CITY OF SPRINGFIELD
EMPLOYEE GROUP HEALTH PLAN SUMMARY SHEET

GROUP NUMBER: 010191CS

MONTHLY COST		Employee Only $466 (100% paid by the City) Family Coverage $449 * ($224.50 deduction, 1st & 2nd pay dates) *Minimum enrollment of dependents for 6 months. If both spouses are City employees, there is no cost for dependent child coverage.
IN-NETWORK PROVIDER		Springfield Mercy is the In-Network Provider. To find an in-network provider, go to http://www.mercy.net or call 417.888.8888.
THIRD PARTY ADMINISTRATOR		**Med-Pay, Inc**. Call **417.886.6886 or 800.777.9087** with questions about coverage or plan design and to request ID card replacement.
ANNUAL DEDUCTIBLE	*In-Network*	Plan participant pays first $500 per person/$1000 per family
	Out-of-Network	Plan participant pays first $1000 per person/$2000 per family
COINSURANCE	*In-Network*	After deductible is met, plan pays 80% of the next $10,000 per person and $20,000 per family, then 100% of covered charges.
	Out-of-Network	After deductible is met, plan pays 60% of the next $15,000 per person and $30,000 per family, then 100% of covered charges.
ANNUAL MAXIMUM OUT-OF-POCKET		
(Deductible plus Coinsurance)	*In-Network*	$2,500 per person/$5,000 per family
	Out-of-Network	$7,000 per person/$14,000 per family
INELIGIBLE EXPENSES		Ineligible expenses do not apply toward the deductible, the maximum out-of-pocket amounts or toward coinsurance coverage.
EMERGENCY ROOM PENALTY		$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.)
PRE-ADMISSION REVIEW		Hospital admissions only: required or $100 penalty; will not apply toward deductible or out-of-pocket maximum.
PREVENTIVE BENEFIT	*In-Network*	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 *includes* recommended preventive services under the Affordable Care Act (ACA). A current listing of recommended preventive services under the ACA can be accessed at www.HealthCare.gov/center/regulations/prevention.html. Benefit *does not include* 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.
	Out-of-Network	Subject to out-of-network deductible and out-of-network coinsurance.
PRESCRIPTION PLAN PROVIDER		**Elixir**: Visit www.elixirsolutions.com or call **800-771-4648** for information about prescription plan benefits.
PRESCRIPTION DRUG BENEFIT	*In-Network*	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.
	RX Annual Maximum Out-of-Pocket (Copays + 20% share in-network)	$4,100 per person/$8,200 per family
	Out-of-Network	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, 2021