of treatment that may be limited to less than 12 hours per day and not be available 7 days a week. The facility must be certified by the Department of Mental Health for treatment of Mental Disorder or Substance Abuse.

Other Facility Provider - shall mean any of the following: Ambulatory Care Facility, Substance Abuse Treatment Facility, free-standing dialysis facility, Outpatient psychiatric facility, psychiatric day treatment facility, psychiatric Hospital, Hospice, Extended Care Facility, or rehabilitation Hospital, which is licensed as such in the jurisdiction in which it is located.

Other Professional Provider or **Professional Provider** - shall mean the following persons or practitioners, including Physicians, acting within the scope of such provider’s license which is certified and licensed in the jurisdiction in which the services are provided:

Audiologist	Vocational Nurse
Anesthetist	Physical Therapist
Certified Athletic Trainers	Registered Nurse
Emergency Medical Technician	Respiratory Therapist
Independent Laboratory Technician	Speech – Language Pathologist
Pharmacist	Clinical Social Worker
Licensed Practical Nurse	
Any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his/her license.	

Out-of-Network - as used in this Plan, refers to medical services or treatment provided by or through an organization other than the organization designated as a Preferred Provider by the City for Network purposes.

Outpatient Care and/or Services - is treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Ambulatory Surgical Center, or the patient's home.

Participating or **In-Network Physician** - shall mean a duly licensed Physician under contract with any of the Plan’s contracted Networks.

Participating or **In-Network Provider -** shall mean any Hospital, Physician, pharmacy, Other Professional Provider, Other Facility Provider or other entity under contract with the Plan’s contracted Networks.

Partial Hospitalization - is an outpatient program specifically designed for the diagnosis or active treatment of a Mental Disorder or Substance Abuse when there is reasonable expectation for improvement or when it is necessary to maintain a patient's functional level and prevent relapse; this program shall be administered in a psychiatric facility which is accredited by the Joint Commission on Accreditation of Health Care Organizations and shall be licensed to provide partial hospitalization services, if required, by the state in which the facility is providing these services. Treatment lasts less than 24 hours, but more than four hours, a day and no charge is made for room and board.

Pharmacy - means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Physician - means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O. Doctor of Podiatry (D.P.M.) and Doctor of Chiropractic (D.C.).

Plan - means City of Springfield Group Health Plan (which is a health benefits plan for Employees of City of Springfield, Missouri).

Plan Participant - means an eligible Employee, an eligible and enrolled dependent or other enrolled individual as referenced under special circumstances in the Eligibility section of this document.

Plan Year - is the 12-month period beginning on January 1 and ending on December 31.

Pre-Admission Testing - is pre-operative or pre-procedural diagnostic screening required to determine the Covered Person's health status prior to a scheduled medical or surgical procedure on an Inpatient or Outpatient basis.

Pre-Existing Condition - is a diagnosed or undiagnosed, symptomatic or assymptomatic, Injury or Sickness that was treated prior to the effective date of a Covered Person's coverage. Treatment includes:

a. Consultation with a Physician; or
b. Seeking a diagnosis or advice or the receipt of medical care or treatment; or
c. A Hospital admission or a Physician visit for testing or for diagnostic purposes or studies; or
d. Obtaining services, supplies, prescription drugs or medicines.

Preferred Provider Organization (PPO) - is a network of selected health care providers who have agreed to provide managed care to PPO program members. PPO members receive their maximum coverage when they go to PPO network providers. They receive reduced benefits for most care if they go to non-network providers.

Pregnancy - is childbirth and conditions associated with Pregnancy, including complications.

Prescription Drug - means any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of a Sickness or Injury.

Reasonable and Necessary - is a term used to qualify occupational, physical, speech and other rehabilitative therapy programs. To be considered Reasonable and Necessary, the following conditions must be met:

1. The services must be considered under accepted standards of medical practice to be a specific and effective treatment for the patient's condition.

2. The services must be of such a level of complexity and sophistication or the condition of the patient must be such that the services required can be safely and effectively performed only by a qualified therapist or under his/her supervision. Services which do not require the performance or supervision of a therapist are not considered reasonable or necessary services, even if they are performed or supervised by a therapist.

3. The development, implementation, management, and evaluation of a patient care plan constitute skilled therapy services when, because of the patient's condition, those activities require the skills of a therapist to meet the patient's needs, promote recovery, and ensure medical safety. Where the skills of a therapist are needed to manage and periodically reevaluate the appropriateness of

a maintenance program because of an identified danger to the patient, those reasonable and necessary management and evaluation services may be covered, even if the skills of a therapist are not needed to carry out the activities performed as part of the maintenance program.

4. While a patient's particular medical condition is a valid factor in deciding if skilled therapy services are needed, the key issue is whether the skills of a therapist are needed to treat the illness or injury, or whether the services can be carried out by non-skilled personnel.

5. There must be an expectation that the patient's condition will improve significantly in a reasonable (and generally predictable) period of time, or the services must be necessary for the establishment of a safe and effective maintenance program required in connection with a specific disease state.

6. The amount, frequency, and duration of the services must be reasonable.

Residential Treatment Facility - meets the following criteria:

1. Operates legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.

2. Is certified by the Department of Mental Health for treatment of Mental Disorder or Substance Abuse.

3. Is primarily engaged in providing diagnostic and therapeutic services for treatment of Mental Disorders and Substance Abuse on an inpatient basis; maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients.

4. Has a Physician in regular attendance; continuously provides 24-hour a day nursing service by a registered nurse (R.N.); has a full-time psychiatrist or psychologist on the staff.

5. Operates on a 24-hour basis, 7 days a week under an organized program.

Restorative Therapy - is a term used in conjunction with occupational, physical, speech or other rehabilitative therapy which must, among other things, be Reasonable and Necessary to the treatment of the individual's Illness or Injury. If an individual's expected restoration potential would be insignificant in relation to the extent and duration of the therapy services required to achieve such potential, the therapy would not be considered Reasonable and Necessary. In addition, there must be an expectation that the patient's condition will improve significantly in a reasonable (and generally predictable) period of time. However, if at any point in the treatment of an illness/injury it is determined that the expectations will not materialize, the services will no longer be considered Reasonable and Necessary and they would, therefore, be excluded from coverage.

Retired Employee - means any former eligible employee covered under the Plan who is receiving or who will receive a pension benefit sponsored by the Employer in the month immediately following the date the employee leaves City service. This includes age and service, duty, and non-duty disability retirements.

Sickness is - For an eligible Employee and covered Spouse: Illness, disease or Pregnancy.

Sickness means physical sickness, mental illness, or functional nervous disorder. A recurrent sickness will be considered one sickness. Concurrent sicknesses will be considered one sickness unless the concurrent sicknesses are totally unrelated. The term "sickness" shall include pregnancy, childbirth or resulting complications,.

Skilled Nursing Facility - is a facility that fully meets all of these tests:

1. It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.

2. Its services are provided for compensation and under the full-time supervision of a Physician.

3. It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.

4. It maintains a complete medical record on each patient.

5. It has an effective utilization review plan.

6. It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mental retardates, Custodial or educational care or care of Mental Disorders.

7. It is approved and licensed by Medicare, the Joint Commission on Accreditation of Healthcare Organizations or the Commission on Accreditation of Rehabilitation Facilities.
   This term also applies to charges incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation hospital, long-term acute care facility or any other similar nomenclature.

Spinal Manipulation - means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Substance Abuse - is regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

Temporomandibular Joint (TMJ) Syndrome - is the treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint. (Refer to Schedule of Benefits and Medical Benefits for what services are covered by this Plan.)

Total Disability (Totally Disabled) - means: In the case of a Dependent child, the complete inability as a result of Injury or Sickness to perform the normal activities of a person of like age and sex in good health.

Usual and Customary Allowance is determined by the Plan Administrator using the information that includes, but is not limited to, the following:

1. Third Party data;
2. Contracted allowables;
3. Medicare data;
4. Historical data of Claims Supervisor;
5. Geographic region of provider;
6. Cross-section of providers in geographic areas other than where the service is provided if the service is performed less frequently or is a newer service;
7. The nature and severity of the condition being treated. It will also consider medical complications or unusual circumstances that require more time, skill or experience; and/or
8. Any other available data to make the determination.
9. When Usual and Customary Allowance cannot be determined with any of the above, the Plan Administrator or its designee has the discretionary authority to decide the reasonable allowance

for the care, treatment or service.

10. The Plan Administrator or its designee has the discretionary authority to determine if the established allowance is Reasonable.

For the purposes of this section, “Reasonable” means not excessive or extreme.

The Plan will consider the actual charge billed if it is less than the Usual and Customary Allowance.

The Plan will pay benefits on the basis of the actual charge billed if it is less than the Usual and Customary Allowance Charge.

The Plan Administrator has the discretionary authority to decide whether a charge is Usual and Reasonable.

Utilization Review Coordinator - means that entity or person(s) selected by the Plan Administrator to perform the Utilization Review Services.

PLAN EXCLUSIONS

For all Benefits shown in the Schedule of Benefits, a charge for the following is not covered:

1. **Abortion -** Services, supplies, care or treatment in connection with an abortion unless the life of the mother is endangered by the continued Pregnancy, a therapeutic abortion is deemed Medically Necessary by an M.D. or D.O. for medical conditions determined to be non-compatible for the life of the fetus or the Pregnancy is the result of rape or incest.

2. **Acupuncture or acupressure -** Services, supplies, care or treatment for acupuncture or acupressure.

3. **Biofeedback.** Charges for services, supplies, care or treatment in connection with biofeedback.

4. **Blood -** For blood donor expenses.

5. **Charges -** For failure to keep scheduled appointments, charges for completion of claim forms or late payment charges.

6. **Chiropractic Care -** Charges by a Chiropractor.

7. **Complications of Non-Covered Treatments -** Care, services or treatment required as a result of complications from a treatment not covered under the Plan are not covered. Complications from a non-covered abortion are covered

8. **Correctional Agency or Court Order -** Care provided while a Covered Person is in the custody or care of a correctional agency or when a Covered Person receives care under the authority of a court order for services rendered as a condition of parole or probation or in lieu of other correctional action.

9. **Cosmetic Reasons -** Care and treatment provided for or in connection with cosmetic and reconstructive procedures. Refer to the Medical Benefits Reconstructive Surgery section for information about covered expenses.

