CITY OF SPRINGFIELD
GROUP HEALTH PLAN

SUMMARY PLAN DESCRIPTION
AND PLAN DOCUMENT

JANUARY 1, 2023

TO ALL ELIGIBLE EMPLOYEES AND THEIR DEPENDENTS:

This booklet describes the medical and prescription drug benefits provided to you and your eligible dependents under the City of Springfield Group Health Plan (Plan). This document replaces and supersedes all prior Summary Plan Description and Plan Documents previously provided to you.

Coverage provided by the Plan as well as the exclusions from coverage are subject to change from time to time, but in accordance with Collective Bargaining Agreements.

On the following pages, you will find a listing of *Important Telephone Numbers* if you have questions about such things as your coverage, need to ask about a claim, need to have medical care pre-certified or preauthorized, or any other questions that you might have. This booklet also provides you with the eligibility requirements to participate in the Plan benefits as well as procedures to follow if you are dissatisfied with the Plan's decision on your medical or prescription drug claims. We urge you to read the entire booklet at least once. If you are married, share it with your spouse and keep it with your important papers so you can refer to it when needed.

IMPORTANT TELEPHONE NUMBERS

If You Have A Question Or Need Information About….	You Should Contact	Contact Information
➢ Eligibility and Enrollment for Coverage ➢ Claims ➢ Plan Benefit Information ➢ First Level Appeals of Denied Medical and Prescription Drug Claims ➢ Health Care Plan ID Cards	Claims Supervisor	Med Pay, Inc. P.O. Box 10909 Springfield, MO 65808 800-777-9087 or 417-886-6886 (Phone) 417-890-0741 (Fax) https://www.med-pay.com/contact-us.html
➢ Medical Network Provider Directory (no charge) ➢ Additions or Deletions of Medical Network Provider	Network Provider for Medical Benefits	Mercy 3265 S. National Springfield, MO 65807 417-888-8888 https://www.mercyoptions.net
➢ Pre-certification of Inpatient Admissions and Medical Services ➢ Second and Third Opinions ➢ Case Management ➢ Appeals of Utilization Management Decisions	Utilization Management (UM) Coordinator	MPI Care P.O. Box 10909 Springfield, MO 65808 800-777-9087 or 417-886-6886
➢ Retail Pharmacies Network (Including Provider Directory At No Cost) ➢ Mail Order (Home Delivery) Pharmacy ➢ Prescription Drug Information ➢ Pre-certification of Certain Specialty Drugs ➢ Direct Member Reimbursement (for Non-Network retail pharmacy use) ➢ Specialty Drug Program Pre-certification and Ordering ➢ First Level Appeals of Denied Prescription Drug Claims	Prescription Benefit Manager (PBM)	Elixir (formerly MedTrakRX) 10895 Lowell Avenue Suite 100 Overland Park, KS 66210 800-771-4648 or 913-262-6851 https://www.elixirsolutions.com/members
➢ Information About COBRA Coverage ➢ Cost of COBRA Coverage ➢ Contributions for Coverage ➢ Second Level Appeals of Denied Medical and Prescription Drug Claims ➢ Copy of Plan Documentation (including Summary of Benefits and Coverage (SBC)) Qualified Medical Child Support Orders (QMCSO)	Plan Administrator	Human Resources City of Springfield Busch Municipal Bldg., 3rd Floor 840 Boonville Avenue Springfield, MO 65802 417-864-1607 (Phone) 417-864-2041 (Fax) HR@springfieldmo.gov (email) https://www.springfieldmo.gov/5324/Employee-Documents (website)
➢ COBRA Premium Payments ➢ COBRA Elections	COBRA Administrator	Med Pay, Inc. P.O. Box 10909 Springfield, MO 65808 800-777-9087 or 417-886-6886 (Phone) 417-890-0741 (Fax) https://www.med-pay.com/contact-us.html
➢ HIPAA Notice of Privacy Practices ➢ Questions and/or Complaints Regarding HIPAA Privacy and Security	HIPAA Privacy Officer and HIPAA Security Officer	Deputy Privacy Officer City of Springfield Busch Municipal Bldg., 3rd Floor 840 Boonville Avenue Springfield, MO 65802 417-864-1607 (Phone) 417-864-1186 (Fax) HR@springfieldmo.gov (email)

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SCHEDULE OF BENEFITS

Benefits described in this Schedule of Benefits are subject to all the terms, exclusions, and limitations of the Plan. This is meant to be a high-level summary of benefits. Additional detail is included in the Medical Benefits section.

MEDICAL BENEFITS	NETWORK PROVIDER	NON-NETWORK PROVIDER
Description	**Member Pays**	**Member Pays**
Medical Benefits in General	You pay the Network Provider Deductible and Coinsurance, then the Plan pays the Benefit Percentage on the following pages	You pay the Non-Network Provider Deductible and Coinsurance, then the Plan pays the Benefit Percentage on the following pages
Deductible		
Individual Deductible	$500 per person per calendar year	$1,000 per person per calendar year
Family Deductible	$1,000 per family per calendar year	$2,000 per family per calendar year
Coinsurance		
Percentage	20% for most services	40% for most services
Coinsurance Maximum		
Individual	$2,000 per person per calendar year	$6,000 per person per calendar year
Family	$4,000 per family per calendar year	$12,000 per family per calendar year
Out-of-Pocket Maximum – Includes medical deductible and coinsurance except as noted below		
Individual Out-of-Pocket Maximum	$2,500 per person per calendar year	$7,000 per person per calendar year
Family Out-of-Pocket Maximum	$5,000 per family per calendar year	$14,000 per family per calendar year

The following charges do not apply toward your calendar year Out-of-Pocket Maximum:

- Penalty for failure to obtain required pre-certification.
- Expenses above the Plan's Allowable Charge.
- Expenses for excluded services.

MEDICAL BENEFITS	NETWORK PROVIDER	NON-NETWORK PROVIDER
Applied Behavior Analysis for Autism Spectrum Disorders – Preauthorization is recommended otherwise reimbursement may be delayed	80% after deductible	60% after deductible
Contraceptive Devices	100%, no deductible	60% after deductible
Durable Medical Equipment – Preauthorization recommended otherwise reimbursement may be delayed	80% after deductible	60% after deductible
Emergency Room and Urgent Care Services		
Hospital Emergency Room	80% after deductible	80% after deductible
Urgent Care or Outpatient Facility	80% after deductible	60% after deductible
Ambulance	80% after deductible	Emergency Services: 80% after deductible Non-Emergency Services: 60% after deductible
Home Health Care – Preauthorization recommended (otherwise reimbursement may be delayed)		
Home Health Care	80% after deductible	60% after deductible
Calendar Year Maximum	60 visits (Combined Network and Non-Network)	
Hospice Care – Pre-certification Required for Inpatient Admissions: A $100 penalty will be charged for failure to obtain pre-certification for scheduled inpatient admissions. The pre-certification penalty will not count toward your calendar year Deductible and Out-Of-Pocket Maximum.		
Inpatient Facility Preauthorization is recommended to avoid non-payment of benefits.	80% after deductible	60% after deductible
Outpatient Services Note: Maximum of 90 days combined for inpatient and outpatient per diem.	80% after deductible	60% after deductible
Room and Board Maximum	90 days combined for inpatient and outpatient per diem	

MEDICAL BENEFITS	NETWORK PROVIDER	NON-NETWORK PROVIDER
Inpatient Hospital Services – Pre-certification Required: A $100 penalty will be charged for failure to obtain pre-certification for scheduled inpatient admissions. The pre-certification penalty will not count toward your calendar year Deductible and Out-Of-Pocket Maximum.		
Semi-Private Room and Board or Medically Necessary Private Room and Board	80% after deductible	60% after deductible
Special Care Units (Intensive Care Unit/Cardiac Care Unit) and Board	80% after deductible	60% after deductible
Inpatient Physician Visits	80% after deductible	60% after deductible
Inpatient Professional Services (Includes Surgeon, Radiologist, Pathologist, and Anesthesiologist)	80% after deductible	60% after deductible
Inpatient Services at Other Health Care Facilities (Includes Skilled Nursing Facility, Rehabilitation Hospital, and Sub-Acute Facilities) – Pre-certification Required: A $100 penalty will be charged for failure to obtain pre-certification for scheduled inpatient admissions. The pre-certification penalty will not count toward your calendar year Deductible and Out-Of-Pocket Maximum.		
Inpatient Physician Visits	80% after deductible	60% after deductible
Inpatient Facility Room and Board (includes Semi-Private Room)	80% after deductible	60% after deductible
Calendar Year Maximum for Skilled Nursing Facility only	60 days	
Laboratory and Radiology Services		
MRIs, MRAs, CAT Scans and PET Scans	80% after deductible	60% after deductible
Other Laboratory and Radiology Services (All charges billed by an independent facility)	80% after deductible	60% after deductible
Maternity		
Prenatal and Postnatal Visits	80%, after deductible	60% after deductible
Breastfeeding Equipment and Supplies, and Lactation Counseling	100%, no deductible	60% after deductible
Delivery (Inpatient Hospital, Birthing Center)	80% after deductible	60% after deductible

MEDICAL BENEFITS	NETWORK PROVIDER	NON-NETWORK PROVIDER
All Other Services, Including Ultrasounds and Professional Delivery Fees	80% after deductible	60% after deductible
Mental Health and Substance Abuse Services – Pre-certification required for Inpatient Services: A $100 penalty will be charged for failure to obtain pre-certification for scheduled inpatient admissions. The pre-certification penalty will not count toward your calendar year Deductible and Out-Of-Pocket Maximum.		
Inpatient Services	80% after deductible	60% after deductible
Outpatient Services	80% after deductible	60% after deductible
Organ Transplants	**Designated**	**Non-Designated**
Facility	80% after deductible	60% after deductible
Physician	80% after deductible	60% after deductible
Organ and tissue transplants are covered except those which are classified as “Experimental and/or Investigational.” All Organ Transplant services, including evaluation, should be preauthorized or benefits may be delayed. Therefore, the Covered Person or his/her physician must call the Utilization Management Coordinator (as listed on page ii) 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.		
Outpatient Services		
Outpatient Hospital Facility Services (Operating Room, Recovery Room, Procedure Room, and Treatment)	80% after deductible	60% after deductible
Outpatient Private Duty Nursing – Preauthorization recommended (otherwise reimbursement may be delayed)	80% after deductible	60% after deductible
Physician Services		
Physician Office Visit	80% after deductible	60% after deductible
Specialist Physician Office Visit	80% after deductible	60% after deductible
Surgery Performed in Physician's Office	80% after deductible	60% after deductible
Spinal Manipulations	80% after deductible	60% after deductible
Calendar Year Maximum	12 manipulations	
Allergy Services	80% after deductible	60% after deductible

MEDICAL BENEFITS	NETWORK PROVIDER	NON-NETWORK PROVIDER
Prescription Drugs (Administered Inpatient, Outpatient or in Physician's Office)		
Administered Inpatient, Outpatient or in Physician's Office	80% after deductible	60% after deductible
Preventive Care		
Physician Office Visit	100%, no deductible	60% after deductible
Laboratory and Radiology	100%, no deductible	60% after deductible
Prosthetic and Orthotics – Preauthorization is recommended (otherwise reimbursement may be delayed)		
Prosthetic Appliances	80% after deductible	60% after deductible
Orthotics	80% after deductible	60% after deductible
Routine Foot Care (for diabetics)		
Specialist Physician Office Visit	80% after deductible	60% after deductible
Routine Well Newborn Care Nursery/Physician Care (Initial Hospital Confinement when newborn is enrolled in the plan)	80% after deductible	60% after deductible
Second Surgical Opinions, Voluntary Note: Refer to Utilization Management Services section	80% after deductible	60% after deductible
Smoking Cessation	100%, no deductible	60% after deductible
Temporomandibular Joint Disorder		
Inpatient and Outpatient Facility and Physician's Services	80% after deductible	60% after deductible
Surgical treatment is covered. Non-surgical treatment requires predetermination. Orthodontia is excluded.		
Therapy Services		
Habilitative Therapy such as physical, occupational and speech therapy	80% after deductible	60% after deductible
Calendar Year Maximum	90 visits per Calendar Year for any combination of services	
Rehabilitative Therapy Inpatient Services – Pre-certification is required	80% after deductible	60% after deductible

MEDICAL BENEFITS	NETWORK PROVIDER	NON-NETWORK PROVIDER
Rehabilitative Therapy Outpatient Short-Term – Preauthorization is recommended otherwise reimbursement may be delayed (Includes Cardiac Rehab, Physical Therapy, Occupational Therapy and Speech Therapy)	80% after deductible	60% after deductible
Weight Management		
Weight Management Coverage only when Medically Necessary and requires utilization review (see obesity description in exclusions section). Preauthorization recommended for weight loss treatment otherwise, reimbursement may be delayed.	80% after deductible	60% after deductible
Obesity screenings and intensive behavioral counseling interventions (individual/group counseling sessions limited to 26 visits per 12-month period)	100%, no deductible	60% after deductible
All Other Covered Medical Expenses		
All Other Covered Medical Expenses	80% after deductible	60% after deductible

PRESCRIPTION DRUG BENEFITS	RETAIL PHARMACY	MAIL ORDER PHARMACY
Generic and Brand Name Drugs	**Network:** You pay a $5 copayment plus 20% of the remaining cost of the prescription drug **Network 90-day:** You pay a $15 copayment plus 20% of the remaining cost of the prescription drug **Non-Network:** Not covered by PBM but may be submitted to Claims Supervisor for payment and subject to out-of-network deductible and coinsurance.	**Network:** You pay 20% of the cost of the prescription drug **Non-Network:** Not covered
Supply Amount	Up to 90-day supply	90-day supply
Network Out-of-Pocket Maximum	The calendar year Out-of-Pocket maximum for Network prescription drugs is: ➢ $4,100 per person ➢ $8,200 per family ➢ $1,500 per person for specialty drugs (Note: The specialty drug Out-of-Pocket maximum applies toward the Prescription Drug Network Out-of-Pocket maximum.)	
Mandatory Generic	If you elect a brand name drug when a generic drug is available, you pay a $5 copayment (the copayment is waived if you use the mail order service) plus: (1) 20% of the total cost of the prescription drug, and (2) the difference in cost between the generic and brand name drug.	
Specialty Drugs (Note: Specialty drug must be obtained through the specialty drug provider designated by the Plan's Prescription Benefit Manager (PBM)	**Network:** You pay 20% of the total cost of the prescription drug. **Non-Network:** Not covered	

DEFINITIONS

The following definitions of terms used in this booklet may be helpful in understanding the benefits provided under the Plan.

AFFORDABLE CARE ACT (ACA)

The Affordable Care Act (ACA), formerly known as the Patient Protection and Affordable Care Act (as may be amended from time to time), was signed into law in 2010. The ACA amended the Internal Revenue Code, the Employee Retirement Income Security Act, and the Public Health Service Act to expand health coverage for Americans covered under public and private health plans.

ACTIVITIES OF DAILY LIVING (ADLS)

ADLs are the things we normally do for self-care, work, homemaking and leisure. Health professionals routinely refer to the ability or inability to perform ADLs as a measurement of the functional status of a person. This measurement is useful for assessing the elderly, the mentally ill, those with chronic diseases, and others to evaluate the type of health care services needed.

Basic ADLs consist of these self-care tasks: bathing/showering; dressing/undressing; eating; transferring from bed to chair, and back; toileting and functional mobility. Only Basic ADLs will be considered when making coverage determinations for Habilitative or Rehabilitative Services under this Plan.

ALLOWABLE CHARGE

Allowable Charge is the amount payable for a specific covered item under this Plan. The Allowable Charge will be a negotiated rate, if one exists.

For claims subject to the No Surprises Act if no negotiated rate exists, the Allowable Charge will be:

- An amount determined by an applicable all-payer model agreement; or
- If no such amount exists, an amount determined by applicable state law; or
- If neither such amount exists, an amount deemed payable by a Certified IDR Entity or a court of competent jurisdiction, if applicable.

If none of the above factors is applicable, the Plan Administrator will exercise its discretion to determine the Allowable Charge based on any of the following: Medicare reimbursement rates, Medicare cost data, amounts actually collected by Providers in the area for similar services, or average wholesale price (AWP) or manufacturer's retail pricing (MRP). These ancillary factors will take into account generally accepted billing standards and practices.

When more than one treatment option is available, and one option is no more effective than another, the least costly option that is no less effective than any other option will be considered within the Allowable Charge. The Allowable Charge will be limited to an amount which, in the Plan Administrator's discretion, is charged for services or supplies that are not unreasonably caused by

the treating Provider, including errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients. A finding of Provider negligence or malpractice is not required for services or fees to be considered ineligible pursuant to this provision.

Notwithstanding these allowances, all charges from all Non-Network providers will be subject to a review for Reasonable allowance. The Covered Person will be responsible for the amount in excess of the Allowable Charge except as prohibited by applicable State and Federal legislation and/or mandates. This excess amount will not apply to Deductible, Coinsurance or Out-of-Pocket maximums.

APPLIED BEHAVIOR ANALYSIS (ABA)

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 includes, but is not limited to, application 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 treatment modalities do not include cognitive therapies, psychological testing, personality assessment, intellectual assessment, neuropsychological assessment, psychotherapy, sex therapy, psychoanalysis, hypnotherapy, family therapy and long-term counseling. Rehabilitative therapy services are not subject to a Plan benefit maximum for these ABA services if listed as covered.

ALTERNATE RECIPIENT

A child who is recognized under a Qualified Medical Child Support Order (QMCSO) as having a right to enrollment under this Plan.

AUTISM SPECTRUM DISORDER

A neurobiological disorder, an Illness of the nervous system, which includes Autistic Disorder, Asperger's Disorder, Pervasive Developmental Disorder Not Otherwise Specified, Rett's Disorder, and Childhood Disintegrative Disorder, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

BOARD-CERTIFIED BEHAVIOR ANALYST (BCBA)

A BCBA is a graduate-level certification in behavior analysis. Professionals certified at the BCBA level are independent practitioners who provide behavior analysis services. BCBAs may supervise

the work of Board-Certified Assistant Behavior Analysts (BCaBAs), Registered Behavior Technicians (RBTs), and other professionals who implement behavior-analytic interventions.

