# CITY OF SPRINGFIELD
# HEALTH BENEFIT PLAN

- **BASICSELECT HEALTH PLAN/PPO**
- **POINT OF SERVICE (POS) PLAN/Open Access III**
- **HIGH DEDUCTIBLE HEALTH PLAN**

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## INTRODUCTION

This document describes the City of Springfield's self-funded medical and prescription drug benefit plans that have been made available to the City of Springfield Employees, Eligible Retirees and COBRA participants. This plan represents the efforts of the City of Springfield to provide Employees, their Dependents and other Covered Persons with the best possible health benefits at an affordable cost. Participants must be enrolled in the plan.

This booklet provides you with a description of all health benefit provisions in the Plan, rights you may have under federal law, how you establish and/or lose eligibility, and how to appeal a claim if it is not handled satisfactorily. Thus, you are being asked to review this booklet and familiarize yourself with the rules, requirements, and benefits to which you may be entitled. ***(Note: Addendums have been added to this booklet for informational purposes only. The provisions of this booklet do not apply to any benefits described in the Addendums.)***

In reviewing this booklet, you will note that a number of terms and phrases are capitalized. This usually means that there is a definition of these terms contained in the Definitions Section or in the specific Plan option in which you are enrolled. It will be helpful to refer to these definitions as you review your benefits.

If you have difficulty in understanding the Point of Service, BasicSelect or High Deductible Health Plan options described in this booklet or your rights under this portion of the Plan, you may contact the Medical Contract Administrator for assistance between 8 a.m. and 5 p.m., Monday through Friday, using the telephone number listed on the General Information section. A customer service representative will assist you in determining your rights and benefits available under the Plan. If you have difficulty understanding the Flexible Spending Account option, you may contact the Flexible Spending Account Administrator. If you have difficulty understanding the Health Savings Account option described in this booklet, please contact your Health Savings Account Administrator.

Any information that you obtain in any manner concerning your rights and benefits may not be relied upon as a guarantee of your rights or that those benefits will be paid in that manner. The availability of benefits is determined solely on the basis of the terms of the Plan as contained in the Plan document. A final determination of your rights and benefits cannot be made until all necessary documentation and information is submitted to the Medical Contract Administrator and your claim is fully adjudicated.

# NOTICES

## HIPAA Special Enrollment Rights

If you are an Employee who declines enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage (or if the Employer stopped contributing towards your or your dependents' other coverage). However, you must request enrollment within thirty-one (31) days after your or your dependents' other coverage ends (or after the Employer stops contributing toward the other coverage).

In addition, if you are an Employee or Retiree and you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within thirty-one (31) days after your marriage and within sixty (60) days after dependent child birth, adoption, or placement for adoption. See the definition of Eligible Retiree for limitations on when a Retiree or a Retiree's Eligible Dependent may enroll in the Plan.

To request special enrollment or obtain more information, contact the Plan Administrator.

## Newborns and Mothers Health Protection Act of 1996

Group health plans generally may not, under federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a Caesarean section, or require that a provider obtain authorization from the plan for prescribing a length of stay not in excess of the above periods. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consultation with the mother, from discharging the mother or her newborn earlier than forty-eight (48) hours (or ninety-six (96) hours, as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

## Women's Health and Cancer Rights

Federal law requires this Plan to provide the following benefits for elective breast reconstruction in connection with a mastectomy:

(A) Reconstruction of the breast on which the mastectomy has been performed;

(B) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

(C) Prostheses and treatment of physical complications in all stages of mastectomy, including lymphedemas

in a manner determined in consultation with the attending Physician and the patient. Such coverage is subject to all other Plan terms and limitations.

**Wellness Program**

Employees and dependents in the City of Springfield Plan are eligible for a free annual wellness screening. The screening is voluntary, but participants who complete the screening in accordance with the terms and conditions outlined by the City of Springfield will be eligible for a reduction in their required contribution for health benefits. The City of Springfield will provide you with additional details regarding the timing and process for taking advantage of your free wellness screening, as well as the contribution requirement for persons who complete the wellness screening and for those who do not, annually at open enrollment.

The wellness program is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will receive an incentive for meeting the criteria specified in the open enrollment materials. Although you are not required to complete the HRA or participate in the biometric screening, only employees who do so will receive the incentive.

Additional incentives may be available for employees who participate in certain health-related activities or achieve certain health outcomes. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting the Plan Administrator.

The information from your HRA and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program. You also are encouraged to share your results or concerns with your own doctor.

***Protections from Disclosure of Medical Information***

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and the City of Springfield may use aggregate information it collects to design a program based on identified health risks in the workplace, the wellness program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in

connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) those necessary in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact the Plan Administrator.

**Premium Assistance Under Medicaid and the Children's Insurance Program (CHIP)**

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you are not already enrolled. This is called a "special enrollment" opportunity, and you

must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

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**If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2020. Contact your State for more information on eligibility –**

| **ALABAMA – Medicaid** | **COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)** |
|---|---|
| Website: http://myalhipp.com/<br><br>Phone: 1-855-692-5447 | Health First Colorado Website: https://www.healthfirstcolorado.com/<br><br>Health First Colorado Member Contact Center:<br><br>1-800-221-3943/ State Relay 711<br><br>CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus<br><br>CHP+ Customer Service: 1-800-359-1991/ State Relay 711<br><br>Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program<br>HIBI Customer Service: 1-855-692-6442 |
| **ALASKA – Medicaid** | **FLORIDA – Medicaid** |
| The AK Health Insurance Premium Payment Program<br><br>Website: http://myakhipp.com/<br><br>Phone: 1-866-251-4861<br><br>Email: CustomerService@MyAKHIPP.com<br><br>Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx | Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html<br><br>Phone: 1-877-357-3268 |
| **ARKANSAS – Medicaid** | **GEORGIA – Medicaid** |
| Website: http://myarhipp.com/<br><br>Phone: 1-855-MyARHIPP (855-692-7447) | Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp<br><br>Phone: 678-564-1162 ext 2131 |

| CALIFORNIA – Medicaid | INDIANA – Medicaid |
| --- | --- |
| Website:<br>https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx<br><br>Phone: 916-440-5676 | Healthy Indiana Plan for low-income adults 19-64<br><br>Website: http://www.in.gov/fssa/hip/<br><br>Phone: 1-877-438-4479<br><br>All other Medicaid<br><br>Website: https://www.in.gov/medicaid/<br><br>Phone 1-800-457-4584 |

| IOWA – Medicaid and CHIP (Hawki) | MONTANA – Medicaid |
|---|---|
| Medicaid Website:<br><br>https://dhs.iowa.gov/ime/members<br>Medicaid Phone: 1-800-338-8366<br><br>Hawki Website:<br><br>http://dhs.iowa.gov/Hawki<br><br>Hawki Phone: 1-800-257-8563 | Website:<br>http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP<br><br>Phone: 1-800-694-3084 |
| **KANSAS – Medicaid** | **NEBRASKA – Medicaid** |
| Website: http://www.kdheks.gov/hcf/default.htm<br><br>Phone: 1-800-792-4884 | Website: http://www.ACCESSNebraska.ne.gov<br><br>Phone: 1-855-632-7633<br><br>Lincoln: 402-473-7000<br><br>Omaha: 402-595-1178 |
| **KENTUCKY – Medicaid** | **NEVADA – Medicaid** |
| Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:<br><br>https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx<br><br>Phone: 1-855-459-6328<br><br>Email: KIHIPP.PROGRAM@ky.gov<br><br>KCHIP Website:<br>https://kidshealth.ky.gov/Pages/index.aspx<br><br>Phone: 1-877-524-4718<br><br>Kentucky Medicaid Website: https://chfs.ky.gov | Medicaid Website: http://dhcfp.nv.gov<br><br>Medicaid Phone: 1-800-992-0900 |
| **LOUISIANA – Medicaid** | **NEW HAMPSHIRE – Medicaid** |
| Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp<br><br>Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP) | Website: https://www.dhhs.nh.gov/oii/hipp.htm<br><br>Phone: 603-271-5218 |

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|---|---|
| | Toll free number for the HIPP program: 1-800-852-3345, ext 5218 |
| **MAINE – Medicaid** | **NEW JERSEY – Medicaid and CHIP** |
| Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms<br><br>Phone: 1-800-442-6003<br><br>TTY: Maine relay 711<br><br>Private Health Insurance Premium Webpage:<br><br>https://www.maine.gov/dhhs/ofi/applications-forms<br><br>Phone: -800-977-6740.<br><br>TTY: Maine relay 711 | Medicaid Website:<br><br>http://www.state.nj.us/humanservices/<br><br>dmahs/clients/medicaid/<br><br>Medicaid Phone: 609-631-2392<br><br>CHIP Website: http://www.njfamilycare.org/index.html<br><br>CHIP Phone: 1-800-701-0710 |
| **MASSACHUSETTS – Medicaid and CHIP** | **NEW YORK – Medicaid** |
| Website: http://www.mass.gov/eohhs/gov/departments/masshealth/<br><br>Phone: 1-800-862-4840 | Website: https://www.health.ny.gov/health_care/medicaid/<br><br>Phone: 1-800-541-2831 |
| **MINNESOTA – Medicaid** | **NORTH CAROLINA – Medicaid** |
| Website:<br><br>https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp<br><br>Phone: 1-800-657-3739 | Website: https://medicaid.ncdhhs.gov/<br><br>Phone: 919-855-4100 |
| **MISSOURI – Medicaid** | **NORTH DAKOTA – Medicaid** |
| Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm<br><br>Phone: 573-751-2005 | Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/<br><br>Phone: 1-844-854-4825 |

| OKLAHOMA – Medicaid and CHIP | UTAH – Medicaid and CHIP |
|---|---|
| Website: http://www.insureoklahoma.org<br><br>Phone: 1-888-365-3742 | Medicaid Website: https://medicaid.utah.gov/<br><br>CHIP Website: http://health.utah.gov/chip<br><br>Phone: 1-877-543-7669 |
| **OREGON – Medicaid** | **VERMONT– Medicaid** |
| Website:<br>http://healthcare.oregon.gov/Pages/index.aspx<br><br>http://www.oregonhealthcare.gov/index-es.html<br><br>Phone: 1-800-699-9075 | Website: http://www.greenmountaincare.org/<br><br>Phone: 1-800-250-8427 |
| **PENNSYLVANIA – Medicaid** | **VIRGINIA – Medicaid and CHIP** |
| Website:<br>https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx<br><br>Phone: 1-800-692-7462 | Website: https://www.coverva.org/hipp/<br><br>Medicaid Phone: 1-800-432-5924<br><br>CHIP Phone: 1-855-242-8282 |
| **RHODE ISLAND – Medicaid and CHIP** | **WASHINGTON – Medicaid** |
| Website: http://www.eohhs.ri.gov/<br><br>Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line) | Website: https://www.hca.wa.gov/<br><br>Phone: 1-800-562-3022 |
| **SOUTH CAROLINA – Medicaid** | **WEST VIRGINIA – Medicaid** |
| Website: https://www.scdhhs.gov<br><br>Phone: 1-888-549-0820 | Website: http://mywvhipp.com/<br><br>Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447) |
| **SOUTH DAKOTA - Medicaid** | **WISCONSIN – Medicaid and CHIP** |
| Website: http://dss.sd.gov<br><br>Phone: 1-888-828-0059 | Website:<br><br>https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm<br><br>Phone: 1-800-362-3002 |

| TEXAS – Medicaid | WYOMING – Medicaid |
|---|---|
| Website: http://gethipptexas.com/<br><br>Phone: 1-800-440-0493 | Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/<br><br>Phone: 1-800-251-1269 |

To see if any other states have added a premium assistance program since July 31, 2020 or for more information on special enrollment rights, contact either:

**U.S. Department of Labor**
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

**U.S. Department of Health and Human Services**
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

## GENERAL INFORMATION

These benefits are for all validly enrolled Employees, Dependents, Retirees and those Employees who have chosen to continue coverage under COBRA, of the City of Springfield.

The following information, together with the information contained in this booklet, form the Summary Plan Description of the Plan.

| | | |
|---|---|---|
| ***Name of Plan:*** | | ***City of Springfield Health Benefit Plan*** |
| 1. | Name and Address of Plan Sponsors: | ***City of Springfield***<br>***Room 309, Municipal Center West***<br>***300 S. Seventh***<br>***Springfield, IL 62701***<br>***1-217-789-2446*** |
| 2. | Employer Identification Number: | ***37-6002037*** |
| 3. | Plan Number: | ***501*** |
| 4. | Type of Plan: | ***Welfare benefit plan providing medical and prescription drug benefits*** |
| 5. | Funding: | ***The medical and prescription drug benefit plans are self-funded by the City of Springfield Self-Insurance Fund. As a result, claims are paid directly out of the general fund of the City of Springfield.*** |
| 6. | Plan Administrator: | ***City of Springfield*** |
| 7. | Plan Design: | ***City of Springfield*** |
| 8. | Medical Contract Administrator: | ***Trustmark Health Benefits***<br>***6240 Spring Parkway***<br>***Suite 400***<br>***Overland Park, KS 66251*** |
| 9. | Adverse Determination Review Facilitator for Administrative Reviews: | ***First Level Appeal***<br>***Trustmark Health Benefits***<br>***6240 Spring Parkway***<br>***Suite 400***<br>***Overland Park, KS 66251***<br><br>***Second Level Appeal***<br>***Health Care Management Organization***<br>***1-800-708-4451*** |

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|---|---|---|
| ***Name of Plan:*** | | ***City of Springfield Health Benefit Plan*** |
| 10. | Adverse Determination Review Facilitator for Medical Reviews: | ***First Level Appeal***<br>***Trustmark Health Benefits***<br>***6240 Spring Parkway***<br>***Suite 400***<br>***Overland Park, KS 66251***<br>***1-800-708-4451***<br><br>***Second Level Appeal***<br>***Health Care Management Organization***<br>***1-800-708-4451*** |
| 11. | Utilization Review Administrator: (Basic Select, POS and HDHP) | ***Trustmark Health Benefits***<br>***6240 Spring Parkway***<br>***Suite 400***<br>***Overland Park, KS 66251***<br>***1-800-708-4451*** |
| 12. | Preferred Provider Organizations HealthLink, Inc.: | ***HealthLink, Inc.***<br>***P.O. Box 419104***<br>***St. Louis, MO 63141-9104***<br>***1-800-624-2356***<br>***www.healthlink.com*** |
| 13. | PHCS: | ***PHCS***<br>***1-800-922-4362***<br>***www.multiplan.com*** |
| 14. | Prescription Drug Card Administrator: | ***Elixir Solutions***<br>***10895 Lowell Ave, Suite 100***<br>***Overland Park, KS 66210***<br>***1-800-771-4648***<br>***www.medtrakrx.com*** |
| 15. | Prescription Mail-Order Service: | ***AllianceRx Walgreens Prime***<br>***P.O. Box 29061***<br>***Phoenix, AZ 85038-9061***<br>***1-800-345-1985*** |
| 16. | Flexible Spending Account Administrator: | ***Connect Your Care***<br>***1-877-292-4040***<br>***www.connectyourcare.com*** |
| 17. | Agent for Service for Legal Process: | ***City Clerk***<br>***City of Springfield***<br>***Room 108, Municipal Center West***<br>***300 S. Seventh***<br>***Springfield, IL 62701***<br>***1-217-789-2216*** |

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|---|---|---|
| ***Name of Plan:*** | | ***City of Springfield Health Benefit Plan*** |
| 18. | Cobra Notice Coordinator: | ***City of Springfield***<br>***Office of Human Resources***<br>***Room 309, Municipal Center West***<br>***300 S. Seventh***<br>***Springfield, IL 62701***<br>***1-217-789-2446*** |
| 19. | Sources of Contribution to the Plan: | ***The cost of providing benefits under the Plan is shared by the Employer and Employees. A schedule will be distributed periodically setting forth the current cost of benefits and the amount of those costs that are paid by the Employer and the Employees.*** |
| 20. | Fiscal Year of the Plan: | ***March 1 through February 28 (February 29 in Leap Years)*** |
| 21. | Effective Date of the Plan Restatement: | ***March 1, 2021*** |
| 22. | Accounting: | ***Periodic financial statements are reported to the Internal Revenue Service. An annual audit is conducted by an independent certified public accountant.*** |

## ERROR REWARD PROGRAM

The City of Springfield has elected to establish an Employee Error Reward Program as part of its Health Benefit Program. The Error Reward Program is offered to encourage Covered Persons and Covered Dependents to assist the City of Springfield in ensuring the providers of medical services and other medical benefits bill the proper and appropriate amounts for Covered Services.

Each Covered Person is encouraged to review all medical statements, invoices or other documents received from any medical service provider for any medical service provided or that relate to any claim for benefits under the City of Springfield Health Benefit Plan. If an error or discrepancy in the billing statement, invoice or other document is found, the Covered Person is encouraged to write a letter addressing the discrepancy or complete the Employer Error Reward Claim Form available through the City of Springfield Office of Human Resources (HR). The letter or completed form must be returned to the Office of Human Resources accompanied by the original bill and evidence supporting the participant's claim. Other required documentation includes the following:

(A) A certified letter of confirmation verifying the error from the health provider or a recalculated bill from the provider; and

(B) The Explanation of Benefits (EOB) supporting the Covered Person's claim or, if an EOB is not applicable, an itemized receipt.

The City of Springfield reserves the right to request additional documentation or information, if necessary, for the completion of the investigation of any alleged error.

If the City of Springfield Health Benefit Program is successful in obtaining a reduction in the cost of the Covered Services as a result of information received from the Covered Person such Covered Person shall be eligible for a reward. This reward shall be 20% of the amount saved by the Plan, up to a maximum of $500 per medical claim per year with a maximum of $2,000 per Plan Year.

### Claim Eligibility Exclusions

The Employee Error Reward is not applicable to the following:

(A) Errors that are duplicate charges (duplicate payment will be considered);

(B) Subrogation Claims;

(C) Errors already found by the City Administration, the Third Party Administrator or the medical provider;

(D) Claims corrected as the result of an appeal;

(E) Worker's Compensation claims;

(F) Checks never received and/or never cashed; or

(G) Any claims submitted beyond the twelve (12) months after the Covered Service is provided. Consideration of a claim after the twelve-month time period requires prior approval by the Plan.

**Claim Eligibility Inclusions**

The Employee Error Reward is applicable to the following:

(A) Incorrect Coordination of Benefits (COB) provided written documentation of the other insurance enrollment has been presented to the City's claims processor prior to the original processing of the claim;

(B) Duplicate Payment;

(C) Incorrect Billing;

(D) Services charged but not received by the Participant;

(E) Overpayment;

(F) Any discount from any medical provider to which the Plan was entitled but failed to receive;

(G) Incorrect PPO Discount;

(H) Processing Error; and

(I) Claims paid on the wrong patient.

**Claims Processing**

Once the appropriate documentation is received from the participant, the Office of Human Resources will complete the following:

(A) A written acknowledgement and review of the claim describing the error.

(B) The Office of Human Resources Benefits Division will forward all documentation to the implicated Third Party Administrator (TPA) for review and a written response.

(C) The TPA must review the alleged claim discrepancy and respond back to the Office of Human Resources regarding the participant's claim within ten (10) working days of receipt of the requested review. Failure to do so will result in the claim being presented to the Plan without the TPA's explanation.

(D) Once received, the Office of Human Resources will compile the TPA's review in conjunction with the Member's claim and assign a reward claim number maintaining the anonymity of the member.

(E) Once assigned, the anonymous claim will be presented to the Plan for consideration regarding the validity of the claim.

(F) If the Error Reward is approved, the Plan will determine the total dollar amount of the claim eligible for the 20% reward.

(G) If the designated TPA is found to be liable for the error, the City will offset the 20% payment to the Covered Person by billing the appropriate TPA committing the oversight.

(H) If the source of the error is the TPA, the reward payment to the Covered Person is not contingent upon the Plan receiving the 20% reimbursement from the TPA prior to the Plan issuing the reward to the Participant.

(I) The City's Medical Contract Administrator will be notified for accounting purposes and to assist the City in recovering the funds paid in error for medical services.

(J) If the Error Reward is found to be non-compensable by the Plan, a letter from the Office of Human Resources will be forwarded to the Member and the TPA explaining the results of the decision.

**Refund and Award Procedures**

(A) Once the medical provider submits the refund to the Medical Contract Administrator will forward the recovered funds, identified as an Error Reward Reimbursement, to the Office of Human Resources.

(B) The Office of Human Resources will deposit the recovered funds based on the revenue source established by the Office of Budget and Management.

(C) Only when the funds are recovered may the Office of Human Resources implement the appropriate processing procedure, based on the Primary Member's status, to issue the refund.

(D) Employees

(1) The reward is only applicable to the Primary Member. If a family member files a claim, the claim is reviewed and the award is generated in the name of the Primary Member. If the Primary Member is an Employee, the Primary Member is subject to regular payroll withholdings for any monies received through the Error Reward Program.

(2) The Benefits Division will forward all accompanying documentation to the Office of Budget and Management Accounting Department for review, processing and the assignment of the expenditure codes. Documentation includes, but is not limited to, the following:

(a) the actual claim;

(b) information substantiating the claim;

(c) documentation identifying the approved award by the Plan;

(d) acknowledgement that the Health Insurance Fund has been reimbursed for the error;

(e) the signature of the staff member requesting the Office of Budget and Management to process the award; and

(f) the authorization of the Director of Human Resource or his designee approving the distribution of the award.

(3) Upon the direction of the Office of Budget and Management's Chief Accountant, the 20% reward will be included as part of the Employee's regular payroll check in accordance with Federal, State and City regulations.

(4) Based on the issued payroll check to the Employee, Payroll will send an e-mail notification to the Office of Human Resources advising the date the award will be released.

(5) The Office of Human Resources will forward a letter confirming the award to the Participant and an optional request form giving permission to the City to release the name of the member acquiring the reward.

(E) Primary Members other than active Employees

Primary Members, other than Employees (including, but not limited to, retirees, surviving spouse/dependents, etc.) are also eligible to submit Error Reward Claims for consideration.

(1) Reward Claims for Primary Members not on the City's regular Payroll will be processed in accordance with all error reward requirements for non-employee personnel and subject to Federal, State and City reimbursement guidelines, provided the following information is submitted to the Office of Budget and Management:

(a) the actual claim;

(b) information substantiating the claim;

(c) documentation identifying the approved award by the Plan;

(d) acknowledgement that the Health Insurance Fund has been reimbursed for the error;

(e) the signature of the HR staff member requesting the Office of Budget and Management to process the reward; and

(f) the authorization of the Director of Human Resources or his designee approving the disbursement of funds.

(2) Upon the direction of the Office of Budget and Management's Chief Accountant, the Error Reward Claim will be processed through the Office of Budget and Management Accounts Payable and may be subject to 1099 reporting.

(3) Once the check is produced, it will be returned to the Office of Human Resources for disbursement. HR will forward to the Primary Member who is not an active employee the check, a letter of award and an optional request form providing the City the authority to release the name of the awarded member.