10. **Custodial Care -** Services or supplies provided mainly as a rest cure, maintenance or Custodial Care.

11. **Dental Expenses -** Care, services or treatment provided for expenses incurred for dental work, unless such care is specifically covered in the Schedule of Benefits or Medical Benefits section of this Plan.

12. **Dental Implants -** Dental implants, including any appliances and/or crowns and the surgical insertion or removal of implants, unless such care is specifically covered in the Schedule of Benefits or Medical Benefits section of this Plan.

13. **Educational or Vocational Testing -** Services for educational or vocational testing or training; non-medical self-care or self-help training; and remedial reading and special education. One Medically Necessary unit of medical educational training is allowed per Illness per lifetime.

14. **Excess Charges -** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Usual and Reasonable Charge.

15. **Exercise Programs -** Exercise programs for treatment of any condition (except for Physician-supervised cardiac or pulmonary rehabilitation, occupational or physical therapy covered by this Plan); charges for enrollment in a health, athletic or similar club; or charges for athletic trainers. (This does not include athletic trainers who are certified and licensed as defined under Other Professional Provider in this Plan.).

16. **Experimental and/or Investigational or Not Medically Necessary -** Care and treatment that is either Experimental/Investigational or not Medically Necessary.

17. **Eye care -** Radial keratotomy or other eye surgery to correct refractive disorders. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages. Accommodating Intra-Ocular Lenses used to replace the lens of the eye following cataract surgery are not covered under this Plan.

18. **Foot and Hand Care -** Treatment of flat feet, corns, calluses and trimming of or treatment of fungal infections of the nails (unless needed in treatment of a metabolic or peripheral-vascular disease and authorized by the Utilization Review Coordinator). Surgical treatment of toenails is eligible if Medically Necessary. Charges for the purchase of orthopedic shoes or devices for the support of flat feet will not be considered a covered expense. Orthopedic shoes that are Medically Necessary for treatment of other conditions will be covered. (Refer to Plan Exclusions - Orthotics for further information.)

19. **Foreign Travel -** Care, treatment or supplies outside of the U.S. if travel is for the sole purpose of obtaining medical services. This exclusion also applies to Prescription Drugs obtained from outside the U.S. even if travel was not required. Exception: Care, treatment or supplies related to an Emergency Medical Condition or Medically Necessary treatment of an Illness while traveling outside the U.S.

20. **Genetic Testing -** Genetic testing is not covered unless it aids diagnosing of a Covered Person with functional abnormalities or who is sumptomatic of an Illness which may be inheritable and the results of the test will impact the treatment being delivered.

21. **Government Coverage -** To the extent permitted by law, medical care, services and supplies which are furnished by a Hospital or facility operated by or at the direction of the United States government or any authorized agency thereof, or furnished at the expense of such government or agency, or by a Physician employed by such a Hospital or facility, unless (1) the treatment is of an emergency nature, and (2) the Covered Individual is not entitled to such treatment without charge by reason of status as a veteran or otherwise. This will also apply to services excluded under "Correctional agency or court-ordered care" listed above. This does not apply to Medicaid or when otherwise prohibited by law. This will also apply to any loss, expense or charge which is incurred while (or related to) the Covered Person is on active duty or training in the Armed Forces, National Guard or Reserves of any state or country. (Upon notice to the City of Springfield of entry into such service, the pro-rata unearned Employee contributions shall be refunded.)

22. **Hair Loss -** Care and treatment for hair loss. Care and treatment includes wigs, hair transplants or any Prescription Drug that promises hair growth, whether or not prescribed by a Physician. The Plan will cover Prescription Drugs if prescribed for hair loss due to alopecia areata or scalp infection or as a result of treatment of a medical condition (i.e. chemotherapy for cancer). A prior authorization is required.

23. **Hearing Aids and Exams -** Charges for services or supplies in connection with hearing aids or exams for their fitting except as defined in the covered benefits section.

24. **Home Modifications -** Expenses for modification of home or living quarters due to medical disabilities.

25. **Hospital Employees -** Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.

26. **Hypnosis -** Charges for hypnosis are not covered.

27. **Illegal Acts -** Charges for services received as a result of injury or sickness caused by or contributed to by engaging in an illegal occupation; by committing or attempting to commit an assault; or illegal acts that are felonious in nature; or by participating in a riot or public disturbance.

28. I**nfertility -** Care, supplies, services and treatment for infertility, including but not limited to, artificial insemination, other artificial methods of conception, in vitro fertilization, services for a surrogate mother, or treatment of sexual dysfunction. If the treatment of the medical condition is

Medically Necessary for an indication other than the promotion of fertility, then the services will be covered. *Exclusion does not apply to care, supplies and services for the diagnosis of infertility.*

29. **Internet Services -** Services, supplies or treatment rendered through the Internet are not covered unless part of an established program or Participating Provider or Pharmacy network of this Plan.

30. **Lost, Stolen or Misused Appliances/DME -** Charges incurred to replace lost or stolen appliances/DME or to replace or repair appliances/DME due, in whole or in part, to improper use or care (according to the manufacturer's guide on proper use

31. **Maintenance -** Care and treatment for Maintenance.

32. **Marital or Pre-Marital Counseling -** Care and treatment for marital or pre-marital counseling.

33. **Military-Related Disability or Coverage -** Care in connection with a military-related disability to which the Covered Person is legally entitled and for which facilities are reasonably available, to the extent permitted by law; or coverage while engaged in service with the armed forces of any international organization, nation or state.

34. **Never Events -** Services, supplies, care or treatment as a result of a Never Events.

35. **No Charge -** Care and treatment for which there would not have been a charge if no coverage had been in force.

36. **Non-Compliance -** All charges in connection with treatments or medications where the patient either is in non-compliance with or is discharged from a Hospital or Skilled Nursing Facility against medical advice.

37. **Non-Emergency Hospital Admissions -** Care and treatment billed by a Hospital for non-medical emergency admissions when the admission is primarily for the patient's convenience.

38. **No Obligation to Pay -** Charges incurred for which the Plan has no legal obligation to pay.

39. **No Physician Recommendation -** Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.

40. **Not Specified as Covered -** Medical services, treatments and supplies which are not specified as covered under this Plan. Medical services, treatments and supplies that meet standards of care, are Medically Necessary, are ordered by a Physician, are not Experimental/ Investigational and not otherwise excluded by this Plan will be covered.

41. **Obesity -** Care and treatment of obesity, weight loss or dietary control. Medically Necessary charge for health problems associated with high-risk Morbid Obesity/Severe Clinical Obesity will be covered. Refer to Weight Management in the Medical Benefits section for details.

42. **Occupational -** Care and treatment of an Injury or Sickness that is occupational (that is, arises from work for wage or profit including self-employment) for which the Covered Person is entitled to benefits under any Workers' Compensation or Occupational Disease Law, or any such similar law.

43. **Orthotics -** Replacement of orthotics will not be covered unless 1) there is sufficient change in the Covered Person's physical condition to make the original device no longer functional or 2) the device has reached its life expectancy and needs to be replaced (but no more frequently than every 3 years). Replacement of the appliance must be pre-authorized. (Refer to Cost Management Services.) The benefit payment will be based on the cost of the treatment which provides professionally satisfactory results at the most cost-effective level. (Refer to Plan Exclusions items Foot and Hand Care for further information).

44. **Personal Comfort Items -** Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, water purifiers, humidifiers, electric heating units,

orthopedic or hypoallergenic pillows and mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, first-aid supplies, non-hospital adjustable beds, hot tubs, whirlpools and exercise equipment. Compression stockings are covered with a prescription / Physician's orders. The prescription must require measurement of the patient for proper fitting. Limit two (2) pair per year.

45. **Plan Design Excludes -** Charges excluded by the Plan design as mentioned in this document.

46. **Prosthetic Devices -** Certain prosthetic devices are not covered under this Plan: electrical convenience aids, either anal or urethral; implants for cosmetic or psychological reasons, penile prostheses for non-organic impotence; dental appliance; remote control devices; devices employing robotics; all mechanical organs; replacement of cataract lenses except when new cataract lenses are needed due to prescription change; and investigation or obsolete devices and supplies. Replacement of prostheses will not be covered unless 1) there is sufficient change in the Covered Person's physical condition to make the original device no longer functional or 2) the device has reached its life expectancy and needs to be replaced (but no more frequently than every 5 years). Replacement of the device must be pre-authorized. (Refer to Cost Management Services.). Replacement due to improper use or care (according to the manufacturer's guide on proper use) will not be covered. Repairs not covered under the warranty or required after the warranty expires will be covered, unless cost-prohibitive. The benefit payment will be based on the cost of the treatment which provides professionally satisfactory results at the most cost-effective level. (Refer to Plan Exclusions for Prosthetic devices for further information.)

47. **Psychoanalysis or Counseling with Relatives -** (except if the counseling is with a covered parent on behalf of a covered minor child)**,** unless stated otherwise in the Medical Benefits section.

48. **Psychological Reasons -** Surgery performed for psychological or emotional reasons.

49. **Relative Giving Services -** Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.

50. **Routine Care -** Charges for non-prescription drugs, vitamins and nutritional supplements unless necessary for the treatment of an illness or as approved by the Utilization Review Coordinator or as defined under the Affordable Care Act (Refer to Preventive Care in the Schedule of Benefits.)

51. **Services Before or After Coverage -** Care, treatment or supplies for which a charge was incurred before a person was Covered under this Plan or after coverage ceased under this Plan.

52. **Sex Changes -** Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment.

53. **Sexual Dysfunction -** Care, services or treatment for sexual dysfunction unrelated to organic disease.

54. **Surgical Sterilization Reversal -** Care and treatment for reversal of surgical sterilization.

55. **Travel or Accommodations -** Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance or emergency helicopter transport charges as defined as a covered expense.

56. **Vision Therapy -** Charges incurred in connection with vision therapy and learning-related vision therapy.

PRESCRIPTION DRUG BENEFITS

PHARMACY DRUG CHARGE

Participating pharmacies have contracted with the Plan through a Pharmacy Benefit Manager (PBM) to charge Covered Persons reduced fees for covered Prescription Drugs. Refer to your health ID card for the PBM's name and phone number.