CELL THERAPY

The transfer of intact, live cells into a patient to help lessen or cure a disease. The cells may originate from the patient (autologous cells) or a donor (allogeneic cells). The cells used in cell therapy can be classified by their potential to transform into different cell types. Pluripotent cells can transform into any cell type in the body and multipotent cells can transform into other cell types, but their repertoire is more limited than that of pluripotent cells. Differentiated or primary cells are of a fixed type. The type of cells administered depends on the treatment. The Claim Supervisor or UM Coordinator will follow protocol for the review of procedures for treatment of an Illness for coverage under this Plan.

CERTIFIED IDR ENTITY

Entity responsible for conducting determinations under the No Surprises Act and that has been properly certified by the Department of Health and Human Services, the Department of Labor, and the Department of the Treasury.

CHIROPRACTIC CARE

The conservative management of neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain and improve function.

CITY

The City of Springfield, Missouri, the sponsor of this Plan of medical and prescription drug benefits.

CLAIMS SUPERVISOR

The entity or person(s) designated by the City Manager to administer the Plan.

COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985 and any regulations promulgated thereunder, as amended.

COVERED CHARGES

Covered Charges are expenses incurred by a Covered Person while enrolled in the Plan for charges listed in the *Medical Benefits, Covered Charges* section of this document. Such expenses are considered Covered Charges to the extent that the services or supplies provided are ordered by an appropriate Physician, are Medically Necessary for the care and treatment of an Injury or Sickness, are not excluded under the Plan, and meet the standards of care for the diagnosis. Covered Charges will only be covered to the extent such charges do not exceed the Allowable Charge.

COVERED PERSON

An eligible Employee and Eligible Dependent who is covered for benefits under the Plan.

CUSTODIAL CARE

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 that could normally be self-administered.

DEPENDENT

The term Dependent includes those persons defined in the *Eligibility and Enrollment* section of this booklet.

DEVELOPMENTAL OR PHYSICAL DISABILITY

A severe, chronic disability that:

(1) Is attributable to cerebral palsy, epilepsy, or any other condition other than mental illness or autism spectrum disorder which results in impairment of general intellectual functioning or adaptive behavior and requires treatment or services

(2) Manifests before the individual reaches nineteen years of age;

(3) Is likely to continue indefinitely; and

(4) Results in substantial functional limitations in three or more of the following areas of major life activities:

(a) Self-care;

(b) Understanding and use of language;

(c) Learning;

(d) Mobility;

(e) Self-direction; or

(f) Capacity for independent living

DURABLE MEDICAL EQUIPMENT

Equipment that (i) can withstand repeated use; (ii) is primarily and customarily used to serve a medical purpose; (iii) is generally not useful to a person in the absence of a Sickness or Injury; and (iv) is appropriate for use in the home.

EMERGENCY MEDICAL CONDITION

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 UM Coordinator or Claims Supervisor will assess emergency treatment/admissions to a Non-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 Network providers.

EMERGENCY SERVICES

Emergency Services are, with respect to an Emergency Medical Condition, the following:

- An appropriate medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital or of an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and

- Within the capabilities of the staff and facilities available at the Hospital or the Independent Freestanding Emergency Department, as applicable, such further medical examination and treatment as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd), or as would be required under such section if such section applied to an Independent Freestanding Emergency Department, to stabilize the patient (regardless of the department of the Hospital in which such further examination or treatment is furnished).

- Emergency Services furnished by a Non-Network Provider or Non-Network emergency facility (regardless of the department of the Hospital in which items or services are furnished) also include post stabilization services (services after the patient is stabilized) and as part of Outpatient observation or an Inpatient or Outpatient stay with respect to the Emergency Medical Condition, until:
  - The provider or facility determines that the participant or beneficiary is able to travel using nonmedical transportation or nonemergency medical transportation; or
  - The participant or beneficiary is supplied with a written notice, as required by federal law, that the provider is a Non-Network provider with respect to the Plan, of the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, of the names of any Network providers at the facility who are able to treat you, and that you may elect to be referred to one of the Network providers listed; and
  - The participant or beneficiary gives informed consent to continued treatment by the Non-Network provider, acknowledging that the participant or beneficiary understands that continued treatment by the Non-Network provider may result in greater cost to the participant or beneficiary.

EMPLOYEE

A person employed by the Employer.

EMPLOYER

The City of Springfield, Missouri.

EXPERIMENTAL AND/OR INVESTIGATIONAL

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, or its designee(s), must make an independent evaluation of the experimental/nonexperimental standings of specific technologies. The Plan Administrator, or its designee(s), 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, or its designee(s), will be final and binding on the Plan. The Plan Administrator, or its designee(s), 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;

(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;

(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; 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.

FMLA

The Family and Medical Leave Act of 1993, the regulations promulgated thereunder and the City's FMLA policies and procedures as amended.

FMLA LEAVE

A leave of absence, intermittent leave, or leave on a reduced schedule, as determined and certified by the Employer.

GENE (MANIPULATION) THERAPY

A therapy that involves altering the genes inside your body in an effort to treat or stop disease. Gene Therapy is the introduction, removal, or change in the content of a person's genetic code with the goal of treating or curing a disease. The transferred genetic material changes how a single protein or group of proteins is produced by the cell. Gene therapy can be used to reduce levels of a disease-causing version of a protein, increase production of disease-fighting proteins, or to produce new/modified proteins.

HABILITATIVE SERVICES

Health care services that help a person with a Developmental or Physical Disability keep, learn or improve skills and functioning for Activities of Daily Living. Examples include therapy for a child who isn't walking or talking at the expected age. These services are limited to physical, occupational, and speech-language therapy. Benefits for Habilitative Services provided by the Plan do not affect or reduce any obligation to provide services under an individualized education program per the Education Code or individualized service plan as described in the Welfare and Institutions Code or Disabilities Education Act.

HIPAA

The Health Insurance Portability and Accountability Act of 1996 and the regulations thereunder, as amended.

HOSPITAL

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) or the Healthcare Facilities Accreditation Program (If the Hospital is not accredited by one of the previous entities but has received accreditation through an entity recognized by the Centers for Medicare and Medicaid Services (CMS) as an alternative to JCAHO, then this Plan will also recognize the facility as accredited.);

- 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.

The term Hospital will not include an institution that is primarily a place for rest, a place for the aged, or a nursing home.

INDEPENDENT FREESTANDING EMERGENCY DEPARTMENT

A health care facility that is geographically separate and distinct, and licensed separately, from a Hospital under applicable state law, and which provides Emergency Services.

INJURY

The term Injury means a physical bodily injury caused by external means.

LEGAL GUARDIAN

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 under the age of 18. (Refer to the Eligibility section of this document for eligibility requirements including coverage beyond this age limit.) For the purposes of this Plan, Legal Guardianship must be established by a court of law.

LEGALLY SEPARATED (LEGAL SEPARATION)

For purposes of this Plan, married spouses who have successfully petitioned a court to recognize their separation.

MAINTENANCE PROGRAMS

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.

MEDICALLY NECESSARY/MEDICAL NECESSITY

Care and treatment that 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 that 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 or its designee(s) has the discretionary authority to decide whether care or treatment is Medically Necessary.

MEDICARE

The term Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as amended.

MORBID OBESITY/SEVERE CLINICAL OBESITY

For non ACA preventive services, morbid obesity/extreme 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 or the body mass index (BMI) is 40 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, who has no other medical conditions caused by severe obesity (co-morbidities or comorbid conditions). The BMI is 35 or greater for those patients with comorbid conditions. There are several classes of obesity: Class 1 (obese): BMI of 30 to < 35; Class 2 (severe): BMI of 35 to < 40; and Class 3 (morbid, extreme): BMI of 40 or higher.

For ACA required preventive services including screenings and behavioral counseling, morbid obesity/extreme obesity/severe clinical obesity is a BMI of 30 or higher for adults. For children, it is based on a BMI percentile determined by age and sex adjusted BMIs calculated as weight in kilograms divided by the square of height in meters. These determinations are the guidelines established by the U.S. Preventive Services Task Force (USPSTF).

NURSE

The term Nurse means a Registered Graduate Nurse, a Licensed Practical Nurse, or a Licensed Vocational Nurse who has the right to use the abbreviation "R.N.," "L.P.N." or "L.V.N."

PARTICIPATING HEALTH CARE FACILITY

A Hospital or Hospital Outpatient department, critical access Hospital, Ambulatory Surgical Center, or other Provider as required by law, which has a direct or indirect contractual relationship with the Plan with respect to the furnishing of a healthcare item or service. A single direct contract or case agreement between a health care facility and a Plan constitutes a contractual relationship for

purposes of this definition with respect to the parties to the agreement and particular individual(s) involved.

PHYSICIAN

A Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.).

PLAN

The City of Springfield Group Health Plan, which includes the rules and regulations, and the program of benefits to be provided by the *City* for eligible Employees and Dependents, as initially established by the *City* and amended and restated thereafter.

PROFESSIONAL PROVIDER

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
- Anesthetist
- Certified Athletic Trainers
- Chiropractor
- Clinical Social Worker
- Emergency Medical Technician
- Independent Laboratory Technician
- Licensed Practical Nurse
- Pharmacist
- Physical Therapist
- Registered Nurse
- Respiratory Therapist
- Speech – Language Pathologist
- Vocational 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.

PROVIDER

A Provider is any entity that provides medical and/or prescription drug services and treatments to a Covered Person. A Provider can be a Physician or other health care practitioner or a facility, whether on a Network or Non-network basis.

QMCSO OR QUALIFIED MEDICAL CHILD SUPPORT ORDER

A court order or decree issued by a court of competent jurisdiction that qualifies as a "Qualified Medical Child Support Order" within the meaning of the Public Health Service Act (PHSA) and the Internal Revenue Code (IRC), as determined in accordance with the written procedures adopted by the *City*.

QUALIFYING PAYMENT AMOUNT

The median of the contracted rates recognized by the Plan, or recognized by all plans serviced by the Plan's Third-Party Administrator (if calculated by the Third-Party Administrator), for the same or a similar item or service provided by a Provider in the same or similar specialty in the same geographic region. If there are insufficient (meaning at least three) contracted rates available to determine a Qualifying Payment Amount, said amount will be determined by referencing a state all-payer claims database or, if unavailable, any eligible third-party database in accordance with applicable law.

REASONABLE

The term reasonable means not excessive or extreme as determined by the Plan Administrator or its designee(s). See also Usual and Customary.

RECOGNIZED AMOUNT

Except for Non-Network air ambulance services, an amount determined under an applicable all-payer model agreement, or if unavailable, an amount determined by applicable state law. If no such amounts are available or applicable and for Non-Network air ambulance services generally, the Recognized Amount shall mean the lesser of a Provider's billed charge or the Qualifying Payment Amount.

REHABILITATIVE SERVICES

Health care services that help you keep, get back, or improve skills and functioning of Activities of Daily Living that have been lost or impaired due to Sickness, Injury, or disability. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient, outpatient and/or office settings.

RESTORATIVE THERAPY

A term used in conjunction with occupational, physical, speech or other rehabilitative therapy which must, among other things, be Reasonable 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. 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 they would, therefore, be excluded from coverage.

SICKNESS OR ILLNESS

The term Sickness or Illness means a physical or mental illness. It also includes pregnancy and complications of pregnancy. Expenses incurred for routine Hospital and pediatric care of a newborn child prior to discharge from the Hospital nursery will be considered to be incurred as a result of Sickness.

SKILLED NURSING FACILITY

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.

TOTALLY AND PERMANENTLY DISABLED

In the case of a Dependent, 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.

USERRA

The Uniformed Services Employment and Re-Employment Rights Act of 1994, as amended.

USUAL AND CUSTOMARY

The term usual and customary means the amount determined by the Plan Administrator using the information that includes, but is not limited to the following:

- Third Party data;

- Contracted allowables;
- Medicare data;
- Historical data of Claims Supervisor;
- Geographic region of provider;
- 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;
- 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
- Any other available data to make the determination.
- 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.
- Even though the Usual and Customary Allowance or network/contracted rate can be determined, 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 as determined by the Plan Administrator.

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

ELIGIBILITY AND ENROLLMENT

EMPLOYEE ELIGIBILITY REQUIREMENTS

As an Employee, you are eligible for coverage under this Plan if you meet the following eligibility requirements:

- You hold 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));
- You must be regularly scheduled to work at least 30 hours per week; and
- You are not an independent contractor or in an emergency, temporary, seasonal, or provisional appointment as defined in the City's Merit Rules.

EMPLOYEE INITIAL ENROLLMENT AND COVERAGE EFFECTIVE DATE.

Your coverage under the Plan will become effective on 12:01 a.m. of the first day of the month following the date you initially meet all of the eligibility requirements. For example, if you start work with the City on March 12 and meet all of the eligibility requirements, your Plan coverage will start on April 1 at 12:01 a.m. The waiting period between your commencement of employment and the date your coverage begins will be no longer than 31 days.

In addition, if your employment begins on the first day of the month, coverage will start on the same day. For example, if you start work on March 1 and meet all of the eligibility requirements, your Plan coverage will start on March 1 at 12:01 am.

TERMINATION OF EMPLOYEE COVERAGE

Your Plan coverage will terminate at the end of the month or on the earliest of the following dates:

- The date any contribution required by you, or on your behalf, is due and unpaid;
- The date of your death;
- The date you enter the Armed Forces (military) on full-time active duty;
- The last day for which the required contribution has been paid if you are on non-FMLA leave without pay; and
- Midnight of the last day of the calendar month in which you cease to be an eligible Employee unless you retire from employment with the City. If you retire, coverage in the Plan will terminate on the last day of the month following the month in which you receive your final paycheck from the City.

REINSTATEMENT OF COVERAGE

If you terminate employment and are reinstated to employment that makes you eligible for Plan coverage within the same calendar month and calendar year, coverage for you and your eligible Dependents will not be terminated or interrupted.

PAYMENT FOR COVERAGE

The City pays the full cost of coverage for eligible Employees who are actively working, on an approved paid leave of absence or on an FMLA-approved leave of absence. If an Employee does not meet the Plan's eligibility criteria for City paid premium, the Employee will be required to make a monthly contribution for his or her own Plan coverage.

If coverage is elected for an eligible spouse and/or child(ren), payment for the cost of that dependent coverage is the Employee's responsibility. Contributions are required while you are actively working and during any type of leave of 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 paycheck 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. Failure to pay premiums will result in termination of coverage.

If both spouses are Employees, the cost for dependent coverage is waived.

INITIAL ELIGIBILITY FOR DEPENDENTS

If you are covered under the Plan, you may elect coverage for your eligible Dependents on the later of the date you become eligible for your own Plan coverage or the date you acquire an eligible Dependent by marriage, birth, adoption, or placement for adoption. A Dependent will be eligible for Plan coverage if he or she meets the definition of Dependent below. Any changes that affect Dependent eligibility need to be reported to the Plan within 31 days.

A Dependent may not be enrolled for coverage unless you are also enrolled. Specific documentation to verify Dependent status may be required by the Plan. Documentation includes copies of your marriage license, a Dependent's Social Security Number, birth certificates, and adoption papers from a court or other state or federal authority.

YOUR ELIGIBLE DEPENDENTS

Your eligible Dependents include the following:

- Your spouse, who is recognized as such by state law. The Plan Administrator may require documentation proving legal marital relationship.
- Each of the following children under age 26:
  - Your natural child;
  - Your adopted child;
  - A child placed with you for adoption ("placed for adoption" means you have assumed and retained the legal obligation for the total or partial support of the child in anticipation of adoption of such child; and the child must be available for adoption, has not attained the age of 18 as of the date of such placement for adoption and the legal process for adoption must have commenced); and

- Your stepchild, provided the stepchild's parent is married to you;

- A child for whom you are recognized as the legal guardian by a court of law with the duty of taking care of and managing the property rights of the child. The Plan will not provide coverage for an individual under legal guardianship who is older than age 18, regardless of whether such individual is Totally and Permanently Disabled.

- Your unmarried child age 26 or older who is Totally and Permanently Disabled with a disability that existed prior to the attainment of age 26 and who will be claimed as a dependent on your federal income tax return for each calendar year for which Plan coverage is provided. The Plan will require initial and periodic proof, which must be provided within 31 days of the request that the child is eligible for Plan coverage. In addition, the Plan reserves the right to have the child examined by a Physician of the Plan Administrator's or its designee(s)' choice, at the Plan's expense, to determine the existence of such incapacity.

  The Plan Administrator, or its designee(s), may require documentation proving dependency, which may include, but is not limited to, copies of marriage certificates, birth certificates, adoption legal documents, court records regarding legal guardianship, tax records, or documentation regarding the severance of parental rights.

(1) A child named as an Alternate Recipient under a medical child support order that qualifies as a Qualified Medical Child Support Order (QMCSO) (including a National Medical Child Support Notice).

DEPENDENT INITIAL ENROLLMENT AND COVERAGE EFFECTIVE DATE

At the time you initially enroll for Plan coverage, you may also enroll your eligible Dependents. Their coverage will become effective at 12:01 a.m. on the first day of the month following the date on which you meet the eligibility requirements for Plan coverage. To activate coverage for your Dependents, you must provide the Plan Administrator or its designee(s) with a completed and signed enrollment form for your Dependents within 31 days of the date you initially became eligible for coverage under the Plan.

If you fail to enroll an eligible Dependent when you are first eligible for coverage or as stated above for a newborn child, you will have two other enrollment opportunities:

- During the Plan's annual Open Enrollment period; or

- During a Special Enrollment period, if applicable.

The required minimum enrollment period for a Dependent is six months from the effective date of the Dependent's coverage. During the first six months, coverage cannot be reduced unless a Dependent ceases to meet the eligibility requirements as defined in the Plan, or if the Employee has selected pre-tax Health Insurance premiums through the City of Springfield Cafeteria Plan and a qualifying event occurs which permits a change in coverage.

WHEN YOU AND ANY OF YOUR DEPENDENTS BOTH WORK FOR THE CITY – (SPECIAL RULE FOR ENROLLMENT)

No individual may be covered under this Plan as both an employee and as a Dependent, nor may any Dependent Child be covered as the Dependent of more than one employee.

If both you and your spouse are both benefits-eligible Employees of the City:

- One of you must be designated as the eligible Employee (primary enrollee) who can elect the medical coverage choices for the entire family, including the other employee (secondary enrollee) as a Dependent spouse, and all Dependent children. The secondary enrollee may not make any independent coverage elections under the Plan.