## PREFERRED PROVIDER FACILITY PROGRAM

### BasicSelect Participants (PPO)

The following Network Providers are recognized by the City of Springfield. This list is subject to change at any time, subject to the sole discretion of the City of Springfield.

| | |
|---|---|
| Illinois, Missouri and within the HealthLink Network Service Area: | HealthLink Network Providers |
| Out-of-area for current Network Providers: | MultiPlan |
| All other Areas: | PHCS Network Providers |

### Point of Service Participants (OAIII)

The following Network Providers are recognized by the City of Springfield. This list is subject to change at any time, subject to the sole discretion of the City of Springfield.

| | |
|---|---|
| Illinois, Missouri and within the HealthLink Network Service Area: | HealthLink Network Providers (HMO-Tier 1 and PPO-Tier 2) |
| Out-of-area for current Network Providers: | MultiPlan |
| All other Areas: (PPO-Tier 2) | PHCS Network Providers |

### High Deductible Health Plan

The following Network Providers are recognized by the City of Springfield. This list is subject to change at any time, subject to the sole discretion of the City of Springfield.

| | |
|---|---|
| Illinois, Missouri and within the HealthLink Network Service Area: | HealthLink Network Providers |
| Out-of-area for current Network Providers: | MultiPlan |
| All other Areas: | PHCS Network Providers |

### Penalty for not using a Network Hospital for In-Patient or Out-Patient Services

Any non-Emergency Treatment received at an Out-of-Network Hospital will be subject to a penalty equal to the billed amount or $2,000, whichever is less. If the treatment cannot be received at an In-Network Provider Hospital, the penalty will not apply if the care was pre-approved by Trustmark who is the Utilization Review Administrator of the medical plan involved.

**Notice**

Information on Network Providers is available, free of charge, from the Preferred Provider Organization(s) listed in the General Information section of this document or from the Employer and is subject to change at any time.

# SUMMARY OF BENEFITS

The schedules in this section provide a summary of Plan benefits. Please read the remainder of this booklet carefully for a detailed explanation of Plan benefits and limitations.

| **SUMMARY OF BENEFITS**<br>**BASICSELECT (PPO)**<br>**March 1, 2021** | | |
|---|---|---|
| | **IN-NETWORK** | **OUT-OF-NETWORK** |
| | **HealthLink & PHCS** | **All Others** |
| **LIFETIME MAXIMUMS** | | |
| Infertility | $10,000 | |
| Bariatric Surgery | $25,000 | |
| **PLAN YEAR MAXIMUMS*, combined In-Network and Out-of-Network*** | | |
| Chiropractic Care | 60 visits per plan year. Visit limits are combined with physical, speech & occupational therapy.<br><br>Out-of-Network providers are limited to $1,000 per plan year. | |
| Therapy - Physical, Speech & Occupational | 60 visits per plan year, combined with chiropractic care, physical, speech & occupational therapy. | |
| Acupuncture | $500 per plan year | |
| Home Health Care | 80 visits per plan year | |
| **DEDUCTIBLE*, combined In-Network and Out-of-Network*** | | |
| Individual | $500 | $500 |
| Family | $1,500 | $2,500 |
| **OUT-OF-POCKET*, does not include prescription drug expenses. Combined In-Network and Out-of-Network*** | | |
| Individual | $1,000 | Unlimited |
| Family | $3,000 | Unlimited |
| **OFFICE VISITS** | | |
| PCP | $40 copay per visit | $40 copay per visit |
| Specialist | $60 copay per visit | $60 copay per visit |
| Chiropractic – *plan year maximums apply* | $40 copay per visit | $40 copay per visit |
| All Other Services | You pay 30% | You pay 40% |
| Acupuncture – *plan year maximums apply* | You pay 30% | You pay 40% |
| Preventive/Well Care | You pay $0 | Not Covered |
| Immunizations | You pay $0 | Not Covered |

| SUMMARY OF BENEFITS<br>BASICSELECT (PPO)<br>March 1, 2021 | | |
|---|---|---|
| | **IN-NETWORK** | **OUT-OF-NETWORK** |
| | **HealthLink & PHCS** | **All Others** |
| **NUTRITIONAL COUNSELING** | | |
| Physician's Office | $40 copay per visit | $40 copay per visit |
| Outpatient Hospital | $50 copay per visit | $50 copay per visit |
| **EMERGENCY CARE** | | |
| Emergency Room | You pay $250 copay, then 30% | You pay $250 copay, then 30% |
| Emergency Medical Transport | You pay 30% | You pay 30% |
| **URGENT CARE** | | |
| Free Standing Facility | You pay $40 copay | You pay $40 copay |
| Outpatient Hospital Facility | You pay $50 copay, then 30% | You pay $50 copay, then 40% |
| Outpatient Hospital Testing | You pay $30 copay, then 30% | You pay $50 copay, then 40% |
| **OUTPATIENT** | | |
| Hospital X-Rays/Labs | You pay $50 copay, then 30% | You pay $50 copay, then 40% |
| **INPATIENT** | | |
| Hospital | $300 copay per admission, then 30% | $300 copay per admission, then 40% |
| Skilled Nursing | $300 copay per admission, then 30% | $300 copay per admission, then 40% |
| **OTHER SERVICES** | | |
| Home Health Care | You pay 30% | You pay 40% |
| Hospice | You pay 30% | You pay 40% |
| Durable Medical Equipment | You pay 30% | You pay 40% |
| **PRESCRIPTIONS** | | |
| Individual Deductible | $50 | Not Covered |
| Family Deductible | $150 | Not Covered |
| Individual Out of Pocket | $1,000 | Not Covered |
| Family Out of Pocket | $3,000 | Not Covered |
| Specialty Drugs | You pay $50 copay | Not Covered |
| Retail, 1-34 day supply | | |
| Generic Drugs | You pay $15 copay | Not Covered |
| Preferred Brand Drugs | You pay $25 copay | Not Covered |
| Non-Preferred Brand Drugs | You pay $45 copay | Not Covered |
| Retail, 84-90 day supply | | |

| SUMMARY OF BENEFITS<br>BASICSELECT (PPO)<br>March 1, 2021 | | |
|---|---|---|
| | **IN-NETWORK** | **OUT-OF-NETWORK** |
| | **HealthLink & PHCS** | **All Others** |
| Generic Drugs | You pay $45 copay | Not Covered |
| Preferred Brand Drugs | You pay $75 copay | Not Covered |
| Non-Preferred Brand Drugs | You pay $135 copay | Not Covered |
| Mail Order, 84-90 day supply | | |
| Generic Drugs | You pay $25 copay | Not Covered |
| Preferred Brand Drugs | You pay $50 copay | Not Covered |
| Non-Preferred Brand Drugs | You pay $100 copay | Not Covered |

| SUMMARY OF BENEFITS<br>POINT OF SERVICE - OPEN ACCESS III<br>March 1, 2021 | | | |
|---|---|---|---|
| | **IN-NETWORK** | | **OUT-OF-NETWORK** |
| | **HealthLink** | **PHCS** | **All Others** |
| **LIFETIME MAXIMUMS, *combined In-Network and Out-of-Network*** | | | |
| Infertility | $10,000 | | |
| Bariatric Surgery | $25,000 | | |
| **PLAN YEAR MAXIMUMS, *combined In-Network and Out-of-Network*** | | | |
| Chiropractic Care | 60 visits per plan year. Visit limits are combined with physical, speech & occupational therapy.<br><br>Out-of-Network providers are limited to $1,000 per plan year. | | |
| Therapy - Physical, Speech & Occupational | 60 visits per plan year, combined with chiropractic care, physical, speech & occupational therapy. | | |
| Acupuncture | $500 per plan year | | |
| Home Health Care | 80 visits per plan year | | |
| **DEDUCTIBLE** | | | |
| Individual | $200 | | $500 |
| Family | $600 | | $1,500 |
| **OUT-OF-POCKET** | | | |
| Individual | $1,000 | | Unlimited |
| Family | $2,250 | | Unlimited |
| **OFFICE VISITS** | | | |
| PCP | $20 copay per visit | $20 copay per visit | You pay 30% |
| Specialist | $40 copay per visit | $40 copay per visit | You pay 30% |
| Chiropractic - *plan year maximums apply* | $20 copay per visit | $20 copay per visit | You pay 30% |
| All Other Services | You pay 15% | You pay 20% | You pay 30% |
| Acupuncture - *plan year maximums apply* | You pay 15% | You pay 20% | You pay 30% |
| Preventive/Well Care | You pay $0 | You pay $0 | Not Covered |
| **NUTRITIONAL COUNSELING** | | | |
| Physician's Office | $20 copay per visit | $20 copay per visit | $20 copay per visit |
| Outpatient Hospital | $50 copay per visit | $50 copay per visit | $50 copay per visit |

| SUMMARY OF BENEFITS<br>POINT OF SERVICE - OPEN ACCESS III<br>March 1, 2021 | | | |
|---|---|---|---|
| Emergency Room | You pay $250 copay, then 15% | You pay $250 copay, then 15% | You pay $250 copay, then 15% |
| Emergency Medical Transport | You pay 15% | You pay 15% | You pay 15% |
| **URGENT CARE** | | | |
| Free Standing Facility | You pay $50 copay | You pay $50 copay | You pay $50 copay |
| Outpatient Hospital Facility | You pay $50 copay, then 15% | You pay $50 copay, then 20% | You pay $50 copay, then 30% |
| Outpatient Hospital Testing | You pay $50 copay | You pay $50 copay | You pay $50 copay |
| **OUTPATIENT** | | | |
| Hospital X-Rays/Labs | You pay $50 copay, then 15% | You pay $50 copay, then 20% | You pay $50 copay, then 30% |
| **INPATIENT** | | | |
| Hospital | You pay 15% | You pay 20% | You pay 30% |
| Skilled Nursing | You pay 15% | You pay 20% | You pay 30% |
| **OTHER SERVICES** | | | |
| Home Health Care | You pay 15% | You pay 20% | You pay 30% |
| Hospice | You pay 15% | You pay 20% | You pay 30% |
| Durable Medical Equipment | You pay 15% | You pay 20% | You pay 30% |
| **PRESCRIPTIONS** | | | |
| Individual Deductible | $50 | $50 | Not Covered |
| Family Deductible | $150 | $150 | Not Covered |
| Individual Out-of-Pocket | $1,000 | $1,000 | Not Covered |
| Family Out-of-Pocket | $3,000 | $3,000 | Not Covered |
| Specialty Drugs | You pay $50 copay | You pay $50 copay | Not Covered |
| Retail, 1-34 day supply | | | |
| Generic Drugs | You pay $10 copay | You pay $10 copay | Not Covered |
| Preferred Brand Drugs | You pay $20 copay | You pay $20 copay | Not Covered |
| Non-Preferred Brand Drugs | You pay $40 copay | You pay $40 copay | Not Covered |
| Retail, 84-90 day supply | | | |
| Generic Drugs | You pay $30 copay | You pay $30 copay | Not Covered |
| Preferred Brand Drugs | You pay $60 copay | You pay $60 copay | Not Covered |
| Non-Preferred Brand Drugs | You pay $120 copay | You pay $120 copay | Not Covered |
| Mail Order, 84-90 day supply | | | |
| Generic Drugs | You pay $25 copay | You pay $25 copay | Not Covered |
| Preferred Brand Drugs | You pay $50 copay | You pay $50 copay | Not Covered |
| Non-Preferred Brand Drugs | You pay $100 copay | You pay $100 copay | Not Covered |

| SUMMARY OF BENEFITS<br>HIGH DEDUCTIBLE HEALTH PLAN<br>March 1, 2021 | | |
|---|---|---|
| | **IN-NETWORK** | **OUT-OF-NETWORK** |
| | **HealthLink & PHCS** | **All Others** |
| **LIFETIME MAXIMUMS*, combined In-Network and Out-of-Network*** | | |
| Infertility | $10,000 | |
| Bariatric Surgery | $25,000 | |
| **PLAN YEAR MAXIMUMS*, combined In-Network and Out-of-Network*** | | |
| Chiropractic Care | 60 visits per plan year. Visit limits are combined with physical, speech & occupational therapy.<br><br>Out-of-Network providers are limited to $1,000 per plan year. | |
| Therapy - Physical, Speech & Occupational | 60 visits per plan year, combined with chiropractic care, physical, speech & occupational therapy. | |
| Acupuncture | $500 per plan year | |
| Home Health Care | 80 visits per plan year | |
| **Deductible*, include medical and Rx*** | | |
| Individual | $2,800 | $5,600 |
| Family | $5,600 | $11,200 |
| **Out-of-Pocket*, includes medical and Rx*** | | |
| Individual | $2,800 | $11,200 |
| Family | $5,600 | $22,400 |
| **OFFICE VISITS** | | |
| PCP, Specialist and Chiropractic | You pay $0 after deductible | You pay 20% after deductible |
| Acupuncture | You pay $0 after deductible | You pay 20% after deductible |
| Preventive/Well Care | You pay $0 | Not covered |
| All Other Services | You pay $0 after deductible | You pay 20% after deductible |
| **NUTRITIONAL COUNSELING** | | |
| Physician's Office | You pay $0 after deductible | You pay 20% after deductible |
| Outpatient Hospital | You pay $0 after deductible | You pay 20% after deductible |
| **EMERGENCY CARE** | | |
| Emergency Room | You pay $0 after deductible | You pay $0 after deductible |

| SUMMARY OF BENEFITS<br>HIGH DEDUCTIBLE HEALTH PLAN<br>March 1, 2021 | | |
|---|---|---|
| | **IN-NETWORK** | **OUT-OF-NETWORK** |
| | **HealthLink & PHCS** | **All Others** |
| Emergency Medical Transport | You pay $0 after deductible | You pay $0 after deductible |
| **URGENT CARE** | | |
| Free Standing Facility | You pay $0 after deductible | You pay 20% after deductible |
| Outpatient Hospital Facility | You pay $0 after deductible | You pay 20% after deductible |
| Outpatient Hospital Testing | You pay $0 after deductible | You pay 20% after deductible |
| **OUTPATIENT** | | |
| Hospital X-Rays/Labs | You pay $0 after deductible | You pay 20% after deductible |
| **INPATIENT** | | |
| Hospital | You pay $0 after deductible | You pay 20% after deductible |
| Skilled Nursing | You pay $0 after deductible | You pay 20% after deductible |
| **OTHER SERVICES** | | |
| Home Health Care | You pay $0 after deductible | You pay 20% after deductible |
| Hospice | You pay $0 after deductible | You pay 20% after deductible |
| Durable Medical Equipment | You pay $0 after deductible | You pay 20% after deductible |
| **PRESCRIPTIONS** | | |
| Specialty Drugs | You pay $0 after deductible | Not Covered |
| Retail, 1-34 day supply | | |
| Generic Drugs | You pay $0 after deductible | Not Covered |
| Preferred Brand Drugs | You pay $0 after deductible | Not Covered |
| Non-Preferred Brand Drugs | You pay $0 after deductible | Not Covered |
| Retail, 84-90 day supply | | |
| Generic Drugs | You pay $0 after deductible | Not Covered |
| Preferred Brand Drugs | You pay $0 after deductible | Not Covered |
| Non-Preferred Brand Drugs | You pay $0 after deductible | Not Covered |
| Mail Order, 84-90 day supply | | |
| Generic Drugs | You pay $0 after deductible | Not Covered |
| Preferred Brand Drugs | You pay $0 after deductible | Not Covered |
| Non-Preferred Brand Drugs | You pay $0 after deductible | Not Covered |

## UTILIZATION REVIEW

The Utilization Review Administrator must be notified prior to any of the following treatments. Failure to do so will result in a penalty in the form of a reduction in benefits otherwise computed. The reduction in benefits shall be the lesser of: (i) actual benefits available under the Plan; or (ii) $500.

### EMERGENCY ADMISSIONS

In an emergency, notification is required within 48 hours prior to admission or the next business day following your admission. If you are unable to call, a family member or friend should call on your behalf. Healthcare providers are not responsible for calling Trustmark, so it is important that you fulfill your obligation to call.

### NON-EMERGENCY OR PLANNED CARE

For non-emergency or planned care, notification is required at least 15 business days before services are rendered for the following:

- Inpatient Admissions
- Partial Admissions
- Home Health Care Services
- Skilled Nursing Services
- Outpatient Weight Loss Services/Treatment
- Outpatient Chemotherapy
- Organ/Tissue Transplant Services/Treatment

## *ARTICLE I PURPOSE*

The Employer has established a medical and prescription drug card benefit plan and desires to have the administration and claims paying functions performed by the Medical and Prescription Drug Card Contract Administrator ("Medical Contract Administrator"). This Plan is adopted for the benefit of the Employees and Retirees of the City of Springfield to provide the benefits as outlined herein.

## *ARTICLE II DEFINITIONS*

Unless otherwise herein indicated, where the following words and phrases appear in this Plan, they shall have the respective meanings set forth in this Article, unless the context clearly indicates to the contrary.

### 2.1 Construction

The masculine gender, where appearing in the Plan, shall be deemed to include the feminine gender, unless the context clearly indicates to the contrary. The words "hereof," "herein," "hereunder" and other similar compounds of the word "here" shall mean and refer to the entire Plan and not to any particular provision or section. Article and Section headings are included for convenience of reference and are not intended to add to, or subtract from, the terms of the Plan.

### 2.2 Definitions

Active Service: A Covered Person will be considered in Active Service on a day that is a scheduled work day if he/she is performing in the customary manner all of the regular duties of his/her employment as a Full-Time Employee either at his/her customary place of employment or at some location at which that employment requires him/her to travel, or if he/she is absent from work solely by reason of vacation. A Covered Person will be considered in Active Service on a day that is not a scheduled workday only if he/she was performing in the customary manner all of the regular duties of his/her employment on the last preceding scheduled workday.

Adult Child: An Employee's biological child, adopted child, foster child, stepchild, or child placed with the Employee for adoption who is under age 26, regardless of residency, dependency, marital status or student status. Adult Child does not include a grandchild, niece, nephew, the child of a domestic/civil union partner or a child for whom the Employee has court-appointed guardianship.

Age and Risk Factor Immunizations: Except where required by law, necessary adult immunizations as determined by your Physician, based on the current Centers for Disease Control and Prevention (CDC) guidelines and Medical Necessity as established by the Utilization Review Manager, based on age, family health history, personal health condition as related to the participant's lifestyle, or as required by law.

Ambulatory Surgical Facility: Any public or private establishment, which is either independent or part of a Hospital, with:

(A) an organized medical staff of Physicians;

(B) permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures;

(C) continuous Physician and Registered Nurse services whenever a patient is in the facility; and

(D) no services or other accommodations for patients to stay overnight.

Autism Spectrum Disorders: Pervasive developmental disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autism, Asperger's disorder and pervasive developmental disorder.

Birthing Center: A facility that is equipped and operated solely to provide prenatal care; to perform uncomplicated, spontaneous deliveries; and to provide immediate postpartum care. A Birthing Center must either be licensed by the state or satisfy all of the following:

(A) be directed by at least one Physician specializing in obstetrics or gynecology;

(B) have a Physician or Nurse Midwife present during each birth;

(C) provide skilled nursing services in the delivery and recovery rooms (under the direction of a Registered Nurse or Nurse Midwife);

(D) have at least two birthing rooms or beds, diagnostic X-ray and lab equipment (or a contract to use such equipment of an area Hospital) and emergency equipment;

(E) admit only patients with low-risk pregnancies (and contract with an area Hospital for transfer of emergency cases); and,

(F) regularly charge for services and supplies.

Chiropractic Services: Treatments including Spinal Manipulations, X-rays and diagnostic services provided by a Chiropractor or Physician.

City of Springfield Health Insurance Program: The self-insured medical plan that operates under the day-to-day administration of the City's Office of Human Resources and the Office of Budget and Management in conjunction with the Plan.

Civil Union: A legal relationship granted to unmarried adult partners by the State of Illinois. A substantially similar legal relationship (other than common law marriage) legally entered into in another jurisdiction when recognized by the State of Illinois shall also be considered a Civil Union.

COBRA: The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Coinsurance Limit: A percentage of Expenses Incurred that must be paid by a Covered Person or Covered Dependent after payment of Deductible Expenses, as determined in accordance with the Summary of Benefits and may be subject to the maximum Out-Of-Pocket limitation specified therein.

Coordination of Benefits: A Plan provision, the purpose of which is to protect the Plan from the overpayment of medical (including prescription drug) claims. The provision applies when a Covered Person or Covered Dependent is covered under two or more health plans at the same time. It is designed so that the payments of all plans do not exceed one-hundred percent (100%) of the covered charges. Coordination of Benefits also designates the order in which health plans pay benefits. One of the two or more plans involved is the Primary Plan and the other plan(s) are Secondary Plans. The Primary Plan pays benefits first and without consideration of the other plans. The Secondary Plan(s) then make up the difference up to the total allowable Expenses Incurred. No plan will pay more than it would have paid without this special provision. When this Plan is a Secondary Plan, it will pay the balance up to the lesser of the two allowed amounts after the Plan's Deductible and Coinsurance are met. Payments from the Primary Plan are applied toward this Plan's Deductible and Coinsurance. The balance due, if any, is the responsibility of the Covered Person.

Covered Dependent: An Eligible Dependent of any Covered Person (Primary Member) for whom coverage became effective (based on the completion of the enrollment form by the Primary Member acknowledging the Covered Dependent) and has not terminated.

Copay/Copayment: The portion of Expenses Incurred that must be paid by a Covered Person or Covered Dependent before benefits are payable. A Copayment may be in place of or in addition to the Plan Year Deductible and Coinsurance amounts as listed in the Summary of Benefits. Copayments will apply to the Out-of-Pocket maximum.

Covered Drug: Any Prescription Legend Drug and such other drugs as may be set forth in the Prescription Drug Card Plan section, when ordered by a Physician by means of a Prescription Order.

Covered Person: An eligible Employee, Surviving Spouse, Dependent child or Retiree who is the Primary Member responsible for the coverage under the Plan becoming effective and for whom coverage has not terminated. Covered Person shall also mean "Member" when referring to the Plans.

Covered Services: Services and supplies specified in the City of Springfield Health Plan document, including any distributed supplements, endorsements and addenda for which benefits are provided, subject to the terms, conditions, limitations and exclusions set forth by the Plan document.

Custodial Care: Care that provides a level of routine maintenance for the purpose of meeting personal needs. This is care that can be provided by a layperson who does not have professional qualifications, skills or training. Custodial Care includes, but is not limited to, the following:

(A) help in walking and getting into or out of bed;

(B) bathing;

(C) dressing;

(D) eating;

(E) administration of or help in using or applying medications, creams or ointments;

(F) routine administration of medical gases after a regime of therapy has been set up;

(G) routine care of a Covered Person, including functions such as changes of dressings, diapers and protective sheets, and periodic turning and positioning in bed;

(H) routine care and maintenance in connection with casts, braces and other similar devices or other equipment and supplies used in the treatment of a Covered Person, such as colostomy and ileostomy bags and in-dwelling catheters;

(I) routine tracheostomy care; or

(J) general supervision of exercise programs, including carrying out of maintenance programs of repetitive exercises that do not require the skills of a therapist and are not skilled rehabilitation services.

Deductible Expenses: The portion of Expenses Incurred that must be paid by a Covered Person or Covered Dependent before any benefits are computed and payable under the Plan.

Dental Services: The care and treatment of the teeth, gums or any services rendered by a dentist or dental surgeon.

Durable Medical Equipment: Equipment that meets all of the following four requirements:

(A) equipment that can be used over again by other patients;

(B) equipment that primarily serves a medical purpose;

(C) equipment that is not useful to people who are not sick or injured; and

(D) equipment that is appropriate for use in the home.

Eligible Dependent:

(A) the Employee's or Retiree's legal spouse or Civil Union partner.

(B) the Employee's or Retiree's biological child, stepchild, adopted child, or a child placed with the Employee or Retiree for adoption who is under age twenty-six (26), without regard to student status, marital status, financial dependency or residency status with the Employee or any other person. Coverage will end on the last day of the month in which the child reaches the applicable limiting age.

