

**CITY OF SPRINGFIELD**  
**HEALTH CARE PLAN SUMMARY SHEET**

<b>MONTHLY COST</b>	Employee Only	\$402 (100% paid by the City)	Family Coverage	\$386 *
			*Minimum enrollment of dependents for 6 months	
<b>PREFERRED PROVIDER ORG. (PPO)</b>	St. John's Health System is the In-Network Provider. To determine if a provider is in-network or to find an in-network provider, go to their website at <a href="http://www.stjohns.com">www.stjohns.com</a> or call 417.888.8888.			
<b>THIRD PARTY ADMINISTRATOR</b>	Med-Pay, Inc. Call 417.886.6886 or 800.777.9087 with questions about coverage or plan design and to request ID card replacement.			
<b>ANNUAL DEDUCTIBLE</b>	<i>In-Network</i>	Plan participant pays first \$500 per person/\$1000 per family		
	<i>Out-of-Network</i>	Plan participant pays first \$1000 per person/\$2000 per family		
<b>COINSURANCE</b>	<i>In-Network</i>	After deductible is met, plan pays 80% of the next \$10,000 per person and \$20,000 per family, then 100% of covered charges.		
	<i>Out-of-Network</i>	After deductible is met, plan pays 60% of the next \$15,000 per person and \$30,000 per family, then 100% of covered charges.		
<b>ANNUAL MAXIMUM OUT-OF-POCKET</b>				
<i>(Deductible plus Coinsurance)</i>	<i>In-Network</i>	\$2,500 per person/\$5,000 per family		
	<i>Out-of-Network</i>	\$7,000 per person/\$14,000 per family		
<b>INELIGIBLE EXPENSES</b>	Ineligible expenses do not apply toward the deductible, the maximum out-of-pocket amounts or toward coinsurance coverage.			
<b>PRE-EXISTING CONDITIONS</b>	12-month waiting period for any illness/injury diagnosed or treated within 3 months prior to the effective date of coverage. Coverage limited to \$250 unless free of treatment for 90 days OR covered for 12 consecutive months.			
<b>EMERGENCY ROOM PENALTY</b>	\$100 (waived when admitted to the Hospital on an emergency basis directly from the ER, if treatment is substantiated by severity or if a physician provides a referral within the time period stated in the Plan Document. ER Penalty does not apply to any deductible or out-of-pocket maximum.)			
<b>PRE-ADMISSION REVIEW</b>	Hospital admissions only: required or \$100 penalty; will not apply toward deductible or out-of-pocket maximum.			
<b>ANNUAL PHYSICAL EXAMINATION</b>	<i>In-Network</i>	For employee: 100% up to \$400 usual and customary cost.		
	<i>Out-of-Network</i>	Subject to out-of-network deductible and out-of-network coinsurance. <i>(Annual physical examination benefit for covered spouse and dependents will apply toward deductible and co-insurance.)</i>		
<b>PRESCRIPTION PLAN PROVIDER</b>	Express Scripts, Inc. (ESI) Call ESI Customer Service at 866.571.5964 for questions about prescription plan benefits.			
<b>PRESCRIPTION DRUG BENEFIT</b>	<i>In-Network</i>	Pharmacy: \$5 co-pay plus 20% of total cost per prescription per 30-day fill; 90-day maximum fill		
	<i>(Using Health/Prescription Plan Card)</i>	Mail order: 20% of cost, limited to a 90-day supply per prescription Mandatory generic: if plan participant elects brand name over generic, cost is the \$5 co-pay (mail order has no co-pay) plus 20% of the total cost plus the difference in price between the generic & brand name.		
	<i>Out-of-Network</i>	After deductible is met, plan pays 60% of the cost for covered prescriptions		
	<i>(Filing Prescription Claim with Med-Pay)</i>			
<b>MAXIMUM LIFETIME PER PERSON</b>	\$2,000,000 - The maximum lifetime benefit amount includes all of the covered charges that accumulates under both the City of Springfield Employee Group Health Plan and the City of Springfield Non-Medicare Retiree Health Plan.			

**NOTE:** All covered benefits are based on usual and customary charges. The above information is only a summary of the City of Springfield Health Care Plan and is subject to change.

**Premium Change Effective July 1, 2009; Plan Design Changes Effective August 1, 2009.**