- If the primary enrollee terminates employment or has a reduction in hours that would ordinarily result in a termination of coverage, the secondary enrollee will immediately be deemed to have eligible Employee coverage, and would have the option to elect coverage for the terminating primary enrollee and/or Dependents provided such election is, in the judgment of the Plan Administrator or its designee(s), consistent with the change in the family's circumstances as a result of the termination of employment or reduction in hours otherwise coverage for the terminating primary enrollee and/or Dependents will end at midnight on the last day of the month that the primary enrollee ceases to be an Employee.

- While your family coverage is in effect and any of your Dependent children become a benefits-eligible Employee of the City and become eligible for coverage as an Employee:

    - That child may not continue coverage as a Dependent Child and will be automatically enrolled as an Employee. If the Employee-child later terminates employment or has a reduction in hours that would ordinarily result in a termination of coverage, and still qualifies as a Dependent child, the Employee-child will immediately be deemed to be eligible as a Dependent child of the Employee-parent. As a result, the Employee-child may be added to the Employee-parent's plan. If elected, contributions for Dependent coverage will be deducted from the pay of the Employee-parent based upon coverage effective dates.

TERMINATION OF DEPENDENT ELIGIBILITY

Your Dependent's coverage will terminate at the end of the month on the earliest of the following dates:

- The date the Plan is terminated or coverage for Dependents is terminated;

- The date the Employee's coverage ends;

- The last day of the calendar month in which your covered Dependent spouse or child loses Dependent status by no longer meeting the definition of a Dependent;

- The date of the Dependent's death;

- 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;

- The date that any contribution required for Dependent coverage is due and unpaid; or

- The date you cease to make any contributions required for coverage of your covered Dependent spouse or child(ren) due to their entry into the Armed Forces or full-time active duty.

SPECIAL ENROLLMENT

There are three special enrollment opportunities to enroll eligible Dependents in the Plan's benefits mid-year:

- **Newly Acquired Spouse:** If you acquire a spouse and his or her Dependent Child(ren) by marriage, you may request enrollment for your new spouse and/or any newly eligible Dependent child(ren) no later than 31 days after the date of marriage. Coverage for your newly acquired Dependent(s) is effective on the first of the month following the date of marriage provided you have provided a completed and signed enrollment form and applicable documentation as described below within 31 days of the date you acquired the new Dependent(s).

- **Newly Acquired Dependent Child(ren):** If Dependent coverage is not currently in force and you acquire any Dependent child(ren) by birth, adoption, or placement for adoption, you may request enrollment for any newly eligible Dependent child(ren) no later than 31 days after birth, adoption, or placement for adoption. Coverage for your newly acquired Dependent(s) is effective on the date of birth, adoption, or placement of adoption provided you have provided a completed and signed enrollment form and applicable documentation as described below within 31 days of the date you acquired the new Dependent(s). The Spouse of the covered Employee may be enrolled as a Dependent of the covered Employee if such Spouse is otherwise eligible for coverage.

  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 child 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. A completed and signed enrollment form and applicable documentation as described below are required for the enrollment request. Coverage for the newly acquired Dependent child(ren) is effective on the date of birth, adoption, or placement of adoption.

- **Loss of Other Coverage:** If your spouse and/or any Dependent child(ren) lose coverage under another group health plan or health insurance policy including COBRA Continuation Coverage, certain types of individual health insurance, Medicare, or other public program, you may request enrollment for your spouse and/or any eligible Dependent child(ren) within 31 days after the termination of their coverage under that other group health plan or health insurance policy. Special enrollment coverage will become effective for you and/or your Dependents on the first day of the month following the qualifying event provided you have provided a completed and signed enrollment form and applicable documentation within 31 days of the date you lost other coverage.

- **HIPAA Special Enrollment**: In addition to those eligible Dependents described elsewhere in this Special Enrollment section, eligible Dependents who were not enrolled when first eligible are

eligible to enroll in a HIPAA Special Enrollment period if conditions specified in 29 CFR § 2590.701-6 are met.

An Employee's eligible Dependent(s) may also enroll in this Plan if the eligible Dependent(s):

- Have coverage through Medicaid or a State Children's Health Insurance Program (CHIP) and your Dependents lose eligibility for that coverage. However, you must request enrollment in this Plan within 60 days after the Medicaid or CHIP coverage ends. Note that if the individual requests enrollment within 60 days of the date of the Special Enrollment opportunity related to Medicaid or CHIP, coverage will become effective on the first day of the month following the date of the event that allowed this Special Enrollment opportunity; or

- Become eligible for a premium assistance program through Medicaid or CHIP. However, you must request Dependent enrollment in this Plan within 60 days after your Dependents are determined to be eligible for such premium assistance.

OPEN ENROLLMENT

Open Enrollment is the period each year as designated by the Plan during which eligible employees may make the elections specified below.

During the annual open enrollment period, you (as the eligible Employee) may elect to add or drop eligible Dependents to or from coverage under the Plan.

All relevant parts of the enrollment form must be completed, and the form must be submitted before the end of the Open Enrollment period to the Plan Administrator or its designee(s) along with proof of Dependent status (as requested). If you do not make an affirmative election during the open enrollment period, you and your eligible Dependents will retain your present coverages or lack thereof. Coverage elected during the open enrollment period will become effective on January 1 of the calendar year following the open enrollment period.

QUALIFIED MEDICAL CHILD SUPPORT OPTIONS

Any child of an Employee who is an alternate recipient under a qualified medical child support order shall be considered as having a right to Dependent coverage under this Plan as of the date of the request on the QMCSO. The enrollment guidelines must be followed and documentation submitted timely. A participant of this Plan may obtain, without charge, a copy of the procedures governing qualified medical child support order (QMCSO) determinations from the Plan Administrator.

MILITARY RIGHTS – UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

If you, the Employee, take a leave of absence for military service (such as active or inactive duty training or active duty in the United States Armed Forces or National Guard), your coverage and your Dependents' coverage under the Plan will generally terminate on the last day of the month in which the military service begins unless you elect to continue coverage under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). To ensure protection of your rights under USERRA, you are obligated to notify the Plan as soon as you are called up for military service.

Under USERRA, you can elect to continue medical and prescription drug coverage for yourself and your Dependents for the period of your leave, up to a maximum of 24 months. If the leave does not exceed 31 days, there is no additional cost to continue your coverage. If the leave exceeds 31 days, the Plan will require you to pay for continued coverage. This right to continue coverage will generally be subject to the Plan's payment, notification, cancellation, and other administrative procedures, time frames and rules for COBRA coverage. If applicable, any continuation coverage will run concurrently with the USERRA coverage.

ELIGIBILITY AND COVERAGE DURING A FAMILY AND MEDICAL LEAVE

If you are covered under the Plan and eligible for Family and Medical Leave (FMLA Leave) in accordance with the Family and Medical Leave Act (FMLA), you will be eligible to continue your coverage and your Dependents' coverage under the Plan during the period of FMLA Leave to the extent required under FMLA.

If you return to employment that makes you eligible for Plan coverage immediately following termination of FMLA Leave, you will not be classified as a reinstated participant but will continue eligibility as if your work in covered employment had continued without interruption.

RESCISSION OF BENEFITS

If an Employee commits fraud or makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Employer or Plan may either void coverage for the Employee and covered Dependents for the period coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action.

COBRA CONTINUATION COVERAGE

YOUR RIGHT TO COBRA CONTINUATION

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." After a qualifying event, COBRA continuation coverage is offered to each person who is a "qualified beneficiary."

You, your Dependent spouse, and your Dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. A Dependent child who is born to or placed for adoption with you during a period of COBRA coverage is also a qualified beneficiary.

As an Employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- You do not work the required number of hours to maintain coverage under the Plan; or
- Your employment ends for any reason.

Your Dependent spouse will become a qualified beneficiary if he or she loses coverage under the Plan because any of the following qualifying events happens:

- You die;
- You do not work the required number of hours to maintain coverage under the Plan;
- Your employment ends for any reason;
- You become entitled to Medicare benefits; or
- You and your spouse divorce or legally separate (it is your responsibility to notify the COBRA Administrator of your divorce or legal separation. If you fail to do so, you must reimburse the Plan for any claims payments for your spouse after the date of your divorce or legal separation).

Your Dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- You die;
- You do not work the required number of hours to maintain coverage under the Plan;
- Your employment ends for any reason;
- You become entitled to Medicare benefits;
- You and your spouse divorce or legally separate; or
- The child stops being eligible for coverage under the Plan as a Dependent.

YOU MUST PROVIDE NOTICE TO THE PLAN OF CERTAIN COBRA QUALIFYING EVENTS

You or your Dependent must provide the COBRA Administrator with timely notice of the following qualifying events:

- Your divorce or legal separation.
- A dependent child ceasing to be covered under the Plan as a Dependent.
- The occurrence of a second qualifying event after an individual has become entitled to COBRA with a maximum of 18 (or 29) months. This second qualifying event could include your death, entitlement to Medicare, divorce or legal separation, or a child losing Dependent status.
- When an individual entitled to COBRA coverage with a maximum of 18 months has been determined by the Social Security Administration to be disabled.
- When the Social Security Administration determines that an individual is no longer disabled.

You or your Dependent must notify the COBRA Administrator of any of the five above listed qualifying events. Failure to provide the proper notice within the required time frames described below may prevent you or your Dependent from obtaining or extending COBRA coverage.

NOTIFICATION PROCEDURES

To notify the Plan of these qualifying events, you must send a letter to the COBRA Administrator containing the following information: the covered Employee's name, the qualified beneficiary's name, the type of qualifying event for which the individual is providing notice, and the date of the event. In the event of divorce or legal separation, you must also submit a copy of the divorce decree or legal separation; in the event of a Social Security Administration determination of disability, you must submit a copy of the Social Security determination; in the event of death, you must submit a copy of the death certificate.

If you are providing notice due to: (i) a divorce or legal separation; (ii) a Dependent losing eligibility for coverage; or (iii) a second qualifying event, the notice must be postmarked no later than 60 days after the later of:

- The date on which the relevant qualifying event occurs; or
- The date on which the qualified beneficiary loses (or would lose) coverage under the Plan as a result of the qualifying event.

If you are providing notice of a Social Security Administration determination of disability, the notice must be postmarked no later than 60 days after the latest of:

- The date of the disability determination by the Social Security Administration;
- The date on which the qualifying event occurs; or
- The date on which the individual loses (or would lose) coverage under the Plan as a result of the qualifying event;

- and before the end of the first 18 months of continuation coverage.

If you are providing notice of a Social Security Administration determination that the individual is no longer disabled, the notice must be postmarked no later than 30 days after the date of the final determination by the Social Security Administration.

Notice may be provided by you, your Dependent, or any representative acting on behalf of you or your Dependent. Notice from one individual will satisfy the notice requirement for all individuals affected by the same qualifying event.

Within thirty (30) days after receiving timely notice of a qualifying event, the COBRA Administrator will furnish you or your Dependent with specific information on when and how to elect continuation coverage, including the cost. Notice given to you or your Dependent spouse will be deemed to be notice to all affected Dependent children living with you or your Dependent spouse.

Within thirty (30) days after you or your Dependent loses eligibility due to your death, termination of employment, or insufficient hours worked, the Plan will furnish you or your Dependent with specific information on when and how to elect continuation coverage, including the cost. Notice given to you or your Dependent spouse will be deemed to be notice to all affected Dependent children living with you or your Dependent spouse. An Employer is required to submit notice of a qualifying event to the COBRA Administrator on account of your death, termination of employment or insufficient hours.

To continue coverage, you and/or your Dependents must make a written election with the Plan within sixty (60) days after the later of: (1) the date coverage would otherwise terminate due to the qualifying event; or (2) the date the individual is notified of the right to continue coverage. 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.

If an individual waives continuation coverage during the 60-day election period, he or she may revoke the waiver and elect continuation coverage at any time within the 60-day period. However, coverage will be provided only from the date of revocation and not retroactive to the date of termination.

UNAVAILABILITY OF COVERAGE

If you provide notice to the Plan of a qualifying event, but are not entitled to COBRA, the Plan will send you a written notice stating the reason why you are not eligible for COBRA. This will be provided within the same time frame that the Plan is required to provide an election notice.

HOW IS COBRA COVERAGE PROVIDED?

When the qualifying event is the death of the Employee, the Employee's becoming entitled to Medicare benefits, the Employee and spouse’s divorce or legal separation, or a Dependent child's losing eligibility as a Dependent, COBRA continuation coverage lasts for up to a total of 36 months for spouses and children who are qualified beneficiaries.

When the qualifying event is the end of employment or reduction of the Employee's hours of employment, and the Employee became entitled to Medicare benefits less than 18 months before the loss of coverage caused by the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the Employee lasts until 36 months after the date of Medicare entitlement.

For example, if a covered Employee becomes entitled to Medicare eight (8) months before the date on which his employment terminates, COBRA continuation coverage for his 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 generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended:

- **Disability extension of 18-month period of continuation coverage**. If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the COBRA Administrator, you and your 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 period of continuation coverage.

- **Second qualifying event extension of 18-month period of continuation coverage**. If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and Dependent children in your family who are qualified beneficiaries can get 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. This extension may be available to the spouse and any Dependent children (if they are qualified beneficiaries) receiving continuation coverage if the Employee or former Employee dies, becomes entitled to Medicare benefits, or gets divorced. The Dependent child is eligible for this extension if he or she stops being eligible under the Plan as a Dependent child.

BENEFITS

The benefits that are available during the continuation coverage period will be the same as those being provided under the Plan to similarly situated Plan participants with respect to whom a qualifying event has not occurred.

OPEN ENROLLMENT

Open enrollment will be made available to COBRA participants in the same manner as for similarly situated Plan participants.

PAYMENT FOR CONTINUATION COVERAGE

Continuation coverage is optional on the part of you and your Dependents. In the event you elect not to continue coverage, each of your eligible Dependents will be entitled independently to elect to continue coverage. Any individual who elects to continue coverage must pay the required self-payment on a timely basis for coverage to continue.

The first self-payment is due within 45 days of the date continuation coverage is elected. It must cover the cost of coverage from the date coverage would otherwise have terminated through the end of the last month for which payment is made. All subsequent self-payments are payable on a monthly basis and due on the first business day of each month for which coverage is intended. Payment will

be considered timely and coverage will be reinstated retroactively if payment is received within 30 days of the first day of the calendar month for which coverage is sought. A Participant who fails to make the required timely self-payment will lose the right to continue self-pay coverage.

SELF-PAYMENT COST

If a Participant elects to continue coverage, he or she must pay the amount of self-payment determined by the Plan. In general, the self-payment amount will not exceed 102% of the Plan's cost of coverage. However, if you and/or your Dependents extend coverage from 18 to 29 months due to disability, the Plan may charge up to 150% of the Plan's cost of coverage for the additional 11 months.

The required self-payment amounts may be increased if the costs to the Plan increase, but generally will be fixed in advance of each 12-month premium cycle. Any qualified beneficiary who is eligible to continue coverage on a self-pay basis will be notified of the cost prior to making an election and prior to any changes in the amount payable.

INTERACTION OF COBRA AND THE AFFORDABLE CARE ACT – OTHER OPTIONS

If you lose group health coverage under the Plan and become eligible for COBRA coverage, you may also become eligible for other coverage options that may cost less than COBRA coverage. For example, you and your family may be eligible to buy an individual plan through the Health Insurance Marketplace, Medicaid, or other group health plan coverage (such as a spouse's plan) through a special enrollment period, even if the other plan generally does not accept late enrollees. If you enroll in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. You can learn more about many of these options and about your rights under the Affordable Care Act at www.healthcare.gov.

WHEN COBRA CONTINUATION COVERAGE ENDS

Continuation coverage under COBRA will end on the earliest of the following dates:

- The first day of the period for which the individual fails to make a timely self-payment;
- The date, after continuation coverage is elected, on which the individual first becomes covered under Medicare;
- If an individual is extending coverage from 18 to 29 months due to disability, the last day of the month 30 days after Social Security Administration determination that the individual is no longer disabled (e.g., SSA determination date of April 15th, coverage will continue until May 31st);
- If an individual is affected by or experiences multiple qualifying events, continuation coverage will not be provided for more than 36 months from the date of the original qualifying event;
- The date the Plan no longer provides group health coverage to any Covered Person.

NOTICE OF TERMINATION OF COBRA

If continuation coverage is terminated before the end of the maximum coverage period, the Plan will send you a written notice as soon as practicable following the Plan's determination that continuation

coverage will terminate. The Notice will set out why continuation coverage will be terminated early, the date of termination, and your rights, if any, to alternative individual or group coverage.

NAME, ADDRESS AND TELEPHONE NUMBER OF THE COBRA ADMINISTRATOR

Director of Human Resources
City of Springfield
Busch Municipal Bldg., 3rd Floor
840 Boonville Avenue
Springfield, MO 65802
417-864-1607 (Phone)
417-864-1186 (Fax)
HR@springfieldmo.gov (email)
https://www.springfieldmo.gov/2035/Insurance (website)

KEEP THE PLAN INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Plan informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan.

IF YOU HAVE QUESTIONS

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the City. For more information about your rights under COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact: The Department of Health and Human Services Center for Medicare and Medicaid Services, 7500 Security Boulevard, Mail Stop S3-16-26, Baltimore, MD 21244-1850, Tel 410.786.3000.

MEDICAL BENEFITS

CALENDAR YEAR DEDUCTIBLE

The annual deductible is the amount of money you must pay each calendar year before the Plan begins to pay benefits. Penalties for failure to obtain pre-certification do not count toward meeting the deductible. The deductible applies to all Covered Charges except where otherwise noted in the Plan's Schedule of Benefits. Costs incurred for prescriptions filled through pharmacy retail and mail order do not apply toward the medical deductible and coinsurance amounts. The deductible accrues toward the Out-of-Pocket maximum.

Note that in general, the Network and Non-network deductibles are interchangeable, meaning that you may use a portion of a Network deductible to meet a Non-network deductible and vice versa. Therefore, if the individual has Non-network services, only the amount up to the Network maximum will be counted toward reaching the family's Network maximum. For example, if an individual has Non-network Covered Expenses of $1,000, $1,000 will be applied to the Non-network deductible. The individual Network deductible amount will be credited $500 for calculating his or her Network deductible and the family unit maximum. The maximum amounts an individual can contribute to the family Network deductible and coinsurance maximums are the amounts up to the Network "per person" maximums.

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.

COMMON ACCIDENT DEDUCTIBLE

If 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.

COINSURANCE

Coinsurance, as shown in the Schedule of Benefits, is the percentage of Covered Charges payable under the Plan after satisfaction of the applicable deductible and/or copayment, subject to any benefit maximum limitations. The coinsurance percentage for services rendered by "Network Providers" is higher than the coinsurance percentage for services rendered by "Non-network Providers".

