

MEDICAL BENEFIT SUMMARY

PREFERRED 90+1500 VAR

POLICY INFORMATION

Group Name: City of Springfield HIP
 Group Number: G0020720
 Plan Name: PREFERRED 90+1500 VAR
 Provider Network: PSN

EMPLOYEE ELIGIBILITY REQUIREMENTS

Minimum Hour Requirement: Twenty (20) Hours
 Waiting Period for New Employees: Per employer policy

SCHEDULE OF BENEFITS

Maximum Lifetime Benefit \$2,000,000
 Annual Deductible \$1,500 per person / \$3,000 per family

The deductible is an amount of covered medical expenses the member pays each calendar year before the plan's benefits begin. The deductible applies to all services and supplies except those marked with a bullet(*).

Out-Of-Pocket Limit

Participating Providers \$2,000 per person / \$4,000 per family per calendar year
 Nonparticipating Providers \$10,000 per person per calendar year

Once the participating and network not available provider out-of-pocket limit has been met, this plan will pay 100% of covered charges for the rest of that calendar year. Once the nonparticipating provider out-of-pocket limit has been met, this plan will pay 100% of covered charges for all providers for the rest of that calendar year. Benefits paid in full and nonparticipating provider charges in excess of the PacificSource fee allowance do not accumulate toward the out-of-pocket limit. Nonparticipating provider charges in excess of the PacificSource allowable fee will continue to be the member's responsibility even after the out-of-pocket limit is met.

SERVICE:	PARTICIPATING PROVIDER/ NETWORK NOT AVAILABLE BENEFIT:	NONPARTICIPATING PROVIDER BENEFIT:
PREVENTIVE CARE		
• Well Baby Care	90%	80%
• Routine Physicals	90%	80%
• Routine Gynecological Exams	100% after \$15 copay per visit	100% after \$15 copay per visit
• Child Immunizations (age 18 and under)	100% after \$10 copay per visit	100% after \$10 copay per visit
• Routine Immunizations (age 19 and over)	90%	80%
PROFESSIONAL SERVICES		
Office and Home Visits	90%	80%
Urgent Care Center Visits	90%	80%
Surgery	90%	80%
HOSPITAL SERVICES		
Inpatient Room and Board	90%	80%
Inpatient Rehabilitative Care	90%	80%
Skilled Nursing Facility Care	90%	80%
OUTPATIENT SERVICES		
Outpatient Surgery	90%	80%
CT/PET Scans, CATH Labs and MRIs	90%	80%
Diagnostic / Therapeutic Radiology & Lab	90%	80%
* Emergency Room Visits	90%	80%
MENTAL HEALTH/CHEMICAL DEPENDENCY SERVICES		
Office Visits	90%	80%
Inpatient Care	90%	80%

This is only a brief summary of benefits. Please refer to the additional information provided for a further explanation of benefits including limitations and exclusions.

SERVICE:	PARTICIPATING PROVIDER/ NETWORK NOT AVAILABLE BENEFIT:	NONPARTICIPATING PROVIDER BENEFIT:
Residential Programs	90%	80%
OTHER COVERED SERVICES		
Physical Therapy	90%	80%
Allergy Injections	90%	80%
Ambulance, Ground	90%	90%
Ambulance, Air	90%	90%
Durable Medical Equipment	90%	80%
Home Health Care	90%	80%
TMJ Services (see limitations)	50%	50%
Chiropractic Care (max 12 visits/yr)	90%	80%

- * In true medical emergencies, nonparticipating providers are paid at the participating provider level.
- Not subject to annual deductible.

Payment to providers is based on the prevailing or contracted PacificSource fee allowance for covered services. Although participating providers accept the fee allowance as payment in full, nonparticipating providers may not. Services of nonparticipating providers could result in out-of-pocket expense in addition to the percentage indicated. Network Not Available payment is allowed when PacificSource has not contracted with providers in the geographical area of the member's residence or work for a specific service or supply. Payment to providers for Network Not Available is based on the usual, customary, and reasonable charge for the geographical area in which the charge is incurred. For more information, refer to the Payment to Providers section in the proposal or member benefit handbook.

