

CITY OF SPRINGFIELD
EMPLOYEE GROUP HEALTH PLAN SUMMARY SHEET

GROUP NUMBER: 010191CS

MONTHLY COST	Employee Only	\$466 (100% paid by the City)	Family Coverage	\$449 * (\$224.50 deduction, 1st & 2nd pay dates) *Minimum enrollment of dependents for 6 months. If both spouses are City employees, there is no cost for dependent child coverage.
IN-NETWORK PROVIDER	Springfield Mercy is the In-Network Provider. To find an in-network provider, go to http://www.mercy.net or call 417.888.8888.			
THIRD PARTY ADMINISTRATOR	Med-Pay, Inc. Call 417.886.6886 or 800.777.9087 with questions about coverage or plan design and to request ID card replacement.			
ANNUAL DEDUCTIBLE	<i>In-Network</i>	Plan participant pays first \$500 per person/\$1000 per family	<i>Out-of-Network</i>	Plan participant pays first \$1000 per person/\$2000 per family
COINSURANCE	<i>In-Network</i>	After deductible is met, plan pays 80% of the next \$10,000 per person and \$20,000 per family, then 100% of covered charges.		
	<i>Out-of-Network</i>	After deductible is met, plan pays 60% of the next \$15,000 per person and \$30,000 per family, then 100% of covered charges.		
ANNUAL MAXIMUM OUT-OF-POCKET				
<i>(Deductible plus Coinsurance)</i>	<i>In-Network</i>	\$2,500 per person/\$5,000 per family		
	<i>Out-of-Network</i>	\$7,000 per person/\$14,000 per family		
INELIGIBLE EXPENSES	Ineligible expenses do not apply toward the deductible, the maximum out-of-pocket amounts or toward coinsurance coverage.			
PRE-ADMISSION REVIEW	Hospital admissions only: required or \$100 penalty; will not apply toward deductible or out-of-pocket maximum.			
PREVENTIVE BENEFIT	<i>In-Network</i>	For employee, spouse & children: 100% coverage of services performed in conjunction with preventive/screening examinations such as a physical examination, laboratory tests, mammograms, gynecologic exams, prostate screening, colonoscopy, immunizations and other exams per the standard criteria for the plan member's age. Benefit <i>includes</i> recommended preventive services under the Affordable Care Act (ACA). A current listing of recommended preventive services under the ACA can be accessed at www.HealthCare.gov/center/regulations/prevention.html . Benefit <i>does not include</i> diagnostic or follow-up services. Plan members may call Med-Pay for questions about eligible preventive services at the number listed on their Health Plan ID card or as noted above.		
	<i>Out-of-Network</i>	Subject to out-of-network deductible and out-of-network coinsurance.		
PRESCRIPTION PLAN PROVIDER	Elixir: Visit www.elixirsolutions.com or call 800-771-4648 for information about prescription plan benefits.			
PRESCRIPTION DRUG BENEFIT	<i>In-Network</i>	Pharmacy: \$5 co-pay plus 20% of the remainder of the cost of the prescription for each 30-day fill; 90-day maximum fill Mail order: 20% of cost, limited to a 90-day supply per prescription Mandatory generic: if plan participant elects brand name over generic, cost is the \$5 co-pay (mail order has no co-pay) plus 20% of the total cost plus the difference in price between the generic & brand name.		
	<i>RX Annual Maximum Out-of-Pocket (Copays + 20% share in-network)</i>	\$4,100 per person/\$8,200 per family		
	<i>Out-of-Network</i>	After out of network deductible is met, plan pays 60% of the cost for covered prescriptions. Claim must be filed with Med-Pay		
GROUP HEALTH PLAN SUMMARY PLAN DESCRIPTION (SPD)	Available electronically: www.springfieldmo.gov/5324/Employee-Documents or CityShare > Human Resources > Benefits > Insurance (Health only). A printed copy is available from Human Resources on request, call 417-864-1607.			

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

Changes Effective January 1, 2022