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 any maximum benefit amount shown in the Schedule of Benefits or any other noted limit of the Plan. The Covered Person must satisfy the deductible, coinsurance, copayment, and benefit limits stated in the Schedule of Benefits.

OUT-OF-POCKET MAXIMUM

The Out-of-Pocket maximum is the most you pay during a one-year calendar year period before the Plan starts to pay 100% of Covered Charges received from Network and Non-network providers. Emergency services performed in a Non-network emergency room will apply to meet the Network out-of-pocket maximum in cost-sharing. The amount of the Out-of-Pocket maximum may be adjusted annually. The family Out-of-Pocket maximum accumulates cost-sharing for any covered family member; however, no one person in the family will be required to accumulate more than this Plan's "per person" annual out-of-pocket maximum. The specialty Out-of-Pocket maximum applies towards the pharmacy Out-of-Pocket maximum. Costs incurred for prescriptions filled through pharmacy retail and mail order do not apply toward the medical deductible amounts.

The following costs do not count toward the medical Out-of-Pocket maximum:

- Premiums and/or contributions for coverage;
- Expenses for medical services or supplies that are not covered by the Plan;
- Charges in excess of the Allowable Charge determined by the Plan which includes balance billed amounts for Non-network providers;
- Pre-certification penalties for non-compliance with Utilization Management program requirements;
- Expenses for the use of Non-network providers, except as provided for the reasons described below in the *Services Within or Outside the Network Area* section below; and
- Charges in excess of the medical Plan's maximum benefits.

SERVICES WITHIN OR OUTSIDE THE NETWORK AREA

In certain circumstances, the Plan will consider Non-Network services to be treated as Network services. These circumstances include:

- A Covered Person has no Network Providers in the specialty required to treat the illness or injury within the PPO Network 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 Claims Supervisor 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 defined by this Plan, midwife services will be paid as Network services if no Network Provider (midwife) is available.
- A Covered Person has an Emergency Medical Condition (on an inpatient or outpatient basis) and has no control regarding the Hospital to which they are 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-Network facility, the Covered Person must be transferred to a Network facility.

- A Covered Person received Physician, diagnostic or anesthesia services by a Non-network provider when the Covered Person did not have a choice of a Network provider or a Network provider was not available while admitted inpatient or outpatient at a Network facility.

- A Covered Person has a specimen for a lab test drawn or an x-ray taken by a Network provider but a Non-network provider performs that lab test or reads the x-ray.

- A Covered Person receives treatment, services, or supplies by a Non-network provider and the charges for the services were negotiated and/or approved by the Utilization Review Coordinator and/or Claims Supervisor as listed in 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 Non-network provider benefit level.

- Continuity of care: In the event a Covered Person is a continuing care patient receiving a course of treatment from a Provider which is In-Network or otherwise has a contractual relationship with the Plan governing such care and that contractual relationship is terminated, not renewed, or otherwise ends for any reason other than the Provider's failure to meet applicable quality standards or for fraud, the Participant shall have the following rights to continuation of care.

  The Plan or its designee(s) shall notify the Covered Person in a timely manner that the Provider's contractual relationship with the Plan has terminated, and that the Covered Person has rights to elect continued transitional care from the Provider. If the Covered Person elects in writing to receive continued transitional care, Plan benefits will apply under the same terms and conditions as would be applicable had the termination not occurred, beginning on the date the Plan's notice of termination is provided and ending 90 days later or when the Covered Person ceases to be a continuing care patient, whichever is sooner.

  For purposes of this provision, "continuing care patient" means an individual who:

  - is undergoing a course of treatment for a serious and complex condition from a specific Provider,
  - is undergoing a course of institutional or Inpatient care from a specific Provider,
  - is scheduled to undergo non-elective surgery from a specific Provider, including receipt of postoperative care with respect to the surgery,
  - is pregnant and undergoing a course of treatment for the Pregnancy from a specific Provider, or
  - is or was determined to be terminally ill and is receiving treatment for such illness from a specific Provider.

  Note that during continuation, Plan benefits will be processed as if the termination had not occurred, however, the Provider may be free to pursue the Participant for any amounts above the Plan's benefit amount.

If a Covered Person receives information with respect to an item or service from the Plan, its representative, or a database maintained by the Plan or its representative indicating that a particular Provider is an In-Network Provider and the Participant receives such item or service in reliance on

that information, the Participant's Coinsurance, Copayment, Deductible, and out-of-pocket maximum will be calculated as if the Provider had been In-Network despite that information proving inaccurate.

NO SURPRISES ACT – EMERGENCY SERVICES AND SURPRISE BILLS

For Non-Network claims subject to the No Surprises Act ("NSA"), Participant cost-sharing will be the same amount as would be applied if the claim was provided by a Network Provider and will be calculated as if the Plan's Allowable Expense was the Recognized Amount, regardless of the Plan's actual Allowable Charge. The NSA prohibits Providers from pursuing Participants for the difference between the Allowable Charge and the Provider's billed charge for applicable services, with the exception of valid Plan-appointed cost-sharing as outlined above. Any such cost-sharing amounts will accrue toward In-Network Deductibles and out of pocket maximums.

Benefits for claims subject to the NSA will be denied or paid within 30 days of receipt of an initial claim, and if approved will be paid directly to the Provider.

Claims subject to the NSA are those which are submitted for:

- Emergency Services;
- Non-emergency services rendered by a Non-Network Provider at a Participating Health Care Facility, provided the Participant has not validly waived the applicability of the NSA; and
- Covered Non-Network air ambulance services.

UTILIZATION MANAGEMENT

The Plan is designed to provide you and your eligible Dependents with financial protection from significant health care expenses. The development of new drugs, medical technology and procedures and the ever-increasing cost of providing health care may make it difficult for the City to afford the cost of maintaining your plan.

To enable your plan to provide coverage in a cost-effective way, your plan has adopted a Utilization 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 City is better able to afford to maintain the Plan and all its benefits. If you follow the procedures of the Plan's Utilization Management Program, you may avoid some out-of-pocket costs. However, if you don't follow these procedures, your plan provides reduced benefits, and you'll be responsible for *paying more out of your own pocket.*

ADMINISTRATION OF THE UTILIZATION MANAGEMENT PROGRAM

The Plan's Utilization Management Program is administered by an independent professional Utilization Management Company operating under a contract with the Plan (hereafter referred to as the UM Coordinator). The health care professionals of the UM Coordinator focus their review on the necessity and appropriateness of hospital stays and the necessity, appropriateness, and cost-effectiveness of proposed medical, surgical and prescription drug services. In carrying out its responsibilities under the Plan, the appropriate UM Coordinator has been given discretionary authority by the Plan Administrator or its designee(s) to determine if a course of care or treatment is

Medically Necessary with respect to the patient's condition and within the terms and provisions of this Plan.

Certain outpatient drugs may require pre-certification as managed by the Prescription Drug Program. The contact information for the UM Coordinator and Prescription Drug Program appear in the *Important Telephone Numbers* in the front of this document.

Medical management requirements described in this section of this booklet do not apply when coverage under this Plan is secondary to another plan providing benefits for a covered individual.

ELEMENTS OF THE UTILIZATION MANAGEMENT PROGRAM: The Plan's Utilization Management Program consists of:

- **Pre-certification (preservice) review:** Review of proposed health care services before the services are provided;

- **Concurrent (continued stay) review**: Ongoing assessment of the health care as it is being provided, typically involving inpatient confinement in a hospital or health care facility or review of the continued duration of healthcare services;

- **Second and third opinions**: Consultations and/or examinations designed to take a second, and, when required, a third look at the need for certain elective health care services;

- **Retrospective review**: Review of health care services after they have been provided; and

- **Case Management**: A process whereby the patient, the patient's family, Physician and/or other Health Care Providers, and the City work together under the guidance of the Plan's independent UM Coordinator to coordinate a quality, timely and cost-effective treatment plan. Case Management services 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.

Restrictions and Limitations of the Utilization Management Program (Very Important Information):

- The fact that your Provider recommends surgery, hospitalization, confinement in a health care facility, or that your Provider proposes or provides any other medical services or supplies doesn't mean that the recommended services or supplies will be an eligible expense or be considered Medically Necessary for determining coverage under the Plan.

- The Utilization Management Program is not intended to diagnose or treat medical conditions, validate eligibility for coverage, or guarantee payment of Plan benefits. The UM Coordinator's certification that a service is Medically Necessary doesn't mean that a benefit payment is guaranteed. Eligibility for and actual payment of benefits are subject to the terms and conditions of the Plan as described in this document. For example, benefits would not be payable if your eligibility for coverage ended before the services were rendered or if the services were not covered by the Plan either in whole or in part.

- All treatment decisions rest with you and your Provider. You should follow whatever course of treatment you and your Provider believes to be the most appropriate, even if the UM Coordinator

does not certify proposed surgery/treatment/service or admission as Medically Necessary or as an eligible expense. However, the benefits payable by the Plan may be affected by the determination of the UM Coordinator.

- With respect to the administration of this Plan, the City, the Claims Supervisor and the UM Coordinator are not engaged in the practice of medicine, and none of them takes responsibility either for the quality of health care services actually provided, even if they have been certified by the UM Coordinator as Medically Necessary, or for the results if the patient chooses not to receive health care services that have not been certified by the UM Coordinator as Medically Necessary.

- Pre-certification of a service does not guarantee that the Plan will pay benefits for that service because, other factors, such as ineligibility for coverage on the actual date of service, the information submitted during pre-certification varies from the actual services performed on the date of service, and/or the service performed is not a covered benefit, may be a factor in non-payment of a service.

PRE-CERTIFICATION (PRESERVICE) REVIEW

How Pre-certification Review Works*:* Pre-certification review is a procedure, administered by the UM Coordinator, to assure that health care services meet or exceed accepted standards of care and that the admission and length of stay in a Hospital or health care facility, surgery, and other health care services are Medically Necessary.

You or your Dependents or your Provider must call the UM Coordinator at the telephone number shown in the *Important Telephone Numbers* chart in the front of this booklet.

- The caller should be prepared to provide all of the following information: the City's name, Employee's name, patient's name, address, and phone number and social security number; Provider's name, and phone number or address; the name of any Hospital or outpatient facility or any other Provider that will be providing services; the reason for the health care services or supplies; and the proposed date for performing the services or providing the supplies.

- If additional information is needed, the UM Coordinator will advise the caller. The UM Coordinator will review the information provided, and will let you, your Provider and the Hospital or other Provider, and the Claims Supervisor know whether or not the proposed health care services have been certified as Medically Necessary.

Failure to obtain pre-certification for the above services will result in a $100 penalty.

When to Request Pre-certification Before and After Hospital Admission (Pre-service and Post-service Review):

The following services must be pre-certified (pre-approved) BEFORE the services are provided:

- All elective Hospital admissions for medical or surgical care. (Note: for pregnant women, pre-certification is required only for hospital stays that last or are expected to last longer than 48 hours for a vaginal delivery and 96 hours for a C-section);

- An upcoming transplant as soon as the participant is identified as a potential transplant candidate;

- All Elective admissions to a Skilled Nursing Facility or Subacute facility/Long Term Acute Care facility.

- All other services should be pre-certified AFTER the services are provided:

- **For unscheduled, non-emergency hospitalization:** Calls for elective services should be made 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.

- **For emergency hospitalization**: Pre-certify as soon as possible but no later than 72 hours after an admission.

An approved pre-certification does not guarantee payment of benefits.

PREAUTHORIZATION

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 UM 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

Preauthorization is not a guarantee that all charges are covered. The Covered Person or the Physician should call the UM Coordinator for preauthorization of the following services:

- Applied Behavior Analysis for Autism Spectrum Disorders
- Home Health Care
- Durable Medical Equipment (greater than $500 purchase value)
- Physical, speech and occupational therapy
- Cardiac rehabilitation therapy
- Weight loss treatment
- Private duty nursing
- Orthotics/Prosthetics

- IV Infusion - Outpatient or Physician's office, except for chemotherapy
- Stereotactic radiosurgery
- Non-network Provider services when Network Providers are available

CONCURRENT (CONTINUED STAY) REVIEW

How concurrent review works: When you are receiving medical services in a Hospital or other inpatient health care facility, the UM Coordinator will monitor your stay by contacting your Providers to assure that continuation of medical services in the health care facility is Medically Necessary, and to help coordinate your medical care with benefits available under the Plan. Concurrent review may include such services as coordinating home health care or durable medical equipment, assisting with discharge plans, determining the need for continued medical services; and/or, advising your Providers of various options and alternatives for your medical care available under this Plan. If at any point your stay or services are found to not be Medically Necessary and that care could be safely and effectively delivered in another environment, such as through home health or in another type of health care facility, you and your Provider will be notified. This does not mean that you must leave the Hospital or stop receiving services, but if you choose to stay or continue services, all expenses incurred after the notification will be your responsibility.

Emergency Hospitalization: If an emergency requires hospitalization, there may be no time to contact the UM Coordinator before you are admitted. If this happens, the UM Coordinator must be notified of the hospital admission within 72 hours. You, your Provider, the hospital, a family member, or friend can make that phone call to the UM Coordinator. This will enable the UM Coordinator to assist you with your discharge plans, determine the need for continued medical services, and/or advise your Providers of the various Network support providers and benefits available for you and offer recommendations, options and alternatives for your continued medical care.

SECOND AND THIRD OPINIONS

Voluntary

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 is not Life-threatening in nature. Refer to the Schedule of Benefits. These benefits also apply if the second opinion is requested by the UM Coordinator. If the second opinion is for non-surgical services, approval is required by the UM Coordinator for coverage under this benefit.

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

While any surgical treatment is allowed a second opinion, there are certain procedures for which surgery is often performed when other treatments are available. Contact the UM Coordinator for specific questions about procedures for which a second opinion is recommended.

Required

You may be asked by the UM Coordinator to obtain a second opinion about a proposed health care service to help determine if the health care service is Medically Necessary, or if an alternative effective approach to the individual patient's health care management exists. A second opinion may be requested when it appears that there may be a question regarding the effectiveness or reliability of a proposed service, the proposed service involves a high risk in relation to the anticipated benefit; or there appear to be conflicting diagnoses, vague indications, or possible inadequate clinical management.

If a second opinion is requested, the UM Coordinator will arrange for an examination by a Provider who is certified by the American Board of Medical Specialists in the field related to the proposed service and is independent of the Provider who proposed the service.

The second opinion Provider may review past medical records along with clinical findings from his or her own examination of the patient and will report his or her findings to the UM Coordinator. If the second opinion recommendation differs from the treating Provider's recommendation, you may be required to obtain a third opinion from another Provider who will be selected in the same manner as the second opinion Provider. The results of the third opinion will be reviewed by the UM Coordinator, and the recommendation of the majority of the Providers (the attending Provider, and the second and third opinion Providers) will prevail.

If, as a result of the second and/or third opinion, it is determined that the procedure recommended by the treating Provider is not Medically Necessary, no benefits will be payable if you choose to undergo the procedure.

RETROSPECTIVE (POST-SERVICE) REVIEW

Claims for medical services or supplies that have not been reviewed under the Plan's Pre-certification, Concurrent Review, or Second and Third Opinion Programs may, at the option of the Claims Supervisor, be subject to retrospective review to determine if they are Medically Necessary. If the Claims Supervisor receives a determination from UM Coordinator or other designated medical review firm that services or supplies were not Medically Necessary, no benefits will be provided by the Plan for those services or supplies.

CASE MANAGEMENT

***How Case Management Works*:** Case Management is a voluntary process, administered by the Utilization Management Coordinator. Its medical professionals work with the patient, family, caregivers, Providers, Claims Supervisor and the Plan Administrator to coordinate a timely and cost-effective treatment program. Case Management services are particularly helpful when the patient needs complex, costly, and/or high-technology services, and when assistance is needed to guide patients through a maze of potential Providers.

Working with the Case Manager: Any Covered Person, Physician, or other can request Case Management services by calling the UM Coordinator at the telephone number shown on the *Important Telephone Numbers* chart in the front of this booklet. However, in most cases, the UM Coordinator will be actively searching for those cases where the patient could benefit from Case Management services, and it will initiate authorization from the Plan Administrator for the UM Coordinator to provide Case Management services.

The Case Manager of the UM Coordinator will work directly with your Provider, Hospital, and/or other health care facility to review proposed treatment plans and to assist in coordinating services, locating Network providers, and obtaining discounts from Non-network Providers, as needed. From time to time, the Case Manager may confer with your treating Providers, and may contact you or your family to assist in making plans for continued health care services, and to assist you in obtaining information to facilitate those services.

You, your family, or your Provider may call the Case Manager at any time at the telephone number shown on the *Important Telephone Numbers* chart in the front of this booklet to ask questions, make suggestions, or offer information.

COVERED CHARGES

Below is a listing of Covered Charges:

(1) **Hospital Services (Inpatient):** Services while confined as a Hospital inpatient include:

- Room & board facility fees in a semiprivate room with general nursing services. Private rooms are covered only if Medically Necessary or if the facility does not provide semi-private rooms. The admitting Physician must provide documentation of the Medical Necessity to the Claims Supervisor prior to or along with the Hospital claim for prompt consideration of the charges.
- Specialty care units within the hospital (e.g., intensive care unit, cardiac care unit).
- Lab/x-ray/diagnostic services.
- Related Medically Necessary ancillary services (e.g., prescriptions, supplies).
- Newborn care.

The professional fees for Physicians and Professional Providers who deliver covered services to patients in a hospital/health care facility are usually billed separately from the facility fee.

The allowed amount for room charges made by a network Hospital having only private rooms will be the network contracted rate.

If a non-network Hospital having only private rooms is utilized, the allowed amount for eligible room charges will be at 80% of the facility's billed private room rate, the Usual and Customary Allowance or the contracted network rate, whichever is less. (Refer to the Schedule of Benefits for exceptions.)

(2) **Physician and Other Health Care Provider Services:** Services include those provided by a Physician or other covered health care Provider in an office, Hospital, urgent care facility, outpatient/ambulatory surgery center or other covered health care facility location. Fees for Physicians and other health care Providers include those for: surgeons, assistant surgeons (if Medically Necessary), certified registered nurse anesthetists, certified nurse midwife, and experts provided under the Utilization Management program for second and third opinions.

