

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

<b>MONTHLY COST</b>	Employee Only	\$466 (100% paid by the City)	Family Coverage	\$449 *
			*Minimum enrollment of dependents for 6 months	
<b>IN-NETWORK PROVIDER</b>	Springfield Mercy is the In-Network Provider. To find an in-network provider, go to <a href="http://www.mercy.net">http://www.mercy.net</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>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>PREVENTIVE BENEFIT</b>	<i>In-Network</i>	For employee, spouse & children: 100% coverage of services performed in conjunction with preventive/screening examinations such as a physical examination, laboratory tests, mammograms, gynecologic exams, prostate screening, colonoscopy, immunizations and other exams per the standard criteria for the plan member's age. Benefit <i>includes</i> recommended preventive services under the Affordable Care Act (ACA). A current listing of recommended preventive services under the ACA can be accessed at <a href="http://www.HealthCare.gov/center/regulations/prevention.html">www.HealthCare.gov/center/regulations/prevention.html</a> Benefit <i>does not include</i> diagnostic or follow-up services. Plan members may call Med-Pay for questions about eligible preventive services at the number listed on their Health Plan ID card or as noted above.		
	<i>Out-of-Network</i>	Subject to out-of-network deductible and out-of-network coinsurance.		
<b>PRESCRIPTION PLAN PROVIDER</b>	MedTrak Services: Visit <a href="http://www.medtrakrx.com">www.medtrakrx.com</a> or call 800-771-4648 for information about prescription plan benefits.			
<b>PRESCRIPTION DRUG BENEFIT</b>	<i>In-Network</i>	Pharmacy: \$5 co-pay plus 20% of the remainder of the cost of the prescription for each 30-day fill; 90-day maximum fill 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>RX Annual Maximum Out-of-Pocket (Copays + 20% share in-network)</i>	\$4,100 per person/\$8,200 per family		
	<i>Out-of-Network</i>	After out of network deductible is met, plan pays 60% of the cost for covered prescriptions. Claim must be filed with Med-Pay		

**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.

**Changes Effective January 1, 2017**