In-Network Provider

All eligible prescription drugs ordered by a doctor and dispensed by a pharmacy or organization licensed to dispense drugs and designated by the City Manager as In-Network Provider will be paid after the co-payment for each prescription as stated in the Schedule of Benefits has been satisfied. Special arrangements have been made with In-Network Provider Pharmacies for direct billing to the Pharmacy Benefit Manager. A list of such organizations is available upon request.

Out-of-Network Provider

All other such drugs, dispensed by a pharmacy or organization licensed to dispense drugs which is not designated by the City Manager as an In-Network Provider will be paid under using the same conditions, deductible, coinsurance and non-covered amounts as other non-network provider coverage, and coverage of 60% of the eligible amount after the deductible is met.

RETAIL PHARMACY CO-PAY

Maximum fill: 90 days

For a prescription drug, the payment is equal $5.00 co-pay per 30-day fill plus 20% of the remainder of the cost per Prescription

90 day fill is only allowed at preferred retail pharmacies as identified by the Prescription Benefit Manager.

When a generic prescription drug is available and the brand name prescription drug is not specifically prescribed due to Medical Necessity, the payment for a brand name prescription drug will be equal to the sum of the $5.00 co-pay for a 30-day fill, 20% of the remainder of the cost of the brand name drug, and the difference in cost between the brand name prescription drug and the generic equivalent of the brand name prescription drug, but not to exceed the actual cost of the drug.

MAIL ORDER PHARMACY CO-PAY

90 day supply

For a prescription drug, the payment is equal to 20% of total cost of the prescription drug.

When a generic prescription drug is available and the brand name prescription drug is not specifically prescribed due to Medical Necessity, the payment for a brand name prescription drug will be equal to the sum of 20% of the total cost of the brand name drug, and the difference in cost between the brand name prescription drug and the generic equivalent of the brand name prescription drug, but not to exceed the actual cost of the drug.

SPECIALTY DRUGS

Specialty drugs are defined as certain genetically engineered compounds designed to target and treat specific major diseases, including AIDS, Alzheimer's disease, asthma, cancer, cystic fibrosis, diabetes, heart disease, hemophilia, hepatitis, lupus, multiple sclerosis, Parkinson's disease, sickle cell anemia, stroke, and tuberculosis. The Plan Administrator shall determine and keep a list of the drugs recognized as specialty drugs under the Plan. The specialty drugs may be oral, injectable, self-administered, or administered in certain settings.

For specialty drugs obtained through the specialty prescription drug program from an In-Network Provider, the maximum patient co-pay charges for such specialty drugs per year shall not exceed $1,500. All costs for such specialty drugs obtained through the preferred provider prescription drug portion of the Plan above the $1,500 annual maximum co-pay amount shall be covered at 100%.

This shall not apply to specialty drugs obtained from or administered by a physician, hospital, health care provider, or a non-preferred prescription drug provider.

Covered Prescription Drugs

1. All drugs prescribed by a Physician that require a prescription either by federal or state law. This does include oral contraceptives purchased at the Pharmacy, but excludes any drugs stated as not covered under this Plan.

2. All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity.

3. Insulin and other diabetic supplies when prescribed by a Physician.

4. Injectable drugs or any prescription directing administration by injection, such as Insulin, Imitrex, Lovenox, Betaseron, Copaxone, Avonex, Epogen, Neupogen or any other medication available to be filled as a self-injectable through the pharmacy. This list is subject to change. For the latest information on approved drugs and to obtain approval for the purchase of the drug through the pharmacy, please contact the PBM at the number listed on your identification card.

5. Other Prescriptions under the Affordable Care Act (ACA). Contraceptives, aspirin and other medications which are required coverage under the ACA will be covered at 100% (deductible waived) if required criteria is met and medication is purchased at a participating in-network pharmacy or through a participating in-network physician's office.

Limits To This Benefit

This benefit applies only when a Covered Person incurs a covered Prescription Drug charge. The covered drug charge for any one prescription will be limited to:

1. Refills only up to the number of times specified by a Physician.

2. Refills up to one year from the date of order by a Physician.

Expenses Not Covered

This benefit will not cover a charge for any of the following:

1. **Administration -** Any charge for the administration of a covered Prescription Drug.

2. **Appetite Suppressants -** A charge for appetite suppressants, dietary supplements or vitamin supplements, except for prenatal vitamins requiring a prescription or prescription vitamin supplements containing fluoride.

3. **Consumed on Premises -** Any drug or medicine that is consumed or administered at the place where it is dispensed.

4. **Devices -** Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device.

5. **Drugs Used for Cosmetic Purposes -** Charges for drugs used for cosmetic purposes, such as anabolic steroids, Retin A or medications for hair growth or removal, unless prior authorized with the Prescription Benefits Manager (PBM) for treatment of an Illness or Injury.

6. **Experimental -** Experimental drugs and medicines, even though a charge is made to the Covered Person.

7. **FDA -** Any drug not approved by the Food and Drug Administration.

8. **Growth Hormones -** Charges for drugs to enhance physical growth or athletic performance or appearance, unless prior authorized with the PBM.

9. **Immunization -** Immunization agents or biological sera.

10. **Infertility -** A charge for infertility medication.

11. **Inpatient Medication -** A drug or medicine that is to be taken by the Covered Person, in whole or in part, while Hospital confined. This includes being confined in any institution that has a facility for the dispensing of drugs and medicines on its premises.

12. **Investigational -** A drug or medicine labeled: "Caution - limited by federal law to investigational use".

13. **Medical Exclusions -** A charge excluded under Medical Plan Exclusions.

14. **No Charge -** A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs.

15. **Non-Legend Drugs -** Any drug for which no prescription is required by federal or state law, unless a specific medication or class of medications is covered under this Plan. Contact the PBM for details (Refer to ID card for phone number).

16. **No Prescription -** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin.

17. **Refills -** Any refill that is requested more than one year after the prescription was written or any refill that is more than the number of refills ordered by the Physician.

18. **Smoking Cessation Products -** Over-the-counter smoking cessation products are not covered.

PROCESSING CLAIMS FOR BENEFITS

Benefits under this Plan shall be paid only if the Plan Administrator determines in its discretion that a Covered Person is entitled to them.

HOW YOU ARE BILLED FOR SERVICES

Charges for medical services are billed by the provider at their normal rates. This is the price an individual would be charged in absence of any contractual arrangements with the provider. When contractual arrangements exist, the claim is re-priced to the discounted rate. This repricing function may be performed by either the Claims Administrator or a PPO Network.

Typically, the claim is submitted by the provider. If the patient must file a claim directly, it must be submitted to the Claims Administrator at the address indicated on the ID card and on Page 2 of this document. Refer to the section below for information required to be submitted on the claim.

Once a Clean Claim is received by the Claims Administrator, it is processed and an Explanation Of Benefits (EOB) is returned to the provider and Employee (or covered dependent if directed to do so) explaining any patient responsibility and/or reimbursement to the appropriate party. Occasionally the Claims Administrator must pend a claim to the provider or Covered Person if enough initial information is not received in order to process the charges. This can cause delays in processing.

If you do not receive timely notice of the determination of your health claim, please contact the Claims Administrator directly at the phone number listed on your ID card or on Page 2 of this document to verify receipt of the claim. You may also contact the provider to make sure the claim was filed correctly.

"Clean Claim" means a claim void of any material errors, omissions of pertinent information, coordination of benefits issues, and any liability issues, as determined by the Plan Administrator. Where not otherwise specified, this Plan follows National Correct Coding Initiative for coding modifiers, bundling/unbundling, and payment parameters. Other guidelines may be applicable where NCCI is silent. The Plan Administrator has full discretionary authority to select guidelines and/or vendors to assist in determinations.

HOW TO FILE A CLAIM

If the medical or prescription claim was not submitted by the Medical Provider to the Third Party Administrator or to the Prescription Benefit Manager by the Pharmacy, that person must:

Obtain a Claim form from the Human Resource office or the Claims Administrator. This form should be used in the following situations:

a. Submit for prescriptions not filed electronically with the Prescription Benefit Manager (PBM); See Schedule of Benefits for Out-of-Network coverage provisions;

b. Attach with all Out-of-Network Provider claims the Covered Person is submitting to the Plan for reimbursement;

c. Submit after services are rendered to a Covered Person for any accident; or

d. When the other insurance coverage for dependents has changed.

Send the claim to the Third Party Administrator as listed on Page 2 of this document.

WHEN CLAIMS SHOULD BE FILED

Claims must be filed with the Claims Administrator within 15 months of the date when charges for the services were incurred.

The following additional filing limitations apply:

1. Charges that were not previously submitted but related to a processed claim are considered a new claim and must be filed in the time limit above.

2. Corrected information submitted on a processed claim is considered an appeal and not a newly filed claim. The filing limit will follow the appeal limit. Refer to the Claim Review and Appeal Procedures section below.

3. If it is not reasonably possible to submit the claim in the time limit above (i.e., if the person has primary insurance with another plan and this plan is the secondary plan, if the person is not capable of submitting the claim due to Illness, etc.), the filing period will be 15 months from the date of service. The Claims Administrator will determine if it was or was not reasonably possible for the claim to be submitted within the time limit above.

4. If the Plan should terminate, all claims must be filed within 90 days of the Plan's termination date.

Benefits are based on the Plan's provisions at the time the charges were incurred.

The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

A request for Plan benefits will be considered a claim for Plan benefits, and it will be subject to a full and fair review.

ASSIGNMENT OF BENEFITS

Amounts payable for Hospital, medical or surgical services may at any time be used to make direct payments to health care providers or, at the option of the Claims Administrator, to the Covered Person for the services. Except as applicable law may otherwise require, no amount payable at any time hereunder may be subject in any manner to alienation by assignment of any kind. Any attempt to assign such amount, whether presently or hereafter payable shall be void.

Benefits unpaid at the Covered Person's death may be paid, at the Plan Administrator's option, to:

a. the Covered Person's beneficiary; or

b. the Covered Person's estate.

If the Covered Person's beneficiary is unable to give a valid release or if benefits unpaid at the Covered Person's death are not more than $2,000, the Claims Administrator may pay up to $2,000 to any relative of the Covered Person who is entitled to the benefit.

Any payment made in good faith will fully discharge the Plan to the extent of the payment.