A primary care Physician (PCP) means a Physician or other who practices general practice, family practice, internal medicine, pediatrics, or obstetrics/gynecology (OB/GYN). All other Physicians are considered specialists under the Plan.

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

- If Bilateral or Multiple Surgical Procedures are performed by one (1) surgeon, benefits will be determined based on the Reasonable charge that is allowed for the primary procedures; 50% of the Reasonable charge will be allowed for each additional procedure performed through the same incision; and 70% of the 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;

- If multiple unrelated surgical procedures are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the 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 Reasonable percentage allowed for that procedure;

- 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, 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, Reasonable allowance or billed charges, whichever is less.

Telemedicine/Telehealth/Telemonitoring

Telehealth is the use of electronic information and communication technologies by a health care provider to deliver health care services to a patient while such individual is located at a different site than where the health care provider is located. Telehealth can provide remote access to services such as medical consultations and information, health assessments and diagnosis. These services are provided to a patient by a healthcare professional through interactive telecommunications devices. Similar to telemedicine, telehealth offers a convenient way for patients in need of frequent follow-up or assessment to receive the services they need when they need them without having to worry about the logistics of traveling to the healthcare professional's office.

Telemedicine is the use of interactive telecommunication devices between a patient and a healthcare professional for the purpose of improving or maintaining the health of the patient. Interactive telecommunication devices consist of audio and visual equipment capable of transmitting two-way, real-time (synchronous) communications between a patient and healthcare professional over a distance from multiple locations. Telemedicine can offer a convenient method of delivering healthcare to patients in rural or underserved areas that may otherwise have limited or no access to the healthcare professionals they need.

Telemonitoring, which can encompass telehealth, also includes, for example, the use of electronic remote monitoring devices for purposes such as blood pressure checks, weight

checks via a telescale for patients with Congestive Heart Failure (CHF) as well as other remote medical intervention and assessment tools from the convenience of the patient's place of residence.

Standard telephone calls, fax transmissions and email, in the absence of other integrated information and data, do not qualify as a Covered Charge under this benefit.

Coverage may also be subject to reasonable utilization management and quality assurance requirements that are consistent with those established for the same service when not delivered via telehealth.

Circumcision

Circumcision is considered under this benefit if performed during the initial Hospital confinement or 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.

(3) **Allergy Services:** Benefits are payable for the evaluation, diagnosis and treatment of allergies (immunotherapy). Allergy services are covered only when ordered by a Physician.

(4) **Ambulance Services for Medical Emergency and Non-Emergency Medical Transport Services:**

- Ground vehicle emergency transportation: Services include those for (i) ground transportation to the nearest appropriate facility as Medically Necessary for treatment of a medical emergency or acute illness/injury; and (ii) Medically Necessary inter-health care facility transfer (e.g., transfer from one hospital to another hospital).

- Air/sea emergency transportation is payable: (i) only when Medically Necessary for treatment of a life-threatening emergency, and (ii) the air/sea transport is required because of inaccessibility by ground transport and/or the use of ground transport would endanger the patient's health status. When air/sea ambulance transportation is required, it is payable to the nearest acute health care facility qualified to treat the patient's emergency condition.

    - Except in life-threatening emergencies, coverage of air/sea transport between Hospitals or other facilities requires preauthorization.

- Non-emergency medical transport: This refers to transport in a vehicle because the patient cannot safely use public or private transportation due to his or her Medically Necessary requirement to be positioned in a wheelchair or stretcher, or because he or she requires the use of medical equipment or non-emergency medical monitoring during transport.

- Ambulette service or other forms of passenger transportation that are available to the public (e.g., buses, taxis, or airplanes) are not covered.

(5) **Ambulatory Surgical Center:** Services include those for an outpatient ambulatory surgical facility/center (e.g., surgicenter, same day surgery, outpatient surgery). The professional fees for Physicians and Providers who deliver covered services to patients in an outpatient (ambulatory) surgery facility are usually billed separately from the facility fee.

(6) **Chemotherapy:** Chemotherapy drugs and supplies administered under the direction of a Physician in a Hospital, health care facility, Physician's office or at home.

(7) **Clinical Trials:** Charges incurred due to participation in either a Phase I, II, III, or IV approved clinical trial, provided the charges are:

- 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

- 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 Participant or Dependent is eligible for payment of charges related to participation in an Approved Clinical Trial if he or she:

- Satisfies the protocol prescribed by the Approved Clinical Trial provider; and

- Either:

  - The individual's network participating provider determines that the individual's participation in the Approved Clinical Trial would be medically appropriate; or

  - 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: (i) the investigational items, devices, services, or drugs being studied as part of the Approved Clinical Trial; (ii) 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 (iii) 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.

(8) **Corrective Appliances: Prosthetic and Orthotic Devices (other than Dental):** Coverage is provided for Medically Necessary Prosthetic and Orthotic devices as follows: (i) the purchase of standard model orthotics or prosthetics; (ii) repair, adjustment or servicing of the device when Medically Necessary; (iii) replacement of the device if there is a change in the Covered Person's physical condition making the current device inoperable or unsatisfactory in order to perform normal daily activities (as certified by the patient's Physician) or if the device cannot be satisfactorily repaired; (iv) occupational therapy adaptive self-help supplies or devices to assist a person in performing Activities of Daily Living such as feeding, dressing or bathing; (v) ostomy and/or urinary catheter supplies; and (vi) external hearing aids. Preauthorization is recommended for prompt processing of claims.

- ***Prosthetic Devices:*** Replacement for prosthetics only as determined to be Medically Necessary and the device must be pre-authorized.

- ***Non-Foot Orthotics:*** 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.

- ***Orthotics:*** Orthopedic shoes that are Medically Necessary will be covered. Replacement of orthotics will not be covered unless (i) there is sufficient change in the Covered Person's physical condition to make the original device no longer functional or (ii) the device has reached its life expectancy and needs to be replaced (but no more frequently than every three (3) years). The benefit payment will be based on the cost of the treatment which provides professionally satisfactory results at the most cost-effective level.

- ***Hearing Aid/amplification Device*:** Supplies include 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).

- ***Hearing exams and hearing aids for newborns*:** Coverage for newborn hearing screening, necessary newborn rescreening, audiological assessment and follow-up and initial amplification device in accordance with Missouri State Law.

(9) **Dialysis:** Services include hemodialysis or peritoneal dialysis and supplies administered under the direction of a Physician in a Hospital, health care facility, Physician's office or at home.

(10) **Durable Medical Equipment:** The 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 Supervisor.

Sales tax and shipping charges on covered equipment are covered expenses. Shipping charges solely for the patient's convenience will not be covered. Durable medical equipment includes, but is not limited to, crutches, trusses, catheters/ostomy supplies, self-injection supplies for covered medications, oxygen/administration equipment, etc.

Rental fees may not exceed, in aggregate, the purchase price of durable medical equipment made and used only for treatment of an injury.

Replacement of durable medical equipment will be considered a Covered Charge 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 or
- if repair is cost-prohibitive or
- if Medically Necessary due to a change in the Covered Person's physical condition.

(11) **Educational Training:** One Medically Necessary unit of educational training is allowed per Illness per lifetime, however, subject to approval by the UM Coordinator a new unit will be allowed when one of the following occurs: a change in diagnosis, prescribed treatment, or prescribed supplies (i.e., non-insulin dependent to insulin dependent diabetes; self-injectable to insulin pump). A unit may be multiple visits with different specialists over multiple days

(12) **Emergency Room Facility:** Services include (i) the use of a Hospital emergency room to treat an Emergency Medical Condition; (ii) ancillary charges performed during the emergency room visit (such as lab or x-rays); and (iii) the professional fees for Physicians and other health care practitioners who deliver covered services to patients in an emergency room.

(13) **Gene and Cell (manipulation) Therapy:** Care, treatment or services for Gene and/or Cell (manipulation) Therapy that is Medically Necessary, meets the standard of care and is not otherwise excluded by the Plan. Prior authorization is required for use of these therapies and they must meet the FDA-approved indications for use. In addition, all therapies must be provided at an approved treatment facility which will be coordinated by the UM Coordinator. If travel is required to obtain the therapy, it will not be covered under the Plan.

(14) **Genetic Testing:** Services include Medically Necessary genetic testing if it aids diagnosing of a Covered Person with functional abnormalities or who is symptomatic of an Illness which may be inheritable, and the results of the test will impact the treatment being delivered or is mandated by state or federal regulations.

Genetic counseling is payable when ordered by a Physician, performed by a qualified genetic counselor (or other qualified Provider), and provided with regard to a genetic test that is payable by this Plan. Certain genetic counseling is payable as a Preventive service in accordance with ACA regulations.

There is no coverage for pre-parental genetic testing (also call carrier testing) intended to determine if a prospective parent or parents have chromosomal abnormalities that are likely to be transmitted to a child of that parent or parents. In addition, there is no coverage of genetic testing of Covered Persons if the testing is performed primarily for the medical management of individuals who are not covered under the Plan.

(15) **Home Health Care:** Benefits include services and supplies only for the care and treatment of an Injury or Sickness when Hospital or Skilled Nursing Facility confinement would otherwise be

required. Home health care services are covered only when ordered by Physician or other health care practitioner and provided by a licensed home health care agency.

A home health care plan must be in place for coverage. It must: (i) be a formally written plan made by the patient's attending Physician every thirty days; (ii) state the diagnosis; (iii) certify that the home health care is in lieu of Hospital confinement; and (iv) specify the type and extent of home health care required for treatment of the patient.

The annual calendar year maximum for skilled nursing care services and supplies (i.e., tubing, tape, bandage) used to provide home health care is 60 visits per person.

Services provided by a home health aide are covered if such services are provided in conjunction with the home health care services provided by a nurse or therapist and the services provided support skilled nursing services.

The following services are considered Covered Charges:

- Part-time or intermittent nursing care by or under the supervision of a registered nurse (RN);
- Part-time or intermittent home health aide services which consist primarily of caring for the patient;
- Physical therapy, occupational therapy and speech therapy provided by a home health care agency;
- 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.

(16) **Hospice:** Benefits include services and supplies 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. Hospice services include inpatient hospice care and outpatient home hospice. There is a 90 day maximum (combined inpatient days and outpatient per diem).

Hospice services are covered only when ordered by a Physician. Bereavement counseling services are covered, if provided 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 Charges for out-patient hospice care include charges for:

- Part-time or intermittent nursing care by an R.N. or L.P.N. as needed to meet the person's assessed needs;
- Psychological and dietary counseling;
- Consultation or case management services by a Physician;
- Physical therapy;

- Part-time or intermittent home health aide services; and
- Medical supplies, drugs, and medicines prescribed by a physician.

The professional fees for Physicians and health care practitioners who deliver covered services to patients in a hospice inpatient facility are usually billed separately from the facility fee.

(17) **Lab Services**: Diagnostic and preventive lab testing and services. The benefit also covers technical and professional fees. Laboratory services will not be covered unless ordered by a Physician or other health care practitioner. Inpatient laboratory services are covered under the Hospital Services benefit.

(18) **Maternity Services:** Maternity services include Hospital and birthing center charges and Physician and certified midwife fees for Medically Necessary maternity services. Coverage for the baby is only payable if the child is a Dependent Child as defined in this Plan, and properly enrolled. Breastfeeding equipment (breast pump) and supplies needed to operate the pump are covered as noted in the provision above describing durable medical equipment. For females who are breastfeeding, the Plan covers comprehensive lactation support and counseling (including breastfeeding classes) at 100%, no deductible, when provided by a Network Provider acting within the scope of his or her license.

Prenatal services not covered under the women's preventive/wellness coverage include, but are not limited to, lab and radiology services, delivery and high-risk prenatal services. Normal plan cost-sharing applies to all eligible female maternity related services including ultrasounds and delivery fees. Two ultrasounds will be considered an eligible expense for a routine pregnancy to determine gestational age and for routine screening. Under federal law, group health plans, like this Plan, generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the Plan may pay for a shorter stay if the attending Physician or health care practitioner, after consultation with the mother, discharges the mother or newborn earlier. Also, under federal law, Plans may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, the Plan may not require that a Physician or other health care practitioner obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-certification.

Elective induced abortion is covered only when 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 a result of rape or incest.

(19) **Mental Health and Substance Abuse Treatment:**

Mental health services:

- Inpatient acute hospital admission, or residential treatment program.
- Outpatient visits including necessary psychological (psychiatric) testing.

Residential treatment programs are covered for individuals needing treatment in a highly structured 24-hour therapeutic environment when care cannot be safely or effectively treated in a less intensive setting. A residential treatment facility must: (i) operate legally as a psychiatric Hospital or residential treatment facility for mental health and be licensed as such by the state in which the facility operates, (ii) be certified by the state department of mental health for treatment of mental disorder or substance abuse; (iii) be primarily engaged in providing diagnostic and therapeutic services for treatment of mental disorders and substance abuse on an inpatient basis; (iv) maintain permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; (v) have a Physician in regular attendance; (vi) continuously provide 24-hour a day nursing service by a registered nurse (R.N.); (vii) have a full-time psychiatrist or psychologist on the staff; and (viii) operate on a 24-hour basis, seven (7) days a week under an organized program.

For Mental Health coverage related to Autism or Applied Behavioral Analysis (ABA), see below:

Autism: The Plan will only cover the evaluation to diagnose an Autism Spectrum Disorder (ASD) and services in an approved Applied Behavior Analysis ASD treatment plan as provided by ASD provider. Habilitative Services for Autism are only covered by the Plan if part of Applied Behavior Analysis ASD treatment plan. (Refer to Therapies for coverage of Rehabilitative Services.)

Applied Behavior Analysis (ABA) is only considered a Covered Charge 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 an ASD treatment plan. An ASD treatment plan must include all elements necessary for this Plan to pay the claim. Such elements include, but are not limited to, a diagnosis, proposed treatment by type, frequency and duration of treatment, and goals. The Plan has the right to review the ASD 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 ASD 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 ASD 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 ABA statutory benefit limit 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 annually upon posting of the new maximum by the Missouri Department of Insurance to determine applicable adjustments for the subsequent Plan Year.

Refer to Habilitative Services for services related to other diagnoses. Refer to Therapies for coverage of Rehabilitative Services.

(20) **Non-congenital transsexualism.** Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change which includes Medically Necessary medications, implants, hormone therapy, surgery, medical and psychiatric treatment. Cosmetic procedures are not covered.

(21) **Oral and TMJ Services:**

Services include:

- Excision of bony growths of the jaw and hard palate.
- Excision of tumors and cysts of the jaws, cheeks, lips, tongue, hard palate and floor of the mouth.
- Incision and drainage of cellulitis.
- Incision of sensory sinuses, salivary glands or ducts.
- Reduction of dislocations and excision of temporomandibular joints (TMJs).
- Osteotomy (e.g., jaw surgery) which is Medically Necessary and not cosmetic in nature.
- 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 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. The Covered Person will be responsible for all charges above that amount.
- Facility and anesthesia charges for pediatric or adult dental procedures that require the use of anesthesia in an ambulatory surgery center or Hospital setting for the following Covered Persons:
  - A child under the age of five;
  - A person who is severely disabled; or
  - A person who has a medical or behavioral condition which requires hospitalization or general anesthesia when dental care is provided.

  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.

  If the Covered Person has elected coverage under the Employer's dental plan, anesthesia charges in the Physician's office will first be eligible under the dental plan and then coordinate coverage under this medical Plan.

- 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 only if that care is for specified oral procedures.

- 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.

- 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.

- 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 Management Coordinator or Plan Administrator or its designee(s).

Oral or craniofacial surgery is limited to cutting procedures to remove tumors, cysts, abscess, acute injury and for reconstructive but not cosmetic purposes. Other than the services noted as covered, the Plan does not cover other dental services, including but not limited to removal of teeth including removal of wisdom teeth, endodontics such as root canal, gingivectomy, procedures in preparation for future dental work or dental implant (such as sinus lift, soft tissue graft, bone graft/replacement).

(22) **Preadmission Testing (Outpatient):** Services include laboratory tests, x-rays and other Medically Necessary tests performed on an outpatient basis prior to a scheduled Hospital admission or outpatient surgery. Services are only covered when ordered by a Physician.

(23) **Prescription Drugs:** Coverage is provided for those pharmaceuticals (drugs and medicines) approved by the U.S. Food and Drug Administration (FDA) that require a prescription and are FDA approved for the condition, dose, method of administration, duration and frequency, if prescribed by a Physician or other health care practitioner authorized by law to prescribe them.

As required by ACA and if prescribed by a Physician, coverage is also provided for FDA-approved female contraceptives (e.g., birth control pills/patch and diaphragms), diabetic blood glucose testing supplies such as lancets and test strips, tobacco cessation products, certain drugs prescribed for reducing the risk for breast cancer and any CDC-recommended vaccinations.

Costs incurred for prescriptions filled through pharmacy retail and mail order do not apply toward medical deductible and coinsurance amount.

Specialty drugs are available on an outpatient basis only when ordered through and managed by the Physician or facility. Specialty drugs obtained from the Plan's specialty pharmacy are managed by the PBM.

Specialty drugs are generally considered high-cost injectable, infused, oral or inhaled products that require close supervision and monitoring and are used by individuals with unique health concerns and include items such as injectables for multiple sclerosis, rheumatoid arthritis or

hepatitis. These drugs may need prior authorization to be covered under the Plan, often require special handling, are date sensitive and are generally available only in a 30-day quantity.

The specialty drug out-of-pocket maximum applies towards the pharmacy out-of-pocket maximum.

Contact the Prescription Benefit Manager (PBM) (whose phone number is listed on the *Important Phone Numbers* chart in the front of this booklet) for the following:

- Information on drugs needing preauthorization (pre-approval to be covered under the Plan) by the clinical staff of the PBM.
- Information on which drugs have a limit to the quantity payable by this Plan.

***Retail Drugs**:* To obtain up to a 30-day supply of a medication, present your ID card to any Network retail pharmacy. Contact the PBM for the location of Network retail pharmacies. A 90-day fill is only allowed at preferred Network retail pharmacies as identified by the PBM. For Network claims where the ID card was not used and you paid for the drug, you can send to the PBM for processing. For eligible prescriptions, a Network Provider will be paid using the same conditions, deductible, coinsurance, copays and non-covered amounts as other Non-network Provider coverage.

Mail Order (Home Delivery) Drug Service: The mail order service is the easiest and least expensive way to obtain many medications, plus the medications are mailed directly to your home. You may use the mail order service to receive up to a 90-day supply of non-emergency, extended-use "maintenance" prescription drugs, such as for high blood pressure or diabetes. Note that not all medicines are available via mail order. Check with the PBM for more information or for instructions on the use of the mail order service.

