

MEDICAL BENEFIT SUMMARY

PLAN INFORMATION

Group Name: City of Springfield
 Group Number: G0020720
 Plan Name: HIP Plan - Preferred 90+1500 S3
 Provider Network: PSN Network

EMPLOYEE ELIGIBILITY REQUIREMENTS

Minimum Hour Requirement: 20 hours per week
 Probationary Waiting Period for New Employees: First of the month following one full month of employment. Employment must begin on or before the first business day of a month for that month to be considered towards eligibility.

Annual Deductible	Per Person, Per Calendar Year	Per Family, Per Calendar Year
All Providers	\$1,500	\$3,000
Out-of-Pocket Limit	Per Person, Per Calendar Year	Per Family, Per Calendar Year
Participating Providers	\$2,000	\$4,000
Non-participating Providers	\$10,000	N/A

The member is responsible for the above deductible and the following co-insurance:

Service	Participating Providers:	Non-participating Providers:
Preventive Care		
Well baby/Well child care	No charge*	20% co-insurance*
Routine physicals	No charge*	20% co-insurance*
Well woman visits	No charge*	20% co-insurance*
Routine mammograms	No charge*	20% co-insurance*
Immunizations	No charge*	20% co-insurance*
Routine colonoscopy	No charge*	20% co-insurance*
Prostate cancer screening	No charge*	20% co-insurance*
Professional Services		
Office and home visits	Deductible then 10% co-insurance	Deductible then 20% co-insurance
Specialty office and home visits	Deductible then 10% co-insurance	Deductible then 20% co-insurance
Office procedures and supplies	Deductible then 10% co-insurance	Deductible then 20% co-insurance
Surgery	Deductible then 10% co-insurance	Deductible then 20% co-insurance
Outpatient rehabilitation services	Deductible then 10% co-insurance	Deductible then 20% co-insurance
Hospital Services		
Inpatient room and board	Deductible then 10% co-insurance	Deductible then 20% co-insurance
Inpatient rehabilitation services	Deductible then 10% co-insurance	Deductible then 20% co-insurance

Skilled nursing facility care	Deductible then 10% co-insurance	Deductible then 20% co-insurance
Outpatient Services		
Outpatient surgery/services	Deductible then 10% co-insurance	Deductible then 20% co-insurance
Advanced diagnostic imaging	Deductible then 10% co-insurance	Deductible then 20% co-insurance
Diagnostic and therapeutic radiology and lab	Deductible then 10% co-insurance	Deductible then 20% co-insurance
Urgent and Emergency Services		
Urgent care center visits	Deductible then 10% co-insurance	Deductible then 20% co-insurance
Emergency room visits	Deductible then 10% co-insurance ^	Deductible then 20% co-insurance ^
Ambulance, ground	Deductible then 10% co-insurance	Deductible then 10% co-insurance
Ambulance, air	Deductible then 10% co-insurance	Deductible then 10% co-insurance
Maternity Services		
Physician/Provider services (global charge)	Deductible then 10% co-insurance	Deductible then 20% co-insurance
Hospital/Facility services	Deductible then 10% co-insurance	Deductible then 20% co-insurance
Mental Health/Chemical Dependency Services		
Office visits	Deductible then 10% co-insurance	Deductible then 20% co-insurance
Inpatient care	Deductible then 10% co-insurance	Deductible then 20% co-insurance
Residential programs	Deductible then 10% co-insurance	Deductible then 20% co-insurance
Other Covered Services		
Allergy injections	Deductible then 10% co-insurance	Deductible then 20% co-insurance
Durable medical equipment	Deductible then 10% co-insurance	Deductible then 20% co-insurance
Home health care	Deductible then 10% co-insurance	Deductible then 20% co-insurance
Temporomandibular Joint (TMJ) Services	Deductible then 50% co-insurance	Deductible then 50% co-insurance
Alternative, Chiropractic Care, Massage	Deductible then 10% co-insurance	Deductible then 20% co-insurance
Transplants	Deductible then No charge	Deductible then 30% co-insurance

This is a brief summary of benefits. Please refer to this Plan Document for additional information or a further explanation of benefits, limitations, and exclusions.

- ^ For emergency medical conditions, non-participating providers are paid at the participating provider level.
- * Not subject to annual deductible.

Additional Information

What is the annual deductible?

Your deductible is the amount of money that you pay first, before this Plan starts to pay. You'll see that many services, especially preventive care, are covered by the Plan without you needing to meet the deductible. The individual deductible applies if you enroll without dependents. If you and one or more dependents enroll, the individual deductible applies for each member only until the family deductible has been met. Deductible expense is applied to the out-of-pocket limit.

Participating provider expense and non-participating provider expense apply together toward your deductible.

What is the out-of-pocket limit?

The out-of-pocket limit is the most you'll pay for covered medical expenses during the calendar year. Once the out-of-pocket limit has been met, the Plan will pay 100 percent of covered charges for the rest of that year. The individual out-of-pocket limit applies only if you enroll without dependents. If you and one or more dependents enroll, the individual out-of-pocket limit applies for each member only until the family out-of-pocket limit has been met. Be sure to check this Plan Document, as there are some charges, such as non-essential health benefits, penalties and balance billed amounts that do not count toward the out-of-pocket limit.

Participating provider expenses and non-participating provider expense apply together toward your out-of-pocket limits.

PRESCRIPTION BENEFIT SUMMARY

Your *Plan Sponsor's* Plan includes coverage for prescription drugs and certain other pharmaceuticals, subject to the information below. This prescription drug Plan does qualify as creditable coverage for Medicare Part D.

You must satisfy the medical plan deductible, shown on the Medical Benefit Summary, before your prescription drug benefits begin for prescription drugs.

The amount you pay for covered prescriptions at participating pharmacies applies toward your participating medical out-of-pocket limit, shown on the Medical Benefit Summary. The co-payment and/or co-insurance for prescription drugs obtained from a participating pharmacy are waived during the remainder of a calendar year in which you have satisfied the medical out-of-pocket limit.

Each time a covered pharmaceutical is dispensed, you are responsible for the co-payment and/or co-insurance below:

	Tier 1: Generic	Tier 2: Preferred	Tier 3: Non-preferred
Participating Retail Pharmacy[^]			
Up to a 90 day supply:	Deductible then 10% co-insurance	Deductible then 10% co-insurance	Deductible then 25% co-insurance
Participating Mail Order Service			
Up to a 90 day supply:	Deductible then 10% co-insurance	Deductible then 10% co-insurance	Deductible then 25% co-insurance
Non-participating Pharmacy			
Regardless of tier up to a 90 day(s) supply:	Deductible then 50% co-insurance or retail co-pay, whichever is greater		
Specialty Drugs – Participating Specialty Pharmacy			
Up to a 30 day supply:	Same as retail pharmacy deductible then co-insurance above		
Specialty Drugs – Not filled through Participating Specialty Pharmacy			
Regardless of tier or day(s) supply:	Not covered (except for 5-day emergency supply)		
Compound Drugs: Prior authorization is required if prescription is over \$1,000.			
Up to a 30-day supply:	Same as retail Tier 3		

[^] Remember to show your PacificSource ID Card each time you fill a prescription at a retail pharmacy.

MAC C - Regardless of the reason or medical necessity, if you receive a brand name drug or if your physician prescribes a brand name drug when a generic is available, you will be responsible for the brand name drug's co-payment and/or co-insurance.