The phrase "placed for adoption" refers to a child whom the Employee intends to adopt, whether or not the adoption has become final, and who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption, and the legal process must have commenced.

"Stepchild" refers to your spouse's legitimate child, adopted child or child born out of wedlock. Your Spouse's stepchild by a previous marriage is not your stepchild.

Your Civil Union partner's legitimate child, adopted child, child placed with your partner for adoption or child born out of wedlock will be considered your stepchild. Your partner's stepchild by a previous partnership is not your stepchild.

Under the City of Springfield Health Insurance Program, your stepchild remains a stepchild and an eligible family member after your divorce from, or the death of, the natural parent, provided that the stepchild continues to live with you in a regular parent-child relationship, as defined by the Federal guidelines for a dependent. If your stepchild stops living with you in a regular parent-child relationship, the child is eligible for coverage under the Consolidated Omnibus Reconciliation Act of 1985 ("COBRA") because he/she no longer meets the definition of an eligible child.

(C) an Employee's or Retiree's unmarried child over age twenty-five (25) but less than thirty (30) years of age if a veteran and an Illinois resident who served in the Armed Forces of the United States and who has received a release or discharge other than a dishonorable discharge. (To be eligible for coverage, the eligible child who is a veteran shall submit to the Plan Administrator a form approved by the Illinois Department of Veterans' Affairs stating the date on which he or she was released from service.) Coverage will end on the last day of the month in which the child reaches the applicable limiting age.

(D) an unmarried child not defined in item (2) who is under age 26 for whom the Employee/Retiree has permanent legal guardianship or is required by court order to provide coverage or support for medical expenses. Coverage will end on the last day of the month in which the child reaches the applicable limiting age.

(E) any unmarried child not defined in items B-D above through age of twenty-five (25) years who resides with the Employee who has been designated through the City of Springfield as a Public Safety Act (PSA) Eligible Dependent. Coverage will end on the last day of the month in which the child reaches the applicable limiting age.

(F) a Covered Dependent child as defined in B-D above who reaches the limiting age and is Totally Disabled, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee for support and maintenance and unmarried.

The Plan requires documentation of a Dependent's relationship to the Employee/Retiree but EXCLUDES the following:

(A) any person who is not a permanent resident within the United States of America or Canada;

(B) any person who is covered under this Plan as an Employee/Retiree;

A dependent child who is an Employee's or Retiree's natural child, stepchild, adopted child or a child placed with the Employee for adoption and also qualifies as an eligible Employee may be enrolled as an Employee or as a Dependent of the Employee or Retiree, but not both.

(C) any person (except an Employee's or Retiree's natural child, stepchild, adopted child or a child placed with the Employee or Retiree for adoption) who is on active duty in any military, naval or air force of any country;

(D) a grandchild, niece or nephew (unless the Employee/Retiree has permanent legal guardianship);

(E) any spouse of an Employee/Retiree who is legally separated or divorced from the Employee/Retiree;

(F) any Employee/Retiree's domestic partner who does not qualify as the Employee/Retiree's spouse or Civil Union partner; or

(G) other individuals living in the covered Employee's or Retiree's home but who are not eligible as defined.

See the definition of Eligible Retiree for limitations on when a Retiree's Eligible Dependent may enroll in the Plan.

Eligible Retiree: An Employee who was enrolled in coverage on the day prior to his/her retirement and is eligible for retirement benefits under applicable statutes governing retirement benefits for Municipal employees or as defined in Chapter 36 of the 1988 Springfield City Code of Ordinances, as amended, or pursuant to the Department of Labor regulation 29 CFR Section 2590.7016-(a)(5) and (b) and who elects the continuation of health insurance coverage as a Retiree.

An Employee who was covered as a dependent under a spouse's insurance on the day prior to his/her retirement and elects coverage pursuant to the special enrollment section of the plan document is an Eligible Retiree, provided he/she meets the requirements outlined in above.

Any Eligible Retiree who retired from the City of Springfield prior to March 1, 2017 shall have a one-time opportunity, either during open enrollment or upon experiencing a Qualifying Event, to enroll or re-enroll himself/herself or his/her Eligible Dependents in the Plan.

Any Eligible Retiree, who retired from the City of Springfield on or after March 1, 2017 and remains enrolled in the Plan upon retirement, shall have a one-time opportunity, either during open enrollment or upon experiencing a Qualifying Event, to enroll his/her Eligible Dependents in the Plan.

On or after March 1, 2017, anyone who becomes an Eligible Retiree and has not elected to continue coverage under the Plan upon retirement may not enroll or re-enroll in the Plan at any future date.

For purposes of enrolling a Retiree or his/her Eligible Dependents in the Plan, a "Qualifying Event" includes the Retiree experiencing a loss of coverage, marriage, divorce, birth, adoption or placement for adoption, provided the Retiree applies for coverage within thirty-one (31) days of such Qualifying Event. In addition, if a Retiree becomes entitled to Medicare due to disability, this may be a Qualifying Event permitting a change to a Retiree's coverage and adding or

removing Eligible Dependents, provided the Retiree notifies the Plan Administrator within thirty-one (31) days of becoming entitled to Medicare.

Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson could reasonably expect the absence of medical attention to result in placing a person's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part.

In an emergency, seek immediate care or call 911 if it is available in your area.

Emergency Treatment: A medical screening examination (as required under Section 1867 of the Social Security Act (EMTALA)) within the capability of the Hospital emergency department, including routine ancillary services, to evaluate a Medical Emergency and such further medical examination and treatment as are within the capabilities of the staff and facilities of the Hospital and required under EMTALA to stabilize the patient.

"Medical Emergency" is an accidental Injury or a sudden and unexpected Sickness that has such severe symptoms the absence of immediate medical attention could result in serious and permanent medical consequences.

"Stabilize" means, with respect to a Medical Emergency, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

Emergency Treatment shall not include treatment of symptoms of a chronic condition unless such symptoms are sudden, unexpected and severe.

Employee: A person who is scheduled to work at least twenty (20) hours per week and who is on the regular payroll of the City of Springfield and specifically excludes a seasonal or temporary Employee. "Employee" includes Public Safety Act employees.

Employer: The City of Springfield, Illinois.

Enrollment Area: The geographic area within the service area of the legal residence where covered Health Services are reasonably accessible to members through the Preferred Provider Organizations listed in the General Information section.

Error Reward Program: A program that is offered to encourage Covered Persons and Covered Dependents to assist the Plan in ensuring the providers of medical services and other medical benefits bill the appropriate amount for Covered Services provided to Covered Persons and Covered Dependents. If the Health Plan is successful in obtaining a reduction in cost of the Covered Services as a result of the information received from the Covered Person providing information as to the error, such Covered Person shall be eligible for a reward.

Essential Health Benefits: To the extent they are covered under the Plan, the benefits described in the state of Utah benchmark plan. Such benefits shall be consistent with those set forth under

the Patient Protection and Affordable Care Act of 2010 and any regulation issued pursuant thereto.

Expenses Incurred: Charges for purchases or services rendered. An expense will be deemed to be incurred on the day the purchase is made or on the day the service is rendered for which the charge is made.

Explanation of Benefits (EOB): A statement detailing the medical benefit account activity of Covered Persons and/or Covered Dependents. The Plan or its designee is responsible for providing an Explanation of Benefits (EOB) in response to the filing of a claim. After services are received by a Covered Person or Covered Dependent from a medical provider, an EOB is sent to the individual explaining the services provided and the charges paid and owed. The EOB must include the following information:

(A) name of provider of service;

(B) date(s) of service;

(C) identification of the service;

(D) provider's charge;

(E) the amount or percentage payable after Deductibles, Copayments, Coinsurance or any other reduction of the amount claimed;

(F) an explanation of any denial, reduction or any other reason for not providing full reimbursement of the amount claimed;

(G) telephone number or address where the Covered Person or Covered Dependent may obtain clarification; and

(H) information on how to file an appeal of a denial of benefits, including the applicable timeframes to file.

In most cases, an Explanation of Benefits is not sent or presented for purchases made under the Prescription Drug Program. Instead, a detailed receipt is given at the time of purchase. The detailed receipt will serve as the Explanation of Benefits.

Extended Care Facility: An institution, or a distinct part thereof, that is licensed pursuant to state and local laws and is operated primarily for the purpose of providing skilled nursing care and treatment for individuals convalescing from Injury or Sickness, and

(A) is approved by and is a participating Extended Care Facility of Medicare;

(B) has organized facilities for medical treatment and provides twenty-four hour nursing service under the full-time supervision of a Physician or Registered Nurse;

(C) maintains daily clinical records on each patient and has available the services of a Physician under an established agreement; and

(D) has transfer arrangements with one or more Hospitals, a utilization review plan in effect and operational policies developed with the advice of, and reviewed by, a professional group including at least one Physician.

This definition does not include an institution operated primarily for Custodial Care, care of the aged, or treatment of mental disease, drug addiction or alcoholism.

Flexible Spending Account (FSA) or Section 125 Cafeteria Plan:

Refer to the Flexible Spending Account plan document for additional information.

Flu Shots Are:

(A) Covered by the Plan when administered by a Network Provider, according to the applicable Benefit Schedule.

(B) Reimbursed up to $30 when administered by the Sangamon County Department of Public Health.

Full-Time Employee: A person who is scheduled to work at least thirty (30) hours per week and who is on the regular payroll of the Employer or for whom the Employer has a contractual responsibility to provide coverage and specifically excludes temporary, seasonal or Part-Time Employees. For purposes of this document and Plan, all elected officials, including aldermen, shall be considered Full-Time Employees. Notwithstanding the foregoing, the Employer reserves the right to treat any individual as a full-time employee where necessary to avoid liability under Code Section 4980H, as long as such determination is made on a uniform, nondiscriminatory basis.

Genetic Information: Information about genes, gene products and inherited characteristics that may be derived from an individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes. The definition also includes information derived from an individual's genetic tests; the genetic tests of the individual's family members (first- through fourth-degree relatives); and the manifestation of a condition in the individual's family members. Genetic information also includes the individual's request for, receipt of, or participation in, clinical research for genetic services (tests, counseling and education) and PKU, BRCA1 or BRCA2 tests.

With respect to a pregnant woman (or her family members), genetic information specifically includes information about the fetus she is carrying or any embryo legally held by the individual or a family member.

Genetic information does not include information about an individual's sex or age, a manifested condition that could reasonably be diagnosed by a medical professional, or analysis of proteins or metabolites directly related to a manifested condition.

Gross Misconduct: A deliberate and willful violation of a reasonable rule or policy of the City of Springfield governing the individual's behavior in performance of their work, provided such

violation has harmed the City of Springfield, the employing unit, or other employees or has been repeated by the individual despite a warning or other explicit instructions from the City of Springfield. In addition, Gross Misconduct occurs when an individual engages in a felony or theft related to their employment.

Health Savings Account or HSA: An account established under Section 223 of the Internal Revenue Code. Such arrangements are individual trusts or custodial accounts, each separately established and maintained by a Participant with a qualified trustee or custodian.

High Deductible Health Plan or HDHP: A High Deductible Health Plan is offered by the City of Springfield and is intended to qualify as a high deductible health plan under Section 223(c)(2) of the Internal Revenue Code.

Home Health Care Agency: An organization, or its distinct part, that

(A) is primarily engaged in providing skilled nursing care and other therapeutic services for, and in the private residences of, persons recovering from Sickness or Injury;

(B) is licensed or approved according to any applicable state or local standards and is operated pursuant to policies established by a professional staff, including at least one (1) Physician and one (1) Registered Graduate Nurse;

(C) provides full-time supervision of its services by a Physician or Registered Graduate Nurse, and maintains clinical records on all of its patients;

(D) has a full-time administrator; and

(E) is not, other than incidentally, engaged in providing care or treatment of the mentally ill or in providing custodial type care.

Home Health Care Plan: A program of continued care and treatment for a Covered Person or Covered Dependent, established and approved in writing by the Physician of the Covered Person or Covered Dependent. The program must be accompanied by the Physician's certification that the proper treatment of the Sickness or Injury would require continued confinement as a Hospital in-patient in the absence of the services and supplies provided as part of the Home Health Care Plan.

Hospice Facility: An entity licensed, approved or authorized to provide in-patient medical relief of pain and supportive care to terminally ill patients. Such entity must have on its premises:

(A) organized facilities to care for and treat terminally ill persons and

(B) a paid staff of medical professionals to supervise such care and treatment.

Hospital: An institution that is accredited by the Hospital Accreditation Program of the Joint Commission on Accreditation of Health Care Organizations (JCAHO) and operated in accordance with the laws pertaining to Hospitals, equipped with permanent facilities for diagnosis, Surgery, twenty-four hour continuous nursing service by Registered Nurses, and a staff of one or more Physicians licensed to practice medicine available at all time and which

provides for compensation, medical and surgical treatment for Injury and Sickness on an in-patient basis. In addition, the term Hospital shall include a Birthing Center and an Ambulatory Surgical Facility. The term Hospital does not include a facility specializing in dentistry or an institution that is, other than incidentally, a place for rest, a place for the aged, a place for drug addicts, a place for alcoholics, a convalescent home or a nursing home.

Hospital Confinement/Admission: Being registered as a bed patient in a Hospital upon the recommendation of a Physician, or as a patient in a Hospital because of a surgical operation, or as a patient receiving Emergency Treatment in a Hospital for an Injury.

HSA-Eligible Individual: An individual who is eligible to contribute to an HSA under Section 223 of the Code and who has elected qualifying High Deductible Health Plan coverage offered by the City of Springfield and who has not elected any disqualifying non-High Deductible Health Plan coverage.

Identification Card: Any card or cards issued in conjunction with any Plan offered hereunder.

Immediate Family: A person's spouse, children, siblings, sibling's spouse, parents, grandparents and grandchildren or any person who normally resides in the Covered Person's or Covered Dependent's home.

In-Network (Participating) Provider: A Provider who has entered into a service agreement with a Preferred Provider Organization (PPO) to provide health care services, supplies or accommodations at a reduced charge. The City of Springfield has entered into agreements with the Preferred Provider Organizations listed in the Preferred Provider section to provide services to persons covered under this Plan.

Injury: Accidental bodily Injury of a Covered Person or Covered Dependent that results from an accident occurring while the Plan is in force with respect to that Covered Person or Covered Dependent and results in loss covered by the Plan. All Injuries sustained by a Covered Person or Covered Dependent in connection with a single accident shall be considered one Injury.

Intensive Care Unit: A section, ward or wing within the Hospital that is separated from other Hospital facilities and

(A) is operated exclusively for the purpose of providing professional care and treatment for critically ill patients;

(B) has special supplies and equipment, necessary for such care and treatment, available on a standby basis for immediate use; and

(C) provides Room and Board and constant observation and care by Registered Nurses or other specially trained Hospital personnel.

Key Employee: A salaried Employee eligible for leave under the Family and Medical Leave Act ("FMLA") of 1993 who is among the highest paid ten percent (10%) of all the Employees employed by the Employer within seventy-five (75) miles of the Employee's worksite.

Leave of Absence: Any absence authorized by the Employer under FMLA or the Employer's standard personnel practices, provided that the Employee returns within the period of authorized absence.

Licensed Practical Nurse: An individual who has received specialized nursing training and practical nursing experience and who is licensed to perform nursing services by the state in which he/she performs such service, other than one who ordinarily resides in the patient's home or who is a member of the patient's Immediate Family.

Medical Care: Services rendered by a Physician for treatment of Sickness or Injury during a visit to a Physician's office or during a visit by a Physician to a Covered Person or Covered Dependent:

(A) when an in-patient in a Hospital or Extended Care Facility;

(B) when a patient in a partial hospitalization psychiatric treatment program; or

(C) when calling on the Covered Person or Covered Dependent at home.

Medically Necessary/Medical Necessity: Care, treatment or supplies recommended or approved by a Physician or Dentist that are consistent with the patient's condition and accepted standards of good medical and dental practice; medically proven to be effective treatment of the condition; are not performed mainly for the convenience of the patient or Provider; are not conducted for research purposes; and are the most appropriate level of service that can be safely provided to the patient. When applied to inpatient care, it further means that the patient's medical symptoms or condition require that the services cannot be safely provided to the patient as an Outpatient.

All of the above criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary.

The Plan Administrator or its designee has the discretionary authority to decide whether care or treatment is Medically Necessary.

Medical Necessity shall mean appropriate medical care for restoring health as determined by a Preferred Physician. In those instances where further authorization is required by the Plan, the decision on such authorization will be made on a timely and prospective basis.

Medicare: The Health Insurance for the Aged and Disabled program established by Parts A and B and Part D of Title XVIII of the Social Security Act, as amended (42 U.S.C. 1395 et seq.).

Medicare-Eligible Beneficiary: A beneficiary who is eligible for Medicare due to age, disability or end-stage renal disease, whether or not the beneficiary enrolls in Medicare.

Member: A Covered Person or Covered Dependent.

Mental Illness: Any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services, or is listed in the current

edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

Necessary Services and Supplies: Any charges made by a Hospital on its own behalf for necessary medical services and supplies actually administered during any Hospital confinement/Admission other than charges for Room and Board, Intensive Care Unit, private duty nursing or Physician's services.

Network (Preferred) Provider: A Physician, Hospital or ancillary provider that has contracted with the Preferred Provider Organization (PPO) to provide services to Covered Persons or Covered Dependents.

Nurse Midwife: Means a person who

(A) is certified by the American College of Nurse Midwives or

(B) is licensed as such by the state where services are rendered.

Out-of-Pocket: That portion of Expenses Incurred that must be paid by a Covered Person or Covered Dependent after payment of Deductible Expenses, all as determined in accordance with the Summary of Benefits. Copayments will apply to the Out-of-Pocket maximum.

Outpatient Treatment: Treatment at a Hospital not requiring confinement and not involving a charge for Room and Board.

Participant: An Employee, Retiree, Primary Member and his or her eligible dependents who are properly enrolled in the Plan and for whom coverage has not terminated.

Patient Protection and Affordable Care Act of 2010: The Patient Protection and Affordable Care Act of 2010 (Public Law 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

Part-Time Employee: A person who is scheduled to work at least twenty (20) hours but less than thirty (30) hours per week and who is on the regular payroll of the Employer and specifically excludes seasonal or temporary employees. Regular Part-Time Employees who elect to participate in the health Plan shall be responsible for one-hundred percent (100%) of the Employee's contribution and for at least fifty percent (50%) of the Employer's contribution.

Pharmacy: An organization doing business as a licensed Pharmacy under an applicable state license or registration number and has entered into a Prescription Drug Agreement with the Plan Administrator.

Physician: A practitioner of the healing arts who is duly licensed in the state where he/she is practicing and who is treating within the scope and limitation of that license. The term Physician will neither include the Covered Person nor his/her spouse, children, brothers, sisters or parents nor any person residing in his/her household.

Plan Year: The 12-month period beginning on March 1 and ending on February 28 (29 if Leap Year).

Pre-Existing Condition: A condition for which medical expenses were incurred or for which a person received Medical Care, treatment, consultation, diagnosis, diagnostic testing, advice, services, supplies or took prescribed drugs or medications during the 180-day period ending on the Eligibility Date of such person's coverage under the Plan or on the first day of a waiting period for coverage, if earlier. Genetic Information is not, by itself, a condition. Pregnancy is not a Pre-Existing Condition. A waiting period shall mean the period that must pass with respect to an individual before the individual is eligible for benefits under the Plan. The Plan does not impose Pre-Existing Condition exclusions.

For purposes of this definition only, the following terms are defined as follows:

(A) "enrollment date" means, with respect to an individual covered under this Plan, the date of enrollment of the individual in the Plan or, if earlier, the first day of the waiting period for such enrollment.

(B) "late enrollee" means, with respect to coverage under a group health plan, a participant or beneficiary who enrolls under the Plan other than during:

(1) the first period in which the individual is eligible to enroll under the Plan or

(2) any special enrollment period.

Notwithstanding the foregoing, there will be no Pre-Existing Condition limitation on any medical benefit offered by the Plan.

Preferred Provider Organization (PPO): A specific network of medical doctors, Hospitals and other health care providers who have covenanted with the City of Springfield to provide health care services at a reduced rate.

Prescription Legend Drug: Any medicinal substance the label of which is required by the Federal Food, Drug and Cosmetic Act to bear the legend -- "Caution: Federal law prohibits dispensing without a prescription."

Public Safety Act 320: The Act referring to required benefits for those Employees as stated in the act and placed as Exhibit A in the document.

Reasonable and Customary: Charges made for medical services and/or supplies essential to the care of an individual that are the amount normally charged by the provider for similar services and supplies and do not exceed the amount ordinarily charged by most providers of comparable services and supplies in the locality where the services or supplies are received for Sickness or Injury comparable in severity to the Sickness or Injury being treated.

Rescission: A cancellation or discontinuance of coverage that has a retroactive effect. A cancellation or discontinuance of coverage is not a Rescission if the cancellation or discontinuance has only a prospective effect or the cancellation or discontinuance is attributable to the failure to timely pay required contributions.

Registered Nurse or Registered Graduate Nurse: A professional nurse who has the right to use the title Registered Nurse (RN) other than one who ordinarily resides in the patient's home or who is a member of the patient's Immediate Family.

Room and Board: All charges commonly made by a Hospital or other facility on its own behalf for room and meals and for all general services and activities essential to the care of registered bed patients.

Service Area: the geographic areas within which the Preferred Provider Organizations listed in the General Information section arrange for the delivery of basic health care services for its members.

Sickness: Disease, illness, mental, emotional or nervous disorders, or pregnancy of a Covered Person or Covered Dependent that results in loss covered by the Plan.

Specialty Injectables/Specialty Prescription Drugs: Any agent that is obtained from a specialty drug Provider because of special handling, storage, administration, monitoring and/or financial requirements.

Social Worker: An individual duly licensed to perform social work in the state in which he/she practices.

Spinal Manipulation: Skeletal adjustment, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Subrogation: The City of Springfield may elect to conditionally pay claims in situations where an Injury, Sickness, disease or disability is caused in whole or in part by (or as a result of) the acts or omissions of a third party, or where other insurance is applicable. As a condition of providing benefits in such situations, the Plan, in accordance with Illinois Law, shall have the right to recoup benefits paid.

Subscriber: Any person, other than a Family Dependent or Covered Dependent, who is covered under the Plan by virtue of employment or other relationship with the City of Springfield. Subscriber and Covered Person have the same meaning.

Substance Abuse: Uncontrollable or excessive abuse of any addictive substance and the resultant physiological or psychological dependence that develops with continued use, requiring medical treatment as determined by a Physician.

Surviving Spouse/Dependent: A Covered Spouse and/or a Covered Dependent child who was covered by the Health Plan at the time of the death of the Covered Person. Such persons have the right to continue coverage at the current retiree rate unless any of the following occurs:

(A) he/she fails to make timely Premium payments;

(B) he/she opts out of the plan;

(C) he/she becomes ineligible based on the Health Plan eligibility criteria; or

(D) the Surviving Spouse remarries.

Substance Abuse Treatment Facility: A facility (other than a Hospital) whose primary function is the treatment of alcohol and Substance Abuse and is duly licensed by the appropriate state and local authorities to provide such services.

Surgery: Operative or cutting procedures, including specialized instrumentations and the correction of fractures or complete dislocations.

Third Party Administrator (TPA): An individual or firm contracted by the City of Springfield to provide enrollment, process claims, pay claims, assess discounts, and manage other functions related to the operation of the City's Health Insurance Program.

