MEDICAL BENEFIT SUMMARY
HIP Plan – Navigator 90+1500 S3

Group Name: City of Springfield
Group Number: G0020720
Provider Network: Navigator
Benefit Year: Calendar Year

Employee Eligibility Requirements

Minimum Hour Requirement: Twenty (20) hours per week

Waiting Period Requirement: First of the month following date of hire. If the date of hire is the first day of the month, coverage will begin that day.

Deductible Per Benefit Year	All Providers	
Individual/Family	$1,500 / $3,000	
Out-of-Pocket Limit Per Benefit Year	**In-network**	**Out-of-network**
Individual/Family	$2,000 / $4,000	$10,000 / NA

Note: In-network out-of-pocket limit accumulates separately from the out-of-network out-of-pocket limit. Even though you may have the same benefit for in-network and out-of-network, your actual costs for services provided out-of-network may exceed this Plan's out-of-pocket limit for out-of-network services. In addition, Out-of-network Providers may in certain circumstances bill you for the difference between the amount charged by the Provider and the amount allowed by this Plan (called Balance Billing). Balance Billing amounts are not counted toward the out-of-network out-of-pocket limit. For additional information about Balance Billing or Allowable Fee, please see the Definitions Section of the Plan Document.

The Member is responsible for any amounts shown above, in addition to the following amounts:

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Preventive Care		
Well baby/Well child care	No Deductible, 0%	No Deductible, 20%
Preventive physicals	No Deductible, 0%	No Deductible, 20%
Well woman visits	No Deductible, 0%	No Deductible, 20%
Preventive mammograms	No Deductible, 0%	No Deductible, 20%
Immunizations	No Deductible, 0%	No Deductible, 20%
Preventive colonoscopy	No Deductible, 0%	No Deductible, 20%
Prostate cancer screening	No Deductible, 0%	No Deductible, 20%
Professional Services		
Office and home visits	After Deductible, 10%	After Deductible, 20%
Naturopath office visits	After Deductible, 10%	After Deductible, 20%

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Specialist office and home visits	After Deductible, 10%	After Deductible, 20%
Telehealth visits	After Deductible, 10%	After Deductible, 20%
Office procedures and supplies	After Deductible, 10%	After Deductible, 20%
Surgery	After Deductible, 10%	After Deductible, 20%
Outpatient Rehabilitation and Habilitation Services	After Deductible, 10%	After Deductible, 20%
Chiropractic manipulation/Spinal manipulation (20 visits per Benefit Year)	After Deductible, 10%	After Deductible, 20%
Acupuncture (12 visits per Benefit Year)	After Deductible, 10%	After Deductible, 20%
Massage therapy ($1,200 per Benefit Year)	After Deductible, 10%	After Deductible, 20%
Hospital Services		
Inpatient room and board	After Deductible, 10%	After Deductible, 20%
Inpatient Rehabilitation and Habilitation Services	After Deductible, 10%	After Deductible, 20%
Skilled nursing facility care	After Deductible, 10%	After Deductible, 20%
Outpatient Services		
Outpatient surgery/services	After Deductible, 10%	After Deductible, 20%
Diagnostic imaging – advanced	After Deductible, 10%	After Deductible, 20%
Diagnostic and therapeutic radiology/laboratory and dialysis – non-advanced	After Deductible, 10%	After Deductible, 20%
Urgent and Emergency Services		
Urgent care center visits	After Deductible, 10%	After Deductible, 20%
Emergency room visits – medical emergency	After Deductible, 10%	After Deductible, 10%
Emergency room visits – non-emergency	After Deductible, 10%	After Deductible, 20%
Ambulance, ground	After Deductible, 10%	After Deductible, 10%
Ambulance, air	After Deductible, 10%	After Deductible, 10%+
Maternity Services**		
Physician/Provider services (Global Charge)	After Deductible, 10%	After Deductible, 20%
Hospital/Facility services	After Deductible, 10%	After Deductible, 20%
Mental Health and Substance Use Disorder Services		
Office visits	After Deductible, 10%	After Deductible, 20%
Inpatient care	After Deductible, 10%	After Deductible, 20%
Residential programs	After Deductible, 10%	After Deductible, 20%
Other Covered Services		
Allergy injections	After Deductible, 10%	After Deductible, 20%

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Durable medical equipment	After Deductible, 10%	After Deductible, 20%
Home health services	After Deductible, 10%	After Deductible, 20%
Transplants	No Deductible, 0%	After Deductible, 30%
Temporomandibular joint (TMJ)	After Deductible, 50%	After Deductible, 50%

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

** Medically necessary services, medication, and supplies to manage diabetes during pregnancy from conception through six weeks postpartum will not be subject to a Deductible, Copayment, or Coinsurance.