CLAIM REVIEW AND APPEAL PROCEDURES

In General

The claim and review and appeal procedures outlined here are designed to afford you a full, fair and fast review of the claim to which the procedures apply. This section describes the claim review and appeal procedures that are effective beginning March 1, 2014.

Health Care Claims

Generally, all health care benefits will be paid as soon as administratively possible. You will be notified of an initial decision within certain timeframes.

Types of Health Care Claims

There are four basic types of health care claims:

Pre-Service. A pre-service claim is a claim for benefits where prior authorization is required. The services that require prior authorization include Hospitalizations and inpatient treatment of mental health disorders and chemical dependency. The Plan will not deny benefits for these procedures or services if:

- It is not possible for you to obtain prior authorization; or
- The prior authorization process would jeopardize your life or health.

Urgent Care. An urgent care claim is a type of a pre-service care claim. An urgent care claim is a claim for medical care or treatment that:

- Would seriously jeopardize your life or health or your ability to regain maximum function if normal pre-service standards were applied; or
- Would subject you to severe pain that cannot be adequately managed without the care or treatment for which approval is sought, in the opinion of a Physician with knowledge of your condition.

Post-service. A post-service claim is a claim for Plan benefits that is not a pre-service claim. When you file a post-service claim, you have already received the services in your claim. A claim regarding rescission of coverage will be treated as a post-service claim.

Concurrent Care. A concurrent care claim is a claim that is reconsidered after it is initially approved and the reconsideration results in:

- Reduced benefits; or
- A termination of benefits.

While other claims have certain deadlines throughout the claim and appeal process, there is no formal deadline to notify you of the reconsideration of a concurrent claim. However, you will be notified as soon as possible and in time to allow you to have an appeal decided before the benefit is reduced or terminated. If you request an extension of approved urgent care treatment, the Plan will act on your request within 24 hours after receiving it, as long as your claim is received at least 24 hours before the expiration of the approved treatment.
If a claim for post-service or concurrent care is approved, payment will be made and the payment will be considered notice that the claim was approved. However, for urgent care and pre-service claims, you will be given written notice of a decision about your claim.

The deadlines differ for the different types of claims as shown in the following paragraphs:

- **Urgent Care Claims.** An initial determination will be made within 72 hours from receipt of your claim. Notice of a decision on your urgent care claims may be provided to you orally as soon as possible, but no later than 72 hours and then will be confirmed in writing within three days after the oral notice. If additional information is needed from you to process your claim, you will be notified as soon as possible, but no later than 24 hours after receipt of your claim. You will then have up to 48 hours to respond. You will then be notified of the Plan's benefit determination on the urgent care claim as soon as possible, but no later than 24 hours after the earlier of the receipt of the information or the end of the period of time allowed to you in which to provide the information.

- **Pre-Service Claims.** An initial benefit determination will be made within 15 calendar days from receipt of your pre-service claim. If additional time is necessary to make a benefit determination on your pre-

service claim due to matters beyond the control of the Plan, the Plan may take up to 15 additional calendar days to make a benefit determination. You will be informed of the extension within the initial 15-day deadline. If additional information is needed from you to process your claim, you will be notified as soon as possible, but no later than 15 days after receipt of your claim. You will have up to 45 days to provide the requested information. You will then be notified of the Plan's benefit determination on the pre-service claim as soon as possible, but no later than 15 days after the earlier of the receipt of the information, or the end of the 45-day time period allowed to you in which to provide the information.

- **Post-Service Claims.** An initial benefit determination will be made within 30 calendar days from receipt of your post-service claim. If additional time is necessary to make a benefit determination on your post-service claim due to matters beyond the control of the Plan, the Plan may take up to 15 additional calendar days to make a benefit determination. You will be informed of the extension within the initial 30-day deadline. If additional information is needed from you to process your claim, you will be notified as soon as possible, but no later than 30 days after receipt of your claim. You will have up to 45 days to provide the requested information. You will then be notified of the Plan's benefit determination on the post-service claim as soon as possible, but no later than 30 days after the earlier of the receipt of the information, or the end of the 45-day time period allowed to you in which to provide the information.

- **Concurrent Care Claims.** While other claims have certain deadlines throughout the claim and appeal process, there is no formal deadline to notify you of the reconsideration of a previously approved claim. However, you will be notified as soon as possible and in time to allow you to have an appeal decided before the benefit is reduced or terminated. If you request an extension of approved urgent care treatment, the Plan will act on your request in the same manner as urgent care claims.

Authorized Representative

This Plan recognizes an authorized representative as any person at least 18 years old whom you have designated in writing as the person who can act on your behalf to file a claim and appeal an adverse benefit determination under this Plan (because of your death, disability or other reason acceptable to the Plan). An authorized representative under this Plan also includes a Health Care Professional. Under this Plan you do not need to designate in writing that the Health Care Professional is your authorized representative if that Health Care Professional is part of the claim appeal.

The Plan requires a written statement from you that you have designated an authorized representative (except for a health care professional who does not require a written statement in order to appeal a claim for a Plan participant) along with the representative's name, address and phone number. To designate an authorized representative, you must submit a completed authorized representative form to the Plan Administrator.
If you are unable to provide a written statement, the Plan will require written proof that the proposed authorized representative has the power of attorney for health care purposes (e.g., notarized power of attorney for health care purposes, court order of guardianship/ conservatorship or is your legal Spouse, parent, grandparent or child over the age of 18).

Once the Plan receives an authorized representative form, all future claims and appeals-related correspondence will be routed to the authorized representative and not to you. The Plan will honor the designated authorized representative until the designation is revoked, or as mandated by a court order. You may revoke a designated authorized representative status by submitting a completed change of authorized representative form to the Claims Administrator.
Authorized representative forms and change of authorized representative forms are available upon request from the Claims Administrator.

The Plan reserves the right to withhold information from a person who claims to be your authorized representative if there is suspicion about the qualifications of that individual.

Payment of Claims

Generally, when providers submit the claims, payment is made directly to the provider. Providers handle all the paperwork for you. However, if you submit the claim, payments are generally made directly to you, unless you assign benefits to the provider.

Examination

The Plan Administrator has the right:

1. To employ a Physician to examine the person whose Illness or Injury is the basis of a claim hereunder when and so often as they may reasonable require during the pending of a claim hereunder;
2. To examine any and all Hospital and medical records relating to a claim under this Plan; and
3. To request and have an autopsy performed in case of death, provided an autopsy is not forbidden by law.

If a Claim Is Denied

Adverse Benefit Determination

For the purpose of the initial and appeal claims processes, an adverse benefit determination is a denial, reduction, or termination of a benefit, or a failure to provide or make payment in whole or in part for a benefit, including any such denial, reduction, termination or failure to provide or make a payment that is based on**:**

- A determination of an individual's eligibility to participate in the Plan;
- A determination that a benefit is not a covered benefit;
- Any utilization review decision, source-of-Injury exclusion, network exclusion, or other limitation on otherwise covered benefits;
- A determination that a benefit is Experimental, Investigative or not Medically Necessary or appropriate; or
- A rescission of coverage, whether or not there is an adverse effect on any particular benefit at that time. A rescission of coverage is a cancellation or discontinuance of coverage that has retroactive effect, except for the following situations:
  - The Plan terminates your coverage back to the date of your loss of employment when there is a delay in administrative recordkeeping between your loss of employment and notification to the Plan of your termination of employment.
  - The Plan retroactively terminates your coverage because of your failure to timely pay the required premiums or contributions for your coverage.
  - The Plan retroactively terminates your former Spouse's coverage back to the date of your divorce.

If you receive an adverse benefit determination, meaning your claim is denied (in whole or in part), you will receive a written notice that will:

- Provide you with certain information about your claim; and
- Notify you of the denial of your claim within certain timeframes.

Information Requirements

When the Plan notifies you of its initial denial of your claim, it will provide:

- Identification of the claim involved, including date of service, provider, and claim amount;
- The specific reason or reasons for the decision, and any Plan standards used in denying the claim;
- The statement that you may request, without charge, the diagnosis code and its corresponding meaning, as well as the treatment code and its corresponding meaning;
- Reference to the Plan provisions on which the decision was based;
- A description of any additional information or material needed to properly process your claim and an explanation of the reason it is needed;
- A description of the Plan's internal review procedures and time periods and information needed to appeal your claim, and notify you of the availability of external review processes for health care claims;
- Contact information for the Plan's Claims Administrator; and
- Disclosure of the availability of, and contact information for, any applicable ombudsman established under the Patient Protection and Affordable Care Act of 2010 to assist individuals with the internal claims and appeals and external review processes for health care claims.

In addition, you have the right to request:

- A copy of any internal rule, guideline, protocol or similar criteria that was relied on in making the decision to deny your claim, or a statement that a copy is available to you at no cost upon request; and

- A copy of the scientific or clinical judgment, or statement that it is available to you at no cost upon request, if your claim is denied due to Medical Necessity, Experimental treatment, or similar exclusion or limit.

If your appeal is due to the denial of an urgent care claim, the notice will also include a description of the expedited review process.

The Plan must also provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim. Such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give you a reasonable opportunity to respond prior to that date.

Additionally, before the Plan can issue an adverse benefit determination on review based on a new or additional rationale, you must be provided, free of charge, with the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give you a reasonable opportunity to respond prior to that date.

Appealing a Denied Claim

If your claim is denied or you disagree with the amount of the benefit, you have the right to have the initial decision reviewed. You must follow the appeals procedure before you may file a lawsuit.

When filing or appealing a claim, you may authorize a representative to act on your behalf. However, you must provide notification to the Claims Administrator authorizing this representative. A health care provider that has knowledge of your medical condition may act as your authorized representative for urgent care claims.

Your written appeal must explain the reasons you disagree with the decision on your claim and you may provide any supporting documents or additional comments related to this review. When filing an appeal you may:

- Submit additional materials, including comments, statements or documents; and

- Request to review all relevant information (free of charge). A document, record or other information is considered relevant if it:

  - Was relied upon by the Plan in making the decision;

  - Was submitted, considered or generated in the course of making the decision (regardless of whether it was relied upon); or

  - Demonstrates compliance with the claims processing requirements.

If you file your appeal on time and follow any applicable required procedures, a new, full and independent review of your claim will be made and the decision will not be deferred to the initial benefit decision maker.

An appropriate fiduciary of the Plan, in this case, the Plan Administrator, will conduct the review and the decision will be based on all information used in the initial determination as well as any additional information submitted.