For purposes of the Error Reward Program, the term Third Party Administrator includes the following:

(A) the Medical Contract Administrator;

(B) the Prescription Drug Administrator; and

(C) the Network Provider.

Total Disability: The Covered Person is completely unable, as a result of Sickness or Injury, to engage in any gainful occupation for which he/she is reasonably fitted by education, training or experience and is not performing work of any kind for wage or profit. A Covered Dependent will be considered to be suffering from Total Disability if, because of a non-occupational Injury or Sickness, he/she is prevented from engaging in all normal activities of a person of like age and sex who is in good health.

Workers Compensation: The City of Springfield's Workers Compensation program, a policy in accordance with Illinois Law that pays benefits to an Employee (or an Employee's family) if the Employee suffers a job-related Injury (including death) or disease related to work.

## *ARTICLE III EMPLOYEE ELIGIBILITY*

### 3.1 Eligibility Requirements

Each Employee and that Employee's Eligible Dependents shall be eligible to participate in the Plan on the date he/she attains status as a Full-Time Employee or regular Part-Time Employee. Regular Part-Time Employees who enroll in the Plan are subject to a partial premium.

Any Eligible Retiree who retired from the City of Springfield prior to March 1, 2017 shall have a one-time opportunity, either during open enrollment or upon experiencing a Qualifying Event, to enroll or re-enroll himself/herself or his/her Eligible Dependents in the Plan.

Any Eligible Retiree, who retired from the City of Springfield on or after March 1, 2017 and remains enrolled in the Plan upon retirement, shall have a one-time opportunity, either during

open enrollment or upon experiencing a Qualifying Event, to enroll his/her Eligible Dependents in the Plan.

On or after March 1, 2017, anyone who becomes an Eligible Retiree and has not elected to continue coverage under the Plan upon retirement may not enroll or re-enroll in the Plan at any future date.

For purposes of enrolling a Retiree or his/her Eligible Dependents in the Plan, a "Qualifying Event" includes the Retiree experiencing a loss of coverage, marriage, divorce, birth, adoption or placement for adoption, provided the Retiree applies for coverage within thirty-one (31) days of such Qualifying Event. In addition, if a Retiree becomes entitled to Medicare due to disability, this may be a Qualifying Event permitting a change to a Retiree's coverage and adding or removing Eligible Dependents, provided the Retiree notifies the Plan Administrator within thirty-one (31) days of becoming entitled to Medicare.

The extent to which a Covered Person must contribute toward the cost of benefits available under the Plan is specified in the Summary Plan Description distributed to each Covered Person during enrollment. It is the responsibility of each Covered Person to report any changes to the eligibility status of a dependent within thirty-one (31) days of the date a dependent ceases to be considered an Eligible Dependent as defined in Article II, Section 2.2.

### 3.2 Eligibility Date

Employee Eligibility for enrollment shall be upon the following occurrences:

(A) New hire — An Employee shall be eligible for coverage under the Plan on the Employee's date of employment with the Employer, provided he/she applies for coverage within thirty-one (31) days of such date.

(B) The occurrence of any Special Enrollment event — An Employee who applies for coverage during a Special Enrollment Period shall be eligible for coverage from the date the Employee provides notice, except in the instance of child birth, adoption or placement for adoption. For purposes of this Plan, a "Special Enrollment Period" includes the following:

(1) the thirty-one (31) day period following the exhaustion of coverage under a Consolidated Omnibus Budget Reconciliation Act of 1986 ("COBRA") continuation provision of a group health plan; loss of Medicare, Medicaid or the termination of coverage under another group health plan as a result of loss of eligibility for such coverage (including as a result of legal separation, divorce, death, termination of employment or reduction in the number of hours of employment); or the termination of employer contributions toward such coverage, provided the following requirements are satisfied:

(a) the Employee was covered under a group health plan or had health insurance coverage at the time coverage under the Plan was previously offered to the Employee; and

(b) the Employee stated in writing that coverage under a group health plan or health insurance coverage was the reason for declining enrollment in the Plan, but only if the Plan requires such written statement at such time and the Employer provides the Employee with notice of such requirement (and the consequences of such requirement) at such time.

If the Employee lost the other coverage as a result of his or her failure to pay premiums or required contributions or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan), the Employee does not have a Special Enrollment right.

(2) the thirty-one (31) day period following the marriage of the Employee or Retiree.

(3) the sixty (60)-day period following one of the following events:

(a) the birth of a child of the Employee or Retiree;

(b) the adoption of an Eligible Dependent by the Employee or Retiree;

(c) the placement of an Eligible Dependent in the home of the Employee or Retiree while adoption proceedings are pending with respect to the Eligible Dependent;

(d) the Employee is covered under a Medicaid plan under Title XIX of the Social Security Act or a State Child Health Insurance Program (SCHIP) under Title XXI of such Act, and coverage of the Employee is terminated due to loss of eligibility for such coverage; or

(e) the Employee becomes eligible for assistance with payment of Employee contributions to this Plan through a Medicaid or SCHIP plan (including any waiver or demonstration project conducted with respect to such plan), and the Employee requests enrollment in this Plan within sixty (60) days after the date the Employee is determined to be eligible for such assistance.

(C) During open enrollment — An Employee who applies for coverage after the thirty-one (31) day or sixty (60) day period, as applicable, following his/her Eligibility Date, change in employment status or a Special Enrollment Period shall be eligible for coverage at the beginning of the next Plan Year after his/her completed application form is received by the Employer during an open enrollment period designated at the discretion of the Employer. See the definition of Eligible Retiree for limitations on when a Retiree or a Retiree's Eligible Dependent may enroll in the Plan.

## *ARTICLE IV DEPENDENT ELIGIBILITY*

### 4.1 Eligibility for Dependent's Coverage

A Covered Person may obtain benefits for his/her Eligible Dependents under the Plan on:

(A) the date the Covered Person is eligible for coverage under the Plan, if on that date, he/she has such Eligible Dependents; or

(B) the date the Covered Person gains an Eligible Dependent, if on that date, he/she is covered by the Plan.

In the event a husband and wife are both eligible to be covered by the Plan as Covered Persons, both spouses may elect coverage as an Employee. Only one parent shall be eligible to cover any Eligible Dependent children they might have.

It is the responsibility of each Covered Person to report any changes to the eligibility status of a dependent within thirty-one (31) days of the date a dependent ceases to be considered an Eligible Dependent as defined in Article II, Section 2.2.

**4.2 Eligibility Date of Dependent's Coverage**

Dependent Eligibility as to enrollment shall be upon the following occurrences:

(A) The Eligibility Date of coverage for each Eligible Dependent will be the later of (i) the date on which the Covered Person who is the source of a dependent's eligibility becomes eligible for dependent coverage or (ii) the date the dependent becomes an Eligible Dependent, subject to the following:

(1) A child of a Covered Person will be considered an Eligible Dependent from the moment of birth and will be eligible for benefits for Sickness or Injury, including the necessary care or treatment of medically diagnosed congenital defects, birth abnormalities or pre-maturity, provided the child is properly enrolled as a dependent of the Covered Person within sixty (60) days of the child's date of birth.

(2) A spouse will be considered an Eligible Dependent from the date the Employee provides notice of the marriage, provided the spouse is properly enrolled as a dependent of the Covered Employee within thirty-one (31) days of the date of marriage.

(3) A dependent acquired other than at the time of birth due to court order, decree, marriage or placement in the home of the Covered Person while adoption proceedings are pending will be considered an Eligible Dependent from the date of such court order, decree, marriage or placement, provided that the dependent is properly enrolled as a dependent of the Covered Person within sixty (60) days of the date of the court order, decree, marriage or placement.

(B) However, if he/she applies for coverage during a special enrollment period, he/she shall be eligible for coverage from the date of the event precipitating the special enrollment period. For purposes of this Section 4.2(B) only, a "Special Enrollment period" includes the following:

(1) the thirty-one (31) day period following the exhaustion of coverage under a COBRA continuation provision of a group health plan; loss of Medicare,

Medicaid or the termination of coverage under another group health plan as a result of loss of eligibility for such coverage (including as a result of legal separation, divorce, death, termination of employment or reduction in the number of hours of employment); or the termination of employer contributions toward such coverage, provided the following requirements are satisfied:

(a) the Eligible Dependent was covered under a group health plan or had health insurance coverage at the time coverage under the Plan was previously offered to the Employee and

(b) the Employee stated in writing that he/she was not applying for coverage for the Eligible Dependent because such Eligible Dependent was covered under a group health plan or had health insurance coverage, but only if the Plan required such written statement at such time and only if the Employer provided the Employee with notice of such requirement (and the consequences of such requirement) at such time.

If the Dependent lost the other coverage as a result of his or her failure to pay premiums or required contributions or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan), the Dependent does not have a Special Enrollment right.

(2) the thirty-one (31) day period following the marriage of the Employee or Retiree;

(3) the sixty (60)-day period following one of the following events:

(a) the birth of a child of the Employee or Retiree;

(b) the adoption of an Eligible Dependent by the Employee or Retiree;

(c) the placement of an Eligible Dependent in the home of the Employee or Retiree while adoption proceedings are pending;

(d) the Employee is covered under a Medicaid plan under Title XIX of the Social Security Act or a State Child Health Insurance Plan (SCHIP) under Title XXI of such Act, and coverage of the Employee or Dependent is terminated due to loss of eligibility for such coverage; or

(e) the Employee becomes eligible for assistance with payment of Employee contributions to this Plan through a Medicaid or SCHIP plan (including any waiver or demonstration project conducted with respect to such plan), and the Employee requests enrollment in this Plan within sixty (60) days after the date the Employee or Dependent is determined to be eligible for such assistance.

(C) An Eligible Dependent who applies for coverage after the thirty-one (31) day period or sixty (60) day period, as applicable, following his/her Eligibility Date shall only be eligible for coverage at the beginning of the next Plan Year after his/her completed

application form is received by the Employer, during an open enrollment period designated at the discretion of the Employer or during a "Special Enrollment Period."

In no event will the Eligibility Date for a dependent precede the Eligibility Date for the Covered Person who determines the dependent's eligibility for benefits under the Plan.

At the time of retirement, Retirees may enroll eligible Dependents who were enrolled immediately prior to retirement. Dependents of a Retired Employee who are acquired due to marriage, birth, adoption or placement for adoption are eligible for Special Enrollment provisions. See the definition of Eligible Retiree for limitations on when a Retiree or a Retiree's Eligible Dependent may enroll in the Plan.

## *ARTICLE V CLAIM PROVISIONS*

## A. CLAIMS

### 5.1 Annual Verification/Claim Form

An Annual Verification/Claim Form ("AVCF") must be completed by a Covered Person or Covered Dependent prior to the beginning of each year. The completed AVCF form must be submitted to the City of Springfield, Office of Human Resources Benefits Division.

### 5.2 Coverage Questions

Coverage Questions should be directed to the Medical Contract Administrator listed in the General Information section.

### 5.3 Plan Selection

Each Employee/Retiree who has satisfied the Eligibility Requirements can select, on behalf of himself/herself and his/her Eligible Dependents, coverage under the BasicSelect Plan, the POS Plan or the High Deductible Health Plan Option. Generally, the differences among the medical options concern the coverage provided, Deductible Expenses, Copayment requirements, and the Out-of-Pocket maximum limit as set forth in the Summary of Benefits section of this Plan. This election shall be made by completing such form or forms as the Employer or Medical Contract Administrator may require. An Employee must select the same plan for both himself/herself and his/her Eligible Dependents.

Each Medicare-Eligible Retiree (or his/her eligible dependent) has the option to select the BasicSelect, POS or High Deductible Health Plan coverage for his/her Eligible Dependents. An Employee's election can be changed only during open enrollment, as a result of a qualifying Special Enrollment event, or at any other period determined at the discretion of the Plan.

### 5.4 How To File A Claim

All claims must be filed with the Medical Contract Administrator listed in the General Information section or other appropriate entity as directed by the Plan Administrator. The Plan Administrator shall be ultimately and finally responsible for adjudicating such claims and for providing full and fair review of the decision on such claims in accordance with the following provisions and with applicable law. This means that Claims will be decided in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the claimant is entitled to them. The responsibility to process claims in accordance with the Plan is delegated to the Medical Contract Administrator (or other appropriate entity as directed by the Plan Administrator) provided, however, that the Medical Contract Administrator (or other appropriate entity) is not a fiduciary of the Plan and does not have the authority to make decisions involving the use of discretion.

Each claimant claiming benefits under the Plan shall be responsible for supplying, at such times and in such manner as the Plan Administrator in its sole discretion may require, written proof

that the expenses were incurred or that the benefit is covered under the Plan. If the Plan Administrator in its sole discretion determines that the claimant has not incurred a covered expense; that the benefit is not covered under the Plan; or if the claimant shall fail to furnish such proof as is requested; or if coverage is rescinded due to fraud or a misrepresentation of a material fact, no benefits shall be payable under the Plan.

**5.5 When Claims must be Filed**

(A) Claims must be filed within one (1) year of the date charges for the services were incurred. **Claims filed later than that date will be denied.** Benefits are based upon the Plan's provisions at the time the charges were incurred. Charges are considered incurred when treatment or care is given or supplies are provided.

(B) A Pre-Service Claim is considered to be filed when the request for approval of treatment or services is made and received in accordance with the Plan's procedures.

(C) A Post-Service Claim is considered to be filed when the following information is received in accordance with the Plan's procedures, together with a Form HCFA or Form UB92 or other approved standardized method:

(1) the date of service;

(2) the name, address, telephone number and tax identification number of the provider of the services or supplies;

(3) the place where the services were rendered;

(4) the diagnosis and procedure codes;

(5) the amount of charges;

(6) the name of the Covered Person; and

(7) the name of the patient.

(D) A Post-Service Claim for Prescription Drugs is considered to be filed at the time the medication is dispensed or when the following information is received in accordance with the Plan's procedures:

(1) the date the drug was dispensed;

(2) the name of the Pharmacy dispensing the drug;

(3) the place where the services were rendered;

(4) the name, strength and quantity of the drug dispensed;

(5) the price of the drug;

(6) the receipt confirming payment for the drug;

(7) the name and social security number of the Covered Person;

(8) the name of the patient; and

(9) if applicable, a copy of the corresponding primary plan's explanation or summary of benefits.

Upon receipt of this information, the claim will be deemed to be filed with the Plan. The Medical Contract Administrator/ Prescription Drug Card Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested as provided herein. This additional information must be received by the Medical Contract Administrator/ Prescription Drug Card Administrator within forty-five (45) days from receipt by the claimant of the request for additional information. **Failure to provide the requested information may result in claims being denied or reduced.**

### 5.6 Timing of Claim Decisions

The Plan shall notify the claimant of the benefit determination within the following time frames:

(A) Pre-Service Claims

(1) If the claimant has provided all of the information needed to process the claim in a reasonable period of time appropriate to the medical circumstances, then the claimant will be notified as soon as possible, but not later than fifteen (15) days after receipt of the claim unless an extension has been requested, then prior to the end of the fifteen (15) day extension period.

(2) If the claimant has not provided all of the information needed to process the claim, then the claimant will be notified as to what specific information is needed as soon as possible, but not later than five (5) days after receipt of the claim. The claimant will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Plan and the claimant (if additional information was requested during the extension period).

(B) Urgent Care Claims

(1) If the claimant has provided all of the information needed to process the claim, then the claimant will be notified as soon as possible, but not later than 72 hours, unless an extension has been requested, then within 48 hours of the end of the extension period. If the notification is provided orally, a written or electronic notification will be provided to the claimant within three days after the oral notification.

(2) If the claimant has not provided all of the information needed to process the claim, then the claimant will be notified as to what specific information is needed within 24 hours of receipt of the claim. The claimant will be provided a reasonable amount of time, but not less than 48 hours, to provide the specified information. If the requested information is not received within the timeframe given to provide the information, the claim will be denied. The claimant will be notified of a determination of benefits within 48 hours after receipt of the requested information. If the notification is provided orally, a written or electronic notification will be provided to the claimant within three days after the oral notification.

(3) If there is an Adverse Benefit Determination on a request involving urgent care where the time for completion of an internal appeal would seriously jeopardize the claimant's life, health or ability to regain maximum function, the claimant, his or her Physician or other health care provider may request an expedited appeal, which may be submitted orally or in writing.

If the request is denied due to treatment being experimental or investigational and the claimant's Physician certifies in writing that treatment would be significantly less effective if not promptly initiated, the claimant may request an expedited external review of the denial.

(C) Concurrent Claims

Any reduction or termination of benefits for concurrent care (other than by Plan Amendment or termination) before the end of an approved period of time or number of treatments is considered a claim denial. The claimant will be notified in advance of the reduction or termination to allow the Claimant opportunity to appeal the decision before the benefit is reduced or terminated.

(1) Claims for concurrent care will be decided within 24 hours of the receipt of the claim, provided such request is made at least 24 hours before the expiration of the prescribed period of time or number of treatments.

(2) Claims for concurrent care that are not received at least 24 hours before the expiration of the prescribed period of time or number of treatments will be decided in accordance with the Urgent Care Claims procedures discussed above.

(3) If the requested health care services are denied and the denial concerns an emergency admission, availability of care, continued stay or health care service and the Claimant has not been discharged from the facility, the Claimant may request an appeal. Upon request for an appeal, the Plan will review the Claim and notify the Claimant, his/her authorized representative, Physician or other health care provider who recommended services of the decision by telephone within 24 hours of receipt of all requested information, but no later than 48 hours after the receipt of the appeal request. A written notice will be provided within three (3) days of the decision.

(D) Post-Service Claims

(1) If the claimant has provided all of the information needed to process the claim in a reasonable period of time appropriate to the medical circumstances, then the claimant will be notified as soon as possible, but not later than thirty (30) days after receipt of the claim unless an extension has been requested, then prior to the end of the fifteen (15) day extension period.

(2) If sufficient information to determine benefits payable under the Plan was not provided, the claimant will be notified of the specific information needed within thirty (30) days of the receipt of the claim. The claimant will have forty-five (45) days from the date of receipt of the notice to provide the requested information.

(3) If the claimant has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the claimant will be notified of a determination of benefits within fifteen (15) days after the receipt of the required information or within fifteen (15) days of the end of the timeframe given to provide the information, whichever is earlier. If additional information is requested during an extension period, then the claimant will be notified of the determination by a date agreed to by the Plan and the claimant.

(E) Extensions – Pre-Service Claims

The benefit determination period may be extended by the Plan for up to fifteen (15) days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial fifteen (15) day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

(F) Extensions – Post-Service Claims

The benefit determination period may be extended by the Plan for up to fifteen (15) days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial thirty (30) day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

(G) Calculating Time Periods

The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the Plan.

### 5.7 Notification of an Adverse Benefit Determination

The Plan shall provide a claimant with a notice, either in writing or electronically, containing the following information:

(A) a reference to the specific portion(s) of the Plan upon which a denial is based;

(B) information sufficient to specifically identify the claim involved (including denial codes);

(C) specific reason(s) for a denial;

(D) a description of any additional information necessary for the claimant to perfect the claim and an explanation of why such information is necessary;

(E) a description of the Plan's appeal procedures and the time limits applicable to the procedures;

(F) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claimant's claim for benefits;

(G) the statement "You and your Plan may have other voluntary alternative dispute resolution options such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office";

(H) any internal rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the claimant, free of charge, upon request);

(I) in the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or an experimental treatment), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided to the claimant, free of charge, upon request; and

(J) a statement disclosing the availability of, and contact information for, any applicable consumer assistance office or ombudsman established to assist individuals with claims and appeals questions.

## B. APPEALS – ADMINISTRATIVE

### 5.8 Appeal of Adverse Benefit Determination — Administrative Claims

In cases where a Claim is wholly or partially denied on the basis of an administrative decision, the Claimant may request an appeal of the Adverse Benefit Determination orally or by writing to the Adverse Determination Review Facilitator listed in the General Information Section. The request for a first appeal must be made within ninety (90) days after the Claimant receives notification of the Adverse Benefit Determination.

(A) Post-Service Claims

(1) First Appeal – Upon request for an appeal of an Adverse Benefit Determination, the Adverse Determination Review Facilitator will review the Claim. Within

three (3) business days, the Adverse Determination Review Facilitator will advise the party requesting the appeal of all information required to evaluate the appeal. The Adverse Determination Review Facilitator will provide the Claimant, his/her authorized representative, Physician and/or other health care Provider a written notice of the decision within fifteen (15) days of receipt of all requested information.

(2) Second Appeal – If the Plan denies a Claimant's first appeal of an Adverse Benefit Determination, the Claimant may submit a request for an appeal to the Adverse Determination Review Facilitator within ninety (90) days of receipt of the Adverse Benefit Determination. The Adverse Determination Review Facilitator, acting on behalf of the Plan, will review the Claim within sixty (60) days.

(3) If an extension is required due to special circumstances, the Plan Administrator shall notify the Claimant in writing of the extension, describing the special circumstances and the date as of which the benefit will be made, prior to the extension commencing.

The Adverse Determination Review Facilitator will provide the Claimant, his/her authorized representative, Physician and/or other health care Provider a written and oral notice of the decision as soon as possible but not later than five (5) days after the decision is made.

(B) Pre-Service Claims (non-urgent)

(1) First Appeal – Upon receipt of a request for an appeal of an Adverse Benefit Determination, the Adverse Determination Review Facilitator will review the Claim. Within three (3) business days, the Adverse Determination Review Facilitator will advise the party requesting the appeal of all information required to evaluate the appeal. The Adverse Determination Review Facilitator will provide the Claimant, his/her authorized representative, Physician or other health care Provider who recommended services a written notice of the decision within fifteen (15) days of the date of receipt of all requested information.

(2) Second Appeal – If the Plan denies a Claimant's first appeal of an Adverse Benefit Determination, the Claimant may submit a request for an appeal to the Adverse Determination Review Facilitator within ninety (90) days of receipt of the Adverse Benefit Determination. The Adverse Determination Review Facilitator, acting on behalf of the Plan, will review the Claim within sixty (60) days.

(3) If an extension is required due to special circumstances, the Plan Administrator shall notify the Claimant in writing of the extension, describing the special circumstances and the date as of which the benefit will be made, prior to the extension commencing.

The Adverse Determination Review Facilitator shall notify the Claimant orally and in writing of the benefit determination as soon as possible, but not later than five (5) days after the benefit determination is made.

(C) Pre-Service Claims (urgent)

(1) First Appeal – Upon request for an appeal of an Adverse Benefit Determination, the Adverse Determination Review Facilitator will review the Claim. Within 24 hours, the Adverse Determination Review Facilitator will advise the party requesting the appeal of all information required to evaluate the appeal. Within 24 hours of receipt of all requested information, the Adverse Determination Review Facilitator will advise the Claimant, his/her authorized representative, Physician or other health care Provider who recommended service of the decision by telephone. A written notice will be provided within three (3) days of the decision.

(2) Second Appeal – If the Plan denies a Claimant's first appeal of an Adverse Benefit Determination, the Claimant may submit a request for an appeal to the Adverse Determination Review Facilitator. The Adverse Determination Review Facilitator will review the Claim within 24 hours and will advise the party requesting the appeal of all information required to evaluate the appeal. The Adverse Determination Review Facilitator will provide the Claimant, his/her authorized representative, Physician and/or other health care Provider who recommended service of the decision by telephone. A written notice will be provided within three (3) days of the decision.