***Direct Reimbursement for Use of a Non-network Retail Pharmacy**:* If you fill a prescription at a Non-network retail pharmacy location, you will need to pay for the drug at the time of purchase and send the claim form, with receipt, to the Claims Supervisor.

Mandatory Generic Program: Under the Plan's mandatory generic program, if you request a brand name drug in place of a generic, you will pay the brand copay: 20% of the remainder for the cost of the name brand drug plus the difference in cost between the generic and brand name drug.

Exclusions: There is no coverage for the following:

- Over-the-counter (OTC) medications except as required by ACA.
- There is no coverage for fertility drugs. See also the exclusions related to Drugs (Medicines) in the Exclusions section of this booklet. Also, see also the definition of "Experimental and/or Investigational" in the Definitions section.
- Appetite suppressants.
- Drugs for cosmetic purposes such as anabolic steroids, Retin A or medications for hair growth or removal unless prior authorized with the PBM for treatment of an illness or injury.

- Drugs that are not approved by the FDA.
- Erectile dysfunction drugs over established quantity limits.
- Growth Hormones when prescribed for short stature syndrome.
- Immunization agents or biological sera.
- Inpatient medications.
- Drugs in excess of refill limitations or requested more than 12 months after the original prescription has been written.

(24) **Preventive Services:** Preventive services are those services performed for screening purposes when the individual does not have active signs or symptoms of a condition. The wellness/preventive services payable by this Plan are designed to comply with ACA regulations. Preventive services are payable without regard to gender assigned at birth, or current gender status.

If the Plan does not have an In-Network provider who can provide a required item or service, the Plan will cover that item or service when provided or performed by a Non-Network provider and will not impose cost-sharing for that item or service.

The preventive services payable by this Plan are designed to comply with ACA regulations Coverage is provided on an in-network basis with no cost sharing (e.g., no deductibles, coinsurance or copays) and on an out-of-network basis with applicable out-of-network cost sharing for the following services:

- Services described in the United States Preventive Services Task Force (USPSTF) A and B recommendations
- Services described in guidelines issued by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control (CDC), and
- Health Resources and Services Administration (HRSA) guidelines including the American Academy of Pediatrics Bright Futures guidelines and HRSA guidelines relating to services for women.

The associated websites for these guidelines (periodically updated) list the types and frequency of payable preventive services, including immunizations:

- https://www.healthcare.gov/what-are-my-preventive-care-benefits/ with more details at http://www.cdc.gov/vaccines/schedules/hcp/index.html
- http://www.hrsa.gov/womensguidelines/ and
- http://www.uspreventiveservicestaskforce.org/BrowseRec/Index (A and B rated recommendations).

When both preventive services and diagnostic or therapeutic services occur at the same visit, you pay the cost share (e.g., coinsurance and deductible) for the diagnostic or therapeutic services but not for the preventive services.

Preventive services are considered for payment when billed under the appropriate preventive service codes (benefit adjudication depends on accurate claim coding by the providers). If the billing for a wellness service is submitted to the Claims Supervisor with a diagnosis code other than "wellness," claims will be processed under the Plan's usual cost-sharing, including deductible/copay/coinsurance.

Services not covered under the wellness/preventive benefit may be covered under another portion of the medical plan. Additional diagnostic services that are Medically Necessary are covered, subject to the Plan's deductibles, coinsurance or copayments, and all other Plan provisions.

If an ACA preventive service recommendation or guideline does not specify the frequency, method, treatment, or setting for the provision of that service, the Plan will use reasonable medical management techniques (such as age, frequency, location, method) to determine coverage parameters.

Where the information in this document conflicts with newly released ACA regulations affecting preventive care coverage, this Plan will comply with the new requirements on the date required.

The Plan will provide coverage through the last day of the plan year, for any preventive items and services specified in any recommendation or guideline in the ACA, even if the recommendation or guideline changes or is no longer an ACA required preventive service during the plan year. However, to the extent a recommendation or guideline for a required ACA preventive service that was in effect on the first day of a plan year is downgraded to a ''D'' rating, or any item or service associated with any recommendation or guideline is subject to a safety recall or is otherwise determined to pose a significant safety concern by a federal agency authorized to regulate the item or service during a plan year, the Plan will not cover these items and services through the last day of the plan year, and will terminate coverage for those items effective on the date of the safety recall or the date the federal agency determines there is a significant safety concern.

(25) **Private Duty Nursing:** Services must be provided by a licensed nurse (R.N., L.P.N. or L.V.N.). Private duty nursing must be Medically Necessary and not custodial in nature. Coverage will be provided for inpatient nursing care only if a Hospital's intensive care unit is filled or the Hospital has no intensive care unit. Outpatient nursing care will be covered only if it is in lieu of inpatient acute care. Outpatient private duty nursing should be preauthorized with the UM Coordinator.

(26) **Radiology (X-Ray), Nuclear Medicine, Imaging, and Radiation Therapy Services (Outpatient):** Radiology refers to the branch of medicine using x-rays, radiopharmaceuticals (like radioisotopes, intravenous dye or contrast materials), magnetic resonance and ultrasound to create images (pictures) of the body that are used to help in the diagnosis and treatment of disease or injury. Common radiology services include x-rays, CT/MRI/PET and bone scan, ultrasound, imaging, angiography, mammography, fluoroscopy, and bone densitometry. Technical and professional fees associated with diagnostic and curative radiology services, including radiation therapy are also covered. Radiology services are covered only if ordered by a Physician. Some radiology services are covered under the preventive services benefit.

(27) **Reconstructive Services and Breast Reconstruction After Mastectomy:** This Plan complies with the Women's Health and Cancer Rights Act (WHCRA). Coverage is to be

provided in a manner determined in consultation with the attending Physician and Covered Person who is receiving benefits in relation to a mastectomy and who elects breast reconstruction in connection with it. These services may include:

- Reconstruction of the breast on which the mastectomy was performed;
- 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.

Coverage also includes the correction of abnormal congenital conditions in a Dependent child born while the parent of such covered child is enrolled as an Employee or Dependent spouse. In addition, the Plan covers the repair (i) of damage from an Injury that occurred while a person covered under the Plan, and (ii) following Medically Necessary surgery for a Sickness that occurred while covered under the Plan.

(28) **Second and Third Opinions:** The service includes only one Physician office visit per opinion. If the second opinion is requested by the UM 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. Any surgical treatment is allowed a second opinion.

(29) **Skilled Nursing Facility (SNF):** Admission to an SNF must be ordered by a Physician because the patient needs inpatient confinement to further care for the condition that caused the hospital confinement. The degree of care necessitating an SNF confinement must be greater than can be provided in a patient's home, but not so much as to require confinement in a Hospital. A patient must be confined as a bed patient in the SNF. The attending Physician must complete a treatment plan, which includes diagnosis, a proposed course of treatment, and a projected date of discharge from the SNF. The care must be likely to result in a significant improvement in the patient's condition. The SNF confinement must immediately follow a hospital confinement of at least three days.

The professional fees for Physicians and health care practitioners who deliver covered services to patients in a SNF are usually billed separately from the facility fee. In lieu of the above criteria, SNF services will be covered if they are pre-certified as Medically Necessary through the Utilization Review program.

Skilled nursing facility confinement is payable up to 60 days per calendar year.

(30) **Spinal Manipulation**: Services include related ancillary services (e.g., office visits) in addition to spinal manipulation, which must be provided by a licensed provider. It is limited to 12 manipulations per calendar year.

(31) **Therapy:** Services include Habilitative, Cardiac and Pulmonary Rehabilitation, Physical Occupational and Speech Rehabilitation and Vision Therapy services as described below.

Habilitative Services provided for Covered Persons with a Developmental or Physical Disability when all of the following are met:

(i) The treatment is ordered by a Physician and is performed/administered by a Physician or a licensed therapy provider acting within the scope of his or her license.

(ii) The services must be provided in a Physician's office or on an Outpatient basis at a Hospital or Alternate Facility (such as health care facility that provides outpatient rehabilitative services). If required, services may be performed in the home setting.

The Plan may require that a treatment plan be provided, request medical records, clinical notes, or other necessary data to substantiate that initial or continued medical treatment is needed. When the treating provider anticipates that continued treatment is or will be required to permit the Covered Person to achieve measurable improvement progress, the Claim Supervisor may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated goals of treatment, and how frequently the treatment plan will be updated.

Habilitative services can fall into two categories:

- Part of the ASD treatment plan with no maximum number of visits
- Part of the benefits mandated under Missouri Revised Statutes and limited to 90 visits per year.

Rehabilitation Services (Cardiac and Pulmonary):

Services include:

- Cardiac rehabilitation determined by a Physician to be Medically Necessary that are provided (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.

- Pulmonary rehabilitation determined by a Physician to be Medically Necessary, restorative, reasonable and necessary. 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. Pulmonary function testing must show FEV1 of less than 60% predicted. Maintenance programs are not covered.

Rehabilitation Services (Physical, Occupational, and Speech):

Services include:

- Short term active, progressive rehabilitation services (occupational or physical therapy) performed by licensed or duly qualified therapists as ordered by a Physician.

- Inpatient rehabilitation services in an acute Hospital, rehabilitation unit or facility or Skilled Nursing Facility for short term, active, progressive Rehabilitation Services that cannot be provided in an outpatient or home setting.

The professional fees for Physicians and health care practitioners who deliver covered services to patients in an inpatient rehabilitation facility are usually billed separately from the facility fee.

Maintenance rehabilitation, coma stimulation services and habilitation services are not covered.

Inpatient rehabilitation services benefit maximum is 60 days per calendar year at the semi-private room rate.

- **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 Definitions section of the Plan.

- **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 Definitions section of the Plan.

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

Vision: Charges incurred in connection with vision therapy for rehabilitative therapy after brain injury, including stroke, are covered if such therapy is Medically Necessary.

(32) **Transplants (Organ and Tissue):** Coverage is provided only for eligible services directly related to Medically Necessary and non-experimental transplants of human organs or tissue including the facility and professional services, FDA approved drugs, and Medically Necessary equipment and supplies.

Organ/tissue procurement is covered. Procurement includes expenses to find the donated organ/tissue (donor search fees), tests on the potential organ/tissue for compatibility, surgery/procedures to remove the organ/tissue, preservation of the organ/tissue until it can be transplanted and transportation fees to deliver the organ/tissue to the patient/recipient. If the organ donor is a Covered Person and the recipient is not, then this Plan will always pay secondary to any other coverage.

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 Utilization Management Coordinator 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.

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

- Pre-transplant patient evaluation for the Medical Necessity of the transplant
- Hospital charges
- Physician charges
- Tissue typing and ancillary services
- Organ procurement or acquisition

(33) **Vision: Initial Contact Lenses or Glasses:** Coverage is provided for initial contact lenses or glasses 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 two 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 the Plan.

(34) **Weight Management:** 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 Management 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 Management Coordinator for approval. 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 UM Coordinator and meet Medically Necessary criteria. Medically Necessary criteria established by the Utilization Review Coordinator. The surgeon must be designated as a Center of Excellence by the American Society of Metabolic & Bariatric Surgery. 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 UM Coordinator and must participate in the follow-up program, as appropriate, which may include an aftercare support group and Physician visits.

PLAN EXCLUSIONS AND LIMITATIONS

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 a result of rape or incest.

(2) **Alternative or complementary medicine.** Services include, but are not limited to, acupuncture, acupressure, holistic medicine, homeopathy, hypnosis, aroma therapy, massage/massage therapy (unless point therapy and prior authorization is obtained from the UM Coordinator), reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), iridology (study of the iris), auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy and electromagnetic therapy.

(3) **Ambulette transportation.** Other forms of passenger transportation that are available to the public (e.g., buses, taxis or airplanes).

(4) **Blood donor.** Expenses related to blood donors.

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

(6) **Child of a Dependent child.** For medical and Hospital care and costs for the child of a Dependent child, unless that child is otherwise eligible under the Plan.

(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 Care.** Services 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 in lieu of other correctional action.

(9) **Cosmetic.** Care and treatment provided for or in connection with cosmetic and reconstructive procedures except as provided under the Covered Charges section. This includes cosmetic procedures related to non-congenital transsexualism, gender dysphoria or sexual reassignment or change.

(10) **Custodial Care.** Services or supplies provided mainly as a rest cure, maintenance or custodial care.

(11) **Dental implants.** 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.

(12) **Educational.** Educational or vocational testing or training; non-medical self-care or self-help training; and remedial reading and special education.

(13) **Employee of Hospital or Skilled Nursing Facility.** 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 this service.

(14) **Excess of Allowable Charges.** The part of an expense for care and treatment of an injury or sickness that is in excess of the Allowable Charges or more than Usual and Customary charges.

(15) **Exercise programs.** Exercise programs for the 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) **Exclusions.** Charges excluded by the plan design as mentioned in this document.

(17) **Experimental or not Medically Necessary.** Care and treatment that is either Experimental/Investigational or not Medically Necessary. This exclusion shall not apply to the extent that the charge is for routine patient care charges for an individual who is a participant in an approved clinical trial with respect to the treatment of cancer or another life-threatening disease or condition. (Refer to "Clinical Trial" in the Medical Benefits section.) The Plan shall not deny, limit or impose additional conditions on routine patient care costs for items and services furnished in connection with participation in the clinical trial. However, this provision does not require the Plan to pay charges for services or supplies that are not otherwise Covered Charges (including, without limitation, charges which the individual would not be required to pay in the absence of this coverage) or prohibit the Plan from imposing all applicable cost sharing and reasonable cost management provisions.

(18) **Foot and Hand care.** Except as provided below, treatment of corns, calluses and trimming of nails (unless needed in treatment of a metabolic or peripheral-vascular disease and authorized by the Utilization Review Coordinator). The following are covered if Medically Necessary.

- Surgical treatment of toenails;
- Charges for the treatment of flat feet, including purchase of orthopedic shoes or supportive devices that have been approved by a physician; and
- Orthopedic shoes for treatment of other conditions.

(19) **Gene and/or cell (manipulation) therapy.** Care, treatment or services for gene and/or cell (manipulation) therapy that does not meet the criteria for coverage under this Plan and is considered Experimental and/or Investigational or is otherwise excluded under this Plan.

(20) **Genetic testing.** Care is not covered unless it aids diagnosing of a Covered Person with functional abnormalities or who is symptomatic of an illness which may be inheritable and the results of the test will impact the treatment being delivered. Certain genetic testing which is a preventive service required under ACA is covered.

(21) **Habilitative Services.** Services that do not satisfy the requirements of being Habilitative Services and are not covered by the Plan:

- Coverage is excluded for services that are solely educational or vocational in nature or otherwise paid under state or federal law for purely educational services. A service that does not help the Covered Person to meet or maintain functional goals in a treatment plan within a prescribed time frame is not a Habilitative Service.
- Coverage is excluded when the member does not meet criteria for coverage as indicated in the Therapy section of this document.
- Coverage is excluded if the service is considered Experimental or Investigational.
- Coverage is excluded for Custodial Care, respite care, day care, therapeutic recreation, vocational training and residential treatment.
- In the absence of a disabling condition, services to improve general physical condition are excluded from coverage.
- Coverage is excluded for programs that do not require the supervision of Physician and/or a licensed therapy provider.
- Coverage is excluded for confinement, treatment, services or supplies that are required: a) only by a court of law, or b) only for insurance, travel, employment, and school or camp purposes.
- Coverage is excluded for services beyond any visit limits, if any, if specified in the member specific benefit document.
- Coverage is excluded for activities that are solely recreational, social or for general fitness such as, gym and fitness club memberships and fees, health club fees, dancing classes, exercise equipment or supplies.
- Hypnotherapy
- Cognitive behavioral therapy
- Vocational habilitation

(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. However, care and treatment, except hair transplants, related to alopecia areata or scalp infection or as a result of treatment of a medical condition (i.e., chemotherapy for cancer) will have Prescription Drug coverage with a prior authorization on file and coverage for a wig.

(23) **Hearing Aids and Exams Assessments -** Charges for services or supplies in connection with hearing aids (including external or implanted hearing aids) or exams for their fitting, hearing screening assessments, and hearing aid assessments. (Also, refer to “Hearing exams and hearing aids for newborns in the Medical benefits section.

(24) **Illegal Coverage.** Notwithstanding anything to the contrary herein, no benefits will be provided for otherwise Covered Charges to the extent that the Plan Administrator and/or the Claims Supervisor, in its discretion, reasonably believes that providing benefits for such services or treatments would be illegal.

(25) **Illegal occupation.** 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.

(26) **Infertility.** 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.

(27) **Lost or stolen 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.

(28) **Maintenance.** Care and treatment for Maintenance.

(29) **Marital or pre-marital counseling.** Care and treatment for marital or pre-marital counseling.

(30) **Military-related Illness or Injury coverage.** Care in connection with a military-related Illness or Injury 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.

(31) **Modification.** Expenses for modification of home or living quarters due to medical disabilities.

(32) **Never events.** Services, supplies, care or treatment as a result of a never events.

(33) **No coverage/no charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.

(34) **No legal obligation.** Charges incurred for which the Plan has no legal obligation to pay.

(35) **Non-compliance.** Charges in connection with treatments or medications where the Covered Person is non-compliant with prescribed treatment even after counseling with the Claims Supervisor. If it is determined by the Claims Supervisor that a Covered Person is repeatedly non-compliant with prescribed treatment and the non-compliance has and will continue to result in additional treatment, the Claims Supervisor may, at its discretion, deny coverage of any additional treatment. The Covered Person will be notified of the effective date and condition, treatments and/or medications that have been determined to be ineligible. The Claims Supervisor will review medical records for compliance by the Covered Person to determine eligibility of additional treatment.

(36) **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.

(37) **Non-medical ancillary care, services or treatment.** Services including but not limited to, vocational rehabilitation, behavioral training, sleep therapy, employment counseling, driving safety and services, training or educational therapy for learning disabilities, developmental delays, mental retardation or autism unless otherwise noted.

(38) **Non-prescription drug/vitamins/supplements**. Charges for non-prescription drugs, vitamins and nutritional supplements unless necessary for the treatment of an Illness and is approved by the UM Coordinator. (Refer to General Plan Information for contact information.)

(39) **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.