Your PacificSource health plan includes coverage for prescription drugs and certain other pharmaceuticals, subject to the information below. Your prescription drug plan does not qualify as creditable coverage for Medicare Part D.

MEDICAL PLAN DEDUCTIBLE

The deductible is an amount of covered prescription drug expense you pay each calendar year before the plan's benefits begin. Your retail pharmacy benefit is also subject to the medical plan's deductible. You must use your PacificSource ID card at participating retail pharmacies to have your pharmacy costs applied to the deductible.

COPAYMENTS (other than for specialty drugs)

Each time a covered pharmaceutical is dispensed, you are responsible for a copayment. Copayments under your plan are as follows:

<i>From a participating Caremark® retail pharmacy using the PacificSource Pharmacy Program (see below):</i>	Tier 1: Generic	Tier 2: Formulary	Tier 3: Nonformulary
Up to 90-day supply:	10%	10%	25%
<i>From a participating mail order service (see below):</i>			
Up to a 90-day supply:	10%	10%	25%
<i>From a participating Caremark® pharmacy without using the PacificSource Pharmacy Program (see below) or from a nonparticipating pharmacy:</i>	50% or the retail pharmacy copayment above, whichever is greater		

PRESCRIPTION DRUG OUT-OF-POCKET LIMIT

Once you have met the annual medical and pharmacy out-of-pocket limit, this plan will pay 100% of covered charges for participating pharmacies for the rest of that calendar year. Benefits paid in full and nonparticipating provider charges do not accumulate toward the out-of-pocket limit.

USING THE PACIFICSOURCE PHARMACY PROGRAM

The Caremark® pharmacy network includes about 98 percent of all independent and large chain pharmacies in the United States. It also includes *drugstore.com*, an Internet-based pharmacy service.

To use the PacificSource pharmacy program, you must show the Caremark® plan number on your PacificSource ID card at the participating pharmacy to receive your plan's highest benefit level.

When obtaining prescription drugs at a participating Caremark® retail pharmacy, the PacificSource pharmacy program can only be accessed through the pharmacy plan number printed on your PacificSource ID card. That plan number -- V222-9485 -- allows the pharmacy to collect the appropriate copayment from you and bill PacificSource electronically for the balance. When you use your PacificSource ID card at participating pharmacies, the pharmacy will charge you the lesser of your copayment or the pharmacy's discounted drug cost plus service fee.

If you do not present your PacificSource ID card at the time of purchase, or if you use a nonparticipating pharmacy, you will need to file a claim for reimbursement and your benefits will be reduced. To submit a claim, send PacificSource your pharmacy receipt, your group name and number, your name and member ID number, and the patient's name and relationship to you. We will reimburse you either 50% of the retail price, or the retail price less your plan's retail copayment, whichever is less.

Mail Order Service

Mail order prescription service is available through your plan for most prescription drugs. If you take a medication on a regular basis, mail order service is a convenient way to order prescriptions and have them delivered directly to your home. There's no shipping and handling charge for standard delivery. For more information about mail order services, please visit the For Members area of our Web site, PacificSource.com.

OTHER COVERED PHARMACEUTICALS

Supplies covered under the pharmacy plan are in place of, not in addition to, those same covered supplies under the medical plan. Copayments for items in this section are applied on the same basis as for other prescription drugs unless otherwise noted.

Diabetic Supplies

- Insulin and diabetic syringes are available for your plan's generic copayment.
- Lancets and test strips are available for your plan's formulary brand copayment.
- Glucagon recovery kits are available for your plan's formulary copay. You may purchase up to two kits at one time, but no more than four kits in any calendar year (unless preauthorized by PacificSource).
- Glucostix and glucose monitoring devices are not covered under this pharmacy benefit, but are covered under your medical plan's durable medical equipment benefit.

Bee Sting Kits

Anaphylactic recovery kits for people with severe allergic reactions to bee stings are available for your plan's nonformulary copay. You may purchase up to two kits at one time, but no more than four kits in any calendar year (unless otherwise preauthorized).

Tobacco Cessation

Program specific tobacco cessation medications are covered with active participation in a plan approved tobacco cessation program.

