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 date of hire. If date of hire is the first day of the month, coverage will begin that day.

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

Please note: Your actual costs for services provided by a non-participating provider may exceed this Plan's out-of-pocket limit for non-participating services. In addition, non-participating providers can bill you for the difference between the amount charged by the provider and the amount allowed by this Plan, and this amount is not counted toward the non-participating out-of-pocket limit.

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
Telemedicine visits	Deductible then 10% co-insurance	Deductible then 20% co-insurance
Office procedures and supplies	Deductible then	Deductible then

	10% co-insurance	20% co-insurance
Surgery	Deductible then 10% co-insurance	Deductible then 20% co-insurance
Outpatient rehabilitation and habilitation 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 and habilitation 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/lab and dialysis	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-Medical Emergency	Deductible then 10% co-insurance	Deductible then 10% co-insurance
Emergency room visits-Non- Emergency	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

Acupuncture, Chiropractic Manipulations, and 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.

* Not subject to annual deductible.

\+ Please note that non-par air ambulance coverage is covered at 200% of the Medicare allowable. Contact Customer Service with questions.

** Medically necessary services, medication, and supplies to manage diabetes during pregnancy from conception through six weeks postpartum will not be subject to a deductible, co-payment, or co-insurance.

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.

Payments to providers

Payment to providers is based on the prevailing or contracted PacificSource fee allowance for covered services. Participating providers accept the fee allowance as payment in full. Non-participating providers are allowed to balance bill any remaining balance that this Plan did not cover. Services of non-participating providers could result in out-of-pocket expense in addition to the percentage indicated.

Preauthorization

Coverage of certain medical services and surgical procedures requires a benefit determination by the Plan before the services are performed. This process is called 'preauthorization'. Preauthorization is necessary to determine if certain services and supplies are covered under this Plan and if you meet the Plan's eligibility requirements. You'll find the most current preauthorization list on the PacificSource website, PacificSource.com/member/preauthorization.