The Plan will notify you, in writing, of the decision on appeal within the timeframes set forth under the different types of claims. However, notice of a determination on your urgent care claims may be provided to you in an expedited manner and may be provided orally.

Appeal Timeframes

The Plan's determination of its decision will be made within certain timeframes. The deadlines differ for the different types of claims as shown in the following information:

- *Urgent Care Claims*. A determination will be made as soon as possible, but not later than 72 hours from receipt of your appeal.

- *Pre-Service Claims*. A determination will be made within 30 calendar days from receipt of your appeal if the appeal process has one level. If the appeal process has two levels, the determination will be made within 15 calendar days from receipt of your appeal for each level.

- *Post-Service Claims*. The Plan has two appeal levels for post-service claims.

  - *First Level of Appeal:* You may appeal the denial of a claim by writing the Claims Administrator and stating that you wish to appeal. In order to be considered, your appeal must be received within 180 days after you are notified of the denial. A determination will be made within 30 days from receipt of your appeal by the Claims Administrator.

  - *Second Level of Appeal:* If the Claims Administrator denies the First Level Appeal, you may file a Second Level of Appeal to the City of Springfield Health Plan Appeals Committee ("Committee"). This Second Level Appeal must be submitted to the Director of Human Resources within 90 days of the date the First Level Appeal is denied by the Claims Administrator. The Director will convene the Committee who will review all documentation, including but not limited to, applicable medical records, plan language and the First Level Appeal and response. If the Committee determines that the claim is to be paid, it will authorize the payment by submitting a response to the Director of Human Resources, who will forward the response to the Claims Administrator which shall pay the claim. If the Committee determines that the claim is not entitled to be paid under the Plan, the Committee will notify the Director of Human Resources who will provide a written response to inform the claimant that the claim remains denied. This written response will be the Final Internal Adverse Benefit Determination. Once a Final Internal Adverse Benefit Determination is made, the member may request an External Review (see section External Review for timelines and requirements).

- *Concurrent Care Claims*. A determination will be made before the termination of your benefit.

A Plan Participant must exhaust the claims appeal procedure before filing a suit for benefits.

Medical Judgments

If your claim is denied on the basis of a medical judgment, the Plan will consult with a health care professional who:

- Has appropriate training and experience in the field of medicine involved in the medical judgment; and

- Was not consulted (or is not subordinate to the person who was consulted) in connection with the initial denial of your claim.

You have the right, upon request, to be advised of the identity of any medical experts consulted in making a determination of your appeal.

Appeal Information Requirements

When the Plan notifies you of its determination on your appeal, it will provide:

- Identification of the claim involved, including date of service, provider, and claim amount;

- The specific reason or reasons for the decision, and any Plan standards used in denying the claim;

- Reference to the Plan provisions on which the decision was based;

- A statement that you may request, without charge, the diagnosis code and its corresponding meaning, as well as the treatment code and its corresponding meaning;

- A statement notifying you that you have the right to request a free copy of all documents, records and other information relevant to your claim;

- Information relating to external review processes for health care claims, and any voluntary appeal procedures offered by the Plan;

- Contact information for the Plan's Claims Administrator; and

- Disclosure of the availability of, and contact information for, any applicable ombudsman established under the ACA to assist individuals with the internal claims and appeals and external review processes for health care claims.

In addition, the notice will include:

- A copy of any internal rule, guideline, protocol or similar criteria that was relied on in making the decision to deny your claim, or a statement that a copy is available to you at no cost upon request; and

- A copy of the scientific or clinical judgment, or statement that it is available to you at no cost upon request, if your claim is denied due to Medical Necessity, Experimental or Investigative treatment, or similar exclusion or limit.

Outline of the Timeframes for Claims and Appeals

	Urgent	**Concurrent**	**Pre-service**	**Post-service**
Plan must make **Initial Claim Benefit Determination** as soon as possible but no later than:	72 hours	Before the benefit is reduced or treatment terminated.	15 days	30 days
Extension permitted during initial benefit determination?	No[1]	No	Yes, one 15-day extension.	Yes, one 15-day extension.
First (initial) Appeal Review must be submitted to the Plan within:	180 days	180 days	180 days	180 days
Plan must make **Appeal Claim Benefit Determination** as soon as possible but no later than:	72 hours	Before the benefit is reduced or treatment terminated.	15 days for each appeal level	30 days for each appeal level
Second Appeal Review must be submitted to the Plan within:	NA	NA	90 days	90 days
Extension permitted during appeal review?	No	No	No	No

[1]*No formal extension for urgent care claims but regulation does allow that if a claimant files insufficient information the claimant will be allowed up to 48 hours to provide the information.*

EXTERNAL REVIEW

GENERAL

This External Review process is intended to comply with the Patient Protection and Affordable Care Act of 2010 ("ACA") external review requirements as set forth in federal regulations and other guidance issued in connection with the implementation of the ACA.

If your appeal of a health care claim, whether pre-service, post-service or urgent care claim, is denied, you may request further review by an independent review organization ("IRO") as described below. In the normal course, you may only request external review after you have exhausted the internal review and appeals process described above.

NOTE that if your claim was denied due to your failure to meet the requirements for eligibility under the terms of the Plan, external review is not available. You are eligible for external review if your initial claim determination or your adverse appeal claim determination involves medical judgment or rescission of your coverage under the Plan.

EXTERNAL REVIEW OF STANDARD CLAIMS

Your request for external review of a standard (not urgent) claim must be submitted, in writing, within four (4) months of the date that you receive the Final Adverse Benefit Determination. For convenience, such a determination is referred to below as an "Adverse Determination," unless it is necessary to address the determination separately. Generally, external review is only available after the internal appeal process has been exhausted and a Final Internal Adverse Benefit Determination has been provided (see Expedited External Review of Claims for more information).

Preliminary Review Procedures

1. Within five (5) business days of the Plan's receipt of your external review request for a standard claim, the Plan will complete a preliminary review of the request to determine whether:

   (a) You are/were covered under the Plan at the time the health care item or service is/was requested or, in the case of a retrospective review, were covered under the Plan at the time the health care item or service was provided;
   (b) The Adverse Determination does not relate to your failure to meet the requirements for eligibility under the terms of the Plan, or does not relate to a decision made solely on a legal or contractual interpretation of Plan terms;
   (c) You have exhausted the Plan's internal appeal process, unless you are not required to exhaust the internal appeal process under the federal interim final regulations (which involve certain limited exceptional circumstances); and
   (d) You have provided all of the information and forms required to process an external review.

2. Within one (1) business day of completing its preliminary review, the Plan will send you a notice in writing as to whether your request for external review meets the threshold requirements for external review.

   (a) If your request for external review is complete but not eligible for external review, the notice will include the reasons for the request's ineligibility.
   (b) If your request for external review is not complete, the notice will describe the information or materials needed to make the request complete, and you will be allowed to perfect your request for external review within the four (4) month filing period or within a 48-hour period following receipt of the notification, whichever is later.

Review by Independent Review Organization

If your request for external review meets the threshold requirements for external review, the Plan will assign the request to an IRO. The IRO will be assigned in accordance with the Plan's rules, which provide an assignment or rotation method that ensures independence and against a bias towards the Plan. The IRO is not eligible for any financial incentive or payment based on the likelihood that the IRO would support the denial of benefits.
Once the claim is assigned to an IRO, the following procedures will apply:

1. The assigned IRO will timely notify you in writing of the request's eligibility and acceptance for external review. This notice will include a statement that you must submit in writing to the assigned IRO within ten

(10) business days following the date you receive the notice from the assigned IRO, additional information that the IRO will consider when conducting the external review. The IRO may, but is not required to, accept and consider additional information submitted after ten (10) business days.

2. Within five (5) business days after the date of assignment to the IRO, the Plan will provide to the IRO any documents and any information considered in making its Adverse Determination. Failure by the Plan to provide documents cannot delay the conduct of the external review. If the Plan fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the adverse benefit determination or the final adverse internal appeal determination. Within one (1) business day after making the decision, the IRO will notify you and the Plan.

3. If you submit additional information related to your claim, the assigned IRO must within one (1) business day forward that information to the Plan. Upon receipt of any such information, the Plan may reconsider its Adverse Determination that is the subject of the external review. Reconsideration by the Plan will not delay the external review. However, if upon reconsideration, the Plan reverses its Adverse Determination, it will provide written notice of its decision to you and the IRO within one (1) business day after making that decision. Upon receipt of such notice, the IRO will terminate its external review.

4. The IRO will utilize legal experts where appropriate to make coverage determinations under the Plan.

5. The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim de novo (as if it is new) and will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law. The IRO also must observe the Plan's applicable standards for clinical review criteria, including Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, unless the criteria are inconsistent with the terms of the Plan or with applicable law. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and appropriate, may consider additional information, including information from your medical records, any recommendations or other information from your treating health care providers, any other information from you or the Plan, reports from appropriate health care professionals, appropriate practice guidelines, the Plan's applicable clinical review criteria and/or the opinion of the IRO's clinical reviewer(s).

6. The assigned IRO will provide written notice of its final external review decision to you and the Plan within 45 days after the IRO receives your request for external review.

7. The assigned IRO's decision notice will contain:

   (a) A general description of the reason for the request for external review, including information sufficient to identify the claim including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, and the reason for the previous denial;
   (b) The date that the IRO received the assignment to conduct the external review and the date of the IRO decision;
   (c) References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
   (d) A discussion of the principal reason(s) for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
   (e) A statement that the IRO's determination is binding except to the extent that other remedies may be available to you or the Plan under applicable State or Federal law;
   (f) A statement of the opportunity to request the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
   (g) A statement that judicial review may be available to you; and
   (h) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the ACA to assist with external review processes.

EXPEDITED EXTERNAL REVIEW OF CLAIMS

You may request an expedited external review if:

1. You receive an adverse Initial Claim Benefit Determination that involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal; or

2. You receive an adverse Appeal Claim Benefit Determination that involves a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function; or, you receive an adverse Appeal Claim Benefit Determination that concerns an admission, availability of care, continued stay, or health care item or service for which you received Emergency Services, but you have not yet been discharged from a facility.