(40) **Obesity**. Care and treatment of obesity, weight loss or dietary control. Medical testing, medications, and office visits associated with any weight loss program, including medications for the purpose of appetite suppression, weight loss, or binge eating. Behavioral or community support programs. Charges incurred for comorbid conditions as a result of morbid obesity (such as treatment for osteoarthritis in lower extremities, heart and blood pressure treatment, etc.) will be eligible as long as it is not a treatment for weight management as previously explained. Refer to Weight Management in the Medical Benefits section for details.

(41) **Occupational services.** 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. If the Covered Person is entitled to these benefits but did not receive them due to a failure to follow that plan's guidelines, this Plan will not consider those eligible charges. The Plan will not pay for any medical benefits related to a condition for which the Covered Person received a settlement for future medical benefits from a workers' compensation carrier.

(42) **Orthotic replacement.** Replacement will not be covered unless (i) there is sufficient change in the Covered Person's physical condition to make the original device no longer functional or (ii) 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. The benefit payment will be based on the cost of the treatment which provides professionally satisfactory results at the most cost-effective level.

(43) **Outside the U.S.** Care, treatment or supplies outside of the U.S**.** if travel is for the sole purpose of obtaining medical service. 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.

(44) **Personal comfort items.** 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) **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; and investigation or obsolete devices and supplies.

Replacement of protheses will not be covered unless (i) there is sufficient change in the Covered Person's physical conditions to make the original device no longer functional or (ii) the device has reached its life expectancy and needs to be replaced (but no more frequently than every 5 years). 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.

(46) **Psychoanalysis.** 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.

(47) **Public program.** To the extent that expenses for the Covered Person or any Dependent is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid.

(48) **Required Prior Authorization.** Care, services or treatment to the extent of the exclusions imposed by any certification requirement shown in the Schedule of Benefits;

(49) **Resides with/related provider.** Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person or Dependent as a spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.

(50) **Reversal of surgical sterilization.** Care and treatment for reversal of surgical sterilization.

(51) **Routine Care.** Routine or periodic examinations, screening examinations, evaluations procedures, preventive medical care, or treatment or services, not directly related to the diagnosis or treatment of a specific Injury, Sickness or pregnancy-related condition which is known or reasonably suspected will only be covered if the benefit is listed in the Schedule of Benefits and explained in the Medical Benefits section or required by applicable law

(52) **Routine dental 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.

(53) **Routine vision services.** Radial keratotomy or other eye surgery to correct refractive disorders. Also, excludes 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.

(54) **Safety devices.** Charges for safety devices such as helmets (except cranial molding helmets), shower chairs, restraints, telephone alert systems, safety eyeglasses and safety enclosure bed frames/canopies (i.e., Vail enclosures, Posey bed enclosures/canopy systems) which are used to prevent a patient from leaving their bed. These devices are not primarily medical in nature and are therefore considered not Medically Necessary.

(55) **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.

(56) **Sexual dysfunction.** Care, services or treatment for sexual dysfunction unrelated to organic disease.

(57) **Surgery.** Surgery performed for psychological or emotional reasons.

(58) **Travel.** 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.

(59) **United State Government.** 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 an 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).

(60) **Vision Therapy**. Charges for vision therapy except as explained in the Medical Benefits section. It is not covered for learning / reading disabilities, to promote learning or for Maintenance programs.

(61) **War.** Services for or in connection with an injury or sickness that is due to war, declared or undeclared.

COORDINATION OF BENEFITS

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 Dependent 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.

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.

a. 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.

b. Plans with a coordination provision will pay their benefits up to the Allowable Charge:

   i. 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").

   ii. 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.

   iii. 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.

   iv. 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:

      (a) 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;

      (b) 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.

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

      (a) 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.

      (b) 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.

(c) 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.

(d) 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.

(e) 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.

c. 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.

d. 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:

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

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

iii. 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.

iv. 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.

v. 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.

e. 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.

f. The Plan will pay primary to Tricare to the extent required by federal law.

g. 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.

Coordination with Medicaid

For purposes of coordinating with Medicaid, this Plan will assume primary payer status for any Participant or Alternate Recipient who is entitled to benefits under a state plan for medical assistance approved under Title XIX of the Social Security Act (Medicaid), unless otherwise required by applicable law. Payment for benefits with respect to a Participant or Alternate Recipient will be made in accordance with any assignment of rights made by or on behalf of such Participant or Alternate Recipient as required by Medicaid under Section 1912(a)(1)(A) of the Social Security Act, 42 U.S.C. 1396k(a)(1)(A). If this Plan has the legal obligation to pay benefits and payment has been made under Medicaid, payment for benefits under this Plan will be made in accordance with state Medicaid law, which provides that the state acquires the rights of the Participant or Alternate Recipient for payment of such benefits.

CLAIMS PROCEDURE AND CLAIMS REVIEW PROCEDURE

Internal Claims and Appeal Procedures

This section describes the procedures followed by the City of Springfield Group Health Plan in making internal claim decisions and reviewing appeals of denied claims. These procedures apply to claims for medical and prescription drug benefits.

The Plan's internal claims and appeal procedures are designed to provide you with full, fair, and fast claim review and so that Plan provisions are applied consistently with respect to you and other similarly situated participants and dependents. In addition, the Plan must consult with a health care professional with appropriate training and experience when reviewing an adverse benefit determination that is based in whole or in part on a medical judgment (such as a determination that a service is not Medically Necessary or appropriate, or is Experimental or Investigational).

The internal claims process pertains to determinations made by the appropriate Claims Supervisor about whether a request for benefits (known as an initial "claim") is payable. If the appropriate Claims Supervisor denies your initial claim for benefits (known as an "adverse benefit determination"), you have the right to appeal the denied claim under the Plan's internal appeals process.

General Information

Claims Supervisor(s)

The Plan Administrator has delegated responsibility for initial claims decisions to the following companies/organizations:

Appropriate Claims Supervisor	Types of Claims Processed
Med Pay, Inc.	• Medical Post-Service Claims
MPI Care	➢ Urgent, Concurrent and Pre-service Medical Claims

Please see Page ii for contact information.

Days Defined

For the purpose of the initial claims and appeal processes, "days" refers to calendar days, not business days.

Discretionary Authority of Plan Administrator and Designees

In carrying out their respective responsibilities under the Plan, the Plan Administrator, other Plan fiduciaries, Claims Supervisor, and other individuals to whom responsibility for the administration of the Plan has been delegated, have discretionary authority to interpret the terms of the Plan and to interpret any facts relevant to the determination, and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made under that discretionary authority will be given full force and effect unless it can be shown that the interpretation or determination was arbitrary and capricious.

Adverse Benefit Determination

An adverse benefit determination, for the purpose of the internal claims and appeal process, means:

- A denial, reduction, or termination of, or a failure to provide or make payment in whole or in part for a benefit, including a determination of an individual's eligibility to participate in the Plan or a determination that a service is not a covered benefit;

- A reduction of a benefit resulting from the application of any utilization review decision, source-of-injury exclusion, network exclusion, or other limitation on an otherwise covered benefit, or failure to cover an item or service for which benefits are otherwise provided because it is determined to be not Medically Necessary or Experimental or Investigational; or

- A rescission of coverage, whether or not there is an adverse effect on any particular benefit.

Authorized Representative

The 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 an initial claim and appeal an adverse benefit determination under the Plan. An authorized representative under the Plan also includes a health care professional. 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. A health care provider with knowledge of your medical condition may act as your authorized representative in connection with an Urgent Care Claim without filing a written statement with the Plan.

The Plan requires you to provide a written statement declaring your designation of an authorized representative (except for a health care professional who does not require a written statement in order to appeal a claim for a claimant)] along with the representative's name, address, phone number, and email address. To designate an authorized representative, you must submit a completed authorized representative form (available from the Claims Supervisor).

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 rather than 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 available from and to be returned to the Claims Supervisor.

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.

Health Care Professional

A health care professional, for the purposes of the claims and appeals provisions, means a Physician or other health care professional licensed, accredited or certified to perform specified health services consistent with state law.

Definition of a Claim

A claim is a request for a Plan benefit made by you or your covered Dependent (also referred to as "claimant") or your authorized representative in accordance with the Plan's reasonable claims procedures.

Types of Claims

Health benefit claims can be filed for medical and prescription drug benefits.

There are four categories of health claims as described below:

- ***Pre-Service Claims*** **(applicable to medical and prescription drug benefits)** - A Pre-Service Claim is a claim for a benefit that requires approval of the benefit (in whole or in part) before health care is obtained.

- ***Urgent Care Claims*** **(applicable to medical benefits)** – An Urgent Care Claim is any Pre-Service Claim for health care treatment that (i) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function if pre-service standards were applied, or (ii) in the opinion of the claimant's attending health care provider with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

- ***Concurrent Claims*** **(applicable to medical benefits)** - A Concurrent Claim is a claim that is reconsidered after an initial approval has been made and results in a reduced or terminated benefit. Also, a Concurrent Claim can pertain to a request for an extension of a previously approved treatment or service.

- ***Post-Service Claims*** **(applicable to medical and prescription drug benefits)** - A Post-Service Claim is a request for benefits under the Plan that is not a Pre-Service Claim. Post-Service Claims are requests that involve only the payment or reimbursement of the cost of the care that has already been provided. A standard paper claim or electronic bill submitted for payment after services have been provided are examples of a Post-Service Claim. A claim regarding the rescission of coverage will be considered to be a Post-Service Claim.

Claim Elements

An initial claim must include the following elements to trigger the Plan's internal claims process:

- Be written or electronically submitted (oral communication is acceptable only for Urgent Care Claims);

- Be received by the Plan Administrator or Claims Supervisor (as applicable);

- Name a specific individual participant and his/her Plan Identification Number;

- Name a specific claimant and his/her date of birth;
- Name a specific medical condition or symptom;
- Provide a description and date of a specific treatment, service or product for which approval or payment is requested (must include an itemized detail of charges);
- Identify the provider's name, address, phone number, professional degree or license, and federal tax identification number (TIN); and
- When another plan is primary payer, include a copy of the other Plan's Explanation of Benefits (EOB) statement along with the submitted claim.

A request is *not* a claim if it is:

- Not made in accordance with the Plan's benefit claims filing procedures described in this section;
- Made by someone other than you, your covered dependent, or your (or your covered dependent's) authorized representative;
- Made by a person who will not identify himself or herself (anonymous);
- A casual inquiry about benefits such as verification of whether a service/item is a covered benefit or the estimated allowed cost for a service;
- A request for prior approval where prior approval is not required by the Plan;
- An eligibility inquiry that does not request benefits. However, if a benefit claim is denied on the grounds of lack of eligibility, it is treated as an adverse benefit determination and the individual will be notified of the decision and allowed to file an appeal;
- The presentation of a prescription to a retail pharmacy or mail order pharmacy that the pharmacy denies at the point of sale. After the denial by the pharmacy, you may file a claim with the Plan;

If you submit a claim that is not complete or lacks required supporting documents, the Plan Administrator or Claims Supervisor, as applicable, will notify you about what information is necessary to complete the claim. This does not apply to simple inquiries about the Plan's provisions that are unrelated to any specific benefit claim or which relate to proposed or anticipated treatment or services that do not require prior approval.

Initial Claim Decision Timeframes

Claim Filing Deadline

Claims should be filed within fifteen (15) months following the date charges were incurred. Failure to file claims within the time required will not invalidate or reduce any claim if it was not reasonably possible to file the claim within such time. However, in that case, the claim must be submitted as soon as reasonably possible and in no event later than fifteen (15) months from the date the charges were incurred.

The time period for making a decision on an initial claim request starts as soon as the claim is received by the appropriate Claims Supervisor, provided it is filed in accordance with the Plan's reasonable filing procedures, regardless of whether the Plan has all of the information necessary to decide the claim. A claim may be filed by you, your covered dependent, an authorized representative, or by a network provider. In the event a claim is filed by a provider, the provider will not automatically be considered to be your authorized representative.

Notice of Adverse Benefit Determination

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

- **Pre-Service Claims (applicable to medical benefits)**

  Claims for Pre-Service (that are not for Urgent Care) will be decided no later than fifteen (15) days after receipt by the appropriate Claims Supervisor. You will be notified in writing (or electronically, as applicable) within the initial fifteen (15) day period whether the claim was approved or denied (in whole or in part).

  The time for deciding the claim may be extended by up to fifteen (15) days due to circumstances beyond the Claims Supervisor's control (e.g., inability of a medical reviewer to meet a deadline); provided you are given written (or electronic, if applicable) notification before the expiration of the initial fifteen (15) day determination period.

  If you improperly file a Pre-Service Claim, the Claims Supervisor will notify you in writing (or electronically, as applicable) as soon as possible, but in no event later than five (5) days after receiving the claim. The notice will describe the proper procedures for filing a Pre-Service Claim. Thereafter, you must re-file a claim to begin the Pre-Service Claim determination process.

  If a claim cannot be processed due to insufficient information, the Claims Supervisor will notify you in writing (or electronically, as applicable) about what specific information is needed before the expiration of the initial fifteen (15) day determination period. Thereafter, you will have 45 days following your receipt of the notice to supply the additional information. If you do not provide the information during the 45-day period, the claim will be denied (i.e., an adverse benefit determination). The claim decision deadline is suspended until the earlier of 45 days or the date the Claims Supervisor receives your response to the request for information. The Claims Supervisor then has fifteen (15) days to make a decision and notify you in writing (or electronically, as applicable).

- **Urgent Care Claims (applicable to medical benefits)**

  In the case of an Urgent Care Claim, if a health care professional with knowledge of your medical condition determines that a claim constitutes an Urgent Care Claim, the health care professional

will be considered by the Plan to be your authorized representative bypassing the need for completion of the Plan's written authorized representative form.

The appropriate Claims Supervisor will decide claims for Urgent Care as soon as possible, but in no event later than 72 hours after receipt of the claim. The Claims Supervisor will orally communicate its decision telephonically to you and your health care professional. The determination will also be confirmed in writing (or electronically, as applicable) no later than three (3) days after the oral notification.

If you improperly file an Urgent Care Claim, the Claims Supervisor will notify you and your health care professional as soon as possible, but in no event later than 24 hours after receiving the claim. The written (or electronic, as applicable) notice will describe the proper procedures for filing an Urgent Care Claim. Thereafter, you must re-file a claim to begin the Urgent Care Claim determination process.

If a claim cannot be processed due to insufficient information, the Claims Supervisor will provide you and your health care professional with a written (or electronic, as applicable) notification about what specific information is needed as soon as possible and no later than 24 hours after receipt of the claim. Thereafter, you will have not less than 48 hours following receipt of the notice to supply the additional information. If you do not provide the information during the period, the claim will be denied (i.e., an adverse benefit determination). Written (or electronic, as applicable) notice of the decision will be provided to you and your health care professional no later than 48 hours after the Claims Supervisor receives the specific information or the end or the period given for you to provide this information, whichever is earlier.

- **<u>Concurrent Claims</u> (applicable to medical benefits)**

If a decision is made to reduce or terminate an approved course of treatment, you will be provided with a written (or electronic, as applicable) notification sufficiently in advance to allow you to request an appeal and obtain a determination before the benefit is reduced or terminated.

A Concurrent Claim that is an Urgent Care Claim will be processed according to the Plan's internal appeals procedures and timeframes described above under the Urgent Care Claim section.

A Concurrent Claim that is not an Urgent Care Claim will be processed according to the Plan's internal appeals procedures and timeframes applicable to the Pre-Service or Post-Service Claim, as applicable, provisions described above in this section.

If the Concurrent Care Claim is approved you may be notified orally followed by written (or electronic, as applicable) notice provided no later than three (3) calendar days after the oral notice.

If the Concurrent Care Claim is denied, in whole or in part, you will be notified orally with written (or electronic, as appropriate) notice.

- **<u>Post-Service Claims</u> (applicable to medical and prescription drug benefit claims)**

  Claims for Post-Service treatments or services will be decided no later than 30 days after receipt by the appropriate Claims Supervisor. You will be notified in writing (or electronically, as applicable) within the 30-day initial determination period if the claim is denied (in whole or in part).

  The time for deciding the claim may be extended by fifteen (15) days due to circumstances beyond the Claims Supervisor's control ; provided you are given written (or electronic, as applicable) notification before the expiration of the initial 30-day determination period.

  If a claim cannot be processed due to insufficient information, the Claims Supervisor will notify you in writing (or electronically, as applicable), before the expiration of the initial 30-day determination period, about what information is needed. Thereafter, you will have 45 days after your receipt of the notice to supply the additional information. If you do not provide the information during the 45-day period, the claim will be denied (i.e., an adverse benefit determination). During the period in which you are permitted to supply additional information, the normal period for making a decision on the claim is suspended. The claim decision deadline is suspended until the earlier of 45 days or until the date the Claims Supervisor receives your written response to the request for information. The Claims Supervisor then has fifteen (15) days to make a decision and notify you in writing (or electronically, as applicable).

Initial Determinations of Benefit Claims

Notice of Adverse Benefit Determination

If the Claims Supervisor denies your initial claim, in whole or in part, you will be provided notice of the denial (known as a "notice of adverse benefit determination"). The notice of adverse benefit determination will be given to you in writing (or electronically, as applicable) within the timeframe required to make a decision on a particular type of claim. The notice of adverse determination must:

- Contact information for the Plan's Claims Supervisor;
- Identify the claim involved (e.g., date of service, health care provider, claim amount if applicable, denial code and its corresponding meaning);
- Give the specific reason(s) for the denial (including a statement that the claimant has the right to request the applicable diagnosis and treatment code and their corresponding meanings; however, such a request is not considered to be a request for an internal appeal or external review);
- If the denial is based on a Plan standard that was used in denying the claim, a description of such standard.
- Reference the specific Plan provision(s) on which the denial is based;
- Describe any additional material or information needed to perfect the claim and an explanation of why such added information is necessary;
- Provide the opportunity, upon request, without charge, reasonable access to and copies of all documents, records, and other information relevant to the initial claims for benefits.

- Provide an explanation of the Plan's internal appeal and external review processes along with time limits and information about how to initiate an appeal and an external review;

- If the denial was based on an internal rule, guideline, protocol or similar criteria, a statement will be provided that such rule, guideline, protocol or similar criteria that was relied upon will provided to you free-of-charge upon request;

- If the denial was based on Medical Necessity, Experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided to you free-of-charge upon request;

- For Urgent Care Claims, the notice will describe the expedited internal appeal and external review processes applicable to Urgent Care Claims. In addition, the required determination may be provided orally and followed with written (or electronic, as applicable) notification; and

- Provide information about the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist you with the Plan's internal claims and appeal processes as well as with the external review process.