(D) Concurrent Care Claims

Appeals to extend concurrent care will be made in accordance with the Urgent Care Claims, Pre-Service Claims or Post-Service Claims procedures discussed above.

## C. APPEALS – MEDICAL CLAIMS

### 5.9 Appeal of Adverse Benefit Determination — Medical Claims

In cases where a Claim is wholly or partially denied based on Medical Necessity, appropriateness, health care setting, level of care or effectiveness, the Claimant may request an appeal of the Adverse Benefit Determination by calling, or writing to the Adverse Determination Review Facilitator listed in the General Information Section. The request for review must be received within one hundred eighty (180) days after receiving notification of the Adverse Benefit Determination.

(A) Post-Service Claims

(1) First Appeal – Upon request for an appeal of an Adverse Benefit Determination, the Adverse Determination Review Facilitator will review the Claim. Within three (3) business days, the Adverse Determination Review Facilitator will advise the party requesting the appeal of all information required to evaluate the appeal. The Adverse Determination Review Facilitator will provide the Claimant, his/her authorized representative, Physician or other health care Provider a written notice of the Plan's decision within fifteen (15) days of receipt of all requested information.

(2) Second Appeal – If the Plan denies a Claimant's first appeal of an Adverse Benefit Determination, the Claimant may submit a request for an appeal to the Adverse Determination Review Facilitator within ninety (90) days of receipt of the Adverse Benefit Determination. The Adverse Determination Review Facilitator will review the Claim within three (3) business days and will advise the party requesting the appeal of all information required to evaluate the appeal. The Adverse Determination Review Facilitator will provide the Claimant, his/her authorized representative, Physician and/or other health care Provider a written notice of the decision within thirty (30) days of receipt of all requested information.

(B) Pre-Service Claims (non-urgent)

(1) First Appeal – Upon request for an appeal of an Adverse Benefit Determination, the Adverse Determination Review Facilitator will review the Claim. Within three (3) business days, the Adverse Determination Review Facilitator will advise the party requesting the appeal of all information required to evaluate the appeal. The Adverse Determination Review Facilitator will provide the Claimant, his/her authorized representative, Physician or other health care Provider who recommended services a written notice of the decision within fifteen (15) days of the receipt of all requested information.

(2) Second Appeal – If the Plan denies a Claimant's first appeal of an Adverse Benefit Determination, the Claimant may submit a request for an appeal to the Adverse Determination Review Facilitator within 60 days of receipt of the Adverse Benefit Determination. The Adverse Determination Review Facilitator will review the Claim within three (3) business days and will advise the party requesting the appeal of all information required to evaluate the appeal. The Adverse Determination Review Facilitator will provide the Claimant, his/her authorized representative, Physician and/or other health care Provider a written notice of the decision within thirty (30) days of receipt of all requested information.

(C) Pre-Service Claims (urgent)

(1) First Appeal – Upon request for an appeal of an Adverse Benefit Determination, the Adverse Determination Review Facilitator will review the Claim. Within 24 hours, the Adverse Determination Review Facilitator will advise the party requesting the appeal of all information required to evaluate the appeal. Within 24 hours of receipt of all requested information, the Adverse Determination Review Facilitator will advise the Claimant, his/her authorized representative, Physician or other health care Provider who recommended services of the decision by telephone. A written notice will be provided within three (3) days of the decision.

(2) Second Appeal – If the Plan denies a Claimant's first appeal of an Adverse Benefit Determination, the Claimant may submit a request for an appeal to the Adverse Determination Review Facilitator. The Adverse Determination Review Facilitator will review the Claim within 24 hours of receipt of the request and will advise the party requesting the appeal of all information required to evaluate the appeal. The Adverse Determination Review Facilitator will provide the Claimant, his/her authorized representative, Physician and/or other health care Provider who recommended service of the decision by telephone. A written notice will be provided within three (3) days of the decision.

(D) Concurrent Care Claims

Appeals to extend concurrent care will be made in accordance with the Urgent Care Claims, Pre-Service Claims or Post-Service Claims procedures discussed above.

**5.10 Notice of Appeal Determination**

The Adverse Determination Review Facilitator will furnish the Claimant with a written or electronic notice of a benefit determination on review at each level, except with Urgent Care Claims, when the notification may be oral followed by written or electronic notification. This written notice will contain the following information:

(A) The specific reason or reasons for the Adverse Benefit Determination and the statement, "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office or state regulatory agency";

(B) Information sufficient to specifically identify the claim involved (including denial codes);

(C) Reference to the specific Plan provisions on which the Adverse Benefit Determination is based;

(D) A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of any relevant document;

(E) A statement describing the Plan's external review procedures and the time limits applicable to such procedures;

(F) Any internal rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the Claimant, free of charge, upon request);

(G) If the Adverse Benefit Decision is based on whether the treatment or service is Medically Necessary or experimental or investigational, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request. Medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified;

(H) A statement disclosing the availability of, and contact information for, any applicable consumer assistance office or ombudsman established to assist individuals with claims and appeals questions; and

(I) A statement regarding the availability of external review.

### 5.11 External Review of Appeals

For Medical Necessity, appropriateness, health care setting, level of care or effectiveness denials, an external review may be requested in writing within four (4) months of the date of receipt of notification that the appeal for approval of coverage of health care services has been denied.

The claimant's request for an external review of a medical claim must be mailed to the Medical Contract Administrator at the address listed in the General Information section. The Plan or its designee will facilitate the process for selection of an external independent review organization.

The claimant's request for an external review must be made to the Director of the Illinois Department of Insurance at:

Illinois Department of Insurance
Office of Consumer Health Insurance
EXTERNAL REVIEW REQUEST
320 W. Washington Street
Springfield, IL 62767
(877) 850-4740 (toll-free phone number)
(217) 557-8495 (fax)

(A) Except in the case of an expedited review at an initial urgent care or concurrent care claim denial, the claimant must have exhausted the internal appeal process before a request for an external review can be made. The internal appeal process will be considered to have been exhausted if:

(1) the claimant has not received the Plan's written decision on his/her pre-service claim appeal within thirty (30) days;

(2) the claimant has not received the Plan's decision on his/her urgent or concurrent care claim appeal within forty-eight (48) hours; or

(3) the Plan agrees to waive the internal appeal exhaustion requirement.

(B) The Plan or its designee will determine whether the request is eligible for external review. After determining the request is eligible for external review, the Plan or its designee will assign an independent review organization (IRO) within five (5) business days.

(C) The IRO will make a decision within forty-five (45) days after the receipt of all necessary information and provide written notification of its decision to all parties involved in the appeal.

### 5.12 Expedited Medical Necessity Review

An expedited review may be requested orally or in writing if the claimant or his/her authorized representative, Physician or other health care Provider involved in the appeal believe that the denial of coverage of health care services could significantly increase risk to the claimant's health.

The claimant's written request for an expedited external review of a medical claim must be mailed to the Medical Contract Administrator. The request may also be made by calling the Medical Contract Administrator. (See the General Information section.)

The claimant's written request for an expedited external review of a prescription drug claim must be mailed to the Director of the Illinois Department of Insurance at the address listed just above.

(A) The Plan or its designee will determine whether the request is eligible for external review. After determining the request is eligible for external review, the Plan or its designee will immediately assign an independent review organization (IRO).

(B) The independent review organization will make a decision no later than two (2) business days after receipt of the required information and provide notification of its decision to all parties involved in the appeal.

A Claimant must exhaust the Claims appeal procedure before filing a suit for benefits. Claimants may have additional rights under state law. For more information, visit http://insurance.illinois.gov/ExternalReview.

## D. OTHER

### 5.13 Appointment of Authorized Representative

A claimant is permitted to appoint an authorized representative to act on his or her behalf with respect to a benefit claim or appeal of a denial. An assignment of benefits by a claimant to a provider will not constitute appointment of that provider as an authorized representative. To appoint such a representative, the claimant must complete a form that can be obtained from the Plan Administrator or the Medical Contract Administrator/Prescription Drug Card Administrator. In the event a claimant designates an authorized representative, all future communications from the Plan will be with the representative, rather than the claimant, unless the claimant directs the Plan Administrator, in writing, to the contrary.

### 5.14 Complaints

A Covered Person or Covered Dependent who has a complaint about any medical or administrative matter concerning the Medical Contract Administrator that is not resolved by his/her Physician or clinic or Hospital personnel may call or write the Medical Contract Administrator or Plan Administrator listed in the General Information Section.

A Covered Person or Covered Dependent who has a complaint about any medical or administrative matter concerning the Prescription Drug Administrator that is not resolved by his/her Physician or clinic or Hospital personnel may call the Customer Service Department at the number listed on his/her plan Identification Card or by writing to the Prescription Drug Administrator or Plan Administrator. (See the General Information section.)

A Covered Person or Covered Dependent may file a complaint with the Illinois Department of Insurance, 320 W. Washington St., Springfield, IL 62767, or with the Illinois Department of Insurance, James R. Thompson Center, 100 W. Randolph St., Ste. 9-301, Chicago, IL 60601-3251. The Department of Insurance may be contacted directly at http://insurance.illinois.gov.

A Plan Participant must exhaust the claims appeal procedure outlined in this document before filing a suit for benefits.

### 5.15 Definitions for Purposes of Claims and Appeals

The following definitions are applicable to terms used in this Article V

(A) "Adverse Benefit Determination" means a denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for a benefit. "Adverse Benefit Determination" will also include a rescission of coverage. This includes any such determination based on an Employee's or Dependent's eligibility to participate in the Plan resulting from the application of any utilization review, source-of-Injury exclusion, network exclusion, Medical Necessity or other limitation on otherwise covered benefits or a determination that a benefit is experimental or investigational.

(B) "Claim" means a request for benefits under the Plan made by a Claimant in accordance with the Plan's procedures for filing benefit Claims, including Pre-Service Claims and Post-Service Claims.

(C) "Claimant" means a Covered Person or his or her authorized representative (including his or her Physician, attorney or other health care Provider) that complies with the Plan's reasonable procedure for making benefit Claims. If the Claim is an Urgent Care Claim, a Health Care Professional, with knowledge of the Covered Person's medical condition, will be permitted to act as the Covered Person's representative.

(D) "Final Adverse Benefit Determination" means an Adverse Benefit Determination that has been upheld by the Plan at the completion of the Plan's appeals procedure or an Adverse Benefit Determination for which the Plan's appeals procedures were not properly followed.

(E) "Health Care Professional" means a Physician or other health care professional licensed, accredited or certified to perform specified health services consistent with state law.

(F) "Post-Service Claim" means any Claim for a Plan benefit that is not a Claim involving Urgent Care or a Pre-Service Claim, or in other words, a Claim that is a request for payment under the Plan for covered medical services already received by the Claimant.

(G) "Pre-Service Claim" means any Claim for a benefit under this Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining Medical Care. These are, for example, Claims subject to Preauthorization.

(H) "Urgent Care Claim" means any Claim for Medical Care or treatment where using the timetable for a non-urgent care determination could seriously jeopardize the life or health of the Claimant; or the ability of the Claimant to regain maximum function; or in the opinion of the attending or consulting Physician, would subject the Claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim. A Physician with knowledge of the Claimant's medical condition may determine if a Claim is one involving Urgent Care. If there is no such Physician, an individual acting on behalf of the Plan applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine may make the determination.

(I) "Concurrent Claim" means a request for an extension of payment or approval of continuing Medical Care or treatment beyond the approved period of time or number of treatments.

### 5.16 Facility of Payment

If a Covered Person or Covered Dependent dies while benefits provided for Hospital, nursing, medical or surgical services remain unpaid, the Plan may, at its option, make direct payments to the individual or institution on whose charges claim is based or to the Surviving Spouse of the Covered Person, or if none, to his/her surviving child or children (including legally adopted child or children) share and share alike, or if none, to the executors or administrators of the Covered Person's or Covered Dependent's estate.

### 5.17 Minor or Incompetency

If a Covered Person or Covered Dependent is a minor or, in the opinion of the Plan, not competent to give a valid receipt for payment of any benefit due him under the Plan and if no request for payment has been received by the Plan from a duly appointed guardian or other legally appointed representative of that person, the Plan may, at its option, make direct payment to the individual or institution appearing to the Plan to have assumed the custody or the principal support of that person.

### 5.18 Discharge

Any payment by the Plan in accordance with these provisions will discharge the Employer and the Medical Contract Administrator from all further liability to the extent of the payment made.

### 5.19 Legal Actions

No action at law or in equity will be brought to recover under the Plan prior to the expiration of sixty (60) days after proof of loss has been filed as required by the Plan, nor will any action be brought unless within two (2) years from the expiration of the time within which proof of loss is required by the Plan.

### 5.20 Physical Examination and Autopsy

The Plan, at its own expense, shall have the right and opportunity, through a Physician of its choice, to examine the person or any individual whose Injury or Sickness is the basis of a claim when and as often as it may reasonably require during the pendency of a claim and to have an autopsy performed by a licensed Physician in case of death where it is not forbidden by law.

The Plan shall be entitled to receive any and all reports regarding such examinations or autopsies.

### 5.21 Time Limitations

If any time limitations provided in the Plan for giving notice of claims, furnishing proof of loss or for bringing any action at law or in equity is less than that permitted by applicable law, then the time limitation provided in the Plan is hereby extended to agree with the minimum permitted by the applicable law.

### 5.22 Withholding of Benefit Payments

In the event any question or dispute shall arise as to the proper person or persons to whom any payments shall be made hereunder, the Plan may direct the Medical Contract Administrator to withhold such payment until there shall have been made an adjudication of such question or dispute, which in the Plan’s sole judgment is satisfactory to it, or until the Plan, the Employer and the Medical Contract Administrator shall have been fully protected against loss by means of such indemnification agreement or bond as it determines to be adequate.

### 5.23 Claims Mistakenly Paid

The Plan shall have the right to recover any payment of claims that have been mistakenly paid on behalf of a claimant. This includes the right to recover benefits paid on the basis of claims filed that were fraudulently or intentionally misstated by the claimant. The claimant will be notified in writing and given an opportunity for review in accordance with Section 5.7. A payment by the Medical Contract Administrator in accordance with the Plan is not an admission by the Plan, the Employer or Medical Contract Administrator that the Expenses Incurred with respect to which a claim for benefits is filed are eligible for benefits under this Plan.

## *ARTICLE VI ADMINISTRATION*

### 6.1 Assignment

Benefits under this Plan may be assigned to a Physician, Hospital or other Provider of services upon written authorization of the Covered Person or Covered Dependent. No assignment of benefits shall be binding on the Plan unless the claims processor is notified in writing and authorizes such assignment prior to payment hereunder.

The health services benefits provided for in this Plan Document are not transferable to another party. Except as listed above, a Covered Person or Covered Dependent shall not assign benefits to anyone, and any attempted assignment is void.

The Plan will pay benefits to the responsible party of an alternate recipient as designated in a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN).

### 6.2 Health Delivery

It is expressly understood that the City of Springfield, Illinois (as a municipal corporation), the Medical Contract Administrator and the contracted Preferred Provider Organization(s) do not undertake to furnish any health services. The City's obligation under the Plan is limited to arranging for the payment of health care services through contracts with professionals in accordance with Plan documents. The City is not, in any event, liable for any act or omission of the professional personnel of any Physician, medical group, Hospital or other provider of services.

### 6.3 Policies and Procedures

The City may adopt reasonable policies, procedures, rules and interpretations consistent with the terms of this Plan Document. These may include, but are not limited to, selection or change of Plans offered.

### 6.4 Right to Receive and Release Information

The City of Springfield, or its designee, is entitled to any service or provider information necessary to administer the Plan, subject to confidentiality requirements. By accepting coverage under the Plan, the Covered Person or Covered Dependent authorizes Providers rendering

services to disclose all facts and furnish reports pertaining to his/her care, treatment and physical condition to the City on request. The City is also authorized to copy these reports as necessary.

The Plan or its designee, pursuant to the reasonable exercise of its discretion, may release to, or obtain from any other company, organization or person, without consent of or notice to any person, any information regarding any person the Plan deems necessary to carry out the provisions of the Plan, or to determine how, or if, they apply. Any claimant under this Plan shall furnish to the Plan or its designee such information as may be necessary to carry out this provision.

The Plan shall provide to the Employer such information as the Employer may need to comply with the information requirements of the Medicare and Medicaid Coverage Data Bank. The Plan and Medical Contract Administrator may rely on the Employer's representations as to the specific information that is necessary to comply with these requirements.

Neither the Plan nor the Medical Contract Administrator may provide the following information to the Employer or the Medicare and Medicaid Coverage Data Bank for the purpose of identifying third parties responsible for health care benefits which were provided by Medicare or Medicaid:

(A) the health status of a Covered Person or Covered Dependent;

(B) the cost of coverage provided to any Covered Person or Covered Dependent; or

(C) any limitations on any specific coverage.

### 6.5 Facility of Reimbursement

If payments that should have been made under this Plan as stated in this provision have been made under any other plan or plans, the Plan may, at its sole option, pay to any organizations making such other payments any amounts that it determines will satisfy the intent of this provision. Amounts so paid shall be deemed benefits paid under this Plan and, to the extent of such payments, the Plan and the Medical Contract Administrator shall be fully discharged from liability under this Plan.

### 6.6 Right to Recovery

If the total payments made by the Plan as to any expenses at any time are more than the maximum payment necessary to satisfy the intent of this provision, the Plan shall have the right to recover the extra amount of such payments from one or more of the following, as the Plan will determine any persons to, or for, or with respect to whom such payments were made, any other insurance companies, and any other organizations.

No benefits shall be paid (whether reduced or not) under this provision, to the extent that it would be inconsistent with any definition, limitation, condition, exception or other policy provision applying to this Plan.

## 6.7 Subrogation

(A) Payment Condition

(1) The Plan may elect, but is not required, to conditionally advance payment or extend credit of medical benefits in those situations where an Injury, Sickness, disease or disability is caused in whole or in part by, or results from, the acts or omissions of a third party, or from the acts or omissions of a Covered Person and/or Covered Dependent where other insurance (such as auto or homeowners) is available. As a condition of providing benefits in such situations, the Plan and its agents shall have the right to recoup all benefits paid:

(a) by subrogation directly from the responsible party (whether an unrelated third party or another Covered Person/Covered Dependent) or its insurer, without regard to whether the Covered Person/Covered Dependent is pursuing a claim against that responsible party;

(b) by reimbursement from the Covered Person/Covered Dependent, when the Covered Person/Covered Dependent has recovered compensation for such Injury from any source described in Section 6.9(A)(4), or

(c) by recovering from the appropriate resource — be it money or other property — by virtue of a constructive trust, in order to create an equitable basis for recovery.

By accepting benefits under the Plan, the Covered Person recognizes this property right or equitable interest of the Plan in any cause of action the Covered Person may have or the proceeds thereof.

(2) The Covered Person/Covered Dependent, his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees, by acceptance of the Plan's payment of Eligible Expenses, to maintain one-hundred percent (100%) of the Plan's payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust and without dissipation except for reimbursement to the Plan or its assignee.

(3) The Plan shall be entitled to recover one-hundred percent (100%) of the benefits paid, without deduction for attorneys' fees and costs (unless otherwise allowed by applicable State law), or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, or other deductions as allowed by and under the applicable law, and without regard to whether the Covered Person/Covered Dependent is fully compensated by his/her net recovery from all the sources described in Section 6.9(a)(4).The obligation exists without regard to allocation or designation of the recovery. The obligation exists whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses.

The Plan explicitly has the first priority right of recovery and/or a first lien to the extent of benefits provided by the Plan, even where a participant or beneficiary is not made whole. Said right and/or lien may be filed with any person or organization responsible, or potentially responsible, to the Covered Person/Covered Dependent for indemnification, the Covered Person's /Covered Dependent's attorney, or the Court. If the Covered Person's/Covered Dependent's net recovery is less than the benefits paid, then the Plan is entitled to be paid all of the net recovery achieved. The Covered Person/Covered Dependent agrees to pay all of his or her own legal fees incurred in litigation against such third parties, and to hold the Plan harmless against any claims made against the Plan by the attorneys retained by the Covered Person/Covered Dependent.

(4) The Plan's rights of subrogation and/or reimbursement shall have priority against and shall constitute a first priority right of recovery and/or a first lien against any and all payments, settlements, judgments or awards made by or received from:

(a) responsible party, its insurer, or any other source on behalf of that party;

(b) first party insurance through medical payment coverage or personal Injury protection;

(c) the Covered Person's/Covered Dependent's uninsured or underinsured motorist coverage;

(d) any policy or contract of insurance from any insurance company or guarantor of a third party;

(e) worker's compensation or other liability insurance company; or,

(f) any other source including, but not limited to, crime victim restitution funds, any medical, disability or other benefit payments, and no-fault or school insurance coverage.

(5) The Plan may, in its own name or in the name of the Covered Person or their personal representative, commence a proceeding or pursue a claim against such other third person for the recovery of all damages in the full extent of the value of any such benefits or services furnished or payments advanced or credit extended by the Plan.

If the Covered Person fails to make a claim against or pursue damages against:

(a) the responsible party, its insurer, or any other source on behalf of that party;

(b) any first-party insurance through medical payment coverage or personal Injury protection;

(c) the Covered Person's uninsured or underinsured motorist coverage;

(d) any policy or contract of insurance from any insurance company or guarantor of a third party;

(e) worker's compensation or other liability insurance company; or

(f) any other source, including, but not limited to, crime victim restitution funds, any medical, disability or other benefit payments, and no-fault or school insurance coverage,

then the Plan or its assignee shall be subrogated to the Covered Person's rights. The Covered Person/Covered Dependent or his or her guardian or the estate of a Covered Person/Covered Dependent, assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any sources listed above.

These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Covered Person.

(B) Obligations

(1) It is the Covered Person's/Covered Dependent's obligation:

(a) to cooperate with the Plan or its agents in defining, verifying and protecting its rights of subrogation and reimbursement;

(b) to provide the Plan with pertinent information regarding the Injury or Sickness, including various forms of documentation, accident reports, settlement reports and any other requested additional information;

(c) to take such action, furnish such information and assistance, and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;

(d) to do nothing to prejudice the Plan's rights of subrogation and reimbursement;

(e) to promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and

(f) to not settle, without the prior consent of the Plan, any claim that the Covered Person/Covered Dependent may have against any legally responsible party or insurance carrier.

(2) Failure to comply with any of these requirements by the Covered Person/Covered Dependent, his or her attorney, or guardian may, at the Plan's discretion, result in a forfeiture of payment by the Plan of medical benefits and any funds or payments due under this Plan may be withheld to satisfy the Covered Person's obligation.

Failure to comply shall render the Covered Person responsible for the attorneys' fees and costs incurred by the Plan in protecting its rights.

(C) Minor Status

(1) In the event the Covered Person/Covered Dependent is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian, as the case may be, shall take and cooperate in any and all action requested by the Plan to seek and obtain any requisite court approval in order to bind the minor and his or her estate insofar as the subrogation and reimbursement provisions are concerned.

(2) If the minor's parents or court-appointed guardian fail or refuse to take such action, the Plan shall have no obligation to advance payment or extend credit of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

(D) Language Interpretation

The Plan Administrator has full discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation/reimbursement rights.

(E) Severability

(1) In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

(2) This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Sickness, Injury, disease or disability.

