# MEDICAL BENEFIT SUMMARY

# PREFERRED 90+100 VAR

## POLICY INFORMATION

| | |
|---|---|
| Group Name: | City of Springfield Pref |
| Group Number: | G0020720 |
| Plan Name: | PREFERRED 90+100 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** $100 per person / $300 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** $350 per person per calendar year

Once the 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.

**Additional Accident Benefit**

Covered Expenses within 90 days of an accident are paid at 100% and are not subject to the deductible. The balance is covered as shown below.

| 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% |

**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: |
|---|---|---|
| Inpatient Care | 90% | 80% |
| 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 qualifies as creditable coverage for Medicare Part D.

### 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:

| *From a participating Caremark® retail pharmacy using the PacificSource Pharmacy Program (see below):* | Tier 1: Generic | Tier 2: Formulary | Tier 3: Nonformulary |
|---|---|---|---|
| Up to 30-day supply: | $7 | $14 | 25% |
| 31 to 60-day supply: | $14 | $28 | 25% |
| 61 to 90-day supply: | $21 | $42 | 25% |
| *From a participating mail order service (see below):* | | | |
| Up to a 45-day supply: | $7 | $14 | 25% |
| 46 to 90-day supply: | $14 | $28 | 25% |
| *From a participating Caremark® pharmacy without using the PacificSource Pharmacy Program (see below) or from a nonparticipating pharmacy:* | 50% or the retail pharmacy copayment above, whichever is greater | | |

### 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 -- V154-9478 -- 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. For example, if your copayment is $7 and the drug's discounted cost plus service fee is only $5.50, a participating pharmacy will only charge you $5.50.

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.

#### *)iabetic 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 follows:

*From Caremark® Specialty Pharmacy Services:*

| | |
|---|---|
| ' Ip 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 copayment, 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 deductible or 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.

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