Preliminary Review

Upon receipt of the request for expedited external review, the Plan will complete a preliminary review of the request as soon as possible to determine whether the request meets the reviewability requirements set forth in the Preliminary Review Procedures section above. The Plan will send you a notice as soon as possible informing you as to whether your request for review meets the threshold requirements for external review, along with other information described in the Preliminary Review Procedures section above.

Review by Independent Review Organization

Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO. The Plan will expeditiously provide or transmit to the assigned IRO all necessary documents and information that it considered in making its Adverse Determination.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described in the procedures for standard review. In reaching a decision, the assigned IRO must review the claim de novo (as if it is new) and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law. The IRO also must observe the Plan's applicable standards for clinical review criteria, including Medical Necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit, unless the criteria are inconsistent with the terms of the Plan or with applicable law.

The IRO will provide notice of the final external review decision, in accordance with the requirements set forth for standard reviews, as expeditiously as your medical condition or circumstances require, but in no event more than seventy-two (72) hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within forty-eight (48) hours after the date of providing that notice, the IRO must provide written confirmation of the decision to you and the Plan.

AFTER EXTERNAL REVIEW

If the final external review reverses the Plan's Adverse Determination, upon the Plan's receipt of notice of such reversal, the Plan will provide coverage or payment for the reviewed claim as soon as possible in accordance with applicable law. The Plan reserves the right to pursue judicial review or other remedies available or that may become available to the Plan under applicable law. The Plan must provide benefits (including making payment on the claim) without delay pursuant to a final external review decision in the claimant's favor, regardless of whether the Plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

If the final external review upholds the Plan's Adverse Determination, the Plan will continue not to provide coverage or payment for the reviewed claim. If you are dissatisfied with the external review determination, you may seek judicial review.

The external review standards provide that an external review decision is binding on the Plan, as well as on the claimant, except to the extent other remedies are available under State or Federal law.

The IRO will maintain records of all claims and notices associated with the external review process for a minimum of six (6) years. An IRO will make such records available for examination by you, the Plan, or State or Federal government oversight agency upon request, except where such disclosure would violate State or Federal privacy law.

COORDINATION OF BENEFITS

Coordination of the Benefit Plans

Coordination of benefits (COB) sets out rules for the order of payment of Covered Charges when two or more plans -- including Medicare -- are paying. When a Covered Person is covered by this Plan and another plan, or the Covered Person's Spouse is covered by this Plan and by another plan or Covered Children are covered under two or more plans, the plans will coordinate benefits when a claim is received.

The plan that pays first according to the COB rules will pay as if there were no other plans involved. As a subsequent plan, this Plan will consider the allowable amount to be the lesser of: 1) what this Plan would have allowed as the primary plan; or 2) the lesser amount allowed by any preceding plan(s). The Total payment by this Plan may be reduced so as not to exceed 100% of this total allowable amount when added to any preceding plan's reimbursement and any responsibility of the Covered Person. Should the reimbursement(s) by any preceding plan(s) exceed this total allowable, no payment will be made by this Plan.

Benefit Plan

This provision will coordinate the medical benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans:

1. Group or group-type plans, including franchise or blanket benefit plans.
2. Blue Cross and Blue Shield group plans.
3. Group practice and other group prepayment plans.
4. Federal government plans or programs. This includes Medicare.
5. Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.
6. No Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

Allowable Charge

For a charge to be allowable it must be a Usual and Reasonable Charge and at least part of it must be covered under this Plan.

Automobile Limitations

When medical payments are available under vehicle insurance which insures the Covered Person, the Plan shall pay excess benefits only, without reimbursement for vehicle plan deductibles. (For purposes of this section, "available" means that the insured has personal injury coverage under his/her personal automobile insurance, and applies whether the coverage is provided directly or indirectly (i.e., under a spouse's or parent's auto policy). This Plan is secondary even if no claim is filed with the auto carrier. Accident claims filed with this Plan will not be considered pending receipt of the auto policy information. If the information is not provided within the requested period, the claim(s) will be denied. (Refer to the Claims Procedure section.)

This Plan shall always be considered the secondary carrier regardless of the individual's election under PIP (personal injury protection) coverage with the auto carrier (only available in some states).

Benefit Plan Payment Order

When two or more plans provide benefits for the same allowable charge, benefit payment will follow these rules.

1. Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.
2. Plans with a coordination provision will pay their benefits up to the Allowable Charge:

a. The benefits of the plan which covers the person directly (that is, as an employee, member or subscriber) ("Plan A") are determined before those of the plan which covers the person as a Dependent ("Plan B").

b. The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or Retired Employee. The benefits of a benefit plan which covers a person as a Dependent of an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a Dependent of a laid off or Retired Employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

c. The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired or a Dependent of an Employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.

d. When a child is covered as a Dependent and the parents are married, are living together whether or not they have ever been married or not separated or divorced, these rules will apply:

   (i.) The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;

   (ii.) If both parents have the same birthday, the benefits of the benefit plan which has covered the patient for the longer time are determined before those of the benefit plan which covers the other parent.

e. When a child's parents are divorced, legally separated or never married, these rules will apply:

   (i.) This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.

   (ii.) This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a Dependent will be considered next. The benefit plan of the parent without custody will be considered last.

   (iii.) This rule will be in place of items (i.) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent.

   (iv.) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are not separated or divorced.

   (v.) If there is no court decree allocating responsibility for a child’s health care expenses or health coverage or for parents who were never married to each other and not living together, the rules apply as follows as long as paternity has been established:

- The Plan of the Custodial Parent;
- The Plan of the spouse of the Custodial Parent;
- The Plan of the non-custodial parent; and then
- The Plan of the spouse of the non-custodial parent.

If a court decree states that one of the parents is responsible for the Dependent Child's health care expenses or health insurance coverage, that Plan is primary. This rule applies to Claim Determination Periods or Plan Years commencing after the Plan is given notice of the court decree.

If a court decree states that both parents are responsible for the Dependent Child's health care expense or health insurance coverage, the provisions of subparagraph (d) of this section shall determine the order of benefits.

For the purposes of this section:

Custodial Parent - means the parent awarded custody by a court decree; or in the absence of a court decree, is the parent with whom the child resides more than one-half of the Calendar Year excluding any temporary visitation. In the case where the parents are not married but are living together, absent any court decree directing otherwise, the Custodial Parent shall be deemed to be the mother of the child and her plan shall be the primary plan.

Claim Determination Period - means a Calendar Year. Claim Determination Period does not include any part of the Calendar Year during which a claimant has no coverage under this Plan, or before the date this COB provision or a similar provision takes effect.

f. If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of allowable charges when paying secondary.

3. Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefit determination by Medicare under Parts A, B and D or this Plan, if the benefit would be less. This Plan will always follow the standard Medicare Secondary Payer rules as may be revised from time to time.

   The coordination of benefits rules set forth above will apply with respect to benefits the Covered Person is entitled to receive from Medicare, except that this Plan will be the primary plan if:

   a. The Covered Person is an Employee age sixty-five (65) or over who has elected coverage under this Plan.

   b. The Covered Person is a Spouse age sixty-five (65) or over of an Employee and has elected coverage under this Plan.

   c. The Covered Person is eligible for Medicare Part A and Part B coverage solely because of end-stage renal disease, but only for the thirty (30) month period beginning with Medicare entitlement.

   d. The Covered Person is eligible for Medicare Part A and Part B coverage solely as a result of disability (within the meaning of the Social Security Act) other than end-stage renal disease.

      Note: The Covered Person is considered to be age sixty-five (65) or over on the first day of the month that person attains age sixty-five (65) as determined by Social

Security Administration. For types of medical expenses not covered by Medicare (for example, Prescription Drugs), this provision does not apply.

4. If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

5. The Plan will pay primary to Tricare to the extent required by federal law.

6. The Plan will pay primary to Medicaid coverage. Your eligibility for coverage under this Plan will not be affected by the fact that you receive medical assistance or are eligible for coverage under Medicaid.

Claims Determination Period

Benefits will be coordinated on a Calendar Year basis. This is called the claims determination period.

Right to Receive or Release Necessary Information

To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Covered Person will give this Plan the information it asks for about other plans and their payment of allowable charges.

Facility of Payment

This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

Right of Recovery

This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Covered Person. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the allowable charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

RIGHT OF SUBROGATION

To the extent authorized by Section 376.433, RSMo 2005, the Plan shall have a right of subrogation against third parties for negligent, reckless or willful acts or omissions by said third part(ies) which cause hospital, medical, surgical, or other health care costs and expenses to be paid out by the Plan to or for any persons covered under the Plan. The scope of the rights, obligations and remedies available to the Plan shall be as the Missouri Department of Social Services has with Medicaid, as set out in Section 208.215, RSMo 2005.

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR

City of Springfield Group Health Plan is the benefit plan of City of Springfield, Missouri, the Plan Administrator, also called the Plan Sponsor. An individual may be appointed by the City Manager of City of Springfield, Missouri to be Plan Administrator and serve at the convenience of the City of Springfield. If the Plan Administrator resigns, dies or is otherwise removed from the position, the City Manager of City of Springfield, Missouri shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

DUTIES OF THE PLAN ADMINISTRATOR

1. To administer the Plan in accordance with its terms.
2. To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.
3. To decide disputes which may arise relative to a Plan Participant's rights.
4. To prescribe procedures for filing a claim for benefits and to review claim denials.
5. To keep and maintain the Plan documents and all other records pertaining to the Plan.
6. To appoint a Claims Administrator to pay claims.
7. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

PLAN ADMINISTRATOR COMPENSATION

The Plan Administrator serves **without** compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

CLAIMS ADMINISTRATOR IS NOT A FIDUCIARY

A Claims Administrator is **not** a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

DELAY OF DUTIES OF PLAN ADMINISTRATOR OR CLAIMS ADMINISTRATOR DUE TO FORCE MAJEURE

Force Majeure is a circumstance not within a person’s control, including but not limited to: fire, flood, war, civil disturbance/riot, court order, strike, partial or complete destruction of facilities, etc. No suit or action in law or equity may be taken against them on account of any of these events. The Plan Administrator and Claims Administrator will have no liability or obligation if their respective services are delayed or not provided; or if medical care is delayed, not provided, or covered as non-network care due to Force Majeure. The Plan Administrator and Claims Administrator will, however, make a good-faith effort to provide services during and subsequent to any of these events.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

For Employee and Dependent Coverage

Funding is derived from contributions by the City of Springfield for eligible employees and contributions made by the covered Employee for Dependents. Funding is also derived from COBRA plan participant's premium contributions.