+ Out-of-network air ambulance coverage is covered at 200 percent of the Medicare allowance. You may be held responsible for the amount billed in excess. Please see the Plan Document for additional information or contact the PacificSource Customer Service team with questions.

Additional information

What is the 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 this 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.

In-network expense and out-of-network 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 Services during the Benefit Year. Once the out-of-pocket limit has been met, this Plan will pay 100 percent of allowed amounts for Covered Services for the rest of that Benefit 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 the 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.

Note that there is a separate category for in-network and out-of-network when it comes to meeting your out-of-pocket limit.

Payments to Providers

Payment to Providers is based on the prevailing or Allowable Fee for Covered Services. In-network Providers accept the Allowable Fee as payment in full. Services of Out-of-network Providers could result in out-of-pocket expense in addition to the percentage indicated.

Prior Authorization

Coverage of certain medical services and Surgical Procedures requires a Benefit Determination by PacificSource before the services are performed. This process is called prior authorization. Prior authorization is necessary to determine if certain services and supplies are covered under this Plan, and if you meet the Plan's eligibility requirements. Prior authorization does not change your out-of-pocket expense for in-network and Out-of-network Providers. You can search for procedures and services that require prior authorization on the website, Authgrid.PacificSource.com (select Commercial for the line of business)

Discrimination is against the law

Both the Plan Sponsor and PacificSource Health Plans comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. The Plan Sponsor and PacificSource do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Formulary: Preferred Drug List (PDL)

Benefit Year: Calendar Year

This Plan includes coverage for Prescription Drugs and certain other pharmaceuticals, subject to the information below. This Plan complies with federal healthcare reform. To check which tier your prescription falls under, call the PacificSource Customer Service team or visit PacificSource.com/find-a-drug.

The amount you pay for covered prescriptions at in-network pharmacies applies toward this Plan's in-network medical out-of-pocket limit, and the amount you pay for covered prescriptions at out-of-network pharmacies applies toward this Plan's out-of-network medical out-of-pocket limit. The medical out-of-pocket limits are shown on the Medical Benefit Summary. The Copayment and/or Coinsurance for Prescription Drugs obtained from an in-network or out-of-network pharmacy are waived during the remainder of the Benefit Year in which you have satisfied the applicable medical out-of-pocket limit.

Medical Deductible

You must meet the medical Deductible, which is shown on the Medical Benefit Summary, before your Prescription Drug benefits begin.

Affordable Care Act Standard Preventive No-cost Drug List

Your prescription benefit includes preventive care drugs at no cost to you and are not subject to a Deductible or MAC penalties. This benefit includes some drugs required by the Affordable Care Act, including tobacco cessation drugs. These drugs are identified on the Drug List as Tier 0.

Each time a covered prescription is dispensed, you are responsible for any amounts shown above, in addition to the following amounts:

Service/ Supply	Tier 1 Member Pays	Tier 2 Member Pays	Tier 3 Member Pays
In-network Retail Pharmacy			
Up to a 90 day supply:	After Deductible, 10%	After Deductible, 10%+	After Deductible, 25%+
In-network Mail Order Pharmacy			
Up to a 90 day supply:	After Deductible, 10%	After Deductible, 10%+	After Deductible, 25%+
Compound Drugs**			
Up to a 90 day supply:	After Deductible, 25%		
Out-of-network Pharmacy			
Regardless of tier up to a 90 day supply:	After Deductible,50%		

Service/ Supply	Tier 1 Member Pays	Tier 2 Member Pays	Tier 3 Member Pays
Specialty Drugs – In-network Specialty Pharmacy			
Up to a 30 day supply:	Same as retail pharmacy		
Specialty Drugs – Out-of-network Specialty Pharmacy			
30 day max fill, no more than three fills allowed per Benefit Year:	Same as retail pharmacy		

+Formulary prescription insulin is not subject to a Deductible and may not exceed $75 per 30 day supply.

**Compounded medications are subject to a prior authorization process. Compounds are generally covered only when all commercially available formulary products have been exhausted and all the ingredients in the compounded medications are on the applicable formulary.

MAC C - Regardless of the reason or Medical Necessity, if you receive a brand name drug or if your Provider prescribes a brand name drug when a generic is available, you will be responsible for the brand name drug's Copayment and/or Coinsurance after the medical Deductible is met. Does not apply to preventive bowel prep kit medications covered under USPSTF guidelines.

If your Provider prescribes a brand name contraceptive due to Medical Necessity it may be subject to prior authorization for coverage at no charge.

See the Plan Document for important information about your Prescription Drug benefit, including which drugs are covered, limitations, and more.