Oral Chemotherapy Medications

Prescribed, orally administered anticancer medications are covered under your pharmacy benefit. If you prefer, you can have these medications covered under your medical plan's chemotherapy benefit instead. If you choose to use your medical benefit, these drugs would be subject to any deductibles, coinsurance, out-of-pocket limits, or pre-existing conditions that apply to your medical plan.

Contraceptives

- Oral Contraceptives
- Depo Provera or Lunelle injections, Ortho Evra Transdermal Patch, NuvaRing Vaginal Contraceptive Ring, or Preven are covered at your plan's formulary brand name copayment.

Diaphragm or cervical caps are available. Copayment for diaphragm or cervical caps are applied on the same basis as for other drugs.

Caremark® Specialty Pharmacy

Caremark® Specialty Pharmacy Services is your provider for many specialty and biotech drugs often used to treat chronic or genetic disorders. The program is designed to help PacificSource members with the following health conditions maximize the value of their health plan benefits:

Asthma	Growth hormone deficiency	Immune disorders	Pulmonary arterial hypertension
Crohn's disease	Hematopoietics	Multiple sclerosis	Pulmonary disease
Enzyme replacement	Hepatitis C	Oncology	RSV prevention
Gaucher's disease	Hormonal therapies	Psoriasis	Rheumatoid arthritis

A complete list of medications covered under this program is available on the For Members area of our Web site, PacificSource.com. If you are using a covered medication, you will be contacted and invited to participate in the program. The Caremark® Specialty Pharmacy Program offers:

- Personal attention from a pharmacist-led Care Team that provides condition-specific education, medication administration instruction, and expert advice to help you manage your therapy
- Easy access to pharmacists and other health experts 24 hours a day, seven days a week
- Easy ordering with a dedicated toll-free number
- Confidential and convenient delivery of medications to the location of your choice

COPAYMENTS FOR SPECIALTY DRUGS

Participating provider benefits for specialty drugs are available when you use Caremark® Specialty Pharmacy services. The Caremark® Specialty Pharmacy Service is not available through the Caremark® retail pharmacy network, and participating provider benefits for specialty drugs are available at a Caremark® retail pharmacy only when preauthorized by PacificSource. Each time a specialty drug is dispensed, you are responsible for a copayment as follows:

From Caremark® Specialty Pharmacy Services:

Up to a 30-day supply: Same as the retail pharmacy copayment above

From a participating Caremark® pharmacy, or from a nonparticipating pharmacy:

50% or retail pharmacy copayment above, whichever is greater

LIMITATIONS AND EXCLUSIONS

- This plan only covers drugs prescribed by a licensed physician (or other licensed practitioner eligible for reimbursement under your plan) prescribing within the scope of his or her professional license, except for:
 - Over-the-counter drugs or other drugs that federal law does not prohibit dispensing without a prescription (even if a prescription is required under state law)
 - Drugs for any condition excluded under the health plan. That includes drugs intended to promote fertility, treatments for obesity or weight loss, tobacco cessation drugs (except as specifically provided for under Other Covered Pharmaceuticals), experimental drugs, and drugs available without a prescription (even if a prescription is provided).
 - Some specialty drugs that are not self-administered are not covered under this pharmacy benefit, but are covered under the medical plan's office supply benefit.
 - Immunizations (although certain immunizations are covered under your health plan's preventive care benefit - please refer to your Member Benefit Summary)
 - Viagra and other drugs and devices to treat impotency
 - Drugs used as a preventive measure against hazards of travel
- Certain drugs require preauthorization by PacificSource in order to be covered. An up-to-date list of drugs requiring preauthorization is available on the For Members area of our Web site, www.pacificsource.com
- Quantities for any drug filled or refilled are limited to no more than a 90-day supply when purchased at retail pharmacy or a 90-day supply at mail order pharmacy service.
- Quantities of Specialty Drugs are limited to no more than a 30-day supply per fill or refill, and are processed through the Caremark® Specialty Drug Program.
- PacificSource may limit the dispensing quantity through the consideration of medical necessity, generally accepted standards of medical practice, and review of medical literature and governmental approval status.
- For drugs purchased at nonparticipating pharmacies or at participating pharmacies without using the PacificSource pharmacy program, reimbursement is limited to an allowable fee. That fee is the wholesale acquisition cost of the medication plus 20%.
- Your share of the cost for prescription drugs does not apply to your medical plan's out-of-pocket limit. Prescription drug copayments are your responsibility even if the medical plan's out-of-pocket limit is satisfied.
- Prescription drug benefits are subject to your plan's coordination of benefits provision. (For more information, see Claims Payment-Coordination of Benefits section)