The level of any contributions will be recommended by the City of Springfield Health Insurance Committee and as approved by the City Manager unless City Council action is required. . These contributions will be used in funding the cost of the Plan as soon as practicable after they have been received.

Benefits are paid directly from the Plan through the Claims Administrator.

CLERICAL ERROR

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, if it is requested, the amount of overpayment will be deducted from future benefits payable.

AMENDING AND TERMINATING THE PLAN

If the Plan is terminated, the rights of the Plan Participants are limited to expenses incurred before termination.

The City of Springfield reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust agreement (if any).

MISREPRESENTATION OR FALSIFICATION OF A CLAIM

If a Covered Person (as the claimant) furnishes false information on any material subject to the Plan, or to any of its agents or employees, the Plan may deny all or part of the Covered Person's claim and may charge him or her for any expenses incurred related to the false information. If benefits have already been paid, based on the false information on a material subject, the Plan may recover the benefits from the Covered Person, plus expenses incurred in such recovery, including attorney's fees, costs and any and all other expenses, and/or may reduce future benefits for the Covered Person's claims until the Plan has recovered the benefits paid.

WORKERS' COMPENSATION

This Plan is not in lieu of and does not affect any requirement for coverage under any workers' compensation law or occupational disease law.

RIGHT OF RECOVERY

Whenever payments have been made by the Plan with respect to Covered Charges in a total amount at any time in excess of the maximum amount of payment necessary at that time to satisfy the intent of the provision, the Plan shall have the right to recover such payments on behalf of Covered Person (including the right to withhold future benefits), to the extent of such excess, from among one or more of the following, as the Plan shall determine:

1. Any Covered Persons to whom or for whom such payments were made;

2. Any insurance companies; and

3. Any other organizations.

RELEASE OF INFORMATION

A Covered Person who is making an application for benefits shall be required by the Plan to authorize any Physician, Hospital, or the Employer, government agency, or any other person, corporation, or organization having information that may be required for a proper determination of the claim by the Plan to release such information to the Plan Administrator. Such Covered Person shall, at the request of the Plan, execute written authorizations necessary to accomplish this purpose.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

HIPAA ELECTRONIC SECURITY STANDARDS COMPLIANCE

COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS

Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"), the Plan documents must be amended to reflect certain obligations required of the City of Springfield.

Therefore, the following provisions apply:

1. The City of Springfield agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the City of Springfield creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

2. The City of Springfield shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

3. The City of Springfield shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Compliance With HIPAA Privacy Standards provisions (3) Authorized Employees and (4) Certification of City of Springfield's described above.

HIPAA PRIVACY RULE

The Plan is hereby amended pursuant to Section 9.1 to bring it in compliance with HIPAA and its implementing regulations, 45 C.F.R. Parts 160 through 164 ("Privacy Rule"), as follows:

Uses and Disclosures of Protected Health Information

The Plan will disclose Protected Health Information ("PHI") in accordance with the City of Springfield HIPAA Privacy Policy and Procedure Manual. A copy of this manual is available in the Benefits Department for review.

Plan Sponsor

City of Springfield, Missouri will be the Plan Sponsor for purposes of the Privacy Rule. City of Springfield City Manager will act for the Plan Sponsor and will be entitled to delegate his/her powers and responsibilities in accordance with usual practices.

Privacy Official

The City Manager will appoint the Privacy Official, who will be entitled to delegate his/her powers and responsibilities in accordance with usual practices.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

NOTICE OF PRIVACY PRACTICES

Effective April 14, 2004

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

This Notice of Privacy Practices describes how the City of Springfield Group Health Plan (referred to in this Notice as the "Plan") may use and disclose your protected health information. This Notice also sets out the Plan's legal obligations concerning your protected health information and describes your rights to access and control your health information. This Notice has been drafted in accordance with the HIPAA Privacy Rule, contained in the Code of Federal Regulations at 45 CFR Parts 160 and 164. Terms not defined in this Notice have the same meaning as they have in the HIPAA Privacy Rule.

If you have any questions or want additional information about this Notice or the policies and procedures described in this Notice, please contact the Plan's Privacy Official using the contact information provided at the end of this Notice.

THE PLAN'S RESPONSIBILITIES

The Plan is required by law to maintain the privacy of your protected health information. It is obligated to provide you with a copy of this Notice setting forth the Plan's legal duties and its privacy practices with respect to your protected health information. The Plan must abide by the terms of this Notice.

USES AND DISCLOSURES OF YOUR HEALTH INFORMATION

The following describes when the Plan is permitted or required to use or disclose your protected health information.

Payment and Health Care Operations: The Plan has the right to use and disclose your health information for all activities that are included within the definitions of "payment" and "health care operations" as defined in the HIPAA Privacy Rule.

> ***Payment:*** The Plan will use or disclose your health information to fulfill its responsibilities for coverage and providing benefits as established under the Plan. For example, the Plan may disclose your health information when a provider requests information regarding your eligibility for benefits under the Plan, or it may use it in order for your claims to be processed.
>
> ***Health Care Operations:*** The Plan will use or disclose your health information to support the Plan's business functions. These functions include, but are not limited to, quality assessment and improvement, reviewing provider performance, licensing, business planning, and business development. For example, the Plan may use your health information for appeals, grievances, external review programs, disease management, and case management.

Business Associates: The Plan contracts with service providers – called business associates – to perform various functions on its behalf. For example, the Plan may contract with a service provider to perform the administrative functions necessary to pay your medical claims. In order to perform these functions or to provide the services, business associates may receive, create, maintain, use, or disclose your health information, but only after the Plan and the business associate agree in writing to contract terms requiring the business associate to appropriately safeguard your information.

Organized Health Care Arrangement (OHCA): The following plans are part of the Plan's OHCA and may share your health information with each other to carry out payment and health care activities: City of Springfield Health Plan, City of Springfield Group Health Plan, and City of Springfield Medical Reimbursement Plans (Union and Nonunion Employees Plans).

Health Care Providers and Other Covered Entities: The Plan may use or disclose your health information to assist health care providers in connection with their treatment or payment activities or to assist other covered entities in connection with certain health care operations. For example, the Plan may disclose your health information to a health care provider for treatment and the Plan may disclose health information to another covered entity to conduct health care operations in the areas of quality assurance and improvement activities or accreditation, certification, licensing, or credentialing. This also means that the Plan may disclose or share your

health information with other health care programs or insurance carriers (such as Medicare, Prudential, etc.) in order to coordinate benefits if you or your family members have other health insurance or coverage.

Required by Law: The Plan may use or disclose your health information to the extent required by federal, state, or local law.

Public Health Activities: The Plan may use or disclose your health information for public health activities that are permitted or required by law. For example, it may use or disclose information for the purpose of preventing or controlling disease, injury, or disability, or it may disclose such information to a public health authority authorized to receive reports of child abuse or neglect. The Plan also may disclose health information if directed by a public health authority.

Health Oversight Activities: The Plan may disclose your health information to a health oversight agency for activities authorized by law. For example, these oversight activities may include audits; investigations; inspections; licensure or disciplinary actions; or civil, administrative, or criminal proceedings or actions. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs, and government agencies that ensure compliance with civil rights laws.

Lawsuits and Other Legal Proceedings: The Plan may disclose your health information in the course of a judicial or administrative proceeding or in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized). If certain conditions are met, the Plan may also disclose health information in response to a subpoena, a discovery request, or other lawful process.

Abuse or Neglect: The Plan may disclose your health information to a government authority that is authorized by law to receive reports of abuse, neglect, or domestic violence. Additionally, as required by law, if the Plan believes you have been a victim of abuse, neglect, or domestic violence, it may disclose your health information to a governmental entity authorized to receive such information.

Law Enforcement: The Plan may disclose your health information for law enforcement purposes. For example, the Plan may disclose you health information to a law enforcement official in response to a court order, warrant, summons, administrative request, or similar process.

To Prevent a Serious Threat to Health or Safety: Consistent with applicable laws, the Plan may disclose your health information if disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. It also may disclose health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

National Security, Military, and Protective Services: The Plan may disclose your health information to authorized military command authorities or federal officials for conducting national security and intelligence activities.

Decedents: The Plan may disclose health information to a coroner, medical examiner, or funeral director when necessary for identifying a deceased person, determining a cause of death, and carrying out their necessary duties. The Plan may also disclose health information to organizations that handle organ, eye, or tissue donation and transplantation.

Workers' Compensation: The Plan may disclose health information to comply with Workers' Compensation laws and other similar programs that provide benefits for work-related injuries or illnesses.

Disclosures to the Plan Sponsor: The Plan (or its health insurance issuers) may disclose your health information to the plan sponsor as allowed by the Privacy Rule.

Information Not Personally Identifiable: The Plan may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

Family Members: **The Plan may disclose your health information to a family member who is involved in your health care, *unless you object or request a restriction*** (in accordance with the process described under "Right to Request a Restriction"). The Plan may also disclose your health information to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location. If you are not present or able to agree to these disclosures of your health information, then, using professional judgment, the Plan may determine whether the disclosure is in your best interest.

Disclosures to the Secretary of the U.S. Department of Health and Human Services: The Plan is required to disclose your health information to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

Disclosures to You or Your Personal Representative: The Plan is required to disclose to you or your personal representative most of your health information when you request access to this information. The Plan will disclose your health information to an individual who has been designated by you as your personal representative and who has qualified for such designation in accordance with relevant law. Prior to such a disclosure, however, the Plan must be given written documentation that supports and establishes the basis for the personal representation. The Plan may elect not to treat the person as your personal representative if it has a reasonable belief that you have been, or may be, subjected to domestic violence, abuse, or neglect by such person; treating such person as your personal representative could endanger you; or the Plan determines, in the exercise of its professional judgment, that it is not in your best interest to treat the person as your personal representative.

OTHER USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

Other uses and disclosures of your health information that are not described in this Notice will be made only with your written authorization. If you provide the Plan with an authorization, you may revoke the authorization in writing, and this revocation will be effective for future uses and disclosures of your health information. However, the revocation will not be effective for information that the Plan has used or disclosed in reliance of the authorization.