Benefit Year: Calendar Year

The following shows the vision benefits available under this Plan for all covered vision exams, lenses, and frames when performed or prescribed by a licensed ophthalmologist or licensed optometrist. Coverage for pediatric services will end on the last day of the month in which the Member turns 19. Copayment and/or Coinsurance for Covered Services apply to the medical out-of-pocket limit.

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Members Age 18 and Younger		
Eye exam	No Deductible, 0%	No Deductible, 0% up to $40 maximum benefit then Member responsibility
Vision hardware	No Deductible, 0% for one pair per Benefit Year for glasses (lenses and frames) or contacts (lenses and fitting)	No Deductible, 0% up to $75 maximum benefit for one pair per Benefit Year for glasses (lenses and frames) or contacts (lenses and fitting) then Member responsibility
Members Age 19 and Older		
Eye exam	No Deductible, 0%	No Deductible, 0% up to $40 maximum benefit then Member responsibility
Single vision lenses	No Deductible, 0%	No Deductible, 0% up to $56 maximum benefit then Member responsibility
Bifocal lenses	No Deductible, 0%	No Deductible, 0% up to $84 maximum benefit then Member responsibility
Trifocal lenses	No Deductible, 0%	No Deductible, 0% up to $116 maximum benefit then Member responsibility
Lenticular lenses	No Deductible, 0%	No Deductible, 0% up to $236 maximum benefit then Member responsibility
Progressive lenses	No Deductible, 0% up to $116 maximum benefit then Member responsibility	No Deductible, 0% up to $116 maximum benefit then Member responsibility
Frames	No Deductible, 0% up to $150 maximum benefit then Member responsibility	No Deductible, 0% up to $150 maximum benefit then Member responsibility

Service/Supply	In-network Member Pays	Out-of-network Member Pays
Contact Lenses (in lieu of glasses)		
Contact lenses	No Deductible, 0% up to $131 maximum benefit then Member responsibility	No Deductible, 0% up to $131 maximum benefit then Member responsibility

Benefit Limitations: Members age 18 and younger

- One vision exam every Benefit Year.
- Vision hardware includes glasses or contacts (lenses and fitting) once per Benefit Year.

Benefit Limitations: Members age 19 and older

- One vision exam every Benefit Year.
- Lenses: One pair every Benefit Year.
- Frames: Once every two Benefit Years.
- Contact lenses: Once every two Benefit Years.
- Elective contact lenses are in lieu of frames and lenses.

Exclusions

- Anti-reflective coatings and scratch resistant coatings.
- Charges for services or supplies covered in whole or in part under any medical or vision benefits provided by an employer.
- Duplication of spare eyeglasses or any lenses or frames for Members age 18 and younger.
- Expenses covered under any workers' compensation law.
- Eye exams required as a condition of employment, required by a labor agreement or government body.
- Lens tint.
- Medical or surgical treatment of the eye.
- Nonprescription lenses.
- Plano contact lenses.
- Polycarbonate lenses for Members age 19 and older.
- Replacement of lost, stolen, or broken lenses or frames.
- Services or supplies not listed as covered expenses.
- Services or supplies received before this Plan's coverage begins or after it ends.
- Special procedures, such as orthoptics or vision training.
- Special supplies, such as sunglasses (plain or prescription) and subnormal vision aids.
- Visual analysis that does not include refraction.

Important information about your vision benefits

This Plan includes coverage for vision services. To make the most of those benefits, it's important to keep in mind the following:

In-network Providers: This Plan is able to add value to your vision benefits by contracting with a network of vision Providers. Those Providers offer vision services at discounted rates, which are passed on to you in your benefits.

Paying for Services: Provider contracts require In-network Providers to bill PacificSource directly whenever you receive Covered Services and supplies. Providers will verify your vision benefits.

In-network Providers should not ask you to pay the full cost in advance. They may only collect your share of the expense up front, such as Copayments and amounts over this Plan's maximum benefit. If you are asked to pay the entire amount in advance, tell the Provider you understand they have a contract with PacificSource and they should bill PacificSource directly.

Sales and Special Promotions: Vision retailers often use coupons and promotions to bring in new business, such as free eye exams, two-for-one glasses, or free lenses with purchase of frames. Because In-network Providers already discount their services through their contract with PacificSource, this Plan's in-network benefits cannot be combined with any other discounts or coupons. You can use this Plan's in-network benefits, or you can use this Plan's out-of-network benefits to take advantage of a sale or coupon offer.

If you do take advantage of a special offer, the In-network Provider may treat you as an uninsured customer and require full payment in advance. You can then send the claim to PacificSource yourself, and this Plan will reimburse you according to this Plan's out-of-network benefits.