Internal Appeal Request Deadline

- ***Health Care Claims*** **(applicable to medical and prescription drug benefits)**

  If an initial health care claim is denied (in whole or in part) and you disagree with the Claims Supervisor's decision, you or your authorized representative may request an internal appeal. You have 180 calendar days following receipt of a notice of adverse benefit determination to submit a written request for an internal appeal. The Plan will not accept appeals filed after this 180-day period. Under limited circumstances, explained below in the section on External Review, you may bypass the Plan's internal claims and/or appeal processes and file a request for an external review.

Internal Appeals Process

Appeal Procedures

The Plan maintains a two-level internal appeals process.

To file an internal appeal, you must submit a written statement to the Plan at the following address:

Med Pay, Inc.
P.O. Box 10909
Springfield, MO 65808
800-777-9087 (Phone)
417-886-2276 (Fax)
https://www.med-pay.com/contact-us.html

Appeal requests involving Urgent Care Claims may be made orally by calling the Claims Supervisor at the telephone number listed above.

Your request for an internal appeal must include the specific reason(s) why you believe the initial claim denial was improper. You may submit any document that you feel is appropriate to the internal appeal determination, as well as submitting any written issues and comments.

As a part of its internal appeals process, the Plan will provide you:

- Upon request and without charge, reasonable access to and copies of all documents, records and other information relevant to your initial claim for benefits;

- The opportunity to submit to the Plan written comments, documents, records and other information relating to your initial claim for benefits;

- A reasonable opportunity to respond to new information by presenting written evidence and testimony;

- A full and fair review by the Plan that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial claim determination;

- The Plan will automatically provide you free of charge, with any new or additional evidence or rationale considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied initial claim. Such evidence or rationale will be provided as soon as possible once it becomes available to the Plan and sufficiently in advance of the date on which notice of an adverse determination on appeal is scheduled to be provided to you. If the new or additional evidence or rationale is received by the Plan so late that it would be impossible to provide it to you in time for you to have a reasonable opportunity to respond, then the period for providing a notice of a final adverse benefit determination will be delayed until you have had a reasonable opportunity to respond. After you respond (or do not respond after having a reasonable opportunity to do so), the Plan (acting in a reasonable and prompt manner) will notify you of its benefit determination upon appeal as soon as it can provide a notice of determination, taking into account any medical exigencies.

- A review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate fiduciary or fiduciaries of the Plan who is neither the individual who made the initial adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual; and

- The Plan will provide you with continued coverage during the pendency of the appeal process.

In deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is Experimental, Investigational, not Medically Necessary or appropriate, the Plan will:

  - Consult with a health care professional who has appropriate experience in the field of medicine involved in the medical judgment; and

  - Is neither an individual who was consulted in connection with the initial adverse benefit determination that is the subject of the appeal nor the subordinate of any such individual; and

- Provide, upon request, the identification of medical or vocational experts consulted in the determination of your appeal.

Appeal Determination Timeframes

➢ ***Health Care Claims***

- ***Pre-Service Claims (applicable to medical benefits).*** Under the Plan's two (2) level appeals process, the Plan sends the first level of review to the appropriate Claims Supervisor who will make the first level determination on the internal appeal of your initial Pre-Service Claim no later than fifteen (15) calendar days from the Plan's receipt of the appeal. You will be sent a written (or electronic, as applicable) notice of the appeal determination. If you are dissatisfied with the first level of appeal review, you may request a second level of review by the City of Springfield Health Plan Appeals Committee. You will have 90 calendar days from the date you received the notice of the first level review determination to request a second level appeal review by sending a written request to the Director of Human Resources for the City of Springfield. A second level appeal determination will be made no later than fifteen (15) days from the Plan's receipt of your request for a second level appeal review. No extension of the Plan's internal appeal review timeframes is permitted.

- ***Urgent Care Claims (applicable to medical benefits).*** This is an expedited internal appeals process under which a written notice regarding a decision on the approval or denial of the internal appeal will be sent to you (and your health care professional) no later than within 72 hours of the Plan's receipt of your (oral or written) request for appeal. If your situation involves an urgent medical condition, for which the timeframe for completing an expedited internal appeal would seriously jeopardize your ability to regain maximum function, and the claim involves a medical judgment or a rescission of coverage, you may seek an expedited external review at the same time that you request an expedited internal appeal (you must seek both).

- **Concurrent Claims *(applicable to medical benefits).*** You may request an internal appeal of a Concurrent Claim by submitting the request orally (for an Urgent Care Claim) or in writing to the Claims Supervisor listed at the beginning of this section. A determination will be made on the internal appeal and you will be notified as soon as possible before the benefit is reduced or treatment is terminated.

- **Post-Service Claims *(applicable to medical and prescription drug benefits).***

  Under the Plan's two (2) level appeal process, the Plan routes the first level of review to the appropriate Claims Supervisor who will make the first level determination on the appeal of your initial Post-Service Claim no later than 30 calendar days from the Plan's receipt of the appeal request. There is no extension permitted in the two (2) level appeal process. Within this 30-day period, you will be sent a written (or electronic, as appropriate) notice of the appeal determination. If the first level appeal determination results in an adverse benefit determination, you will have 90 calendar days from the date the first level appeal is denied to request a second level appeal review in writing to the City of Springfield Health Plan Appeals Committee. The City of Springfield Health Plan Appeals Committee will then make a second level determination no later than 30 calendar days from its receipt of the second level appeal. You will then be provided with a written (or electronic, as applicable) notification of the second-

level appeal determination no later than 30 days after the Plan's receipt of your request for a second level appeal.

Notice of Adverse Benefit Determination Upon Appeal

A written (or electronic, as applicable) notice of the appeal determination must be provided to you that includes:

- The specific reason(s) for the adverse benefit determination upon appeal, including (i) the denial code (if any) and its corresponding meaning, (ii) a description of the Plan's standard (if any) that was used in denying the claim, and (iii) a discussion of the decision;
- Reference to the specific Plan provision(s) on which the denial is based;
- A statement that you are entitled to receive upon request, free access to and copies of documents relevant to the claim;
- An explanation of the external review process, along with any time limits and information about how to initiate a request for an external review;
- If the denial was based on an internal rule, guideline, protocol or similar criterion, a statement must be provided that such rule, guideline, protocol or criterion will be provided free of charge, upon request;
- If the denial was based on a medical judgement (Medical Necessity, Experimental or Investigational), a statement must be provided that an explanation regarding the scientific or clinical judgement for the denial will be provided free of charge, upon request; and
- Disclosure of the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist you with internal claims and appeals and external review processes.

This concludes the appeal process under this Plan. The Plan does not offer a voluntary appeal process.

Limitation On When A Lawsuit May Be Started

You or any other claimant may not start a lawsuit or other legal action to obtain Plan benefits, including proceedings before administrative agencies, until after all administrative procedures have been exhausted (including this Plan's internal claims and appeal procedures described in this section) for every issue deemed relevant by the claimant, or until 90 days have elapsed since you filed a request for appeal review if you have not received a final decision or notice that an additional 60 days will be necessary to reach a final decision. In addition, you are not required to exhaust external review before seeking judicial remedy.

No lawsuit may be started more than three years after the end of the year in which services were provided.

Elimination of Conflict of Interest

To ensure that the persons involved with adjudicating claims and appeals (such as claim adjudicators and medical experts) act independently and impartially, decisions related to those persons' employment status (such as decisions related to hiring, compensation, promotion, termination or retention), will not be made on the basis of whether that person is likely to support a denial of benefits.

External Review of Claims

If your initial claim for health care benefits has been denied (i.e., an adverse benefit determination) in whole or in part, and you are dissatisfied with the outcome of the Plan's internal claims and appeals process, you may (under certain circumstances) be able to seek external review of your claim by an Independent Review Organization ("IRO"). This process provides an independent and unbiased review of eligible claims in compliance with the Affordable Care Act.

Claims Eligible For The External Review Process

Post-Service, Pre-Service, Urgent Care, and Concurrent Care Claims, in any dollar amount, are eligible for external review by an IRO if:

- An eligible Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) by the Plan that involves medical judgment (including, but not limited to, those based on the Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; its determination that a treatment is Experimental or Investigational; its determination whether a Claimant or beneficiary is entitled to a reasonable alternative standard for a reward under a wellness program; its determination whether a Plan is complying with the nonquantitative treatment limitation provisions of Code section 9812 and § 54.9812-1, which generally require, among other things, parity in the application of medical management techniques), as determined by the external reviewer.

- An Adverse Benefit Determination that involves consideration of whether the Plan is complying with the surprise billing and cost-sharing protections set forth in the No Surprises Act.

- A rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

Claims Not Eligible For The External Review Process

The following types of claims are not eligible for the external review process:

- Claims that involve only contractual or legal interpretation without any use of medical judgment.

- A determination that you or your dependent are not eligible for coverage under the terms of the Plan.

- Claims that are untimely, meaning you did not request review within the four (4) month deadline for requesting external review.

- Claims for which the Plan's internal claims and appeals procedure has not been exhausted (unless a limited exception applies).

- Claims that relate to benefits that the Plan provides through insurance since they are subject to the insurance company's external review process, not this process.

In general, you may only seek external review after you receive a "final" adverse benefit determination under the Plan's internal appeals process. A "final" adverse benefit determination means the Plan has continued to deny your initial claim in whole or part and you have exhausted the Plan's internal claims and appeals process.

Under limited circumstances, you may be able to seek external review before the internal claims and appeals process has been completed:

- If the Plan waives the requirement that you complete its internal claims and appeals process first.

- In an urgent care situation (see "Expedited External Review Of An Urgent Care Claim"). Generally, an urgent care situation is one in which your health may be in serious jeopardy or, in the opinion of your health care professional, you may experience pain that cannot be adequately controlled while you wait for a decision on your internal appeal.

- If the Plan has not followed its own internal claims and appeals process and the failure was more than a minor error. In this situation, the internal claims and appeal is "deemed exhausted," and you may proceed to external review. If you think that this situation exists, and the Plan disagrees, you may request that the Plan explain in writing why you are not entitled to seek external review at this time.

External Review Of A Standard (Non-Urgent Care) Claim

Your request for external review of a standard (not Urgent Care) claim must made in writing within four (4) months after you receive notice of an adverse benefit determination.

Because the Plan's internal claims and appeals process generally must be exhausted before external review is available, external review of standard claims will ordinarily only be available after you receive a "final" adverse benefit determination following the exhaustion of the Plan's internal claims and appeals process.

Submit your request for the standard external review process to:

Director of Human Resources
City of Springfield
Busch Municipal Bldg., 3rd Floor
840 Boonville Avenue
Springfield, MO 65802
417-864-1607 (Phone)
417-864-2041 (Fax)
HR@springfieldmo.gov (email)

Preliminary Review Of A Standard (Non-Urgent Care) Claim By The Plan

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

- 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, you were covered at the time the health care item or service was provided.

- The adverse benefit determination satisfies the above-stated requirements for a claim eligible for external review and does not, for example, relate to your failure to meet the requirements for eligibility under the terms of the Plan; or to a denial that is based on a contractual or legal determination, or a failure to pay premiums causing a retroactive cancellation of coverage.

- You have exhausted the Plan's internal claims and appeals process (or a limited exception allows you to proceed to external review before that process is completed).

- Your request is complete, meaning that you have provided all of the information or materials required to process an external review.

Within one (1) business day of completing its preliminary review, the Plan will notify you in writing whether:

- Your request is complete and eligible for external review.

- Your request is complete but not eligible for external review. (In this situation, the notice will explain why external review is not available, and provide contact information for the Department of Insurance.

- Your request is incomplete. (In this situation, the notice will describe the information or materials needed to make the request complete. You must provide the necessary information or materials within the four (4) month filing period, or, if later, within 48 hours after you receive notification that your request is not complete.)

Review Of A Standard (Not Urgent Care) Claim By The IRO

If your request is complete and eligible for external review, the Plan will assign it to an accredited IRO. The Plan has arranged for at least three (3) accredited IROs to provide external review of claims, and it rotates assignments among these IROs. In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of claims.

Once the claim has been assigned to an IRO, the following procedures apply:

- The IRO will timely notify you in writing that your request is accepted for external review.

- The IRO will explain how you may submit additional information regarding your claim if you wish. In general, you must provide additional information within ten (10) business days from the original submission. The IRO is not required to, but may, accept and consider additional information you submit after the ten (10) business day deadline.

- Within five (5) business days after the claim has been assigned to the IRO, the Plan will provide the IRO with the documents and information it considered in making its adverse benefit determination.

- If you submit additional information related to your claim, the IRO must forward that information to the Plan within one (1) business day. Upon receipt of any such information (or at any other

time), the Plan may reconsider its adverse benefit determination regarding the claim that is the subject of the external review. Any reconsideration by the Plan will not delay the external review. If Plan reverses its determination after it has been assigned to an IRO, the Plan 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.

- The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim *de novo,* meaning that the IRO is not bound by the Plan's previous internal claims and appeal decisions. However, the IRO must review the Plan's terms to ensure that its decision is not contrary to the terms of the Plan, unless those terms are inconsistent with applicable law. For example, the IRO must observe all of the Plan's standards, including standards for clinical review, Medical Necessity, appropriateness, health care setting, level of care, and effectiveness of a covered benefit.

- To the extent additional information or materials are available and appropriate, the assigned IRO may consider the 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).

- In a standard case, the IRO will provide written notice of its final decision to you and the Plan within 45 days after the IRO receives the request for the external review.

The IRO's decision notice will contain:

- A general description of the reason(s) 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), and the reason for the previous denial.

- The date that the IRO received the assignment to conduct the external review and the date of the IRO decision.

- References to the evidence or documents, including the specific coverage provisions and evidence-based standards, considered in reaching its decision.

- A discussion of the principal reason(s) for the decision, including the rationale for the decision and any evidence-based standards upon which it relied.

- A statement that the IRO's decision is binding on you and the Plan, except to the extent that other remedies may be available to you or the Plan under applicable state or federal law.

- A statement that judicial review may be available to you.

- A statement regarding assistance that may be available to you from an applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act.

Missouri Division of Insurance
301 W. High St., Room 530
Jefferson City, MO 65101

(573) 751- 4126
https://insurance.mo.gov/consumers/

Expedited External Review Of An Urgent Care Claim

You may request an expedited external review in the following situations if:

- You receive an adverse benefit determination regarding your initial claim 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.

- You receive a "final" adverse benefit determination after exhausting the Plan's internal appeals procedure that (i) involves a medical condition for which the timeframe for completion of an standard external review would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function; or (ii) concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, and you have not yet been discharged from a facility.

Submit your request for expedited external review to:

Director of Human Resources
City of Springfield
Busch Municipal Bldg., 3rd Floor
840 Boonville Avenue
Springfield, MO 65802
417-864-1607 (Phone)
417-864-2041 (Fax)
HR@springfieldmo.gov (email)

Preliminary Review Of An Urgent Care Claim By The Plan

As soon as possible upon receipt of a request for expedited external review, the Plan will complete a preliminary review of the request to determine whether the requirements for preliminary review are met (as described above for the standard claim external review process). The Plan will defer to your attending health care professional's determination that a claim constitutes "urgent care." The Plan will immediately notify you (e.g., telephonically, via fax) whether your request for review meets the requirements for expedited review, and if not, it will provide or seek the information described above for the standard claim external review process.

Review Of An Urgent Care Claim By The IRO

Upon a determination that a request is complete and eligible for an expedited external review following the preliminary review, the Plan will assign an accredited IRO. The Plan has arranged for at least three (3) accredited IROs to provide external review of claims and rotates assignments among those IROs. In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of claims.

The Plan will expeditiously provide or transmit to the IRO all necessary documents and information that it considered in making its internal adverse benefit determination.

The 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 IRO must review the claim *de novo* meaning that it is not bound by any previous decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO decision must not be contrary to the terms of the plan, unless the terms are inconsistent with applicable law. For example, the IRO must observe all of the Plan's standards, including standards for clinical review, Medical Necessity, appropriateness, health care setting, level of care, and effectiveness of a covered benefit.

The IRO will provide notice of the final external review decision, in accordance with the requirements set forth above for the standard claim external review process, as expeditiously as your medical condition or circumstances require, but not more than seventy-two (72) hours after the IRO receives the request for an expedited external review. If notice of the IRO decision is not provided to you in writing, the IRO must provide written confirmation of the decision to you and the Plan within forty-eight (48) hours after the decision is made.

What Happens After the IRO Decision is Made?

- If the IRO's final external review decision reverses the Plan's internal adverse benefit determination, upon the Plan's receipt of such reversal, the Plan will immediately provide coverage or payment for the reviewed claim. However, even after providing coverage or payment for the claim, the Plan may, in its sole discretion, seek judicial remedy to reverse or modify the IRO's decision.

- If the final external review upholds the Plan's internal adverse benefit determination, the Plan will continue not to provide coverage or payment for the reviewed claim.

- Once an IRO reviews an appeal, its decision is binding.

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.

HIPAA PRIVACY AND SECURITY
Notice of Privacy Practices

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 your 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:

HIPAA Privacy Official
Director - Human Resources
City of Springfield
840 Boonville Avenue
Springfield, MO 65802
417-864-1600
HR@springfieldmo.gov

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. lf 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. lt 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 Supervisor 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 Supervisor is Not a Fiduciary

A Claims Supervisor 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 Supervisor 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 Supervisor 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 Supervisor 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 Supervisor.

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.

lf, 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. ln 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

lf 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

lf 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. lf 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.

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 Supervisor 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 will be determined under the laws of the State of Missouri to the extent required. Otherwise, the Plan will follow federal law.

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, 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.

Amendment and Termination – The Employer has the authority to amend, modify or terminate this Plan for all plan members from time to time as it deems proper. Any amendment, modification or termination will be in writing and shall be formally adopted as an amendment to this Plan.

Facility of Payment – If the Claims Supervisor or its designee determines that you cannot submit a claim or prove that you or your covered dependent paid any or all of the charges for health care services that are covered by the Plan because you are incompetent, incapacitated or in a coma, the Plan may, at its discretion, pay Plan benefits directly to the health care professional(s) who provided the health care services or supplies, or to any other individual who is providing for your care and support. Any such payment of Plan benefits will completely discharge the Plan's obligations to the extent of that payment. Neither the Plan, Plan Administrator, appropriate Claims Supervisor nor any other designee of the Plan will be required to see to the application of the money so paid.

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.

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