### 6.8 Excess Insurance Provision

If, at the time of Injury, Sickness, disease or disability, there is available, or potentially available based on information known or provided to the Plan, to the Covered Person/Covered Dependent any other insurance or other form of indemnification including, but not limited to, judgment at law or settlements, the benefits under this Plan shall apply only as excess insurance over such other sources of indemnification. The Plan's benefits shall be excess to:

(A) the responsible party, its insurer, or any other source on behalf of that party;

(B) any first-party insurance through medical payment coverage or personal Injury protection;

(C) the Covered Person's/Covered Dependent's uninsured or underinsured motorist coverage;

(D) any policy or contract of insurance from any insurance company or guarantor of a third party;

(E) worker's compensation or other liability insurance company; or

(F) any other source including, but not limited to, crime victim restitution funds, any medical, disability or other benefit payments, and no fault or school insurance coverage.

### 6.9 Coordination of Benefits

In addition to benefits payable under this Plan, a Covered Person or Covered Dependent may be entitled to benefits from other plans, payable on account of the same Sickness or Injury. The other plans are those that provide benefits or services for or by reason of medical, pharmacy or dental care or treatment, when such benefits or services are provided on a group basis, whether insured or not; by no-fault automobile insurance; homeowners insurance; by any government or tax-supported program (including Medicare); or any similar plan or program.

This provision is applicable when the total benefits that would be payable in the absence of any coordination of benefits provision under this Plan and under all plans covering an individual exceed the Expenses Incurred during a Plan Year. The amount of benefits payable under this Plan may be reduced to the extent that the total payment provided by all plans does not exceed the total allowable Expenses Incurred for the service.

One of the two or more plans involved is the Primary Plan and the other plan(s) are Secondary Plans. The Primary Plan pays benefits first and without consideration of the other plans. The Secondary Plan(s) then make up the difference up to the total allowable Expenses Incurred. No plan will pay more than it would have paid without this special provision.

When this Plan is a secondary plan, it will pay the balance up to the lesser of the two allowed amounts after the Plan's deductible and coinsurance are met. Payments from the primary plan are applied toward this Plan's deductible and coinsurance. The balance due, if any, is the responsibility of the Covered Person.

The following rules apply to determine which plan is Primary and which plan is Secondary. If one plan has no coordination of benefits provision, it is automatically Primary.

(A) A plan will be Primary if it covers the individual as an employee and Secondary if it covers the individual as a dependent.

(B) If an individual is covered as a dependent under two or more plans, the plan that covers the individual as a dependent of the person whose birthday falls earlier in the year is Primary. If both individuals share the same date of birth, the plan covering the individual for the longer period of time is Primary.

(C) In the case of children of divorced or unmarried parents, in the absence of court-determined responsibility, the plan covering the parent with custody is Primary. If the parent without custody has court-determined responsibility, but does not have health benefits available for children, then the plan covering the parent with custody is Primary.

(D) A plan will be Primary if it covers the individual as an employee and Secondary if it covers the individual (i) as a former employee, (ii) as a retiree, or (iii) as an individual who has elected to continue benefits under the Plan pursuant to Article VII herein.

(E) If none of the above rules apply, a plan will be Primary if it has covered the individual for the longer period of time and Secondary if it has covered the individual for the shorter period of time.

Notwithstanding any provision herein to the contrary, if a covered Retiree or his/her Covered Dependent is eligible for Medicare, benefits otherwise payable on behalf of that covered Retiree or his/her Covered Dependent shall be reduced by the amount of benefits available from Medicare, regardless of whether such benefits are actually received from Medicare.

Information necessary to the administration of this provision will be required at the time a claim is submitted.

### 6.10 Termination of Coverage

The Employer or Plan has the right to rescind any coverage of the Employee and/or Retiree and/or Dependents for cause, making a fraudulent claim or an intentional material misrepresentation in applying for or obtaining coverage or obtaining benefits under the Plan. The Employer or Plan may either void coverage for the Employee and/or covered Retirees and/or Covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least thirty (30) days advance written notice of such action. The Employer will refund all contributions paid for any coverage rescinded; however, claims paid will be offset from this amount. The Employer reserves the right to collect additional monies if claims are paid in excess of the Employee's and/or Retiree's and/or Dependent's paid contributions.

(A) Termination of Covered Person Coverage

The coverage of any Covered Person with respect to himself/herself shall automatically cease, except as provided in any extension of benefits or continuation of benefits provision, upon the earliest of:

(1) the date the Plan is terminated;

(2) the end of the month during which the Covered Person ceases to be in a class of Employees eligible for coverage;

(3) the date beginning the period for which the Covered Person has failed to make any required contribution for coverage;

(4) the end of the month during which his/her employment with the Employer terminated;

(5) the date of the Covered Person's death; or

(6) the end of month (unless divorce or death), in the case of an Eligible Retiree.

(B) Termination of Covered Dependent Coverage

The coverage of any Covered Dependent shall automatically cease, except as provided in any extension of benefits or continuation of benefits provision, upon the earliest of:

(1) the date coverage terminates for the Employee upon whom the Covered Dependent(s) depend for eligibility;

(2) the last day of the month during which such dependent ceases to be an Eligible Dependent;

(3) the date beginning the period for which the Covered Person or Covered Dependent has failed to make any required contribution for Dependent Coverage, if contributions are required;

(4) the date the Plan is terminated;

(5) the date of the Covered Dependent's death; or

(6) the date of the divorce, for the Covered Dependent Spouse and Covered Dependent children for whom the covered Employee or Retiree does not have legal guardianship, including step children.

**6.11 Extension of Benefits**

If coverage under the Plan would otherwise terminate with respect to a Covered Person or Covered Dependent, without regard to the continuation of benefits provisions in Article VII herein, benefits under the Plan may nevertheless be extended under the specific circumstances enumerated herein.

(A) Extension of Coverage for Disabled Child

The maximum age for a dependent child as specified in this Plan shall not serve to terminate or preclude coverage for any child who is incapable of self-sustaining employment by reason of mental or physical disability provided:

(1) such child is unmarried and dependent upon the Employee for at least fifty percent (50%) of his/her support and maintenance;

(2) such child was a Covered Dependent and was suffering from such mental or physical disability on the date his/her status as a Covered Dependent would otherwise terminate; and

(3) proof of such incapacity is furnished to the Employer at such times as the Employer may reasonably require by the Covered Person on the child's behalf

(B) Hospital Confinement

If coverage under the Plan would otherwise terminate with respect to a Covered Person or Covered Dependent who is an in-patient in a Hospital, Extended Care Facility or Substance Abuse Treatment Facility, or a patient in a Partial Hospitalization Psychiatric Treatment Program, benefits will continue to be provided, subject to any applicable benefit maximum provisions described herein, until the earlier of

(1) date of discharge from the Hospital or other facility or program or

(2) three (3) calendar months.

(C) Continuation During Periods of Employer-Certified Disability

A Covered Person may remain eligible if Active, full-time work ceases due to disability. This continuance will end when, according to its personnel policies, the City of Springfield determines the Covered Person is no longer disabled.

A disabled Covered Person who is a fireman, police officer, elected official or municipal Employee may continue coverage for the period of disability if:

(1) The Covered Person and his or her Covered Spouse and/or Dependents were covered under the Plan the day immediately prior to the date of disability.

(2) The Covered Person and his or her Covered Spouse and/or Dependents are eligible to continue health insurance coverage pursuant to:

(a) Section 367(f) of the IL Insurance Code (firemen);

(b) Section 367(g) of the IL Insurance Code (police officers);

(c) Section 367(h) of the IL Insurance Code (deputies);

(d) Section 367(j) of the IL Insurance Code (municipal employees).

(3) The Covered Person pays any required contribution for coverage.

(4) Should the Covered Person or Covered Spouse become eligible for Medicare, the benefits under the Plan shall be secondary to Medicare.

While continued, coverage will be that which was in force on the last day worked as an Active Employee. However, if benefits reduce for others in the class, they will also reduce for the continued person.

(D) State Mandate, Collective Bargaining Agreement or Employer Personnel Policy

If coverage under the Plan would otherwise terminate with respect to a Covered Person or Covered Dependent, benefits will continue to be provided for those individuals to the extent required by law, a collective bargaining agreement in effect with respect to the Employer or the Employer's personnel policies.

(E) Survivorship Benefit

An Eligible Dependent of a deceased Employee who died while covered under the Plan may continue to receive benefits under the Plan as long as the dependent continues to pay the cost of such coverage as periodically established by the Employer, does not remarry (Spouse only) or does not become eligible to make an election under Section 7.1 (COBRA).

In the event of the death of a covered Retiree or disabled Employee, the Surviving Spouse and Eligible Dependent children may be eligible for continued coverage under the Plan, as outlined in Sections 367(f), 367(g), 367(h) and 367(j) of the Illinois Insurance Code, if

(1) the Surviving Spouse and/or Eligible Dependents were covered under the Plan on the date of death and

(2) the retirement or disability period does not end with the death of the Retired or disabled Employee.

Coverage will remain in effect for the Surviving Spouse until the Surviving Spouse remarries or dies.

(F) Eligible Retirees

A Covered Person who becomes an Eligible Retiree while covered under the Plan can continue to receive benefits under the Plan as long as the Eligible Retiree continues to pay the cost of such coverage as periodically established by the Employer. This provision also applies to those persons who were Covered Dependents of the Employee at the time he/she became an Eligible Retiree. All Eligible Retirees are eligible to continue coverage under the BasicSelect option, the POS option or High Deductible Health Plan option. See the definition of Eligible Retiree for limitations on when a Retiree or a Retiree's Eligible Dependent may enroll in the Plan.

A Covered Employee who is a fireman, police officer, elected official or municipal Employee (and his or her Covered Spouse and/or Covered Dependent children) may qualify for continued coverage for the period of retirement under the following conditions:

(1) The Covered Person and his or her Covered Spouse and/or Dependents were covered under the Plan the day immediately prior to the date of retirement.

(2) The Covered Person and his or her Covered Spouse and/or Dependents are eligible to continue health insurance coverage pursuant to:

(a) Section 367(f) of the IL Insurance Code (firemen);

(b) Section 367(g) of the IL Insurance Code (police officers);

(c) Section 367(h) of the IL Insurance Code (deputies);

(d) Section 367(j) of the IL Insurance Code (municipal employees).

(3) Payment of any required contribution for coverage is made.

(4) Should the Covered Person or Covered Spouse become eligible for Medicare, the benefits under the Plan shall be secondary to Medicare.

Upon enrollment in Medicare Parts A & B, a Retired Employee or the Spouse of a Retired Employee may:

(a) continue coverage in the BasicSelect, POS or High Deductible Health Plan options; or

(b) continue coverage under this Plan, provided the Covered Dependent continues to meet the eligibility requirements for coverage.

### 6.12 General Limitations

Unless otherwise provided, and in addition to any limitations or exclusions stated in the respective benefit descriptions, no benefits are payable under this Plan for the following:

(A) charges for which payment is not legally required;

(B) treatment paid for by any agency of the United States Government or any state or political subdivision, or provided by or in a Hospital operated by any agency of the United States Government or any state or political subdivision, unless Covered Person or Covered Dependent is legally required to pay such charges;

(C) circumstances beyond the City's control. In the event of major disaster, terrorist event, epidemic, war or other circumstances beyond the City's control, the City will not be responsible for any delay or failure to provide services due to lack of available facilities or personnel;

(D) for or in connection with:

(1) Sickness or Injury for which the Covered Person or Covered Dependent is entitled to benefits under any Worker's Compensation Law, Employer's Liability Law, or similar laws;

(2) Hospital, surgical and medical services or supplies unless such expense is incurred upon the recommendation of a Physician for diagnosis or treatment of an Injury or Sickness;

(3) Injury or Sickness arising out of war — declared or undeclared — or service in any military force or civilian non-combatant unit serving with such force;

(4) services or supplies that constitute personal comfort or beautification items, television or telephone use, education or training, or expenses actually incurred by persons who are not Covered Persons or Covered Dependents;

(5) cosmetic Surgery, except for treatment necessitated by accidental Injury or Surgery or to provide proper bodily functions, including correction of a congenital malformation such as a cleft lip and cleft palate;

(6) except as specified elsewhere, health examinations of a routine periodic nature or Expenses Incurred for immunizations not necessary for the treatment of a Sickness or Injury, except where required by law;

(7) services performed by any person who is a member of the Covered Person's or Covered Dependent's Immediate Family or who normally resides in the Covered Person's or Covered Dependent's home;

(8) services, supplies or treatments not recognized by the American Medical Association as generally accepted and Medically Necessary for the diagnosis and/or treatment of an active Sickness or Injury; or charges for procedures, surgical or otherwise, which are specifically listed by the American Medical Association as having no medical value; or drugs not approved for use by the U.S. Food and Drug Administration;

(9) charges incurred outside the United States if the Covered Person or Covered Dependent traveled to such a location for the primary purpose of obtaining medical services, drugs or supplies;

(10) hospitalization when such confinement occurs primarily for physiotherapy, hydrotherapy, convalescent or rest care, or any routine physical examinations or tests not connected with the actual Sickness or Injury, except as otherwise specified herein;

(11) eye refractions, the purchase or fitting of eyeglasses, contact lenses, hearing aids or such similar aid devices. This exclusion shall not apply to the initial purchase of eyeglasses or contact lenses following cataract Surgery;

(12) professional nursing services if rendered by other than a Registered Graduate Nurse or Licensed Practical Nurse, unless such care was vital as a safeguard of the Covered Person's or Covered Dependent's life and unless such care is specifically listed as a benefit elsewhere in the Plan;

(13) reversal of elective sterilization;

(14) travel and transportation expenses, even though treatment is prescribed by a Physician or attending Physician;

(15) IQ testing or educational training;

(16) vitamins or dietary supplements (preauthorization required), except where required by law;

(17) housekeeping or Custodial Care;

(18) weak, unstable or flat feet, or bunions, unless an open cutting operation is performed or for treatment of corns, calluses or toenails, unless at least part of the nail root is removed, or purchase of orthopedic shoes or other devices for support of the feet (custom-molded inserts are covered if a letter of Medical Necessity is submitted and approved);

(19) enrollment in a health, athletic or similar club or weight loss, non-smoking or similar programs, except as otherwise specifically provided herein;

(20) purchase or rental of supplies of common use such as exercise cycles, air purifiers, air conditioners, water purifiers, hypoallergenic pillows or mattresses or waterbeds;

(21) purchase or rental of motorized transportation equipment (except electric wheelchairs when Medically Necessary), escalators, elevators, saunas, steam baths, or swimming pools;

(22) the following services, except where required by law:

(a) sex transformation and hormones related to such treatment;

(b) penile implants, unless underlying health condition; or

(c) treatments related to feelings of sexual inadequacy;

(23) radial keratotomy or keratoplasty;

(24) chelation therapy;

(25) a Hospital Confinement/Admission preceding elective Surgery by more than twenty-four (24) hours, unless the delay is Medically Necessary;

(26) Injury or Sickness arising out of the voluntary participation in a riot or the commission of an illegal act or crime. This exclusion does not apply if the Injury or Sickness resulted from an act of domestic violence or a medical (including both physical and mental health) condition;

(27) replacement of cataract lenses when a prescription change is not required or the prescribing and fitting of an artificial eye;

(28) treatment of temporomandibular joint syndrome with intraoral prosthetic devices or any other procedure to alter vertical dimension;

(29) prescription drugs, except as specified in the benefits sections of the Plan, pursuant to the terms of the drug card program maintained by the Employer, except for the purpose of coordinating benefits with another plan;

(30) services or supplies not specifically mentioned in the Plan;

(31) services for maintenance care;

(32) cardiac rehabilitation - Phase III;

(33) acupuncture in excess of $500 per person per Plan Year;

(34) charges for missed or late appointments or late charges of any nature;

(35) contraceptive devices and birth control medications except as listed as covered expense elsewhere, except where required by law;

(36) complications arising from a non-covered benefit;

(37) treatment, services and supplies in connection with any loss sustained as a consequence of the Covered Person being intoxicated or under the influence of any narcotic unless administered on the advice of a Physician. Whether the Covered Person is intoxicated shall be determined by the law and jurisdiction of that geographical area in which the loss or cause of loss is incurred. Expenses for the treatment of Substance Abuse as specified in this Plan are covered. This exclusion does not apply if the Injury or Sickness resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(38) health services and associated expenses for surrogate parenting and health services for the birth of an adopted child who is not a qualified dependent at birth;

(39) breast implant removals will be covered for those removals that are Medically Necessary due to Sickness or Injury. This benefit does not apply to Surgery performed for the removal of breast implants that were implanted solely for cosmetic reasons;

(40) notwithstanding any provision to the contrary, no benefits are payable under the Plan for Expenses Incurred for treatment that is not Emergency Treatment that results in a Hospital Confinement/Admission during the period each week between noon on Friday and midnight on the next following Sunday;

(41) Expenses Incurred for behavioral, social maladjustment, lack of discipline or other antisocial actions that are not specifically the result of Mental Illness;

(42) elective abortions, except where necessary to preserve the life of the mother;

(43) school/sports physicals;

(44) any taxes or other assessments owed with respect to Expenses Incurred for medical services (other than sales tax);

(45) any limitations on benefits contained in the Summary of Benefits;

(46) if Hospitalized on Effective Date, Expenses incurred prior to the effective date of any Plan(s). A Member hospitalized on the effective date of eligibility must notify the Medical Contract Administrator, and when medically stable, transfer to an In-Network participating Hospital;

(47) Dental Services not elsewhere listed as a covered medical expense;

(48) Services and supplies not provided under the direction of a Physician and that are not Medically Necessary for diagnosis and treatment of Injury, Sickness or pregnancy;

(49) Treatment and services related to acupressure and hypnotherapy, unless Medically Necessary; and

(50) Genetic testing.

(E) Expenses for "experimental treatment" for a Covered Person or Covered Dependent. For the purpose of this Section, a treatment or procedure shall be deemed an "experimental treatment" when the treatment or procedure involved is given that designation or a similar designation in connection with the administration of Medicare or by the American Medical Association.

Notwithstanding the foregoing, "experimental treatment" shall not include an approved clinical trial. An "approved clinical trial" means a phase I, II, III, or IV trial if it is conducted for the prevention, detection, or treatment of cancer or another disease or condition likely to lead to death unless the course of the disease or condition is interrupted.

An approved clinical trial's study must be (1) approved or funded by one or more of: (a) the National Institutes of Health (NIH), (b) the Centers for Disease Control and Prevention (CDC), (c) the Agency for Health Care Research and Quality (AHCRQ), (d) the Centers for Medicare and Medicaid Services (CMS), (e) a cooperative group or center of the NIH, CDC, AHCRQ, CMS, the Department of Defense (DOD), or the Department of Veterans Affairs (VA), (f) a qualified non-governmental research entity identified by NIH guidelines for grants; or (g) the VA, DOD, or Department of Energy (DOE) if the study has been reviewed and approved through a system of peer review that the Secretary of HHS determines is comparable to the system used by NIH and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review; (2) a study or trial conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or (3) a drug trial that is exempt from investigational new drug application requirements.

## 6.13 Coordination with Medicare and Medicaid

(A) Medicare

This Plan will be considered the Primary Plan for Covered Persons who are current Employees and their Covered Dependents who are nevertheless eligible for Medicare benefits if (i) such Covered Persons or Covered Dependents are age sixty-five (65) or older and their Employer employs twenty (20) or more Employees, or (ii) such Covered Persons or Covered Dependents are disabled and any Employer under this Plan employs one-hundred (100) or more Employees. Except to the extent required by law for end-stage renal disease, Medicare shall be considered the Primary Plan for all other Covered Persons who become eligible for Medicare and their Covered Dependents, unless the Covered Person on behalf of himself or herself and his/her Covered Dependents rejects coverage under this Plan. In the event of an election to terminate coverage, benefits will no longer be available under this Plan as either a Primary Plan or a Secondary Plan.

(B) A Special Note About the Impact of Disability-Based Medicare on your Retiree Coverage

If you become eligible for Medicare due to disability, Medicare shall be considered the Primary Plan and your retiree health coverage under this Plan shall be considered the Secondary Plan, as described above. This means your retiree health coverage under this Plan will pay a reduced amount as if you are enrolled in Medicare Parts A and B, regardless of whether you actually enroll in those coverages. As a result, you will be responsible for the expenses that Medicare would have paid and you will incur a larger out-of-pocket expense.

If you are enrolled in a Medicare+Choice (Medicare Part C) plan on a primary basis (the Plan shall be considered the Secondary Plan), you should follow all rules of that plan that require you to seek services from that plan's participating providers. When the Plan is considered the Secondary Plan, it will pay any benefits available to you under the Plan as if you had followed all rules of the Medicare+Choice plan. You will be responsible for any additional costs or reduced benefits that result from your failure to follow these rules, and you will incur a larger out-of-pocket cost.

Your Medicare entitlement will not impact your prescription drug coverage under the Plan. As a reminder, Medicare Part D (the prescription drug component of Medicare) can assess a penalty if you enroll later than when you initially become eligible. Notwithstanding the foregoing, the Plan offers creditable prescription drug coverage, so as long as you are enrolled in the Plan's prescription drug coverage, the Medicare Part D late enrollment penalty should not apply if and when you eventually enroll in Medicare Part D. For most individuals it does not make sense to enroll in both Plan prescription drug coverage and Medicare Part D. That said, you should decide what prescription drug coverage works best for you based on your individual medical condition and your health and financial needs.

(C) Medicaid and SCHIP

Payment for Expenses Incurred with respect to a Covered Person or Covered Dependent under the Plan will be made in accordance with any assignment of rights made by, or on behalf of, such Covered Person or Covered Dependent as required by a State plan for medical assistance approved under Title XIX of the Social Security Act pursuant to Section 1912(a)(1)(A) or a State Child Health Insurance Program (SCHIP) approved under Title XXI of such Act. In enrolling or in determining or making any payments for Expenses Incurred of a Covered Person or Covered Dependent, the fact that the Covered Person or Covered Dependent is eligible for, or is provided medical assistance under, a State plan for medical assistance approved under Title XIX or a State Child Health Insurance Program approved under Title XXI of the Social Security Act will not be taken into account. To the extent that payment has been made under a State plan for medical assistance approved under Title XIX or a State Child Health Insurance Program approved under Title XXI of the Social Security Act when the Plan has a legal liability to make payment for the Expenses Incurred constituting such assistance, payment for the Expenses Incurred under this Plan will be made in accordance with any State law that provides the State has acquired the rights with respect to a Covered Person or Covered Dependent to such payment for such Expenses Incurred.

## 6.14 Qualified Medical Child Support Order

The Plan shall comply with the terms of a Qualified Medical Child Support Order ("QMCSO"), directing the Plan to provide benefits to one or more alternate recipients, pursuant to the procedure set forth below:

(A) An original court order that purports to be a QMCSO must be served on the Plan's agent for service of legal process ("Agent"). The original court order must include the case caption, location of the court, case number, and the signature of execution (such as a judge or administrative law judge).

(B) Within ten (10) days of the receipt of such an order, the Agent shall deliver the order to the Medical Contract Administrator.

(C) The Medical Contract Administrator shall, within twenty (20) days of its receipt of the order, make a preliminary determination as to whether or not the order satisfies the requirements to be a QMCSO. In order to satisfy those requirements, an order must contain at least the following information:

(1) a clause that creates or recognizes the existence of a dependent's right to receive benefits under the Plan;

(2) the name and last known mailing address of the Covered Person with respect to whom the order is issued and each dependent covered by the order;

(3) the social security number of each dependent covered by the order;

(4) a reasonable description of the type of coverage to be provided by the Plan to each dependent;

(5) a clause that specifies the order to which the Plan applies, as well as the time period to which the order applies; and

(6) a clause that states the order does not require the Plan to provide any type or form of benefit not otherwise provided under the Plan.