GENERAL INFORMATION ABOUT PRESCRIPTION DRUGS

Formulary Drugs

A *drug formulary* is a list of preferred medications used to treat various medical conditions. The formulary is used to help control rising healthcare costs while ensuring that you receive medications of the highest quality. It is a guide for your doctor and pharmacist in selecting drug products that are safe, effective and cost efficient. The formulary is made

up of both generic and brand name products. The current formulary includes approximately 750 commonly prescribed generic and brand name medications. The formulary is developed by Caremark® in cooperation with PacificSource. *Nonformulary* drugs are covered brand name medications not on the formulary.

Generic Drugs

Generic drugs are equivalent to name brand medications. Name brand medications (such as Valium) lose their patent protection after a number of years. At that time any drug company can produce the drug, and the manufacturer must pass the same strict FDA standards of quality and product safety as the original manufacturer. Generic drugs are less expensive than brand name drugs because there is more competition and there is no need to repeat costly research and development. Your pharmacist and doctor are encouraged to use generic drugs whenever they are available.

BENEFIT SUMMARY

VISION

Your group insurance plan covers vision exams, eyeglasses, and contact lenses. The following shows the vision benefits available.

BENEFIT PERIOD

Eye Exam: Once every 12 months age 17 and younger, every 24 months age 18 and older

Lenses: One pair every 12 months age 17 and younger, every 24 months age 18 and older

Frames: One every 12 months age 17 and younger, every 24 months age 18 and older

Contact Lenses: Once every 12 months age 17 and younger, every 24 months age 18 and older

SERVICE/SUPPLY	Participating Provider Benefit	Nonparticipating Provider Benefit
Eye Exam	100%	\$40
Hardware		
* Lenses (maximum per pair)		
➤ Single Vision	100%	\$56
➤ Bifocal	100%	\$84
➤ Trifocal	100%	\$116
➤ Lenticular	100%	\$236
Progressive	\$116	\$116
* Frames	\$75	\$75
* Contacts (in place of glasses)	\$131	\$131
* Participating Providers discount these services.		
➤ Participating Providers accept these benefit amounts as payment in full.		

The amounts listed above are the maximum benefits available for all vision exams, lenses, and frames furnished during any benefit period. If charges for a service or supply are less than the amount allowed, the benefit will be equal to the actual charge. If only one lens is supplied, the allowance for the lens is 50 percent of the lens allowance shown above.

Limitations and Exclusions

The out-of-pocket expense for vision services (copayments and service charges) does not apply to the medical deductible or out-of-pocket limit of the policy. Also, the member continues to be responsible for the vision copayments and service charges regardless of whether the policy's out-of-pocket limit is satisfied.

Covered expenses do not include, and no benefits are payable for:

- Special procedures such as orthoptics or vision training
- Special supplies such as sunglasses (plain or prescription) and subnormal vision aids
- Tint
- Plano contact lenses
- Anti-reflective coatings and scratch resistant coatings
- Separate charges for contact lens fitting
- Replacement of lost, stolen, or broken lenses or frames
- Duplication of spare eyeglasses or any lenses or frames
- Nonprescription lenses
- Visual analysis that does not include refraction
- Services or supplies not listed as covered expenses
- Charges for services or supplies covered in whole or in part under any other medical or vision benefits provided by the employer
- Eye exams required as a condition of employment, or required by a labor agreement or government body
- Expenses covered under any workers' compensation law.
- Services or supplies received before this plan's coverage begins or after it ends.
- Medical or surgical treatment of the eye