CONTACTING YOU

The Plan (or its health insurance issuers or third party administrators) may contact you about treatment alternatives, appointment reminders, or other health benefits or services that might be of interest to you.

YOUR RIGHTS

The following describes your rights with respect to your protected health information.

Right to Request a Restriction: You have the right to request a restriction on the health information the Plan uses or discloses about you for payment or health care operations. You also have a right to request a limit on disclosures of your health information to family members who are involved in your care or the payment for your care. **The Plan is not required to agree to any restriction that you request.** If the Plan agrees to the restriction, it can stop complying with the restriction upon providing notice to you.

Your request must be in writing and include the health information you wish to limit, whether you want to limit the Plan's use, disclosure, or both, and (if applicable) to whom you want the limitations to apply (for example, disclosures to your spouse). To request a restriction on your health information, you should complete and submit the *Request to Restrict Certain Uses and Disclosures of Health Care Information* form to the Plan's Privacy Official using the contact information at the end of this Notice.

Right to Request Confidential Communications: If you believe that a disclosure of all or part of your health information may endanger you, you may request that the Plan communicate with you in an alternative manner or at an alternative location. For example, you may ask that all communications be sent to your work address. The Plan will accommodate a request for confidential communications that is reasonable and states that the disclosure of all or part of your health information could endanger you.

Your request must be in writing and specify the alternative means or location for communication with you. It also must state that the disclosure of all or part of your health information in a manner inconsistent with your instructions would put you in danger. To request confidential communications of your health information, you should complete and submit the *Request for Confidential Communications of Health Care Information* form to the Plan's Privacy Official using the contact information at the end of this Notice.

Right to Request Access: You have the right to inspect and copy your health information (such as medical and billing records) that may be used to make decisions about your benefits. If you request copies, the Plan may charge you for the cost of copying, mailing and/or other associated supplies as allowed by Missouri Statutes §191.227.

Note, under federal law, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and

health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, you may have a right to have a decision to deny access reviewed.

Your request must be in writing. To request access to your health information, you should complete and submit the *Request for Access to Health Care Information* form to the Plan's Privacy Official using the contact information at the end of this Notice.

Right to Request an Amendment: You have the right to request an amendment of your health information held by the Plan if you believe that information is incorrect or incomplete. However, this right does not require that the Plan alter or change the original record. In certain cases, the Plan may deny your request for an amendment. For example, the Plan may deny your request if the information you want to amend is accurate and complete or was not created by the Plan. If the Plan denies your request, you have the right to file a statement of disagreement. Your statement of disagreement will be linked with the disputed information and all future disclosures of the disputed information will include your statement.

Your request to amend or correct your health information must be in writing and set forth a reason(s) in support of the proposed amendment. To request an amendment, you should complete and submit the *Request for Amendment/Correction of Health Care Information* form to the Plan's Privacy Official using the contact information at the end of this Notice.

Right to Request an Accounting: You have the right to request an accounting of certain disclosures the Plan has made of your health information. You can request an accounting of disclosures made up to six years prior to the date of your request; however, the Plan is not required to account for disclosures made prior to April 14, 2004. You are entitled to one accounting free of charge during a twelve-month period. There will be a charge to cover the Plan's costs for additional requests within that twelve-month period. The Plan will notify you of the cost involved and you may choose to withdraw or modify your request before any costs are incurred.

To request an accounting, you should complete and submit the *Request for Accounting of Health Care Information* form to the Plan's Privacy Official using the contact information at the end of this Notice.

Right to a Paper Copy of This Notice: You have the right to a paper copy of this Notice, even if you have agreed to accept this Notice electronically. To obtain such a copy, please contact the Plan using the contact information at the end of this Notice.

COMPLAINTS

If you believe the Plan has violated your privacy rights, you may complain to the Plan or to the Secretary of the U.S. Department of Health and Human Services. To file a complaint with the Plan, contact the Privacy Official using the contact information at the end of this Notice. The Plan will not retaliate against you for filing a complaint.

CHANGES TO THIS NOTICE

The Plan reserves the right to change the provisions of this Notice and make the new provisions effective for all protected health information that it maintains. If the Plan makes a material change to this Notice, it will provide a revised Notice to you at the address the Plan has on record for the participant enrolled in the Plan.

CONTACT INFORMATION

To exercise any of the rights described in this Notice, to receive more information, or to file a complaint, please contact:

Sheila R. Maerz
HIPAA Privacy Official
Director - Human Resources
City of Springfield
840 Boonville Avenue
Springfield, MO 65802
417-864-1600
email: smaerz@springfieldmo.gov

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded Employee group health Plan and the administration is provided through a Third Party Claims Administrator and a Prescription Benefit Manager. The funding for the benefits is derived from the funds of the City of Springfield Health Insurance Fund and contributions made by covered Employees and/or eligible dependents. The City of Springfield may insure claims for specific and/or aggregate "Stop-Loss" claim reimbursement through a re-insurance contract.

PLAN NAME: City of Springfield Employee Group Health Plan

TAX ID NUMBER: 44-6000268

PLAN EFFECTIVE DATE: January 1, 1985

PLAN YEAR: January 1 through December 31

CITY OF SPRINGFIELD INFORMATION:

City of Springfield, Missouri
840 Boonville Avenue
Springfield, Missouri 65802
(417) 864-1607

PLAN ADMINISTRATOR AND AGENT FOR SERVICE OF LEGAL PROCESS:

Director of Human Resources
City of Springfield, Missouri
840 Boonville Avenue
Springfield, Missouri 65802
(417) 864-1607

GENERAL PROVISIONS

Governing Law – The Plan is established in the State of Missouri. All questions arising under the Plan shall be determined under the laws of the State of Missouri unless a federal law specifically applies.

Alienation – No benefits under this Plan may be assigned, or be subject to anticipation, garnishment, attachment, execution, or levy of any kind, or be liable for your debts or obligations, except that you may assign benefits to a provider of medical services or supplies. We may direct that benefits under this Plan be paid directly to the provider of the benefits or to both you and the provider of benefits in whatever manner we authorize.

If a person who is entitled to receive a payment under the Plan, it is in our opinion, incapable of giving a valid receipt for the payment and if no guardian has been appointed for that person we may make the payment to the person or persons who in our opinion have assumed the obligations of caring for the person on whose behalf the payment is made.

Amendments – The Employer has the authority to amend and modify this Plan for all plan members from time to time as it deems proper. Any amendment or modification will be in writing and shall be formally adopted as an amendment to this Plan.

General Information – The Plan is funded through the Employer and Employee contributions except that self-payment by employees, Dependents or other plan participants to maintain their coverage is required in some circumstances. The funds are held until they are disbursed. Plan records are maintained on the basis of a fiscal year ending December 31.

Agent for Service of Process – Service of process on the Employer shall be in accordance with the law of the State of Missouri. Venue with respect to litigation arising out of the Plan shall be in Greene County Circuit Court.

Applications

The Plan Administrator may use misstatements or omissions in the applications of an Employee to contest the validity of coverage, reduce coverage or deny a claim; but the Plan Administrator must first furnish the Employee or the Employee's beneficiary with a copy of that application. The Plan Administrator will not use a person's application to contest or reduce coverage, which has been in force for two years or more during that person's lifetime. However, if the Employee or Dependent is not eligible for coverage, there is no time limit on the Plan Administrator's right to contest coverage or deny a claim.

Statements in an application are treated as representations, not as warranties.

Legal Actions

No legal action can be brought until at least sixty (60) days after the Plan Administrator has been given written proof of loss. No legal action can be brought more than three years after the date written proof of loss is required.

THIS IS A LISTING OF THE CORRESPONDING COUNCIL BILL/GENERAL ORDINANCE INFORMATION PERTAINING TO THE CREATION OF AND THE CHANGES TO THE CITY OF SPRINGFIELD HEALTH INSURANCE PLAN AS RECOMMENDED BY THE HEALTH INSURANCE COMMITTEE AND APPROVED BY CITY COUNCIL. ALL COUNCIL BILLS ARE ON FILE IN THE CITY CLERK'S OFFICE.

DESCRIPTION	COUNCIL BILL DATE	COUNCIL BILL #	ORD. #	APPROVAL BY CITY MANAGER (per Merit Rule 25.1)
Created	01/01/85	84-456	3571	N/A
Change	03/18/85	85-128	3601	N/A
Change	01/20/86	86-006	3716	N/A
Change	12/22/86	86-601	3812	N/A
Change	03/16/87	87-091	3827	N/A
Change	05/23/88	88-184	3918	N/A
Change	01/16/89	89-007	3986	N/A
Change	03/27/89	89-122	4014	N/A
Change	01/02/90	90-003	4096	N/A
Change	01/28/91	91-009	4193	N/A
Change	01/13/92	91-343	4248	N/A
Change	01/11/93	92-372	4324	N/A
Change	05/31/94	94-140	4433	N/A
Change	02/06/95	95-030	4492	N/A
Change	10/16/95	95-342	4562	N/A
Change	04/14/97	97-097	4690	N/A
Change	07/29/97	97-247	4734	N/A
Change	07/06/98	98-232	4814	N/A
Change	07/19/99	99-251	4918	N/A
Change	11/27/00	00-340	5033	N/A
Change	12/17/01	01-368	5137	N/A
Change	02/11/02	02-050	5153	N/A
Change	06/17/02	02-157	5194	N/A
Change	11/28/05	05-352	5506	N/A
Change	11/27/06	06-416	5622	N/A
Change	07/30/07	07-224	5696	N/A
Change	08/07/07	07-255	5705	N/A
Change	10/30/07	07-349	9540	N/A
Change	11/18/08	08-352	5797	N/A
Change	06/01/09	09-112	5820	N/A
Administrative Change	Not Required	N/A	N/A	12/02/2009
Administrative Change	Not Required	N/A	N/A	09/24/2010
Administrative Change	Not Required	N/A	N/A	10/22/2010
Administrative Change	Not Required	N/A	N/A	09/06/2011
Administrative Change	Not Required	N/A	N/A	12/20/2011
Administrative Change	Not Required	N/A	N/A	12/10/2012
Administrative Change	Not Required	N/A	N/A	12/05/2013
Administrative Change	Not Required	N/A	N/A	2/19/2014
Administrative Change	Not Required	N/A	N/A	10/1/2014
Administrative Change	Not Required	N/A	N/A	11/21/2014