(D) An order that, in the judgment of the Medical Contract Administrator, does not meet the requirements of a QMCSO shall be returned to the legal counsel who prepared the order for revision. Revised orders that are resubmitted shall be considered new orders and shall be reviewed in accordance with the procedures set forth in this Section.

(E) When the Medical Contract Administrator makes a preliminary determination that an order satisfies the requirements of QMCSO, it shall forward the order to the Employer for review. The Employer shall make the final determination of the status of the order.

(F) The Medical Contract Administrator shall notify all parties involved of the Employer's decision and of the respective parties' entitlement to benefits.

### 6.15 Qualified Medical Child Support Order/National Medical Child Support Notice

The term "Qualified Medical Child Support Order" (QMSCO) means an order that creates or recognizes the Dependent's right to receive benefits under this Plan. The term Qualified Medical Child Support Notice shall also include a National Medical Child Support Notice. A support order may be issued by a state court or through a state administrative process. If an Employee has a Dependent child and the Employer receives a Medical Child Support Order identifying the child's right to enroll in the Plan, the Plan Administrator will notify both the Employee and the Dependent that the order has been received. The notification will also indicate the Plan's procedure for determining whether the Medical Child Support Order is qualified.

To be a Qualified Medical Child Support Order, the order must clearly specify all of the following:

(A) Employee name and last known mailing address and

(B) the name and mailing address of the Dependent specified in the order.

The Dependent may designate another person, such as a custodial parent or legal guardian, to receive the Summary Plan Description, reimbursement for claims, explanation of benefit forms and other Plan materials.

If the Plan Administrator decides that the order is not a Qualified Medical Child Support Order, each Dependent specified in the order as entitled to enroll in the Plan may submit a written appeal to the Plan Administrator.

The Employer will not disenroll or eliminate coverage of any such child until any of the following apply:

(A) Satisfactory written evidence is provided that the order is no longer effective.

(B) Comparable coverage through another plan will take effect no later than the disenrollment date.

(C) The Employer eliminates Dependent coverage for all Participants.

(D) The Employer terminates the Plan for all Covered Persons.

Enrollment of a Dependent in response to a Qualified Medical Child Support Order will be made upon the later of the date specified in the order or the date the Plan Administrator determines that the order is a Qualified Medical Child Support Order.

Copies of the Plan's procedures governing Qualified Medical Child Support Orders and a sample Qualified Medical Child Support Order may be obtained without charge by contacting the Plan Administrator.

Reimbursement of benefit payments under the Plan pursuant to a Qualified Medical Child Support Order may be made to the Covered Dependent or the Covered Dependent's custodial parent. The Plan shall not consider Medicaid eligibility in enrolling a Covered Dependent in the Plan. The Plan shall also comply with the Covered Dependent's assignment of rights under Medicaid.

## *ARTICLE VII CONTINUATION OF BENEFITS*

### A. COBRA

In accordance with the Consolidated Omnibus Budget Reconciliation Act of 1986 ("COBRA"), continuation coverage under the Plan is available to Qualified Beneficiaries under certain specified conditions.

For the purpose of this Article VII, "Qualified Beneficiary" means any beneficiary defined as such pursuant to Section 607(3) of ERISA and generally includes any Covered Person or Covered Dependent whose coverage under the Plan would otherwise terminate upon occurrence of any of the events specified in this Article VII. The term "Qualified Beneficiary" shall also include any child born to or placed for adoption with the Covered Person during the period of continuation coverage described in this Article VII, provided such child qualifies as an Eligible Dependent.

If an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a spouse or Dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual.

Federal law does not recognize domestic partners, common-law marriage partners, Civil Union Partners or their children as Qualified Beneficiaries.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

## 7.1 Eligibility to Make Election

A Qualified Beneficiary may elect to continue coverage under the Plan if coverage would otherwise cease under the Plan due to a Qualifying Event. A "Qualifying Event" is any of the following if the Plan provided that the Qualified Beneficiary would lose coverage in the absence of COBRA continuation coverage:

(A) the Covered Person's death;

(B) termination of a Covered Employee's employment (other than by reason of the Employee's Gross Misconduct) or reduction of the covered Employee's hours (whether voluntary or involuntary);

(C) divorce or legal separation of the Covered Person and his/her spouse. If the Covered Person reduces or eliminates his/her Spouse's Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the spouse's coverage was reduced or eliminated before the divorce or legal separation.

(D) the Covered Person's enrollment in any part of the Medicare program;

(E) a Covered Person's child ceasing to be an Eligible Dependent; or,

(F) for a Retiree or a Retiree's Dependent, a proceeding in bankruptcy under Title 11, United States Code, commencing on or after July 1, 1986, with respect to the Employer.

In the case of bankruptcy proceedings as described in (f) above, a loss of coverage includes a substantial elimination of coverage with respect to a Qualified Beneficiary within one (1) year before or after the date of commencement of the proceedings.

Notwithstanding the above, a Qualified Beneficiary is not entitled to elect continuation coverage if the Covered Person's termination of employment is for Gross Misconduct as determined by the Employer in its sole discretion, pursuant to a uniform, nondiscriminatory policy. Gross Misconduct occurs when the Covered Person engages in a deliberate and willful violation of a reasonable rule or policy of the City of Springfield governing the individual's behavior in performance of their work, provided such violation has harmed the City of Springfield, the employing unit, or other employees, or has been repeated by the Covered Person despite a warning or other explicit instructions from the City of Springfield. In addition, Gross Misconduct occurs when the Covered Person engages in a felony or theft related to their employment.

## 7.2 Election Period and Procedure

A failure to continue your group health coverage may affect your rights under federal law. You should take into account that you may have special enrollment rights under federal law (HIPAA). You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's employer) within 30 days after Plan coverage ends due to a Qualifying Event listed above. You will also have the same special right at the end of COBRA continuation coverage if you get COBRA continuation coverage for the maximum time available to you.

The election to continue coverage must be made during the period beginning on the day when coverage would otherwise cease under the Plan and ends sixty (60) days after the later of (i) such date, or (ii) if applicable under Section 7.7, the date when the Qualified Beneficiary is notified of the right to make such election. A Qualified Beneficiary's failure to comply with the procedures and requirements established by the Employer for making the election shall constitute the failure to make an election to continue coverage as provided herein. The written waiver by a Qualified Beneficiary (or by the Covered Person or his/her spouse on behalf of a Qualified Beneficiary) of the election to continue coverage shall terminate the Qualified Beneficiary's right to later make an election, unless the Qualified Beneficiary revokes the waiver within the sixty (60) day election period described above. However, if a waiver is revoked, continuation coverage will be effective on the date the revocation is made and will not be retroactive to the date of the event described in the Eligibility to Make Election Changes section.

Note: If a covered Employee who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, and the Employee and his or her Covered Dependents have not elected COBRA coverage within the normal election period, a second opportunity to elect COBRA coverage will be made available for themselves and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their group health plan coverage ended. Any person who qualifies or thinks that he and/or his family members may qualify for assistance under this special provision should contact the Plan Administrator for further information.

The Trade Act of 2002 also created a tax credit for certain TAA-eligible individuals and for certain retired Employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. Recent changes in the law increased this assistance temporarily to 80%, and temporarily extended the period of COBRA continuation coverage for eligible individuals. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Consumer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available atwww.doleta.gov/tradeact.

### 7.3 Benefits

A Qualified Beneficiary who elects continuation coverage as provided herein shall be eligible to receive the same benefits to which a Covered Person or Covered Dependent under similar circumstances are otherwise entitled. If benefits under the Plan are increased, decreased or otherwise amended or changed either prior to or subsequent to the Qualified Beneficiary's election of continuation coverage, each Qualified Beneficiary will be entitled to benefits comparable to those available to a Covered Person or Covered Dependent under similar circumstances.

### 7.4 Payment for Benefits

A Qualified Beneficiary is required to contribute toward the cost of continuing the benefits as provided herein ("Continuation Premium"). The amount of the Continuation Premium or schedule of Continuation Premiums for different classes of Qualified Beneficiaries shall be determined from time to time by the Employer. The Employer shall also establish procedures for providing notices of the amounts due and payment of the Continuation Premium. A Qualified Beneficiary's failure to pay the Continuation Premium by the due date (including any grace period if the Employer establishes such a period) shall result in the Qualified Beneficiary's termination of continuation coverage as of the date covered by the last paid Continuation Premium and such Qualified Beneficiary shall be precluded from extending, renewing or reelecting such continuation coverage.

### 7.5 Duration of Continuation Coverage

A Qualified Beneficiary electing to purchase continuation coverage under the Plan shall be eligible to continue coverage until the earliest of the following events:

(A) the date eighteen (18) months after the date of a Covered Person's termination of employment or reduction in hours;

(B) the date thirty-six (36) months after the date of any other event described in Section 7.1 other than a Covered Person's termination of employment or reduction in hours (except that if a Covered Person who is an Employee has a termination of employment or reduction in hours entitling him or her to continuation coverage within eighteen (18) months of the date of his or her entitlement to Medicare, then the period of Continuation Coverage for the Qualified beneficiaries other than the Covered Person shall not terminate prior to the close of the thirty-six (36)-month period beginning on the date the Covered Person became entitled to Medicare);

(C) the date the Employer ceases to provide any health benefit plan for any similar class of its Employees;

(D) the date the Qualified Beneficiary first becomes covered after the date of his or her election of Continuation Coverage (as an Employee or otherwise) by another group health plan that does not contain any exclusion or limitation with respect to any Pre-Existing Condition of such Qualified Beneficiary or the date the Qualified Beneficiary becomes entitled to benefits under Medicare;

(E) the date that is the last day of the period for which the Qualified Beneficiary's Continuation Premium payments have been paid (including any grace period if the Employer establishes such a period) as determined by the Employer;

(F) in the case of a Qualified Beneficiary who is determined, under Title II or XVI of the Social Security Act ("Act"), to have been disabled at any time during the first sixty (60) days of continuation coverage, the earlier of (i) the date twenty-nine (29) months after the date of such continuation coverage (but only if the Qualified Beneficiary has provided notice of such determination under ERISA Section 606(3) within sixty (60) days after the date of determination, and before the expiration of eighteen (18) months from the date of occurrence of the qualifying event), or (ii) the end of the month next following the date of final determination under Title II or XVI of the Social Security Act that the Qualified Beneficiary is no longer disabled.

If more than one event that would entitle the Qualified Beneficiary to elect continuation coverage occurs (as described in Section 7.1 herein), the first occurring of such events shall be the measuring date for purposes of the maximum possible length of continuation coverage under this Section 7.5. In addition, the maximum period available for continuation coverage pursuant to Article VII is measured from the date of occurrence of the Qualifying Event specified in Section 7.1, and is not delayed or extended by any extension of benefits period available pursuant to Section 6.13 herein.

Notwithstanding anything in this Section to the contrary, in the case of the Covered Person's termination of employment (other than by reason of such Employee's Gross Misconduct) or reduction of his hours that occurs less than eighteen (18) months after the date the Covered Person became eligible for benefits under Title XVIII of the Social Security Act, the period of coverage under this Article VII for any Qualified Beneficiary, other than the Covered Person, shall not terminate before the close of the thirty-six (36)-month period beginning on the date the Covered Person became entitled to such benefits.

### 7.6 No Option to Convert to Individual Coverage

A Qualified Beneficiary has no option to convert to individual coverage upon termination of coverage under the Plan.

### 7.7 Administration

(A) Notice on Death, Termination, Reduction of Hours, or Entitlement to Medicare

Within thirty (30) days of a Covered Person's death, termination of service, reduction of hours, or entitlement to Medicare, the Employer shall inform the Plan Administrator that the Qualified Beneficiaries may be eligible to elect continuation coverage. The Employer or Plan Administrator, at the direction of the Employer, shall then notify the Qualified Beneficiaries of their rights to elect continuation coverage pursuant to procedures established by the Employer.

(B) Notice of Change in Marital Status or Dependent Status

If a Covered Person becomes divorced or legally separated, or if a child of a Covered Person ceases to be eligible for coverage under the Plan because (s)he is no longer an Eligible Dependent, either the Covered Person, the Covered Person's spouse or the Covered Person's child must notify the Employer of these events within sixty (60) days of their occurrence in order for the respective Qualified Beneficiary to be eligible to elect continuation coverage. Notice by a Qualified Beneficiary of the occurrence of an event giving rise to an election does not act as an election to receive continuation coverage under the Plan. In the event of divorce or legal separation, the Employer, if notified within the time period specified in this Subsection (B), shall notify the other Qualified Beneficiaries of their eligibility to elect continuation coverage. The notice may be provided orally or in writing and must disclose the following:

(1) the name and Plan identification numbers of the Covered Person and the individuals affected by the event;

(2) proof of the individual's divorce, separation or loss of status as an Eligible Dependent; and

(3) the date of such event.

(C) Notice of Disability

If a Covered Person or Covered Dependent is determined, under Title II or XVI of the Act, to have been disabled at any time during the first sixty (60) days of continuation coverage, the Covered Person or Covered Dependent, as the case may be, must notify the Plan Administrator of the determination under the Act within sixty (60) days of the latest of the following to occur:

(1) the date of the Social Security Administration disability determination (sometimes referred to as the "award letter");

(2) the date of the termination of employment or reduction in hours entitling the Qualified Beneficiary to COBRA continuation coverage;

(3) the date the Qualified Beneficiary otherwise loses coverage under the Plan as a result of the termination of employment or reduction in hours; or

(4) the date the Qualified Beneficiary is informed of the obligation to provide notice of disability as provided herein.

Notwithstanding the above, the notice of determination must be provided to the Plan Administrator before the expiration of eighteen (18) months from the date of occurrence of the termination of employment or reduction in hours. The notice must be provided to the Plan Administrator in writing and must disclose (i) the name and Plan identification number of the disabled Covered Person or Covered Dependent and (ii) the determination notice provided pursuant to the Act to the disabled Covered Person or Covered

Dependent. The Qualified Beneficiaries must also notify the Plan Administrator in writing within thirty (30) days of the date of any final determination under the Act that the Covered Person or Covered Dependent is no longer disabled. The notice shall disclose (i) the name and Plan identification number of the disabled Covered Person or Covered Dependent and (ii) the final determination Notice provided pursuant to the Act that the person is no longer disabled.

(D) Notice of Coverage Under Group Health Plan or Entitlement to Medicare

If a Qualified Beneficiary (i) becomes covered (as an employee or otherwise) by another group health plan that does not contain any applicable exclusion or limitation with respect to any Pre-Existing Condition of such Qualified Beneficiary, or (ii) becomes entitled to benefits under Medicare, the Qualified Beneficiary must notify the Plan Administrator of such event in writing within thirty (30) days of such coverage date.

(E) General

(1) Multiple Events. If more than one event described in Section 7.1 occurs, the first such event occurring will determine which one of either Subsection (A) or (B) of this Section 7.7 is applicable.

(2) Current Addresses. The notification of election rights under COBRA will generally be made by U.S. Mail to the Qualified Beneficiary's last known address. As a result, it is important for each Covered Person and Covered Dependent to timely provide the Employer with his or her current mailing address.

(3) Interpretation. In the event of any inconsistency or omission, this Section and the applicable provisions of the Plan shall be construed, interpreted and administered in a manner which meets the minimum requirements of COBRA.

### 7.8 COBRA Rates

The monthly COBRA rate reflects the total cost of the Employer's health insurance and the Federal allowable 2% administrative fee.

## B. FMLA

In accordance with the Family and Medical Leave Act of 1993 ("FMLA"), continuation coverage under the Plan is available to Covered Persons and their Covered Dependents under certain specified conditions.

## 7.9 Continuation of Benefits/Limitations

A Covered Person who takes a Leave of Absence under the City of Springfield's applicable provisions and the provisions of FMLA is entitled to continued coverage under the Plan for himself/herself and his/her Covered Dependents. Benefits under the Plan are available to the same extent as if the Covered Person had been in Active Service during the entire leave period, subject to the following terms and conditions:

(A) Coverage shall cease for a Covered Person (and his Covered Dependents) for the duration of the leave if at any time the Covered Person is more than thirty (30) days late in paying any required contribution.

(B) A Covered Person who declines coverage during the leave or whose coverage is terminated as a result of his failure to pay any required contributions shall, upon return from the leave, be entitled to be reinstated to the Plan on the same terms as prior to taking the leave without any qualifying period or physical examination.

(C) If a Covered Person who is a Key Employee does not return from leave when notified by the Employer that substantial or grievous economic Injury will result from his reinstatement, the Key Employee's entitlement to Plan benefits continues unless and until the Covered Person advises the Employer that he/she does not desire restoration to employment at the end of the leave period, or the leave entitlement is exhausted, or reinstatement is actually denied.

(D) Any portion of the cost of coverage that had been paid by the Covered Person prior to the leave must continue to be paid by the Covered Person during the leave. If the cost is raised or lowered during the leave, the Covered Person shall pay the new rates. If the leave is unpaid, the Covered Person and the Employer shall negotiate a reasonable means for paying the Covered Person's portion of the cost.

(E) If the Employer provides a new health plan or benefits or changes the health benefits or Plan while the Covered Person is on leave, the Covered Person is entitled to the new or changed plan and benefits to the same extent as if the Covered Person were not on leave.

(F) The Employer may recover its share of the cost of benefits paid during a period of unpaid leave if the Covered Person fails to return to work after the Covered Person's leave entitlement has been exhausted or expires, unless the reason the Covered Person does not return to work is due to (i) the continuation, recurrence, or onset of a serious health condition that would entitle the Covered Person to additional leave under FMLA; or (ii) other circumstances beyond the Covered Persons' control. If a Covered Person fails to return to work because of the continuation, recurrence or onset of a serious health condition, thereby precluding the Employer from recovering its share of the cost of benefits paid on the Covered Person's behalf during a period of unpaid leave, the Employer may require medical certification of the Covered Person's or the Covered Dependent's serious health condition. The Covered Person is required to provide medical certification within thirty (30) days from the date of the Employer's request. If the Employer requests medical certification and the Covered Person does not provide

such certification in a timely manner, the Employer may recover the costs of benefits paid during the period of unpaid leave.

## C. MILITARY LEAVE

In accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), or as may be provided by the City of Springfield, continuation coverage under the Plan is available to Covered Persons and their Covered Dependents under certain specified conditions. Any extension of benefits period provided pursuant to this Section shall not postpone the starting date for measurement of the maximum period available for continuation of benefits pursuant to the COBRA Continuation of Benefits (Section A) described above.

### 7.10 Election and Duration of Coverage

A Covered Person may elect to continue coverage under the Plan for himself/herself and his/her Covered Dependents if coverage would otherwise cease under the Plan due to that person's absence from employment with the Employer by reason of his service in the uniformed services. The maximum period of coverage available to all Covered Persons and Covered Dependents under the provisions of this Section shall be the lesser of:

(A) the twenty-four (24) month period beginning on the date on which the Covered Person's military leave began or

(B) the day after the date on which the Covered Person fails to apply for or return to a position of employment with the Employer following the expiration of leave as set forth in Section 4312(e) of USERRA.

### 7.11 Benefits

Benefits under the Plan for Covered Persons and Covered Dependents under an election for military leave continuation coverage shall be the same benefits as provided to all other Covered Persons and Covered Dependents. If benefits under the Plan are increased, decreased or otherwise amended or changed, either prior to or subsequent to the election of continuation coverage, the benefits provided pursuant to this continuation coverage will be the same as those available to all other Covered Persons and Covered Dependents.

### 7.12 Payment for Benefits

A Covered Person is required to contribute toward the cost of continuing the benefits as provided herein ("Continuation Premium"). The amount of the Continuation Premium or schedule of Continuation Premiums for different classes of coverage shall be determined from time to time by the Employer. The Employer shall also establish procedures for the billing and payment of the Continuation Premium. A Covered Person's failure to pay the Continuation Premium by the due date (including any grace period if the Employer establishes such a period) shall result in the termination of continuation coverage as of the date covered by the last paid Continuation Premium and such Covered Person shall be precluded from extending, renewing or reelecting such continuation coverage.

### 7.13 Employee Returning from Military Leave

In the case of a Covered Person whose coverage under the Plan was terminated by reason of service in the uniformed services, the Covered Person and his/her Eligible Dependents shall automatically be eligible for benefits upon returning. In addition, no other Plan limitation of exclusion shall apply to such returning Employee and his/her Eligible Dependents to the extent that such limitation or exclusion would not have applied had the Employee remained on the Plan during the military leave period. However, the preceding sentence shall not apply to the coverage of any Sickness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of service in the uniformed services.

## *ARTICLE VIII MISCELLANEOUS*

### 8.1 Non-Alienation of Benefits

Benefits payable under this Plan shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution, or levy of any kind, either voluntary or involuntary, including any such liability that is for alimony or other payments for the support of a spouse or former spouse or for any other relative of a Covered Person or Covered Dependent prior to actually being received by the person entitled to the benefit under the terms of the Plan, and any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, charge or otherwise dispose of any right to benefit payable hereunder, shall be void. This Plan shall not in any manner be liable for, or subject to, the debts, contracts, liabilities, engagements or torts of any person entitled to benefits hereunder.

### 8.2 Invalid Provision

If any term or provision of this Plan or the application thereof to any person or circumstance shall to any extent be invalid or unenforceable, the remainder of this Plan, or the application of such term or provision to such persons or circumstances other than those to which it is invalid or unenforceable, shall not be affected thereby, and each term and provision of this Plan shall be valid and shall be enforced to the fullest extent permitted by law.

### 8.3 Governing Law

The interpretation of the terms and provisions of this Plan shall be governed by the Laws of the State of Illinois where it has been executed, except where preempted by federal law.

### 8.4 Amendment/Termination

It is the intention of the Employer to maintain the Plan indefinitely. However, the Employer reserves the right to amend or terminate the Plan at any time, provided that no such amendment or termination shall diminish or eliminate any claim for any benefit to which a Participant shall have become entitled prior to such amendment or termination of the Plan.

### 8.5 Exclusive Benefit/Legal Enforceability

The Plan has been established, and is being maintained, for the exclusive benefit of the Employees of the Employer. The Plan terms as provided herein are legally enforceable by the Employees.

### 8.6 Action by Employer

Any action by the Employer under this Plan, including an action to amend or terminate the Plan, may be made by resolution of the City Council, or by action of any person or persons duly authorized by the City Council to take such action.

## *ARTICLE IX INTERPRETATION OF PLAN*

Final authority for interpretation of the terms and provisions of the Plan is vested in the Employer. Any interpretation so required by the Employer shall be made in good faith, subject to reasonable care and prudence, and all such interpretations are final. The Employer shall have discretionary authority to determine eligibility for benefits or to construe the terms of the Plan.

# BASICSELECT PLAN
# POINT OF SERVICE PLAN
# HIGH DEDUCTIBLE HEATH PLAN

## *ARTICLE X BASICSELECT , POINT OF SERVICE AND HIGH DEDUCTIBLE PLANS*

## A. PREFERRED PROVIDERS

### 10.1 Plan Descriptions

(A) The BasicSelect plan is a health benefit plan designed for City of Springfield Employees that offers access to In-Network benefits and Out-of-Network benefits.

The BasicSelect plan allows a Participant to choose where to receive health care services. The level of coverage is determined by where services are received. If a Participant chooses to receive services from In-Network (Preferred) Providers, the highest level of coverage is received. Choosing to receive services from Out-of-Network (Non-Preferred) Providers will result in a lower level of coverage and more out-of-pocket expenses. Charges from In-Network Providers are not subject to Usual and Reasonable charge limitations because of their contract with the Plan.

There are substantial penalties for failing to use an In-Network Hospital provider. You will only receive In-Network benefits from Physicians within the Network. No referrals are required for In-Network or Out-of-Network providers.

(B) The Point of Service (POS) plan is a health benefit plan designed for City of Springfield Employees that offers access to In-Network benefits and Out-of-Network benefits.

The POS Plan allows members to access In-Network benefits by using any provider in the network while also allowing access to Out-of-Network benefits if the provider is not in the provider network.

Under the POS plan, Covered Persons or Covered Dependents may access In-Network and Out-of-Network benefits by choosing a Physician, specialist or other provider from the Network(s) while also receiving care from a provider outside the Network(s). There are substantial penalties for failing to use an In-Network Hospital provider. You will only receive In-Network benefits from Physicians within the Network(s). No referrals are required for In-Network or Out-of-Network providers.

(C) The High Deductible Health Plan (HDHP) is a health benefit plan designed for City of Springfield Employees that offers access to In-Network benefits and Out-of-Network benefits.

The HDHP is very similar to the POS Plan, described above. However, if you elect the HDHP, you will pay a higher annual Deductible than in the POS Plan and the BasicSelect Plan options. You will have the choice of using In-Network or Out-of-Network providers. You will pay 100% of your eligible expenses, including prescriptions drug expenses, until you reach your annual Deductible. Preventive care services are covered at 100%, no Deductible applies. Once you reach the Out-of-Pocket maximum, the HDHP pays the full cost of covered expenses for In-Network Providers.

If you choose the HDHP, you can also participate in the Health Savings Account (HSA). An HSA enables you to save for covered medical expenses on a tax-preferred basis. See the Health Savings Account section below for more information.

## 10.2 Preferred Providers

(A) PPO Facility Usage Requirement

The Preferred Provider Facility program described on page xxiii is designed to provide maximum benefits for using In-Network facilities for all medical facility-related services. Although Covered Persons and Covered Dependents may continue to obtain treatment at the facility of their choice, Hospital benefits paid under this Plan will be maximized when the services of In-Network Providers are used.

All Covered Persons or Covered Dependents will be required to obtain all Hospital services at an In-Network Provider in order to maximize their benefits.

If a Covered Person or Covered Dependent chooses to obtain Hospital services at any Out-of-Network Hospital or facility, all eligible Hospital services will be reimbursed at the applicable Coinsurance rate after Deductibles have been satisfied and any penalty has been applied. Please refer to the Preferred Provider Facility Program (page xxiii) for the dollar amount of the penalty.

(B) Exceptions to the Preferred Provider Agreement

The following situations will allow for Covered Persons or Covered Dependents to receive Hospital services at an Out-of-Network Hospital facility without being charged a penalty:

(1) A procedure is not available at an In-Network Hospital facility when preauthorized by the Utilization Review Administrator;

(2) Benefits are available for all Covered Persons and Covered Dependents under the Plan for emergency Medical Care and emergency accident care at any Hospital or any other facility that meets the definition of Hospital. This could include, but is not limited to, a Hospital, clinic or Physician's office. The condition for which the Covered Person or Covered Dependent obtains treatment must meet the definition of "Emergency Treatment" as defined by this Plan under Section 2.2; or

(3) If a Covered Person or Covered Dependent receives services from an Out-of-Network Physician (e.g., anesthesiologist, pathologist, radiologist, emergency room Physician) at an In-Network Provider facility, the charges for such services will be reimbursed at the In-Network Provider reimbursement rate listed in the POS Summary of Benefits.

## 10.3 Continuity of Care

(A) Continued Care Coverage with Terminating Physicians

If the treating Physician's contract terminates, the Covered Person or Covered Dependent may be eligible for coverage of continued treatment during a transitional period if in an ongoing course of treatment or if pregnant. The following conditions must be met: (i) the Physician termination did not involve potential harm to a patient or disciplinary action by a state licensing board; (ii) the Physician remains in the area; and (iii) the Physician agrees to abide by the terms and conditions of the terminating contract. The Covered Person must contact the Customer Service Department at the number on the back of his/her Plan ID Card within 30 days of receiving the termination notice if coverage of continued care with a terminating Physician is desired.

(1) Ongoing Course of Treatment. If a Covered Person or Covered Dependent is in an ongoing course of treatment, the Plan will cover continued treatment with that Physician for a period of 90 days. The 90-day period starts on the date the Covered Person/Covered Dependent receives notice from the Network Administrator that the Physician's contract is terminating.

(2) Maternity Care. If a Covered Person or Covered Dependent is pregnant and has entered week 13 of her Pregnancy by the date of the Physician's termination, the Plan will cover continued care with that Provider through post-partum care.

(B) Continued Care Coverage for New Members

If the treating Physician is not a Preferred Provider for the Plan, a Covered Person may be eligible for coverage of continued treatment during a transitional period with that Physician if in an ongoing course of treatment or if pregnant. The Physician must agree to accept reimbursement rates similar to other Preferred Providers for the Plan and comply with the Contract Administrator's quality assurance requirements and policies and procedures. A Covered Person must contact the Customer Service Department within 15 days of his or her effective date of coverage if coverage of continued care with a non-Preferred Physician is desired.

(1) Ongoing Course of Treatment. If a Covered Person or Covered Dependent is in an ongoing course of treatment, the Plan will cover continued treatment with the treating Physician for a period of 90 days from the Covered Person's or Covered Dependent's effective date of coverage.

(2) Maternity Care. If a Covered Person or Covered Dependent is pregnant and has entered week 13 of her Pregnancy on her effective date of coverage, the Plan will cover continued care with the treating Physician through post-partum care. Pregnancy is not subject to the Pre-Existing Condition limitation.

### 10.4 Provider-Patient Relationship

The City's relationship with Preferred Providers is an independent contract relationship. Preferred Providers are not employees or agents of the Preferred Provider Organizations or the City.

The Preferred Provider Organization's Physicians shall maintain traditional Physician-patient relationships with Members, and nothing in this Plan Document shall be deemed to affect in any manner whatsoever the Physician-patient relationship.

Information from medical records and information received by Preferred and Non-Preferred Providers and Physicians incident to the Physician-patient relationship shall be kept confidential. It shall not be disclosed without the written consent of the patient or, if the patient is a minor, without the written consent of the patient's parent or legal guardian, except as otherwise provided by State or federal law.

The Preferred Provider list is subject to change without prior notification.

It is the Member's responsibility to verify that services are obtained through a Preferred Provider or participating facility. The directory of Preferred Providers for City of Springfield Members is available on the internet at www.healthlink.com or www.multiplan.com.

## B. LIMITATIONS

### 10.5 Utilization Review Limitation

The Utilization Review Administrator must be notified with respect to any Covered Person or Covered Dependent:

(A) prior to any scheduled or non-emergency Hospital Confinement/Admission;

(B) within the latter of forty-eight (48) hours or two working days after Hospital Confinement/Admission for Emergency Treatment;

(C) for obstetric care exceeding forty-eight (48) hours for a vaginal delivery or ninety-six (96) hours for a Cesarean delivery; or

(D) prior to receipt of certain major diagnostic services as listed in the Utilization Review section in the Summary of Benefits.

Upon notification, the Utilization Review Administrator will certify the following:

(A) the Medical Necessity for the Hospital Confinement/Admission;

(B) the appropriateness of the place of treatment for the Sickness or Injury;

(C) the duration of the Hospital Confinement/Admission; and

(D) the extension, if necessary, of a previously certified Hospital Confinement/Admission.

For the purpose of this Section, "Medical Necessity" means that the medical treatment of a Sickness or Injury is:

(A) necessary;

(B) professionally acceptable to a majority of the Physicians in the appropriate medical or surgical specialty; and

(C) approved by any applicable regulatory agencies or authorities.

The Utilization Review Administrator will notify the Covered Person or Covered Dependent as to the number of approved days that will be provided. Continuing care beyond the expiration date or number of approved days in the initial preauthorization request must be authorized by the Utilization Review Administrator. If the Covered Person or Covered Dependent fails to notify the Utilization Review Administrator as required herein or fails to follow the instructions of the Utilization Review Administrator following notification, the benefits otherwise available under the Plan (after application of all other limitations prescribed herein) shall be further reduced by the lesser of: (1) actual benefits available; or (2) $500.

If the preauthorization request is denied, the Plan will not provide coverage for requested services.

Expenses excluded in accordance with this Section shall not apply toward satisfaction of any other limitation herein, including the Out-of-Pocket maximum limitation.

Preauthorization procedures are described in detail in the Claims Review Procedure section.

### 10.6 Case Management

In the case where the patient's condition is expected to be or is of a serious nature, the Plan, pursuant to the reasonable exercise of its discretion, may arrange for review and/or case management services from a professional qualified to perform such services. Upon the advice of such professional and the approval of the Plan, the Medical Contract Administrator shall have the right to alter or waive the normal provisions of this Plan when it is reasonable to expect a cost-effective result can be achieved without a sacrifice to quality of patient care.

### 10.7 Deductible Expenses

During each Plan Year, except where specifically indicated to the contrary, each Covered Person or Covered Dependent shall be responsible for the Deductibles as set forth in the Summary of Benefits.

If, in any Plan Year, covered members of a family incur covered expenses that are subject to the Deductible that are equal to or greater than the dollar amount of the family Deductible shown in the Schedule of Benefits, then the family deductible will be considered satisfied for all family members for that Plan Year.

Non-Essential Health Benefits may have separate Lifetime or Plan Year limitations.

## 10.8 Out-of-Pocket Maximum

During each Plan Year, except where specifically indicated to the contrary, each Covered Person or Covered Dependent shall be responsible for the Out-of-Pocket maximum as set forth in the Summary of Benefits.

If, in any Plan Year, covered members of a family incur covered expenses that are subject to the Out-of-Pocket maximum that are equal to or greater than the dollar amount of the family Out-of-Pocket amount shown in the Schedule of Benefits, then the family Out-of-Pocket maximum will be considered satisfied for all family members for that Plan Year.

## 10.9 Maximum Benefits While Covered Under These Plans

The Schedule of Benefits may contain separate Essential Health Benefits/non-Essential Health Benefits maximum benefit limitations for specified conditions and/or services. Any separate maximum benefit will include all such benefits paid by the Plan for the covered person during any and all periods of coverage under the Plan.

Notwithstanding any provision of the Plan to the contrary, all benefits received by an individual under any benefit option, package or coverage under the Plan shall be applied toward the applicable maximum benefit paid by the Plan for any one covered person for such option, package or coverage under the Plan, and also toward the maximum benefit under any other options, packages or coverages under the Plan in which the individual may participate in the future.

Non-Essential Health Benefits may have separate Lifetime or Plan Year limitations.

## 10.10 Benefit Schedule

The following are the benefits to which the Covered Person and his or her Covered Dependents are entitled to receive as Members. Certain benefits must be authorized by the Utilization Review Administrator, as provided in the Summary of Benefits. Benefits are subject to any applicable Deductible, Coinsurance, Copayment or other limitations as described in the Summary of Benefits.

(A) Amino-Based Elemental Formulas

Amino-based elemental formulas, regardless of how they are delivered, for the diagnosis and treatment of eosinophilic disorders and short bowel syndrome when prescribed by a Physician as Medically Necessary.

(B) Autism Spectrum Disorders

Coverage for the diagnosis and Medically Necessary treatment of Autism Spectrum Disorders for a Covered Dependent under 26 years of age.

Treatment includes direct, consultative or diagnostic psychiatric care; direct or consultative psychological care; habilitative or rehabilitative care; and therapeutic care.

Services must be provided by a Physician, a licensed clinical psychologist with expertise in diagnosing Autism Spectrum Disorders or a certified, registered or licensed health care professional with expertise in treating effects of Autism Spectrum Disorders when the care is determined to be Medically Necessary and ordered by a Physician. Coverage for Medically Necessary early intervention services must be delivered by a certified early intervention specialist.

(C) Bariatric Surgery

Prior approval required, coverage provided when Medically Necessary (limited to $25,000 per lifetime).

(D) Blood or Blood Components

Processing and administration of blood or blood components, including the cost of the actual blood or blood components, unless replaced.

(E) Breast Cancer Pain Therapy

Medically Necessary pain therapy related to the treatment of breast cancer is covered. "Pain therapy" means pain therapy that is medically based and includes reasonably defined goals including, but not limited to, stabilizing or reducing pain, with periodic evaluations of the efficacy of the pain therapy against these goals.

(F) Cardiac Rehabilitation Services

Phase I and Phase II cardiac rehabilitation services are covered.

Phase I cardiac rehabilitation includes, but is not limited to, the evaluation by a Physician of the patient's ability to care for himself/herself, his/her ability to exercise, counseling and providing education about any lifestyle changes that may be required while the individual is Hospital confined.

Phase II cardiac rehabilitation includes, but is not limited to, closely monitored outpatient exercise programs, education and counseling under the supervision of a Physician. Medications may also be prescribed.

(G) Chiropractic Care

Chiropractic services and Spinal Manipulations are covered, subject to the limitations described in the Summary of Benefits, when provided by a duly licensed chiropractor in the state where he or she is practicing and who is treating within the scope and limitation of that license.

Chiropractic services include treatments, X-rays and other diagnostic services provided by a chiropractor or Physician.

Spinal manipulation means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

(H) Dental Services

(1) Dental Services rendered by a Dentist or Physician that are required as a result of accidental Injury to the jaws, teeth, mouth or face.

(2) Anesthetics provided in conjunction with Dental Services provided in a Hospital or Ambulatory Surgical Facility for a Covered Person age six and under, a Covered Person with a medical condition that requires hospitalization or general anesthesia, or a Covered Person who is disabled. "Disabled" means an individual of any age with a chronic disability that is likely to continue, attributable to a mental or physical impairment or combination thereof, and results in substantial functional limitations in areas of major life activities, including: self-care, receptive and expressive language, learning, mobility, capacity for independent living, or economic self-sufficiency.

(3) Oral Surgery, including the following:

(a) surgical removal of bony impacted teeth;

(b) excision of tumors or cysts of the jaw, cheeks, lips, tongue, roof and floor of the mouth;

(c) surgical procedures to correct congenital birth defects or accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth;

(d) excision of exostosis of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bone; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; reduction or dislocation, or excision of the temporomandibular joints; and

(e) Surgery for organic anatomic disease of the temporomandibular joint which is demonstrable by radiography, MRI scan and/or orthoscopic examination; however, Surgery for dental-related temporomandibular joint pain syndrome or orthodontic defects and treatment of overbite or underbite are not covered.

(I) Diabetic Self-Management and Training

Outpatient self-management training and education for the treatment of types 1 and 2 diabetes and gestational diabetes mellitus are covered when Medically Necessary and provided by a qualified Provider. Coverage is limited to the following:

(1) three (3) visits within one year of the initial diagnosis of diabetes;

(2) two (2) visits upon a determination by the Covered Person's or Covered Dependent's Physician that a significant change in the individual's symptoms or medical condition has occurred. A "significant change" in condition means symptomatic hyperglycemia (greater than 250 mg/dl on repeated occasions), severe hypoglycemia (requiring the assistance of another person), onset or progression of diabetes, or a significant change in medical condition that would require a significantly different treatment regimen;

(3) two (2) visits for nutritional counseling per Plan Year; and

(4) self-education.

(J) Durable Medical Equipment

Durable Medical Equipment for home use, when Medically Necessary and ordered by the Member's Physician. Coverage includes, but is not limited to, standard wheelchairs, walkers, crutches, colostomy supplies, traction equipment, standard Hospital beds, oxygen and oxygen administration. Rental or purchase of such equipment is at the option of the Plan. Worn or obsolete equipment will be replaced as determined by the Plan.

What is not covered includes the following:

(1) replacement or repair of items covered under this benefit that were lost, destroyed or made unusable due to a Member's carelessness, misuse or deliberate actions.

(2) disposable, over-the-counter, or non-durable items such as linens, bandages, hairpieces, incontinence supplies, needles or syringes.

(3) stair lifts, motorized scooters and electric wheelchairs (except when Medically Necessary). Home alterations are also not covered.

(K) Emergency Treatment

Expenses Incurred for initial Emergency Treatment in a Hospital emergency room or by a Physician for an Emergency Medical Condition are covered.

It shall not include treatment of symptoms of a chronic condition unless such symptoms are sudden, unexpected and severe. Should the patient be admitted to a facility, the emergency room Copayment is waived.

Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson could reasonably expect the absence of medical attention to result in placing his or her health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part.

(1) In-Network

Medically Necessary services received for a life-threatening condition or other serious conditions that meet emergency criteria, which arise suddenly and require immediate attention to avoid jeopardy to the health of a Member. Non-urgent or non-emergency matters will be treated as a non-emergency claim.

(2) Out-of-Area

Out-of-area benefits are limited to emergency care required before the Member can, without medically harmful results, return to the Enrollment Area. Care that is required as a result of circumstances that could reasonably have been foreseen prior to departure from the Enrollment Area is not considered out-of-area benefits.

In such instances, payment will be made for unexpected hospitalization due to the complications of pregnancy at the In-Network rate. Routine delivery, either vaginally or by Cesarean section, will not be reimbursed at the In-Network rate outside the Enrollment Area, unless the Member is detained due to circumstances beyond her control.

Routine primary care, such as, but not limited to, check-ups, diagnostic tests, immunizations or preventive procedures, if provided outside the Enrollment Area, will not be paid at the In-Network rate of reimbursement.

(3) Notification Requirements for Emergency Care

If admitted to a Hospital, a Participant receiving emergency care must notify the Utilization Review Administrator of the emergency incident within forty-eight (48) hours of admission or, if unable to do so because of the medical condition, as soon as reasonably possible. Failure to notify the Utilization Review Administrator may result in the Member being responsible for all or part of Expenses Incurred.

(L) Erectile Dysfunction

Coverage is limited to a prescription of six pills per month.

(M) Family Planning Services

Family planning services are covered when provided by an In-Network Provider as follows:

(1) Information, instruction and medical counseling services on family planning issues, including the use of contraceptive devices and birth control medication;

(2) Surgical procedures, such as elective vasectomies and elective tubal ligations;

(3) Therapeutic termination of pregnancy when Medically Necessary; and

(4) Infertility services provided as outlined below.

Family Planning benefits are only available in-network. Benefits are subject to the type of service provided.

(N) Foot Care

Foot care is covered for Members under active treatment for metabolic or peripheral vascular diseases when Medically Necessary.

(O) Habilitative Services

Medically Necessary habilitative services are covered for children under 26 years of age who have been diagnosed with a congenital, genetic or early-acquired disorder by a Physician licensed to practice medicine in all its branches.

Habilitative services include occupational therapy, physical therapy, speech therapy and other services prescribed by the treating Physician pursuant to a treatment plan to enhance the child's ability to function.

Congenital, genetic and early-acquired disorders include hereditary disorders, autism or an Autism Spectrum Disorder, cerebral palsy or disorders resulting from Illness or Injury that occurred prior to the child's developing functional life skills, such as walking, speaking or self-care skills.

(1) Treatment must be Medically Necessary and therapeutic. Treatment shall be administered by licensed Providers (speech-language pathologist, audiologist, occupational therapist, physical therapist, Physician, nurse, optometrist, nutritionist, Social Worker or psychologist) under the direction of the treating Physician.

(2) Treatments that are experimental or investigational are not covered. Services that are solely educational in nature or reimbursed under State or federal law are not covered. Treatment of Serious and Non-Serious Mental Health Care or other mandated benefits are not included under this benefit.

(P) Hearing Exams

Hearing exams are covered when provided by a licensed audiologist and Medically Necessary.

(Q) Home Health Care Services

(1) Benefits

Reasonable and Customary Expenses Incurred for Medically Necessary Services and Supplies furnished in the home of the Covered Person or Covered Dependent in accordance with a Home Health Care Plan for care. Services must be

authorized by the Utilization Review Administrator. In-Network and Out-of-Network benefits are limited to eighty (80) visits per Plan Year.

Expenses covered under this Section include the following:

(a) part-time or intermittent nursing care by or under the supervision of a Registered Graduate Nurse;

(b) part-time or intermittent home health aide services, when provided by a person specifically trained to provide such services, that consist primarily of caring for the patient;

(c) physical therapy, occupational therapy, speech therapy, nutritional therapy, respiratory therapy or inhalation therapy provided by the Home Health Care Agency; and

(d) medical supplies, drugs and medications prescribed by a Physician, and laboratory and other diagnostic services by or on behalf of a Hospital, to the extent such items would have been paid by the Plan if the Covered Person or Covered Dependent had remained in the Hospital or Skilled Nursing Facility.

(2) Limitations

Each visit by a Home Health Care Agency team member, other than a home health aide, shall be considered as one Home Health Care visit; four (4) hours of health aide service shall be considered as one Home Health Care visit; eight (8) hours of service shall be considered as one day; and hours are cumulative. Benefits are available under this Section for no more than eighty (80) Home Health Care visits per person per Plan Year. In addition, no benefits are payable under this Section for the following:

(a) Services or supplies not covered by the Home Health Care Plan;

(b) Services performed by an individual who ordinarily resides in the Covered Person's or Covered Dependent's home or is a member of the Covered Person's or Covered Dependent's Immediate Family;

(c) Services of any Social Worker;

(d) Expenses Incurred for transportation; or

(e) Services or supplies rendered during any period in which the Covered Person or Covered Dependent is not under the continuing care of a Physician.

No Expenses Incurred for which benefits are payable in accordance with this Section shall be considered Expenses Incurred for the purpose of computing

benefits payable under any other Section of the Plan. The benefits payable pursuant to this Section are subject to the Deductible and Coinsurance listed in the Summary of Benefits.

(R) Home Infusion

Parenteral administration of home IV antibiotics, parenteral nutrition, chemotherapy, IV hydration or pain management as well as enteral nutrition when ordered by a Physician and medical criteria has been met. Services must be authorized by the Utilization Review Administrator.

(S) Hospice Care

Reasonable and Customary Expenses Incurred for services and supplies not otherwise covered by this Plan, furnished for care in accordance with a hospice care program that meets the standards of the National Hospice Organization or, if required by the state, is licensed, registered or certified by the state as a hospice care program, provided such hospice care is provided only where a Physician determines the individual is terminally ill.

Hospice care includes the following:

(1) Hospice confinement or home care;

(2) Part-time nursing care (preauthorization required);

(3) Consultation and case management services by a Physician;

(4) Physical therapy; and

(5) Up to five (5) visits for bereavement counseling to the family of a terminally ill person.

Hospice Care does not include the following:

(1) funeral arrangements;

(2) financial or legal counseling; or

(3) homemaker services.

No expenses Incurred for which benefits are payable in accordance with this Section shall be considered Expenses Incurred for the purpose of computing benefits payable under any other Section of the Plan herein.

(T) Hospital Services (Deductible Applies)

(1) Inpatient Services

(a) Hospital services are provided as long as Medically Necessary and authorized by the Utilization Review Administrator, and the hospitalization of the Member is ordered or authorized by a Physician. Hospital services include Room and Board, nursing care and additional services that may be necessary, including the use of the operating room, intensive care facilities, diagnostic and therapeutic radiology, laboratory procedures, anesthesia, medication and supplies.

(b) Members will be hospitalized in a semi-private room, unless it is deemed Medically Necessary by the attending Physician for a Member to occupy a private room. If a Member elects to occupy a private room and it is not Medically Necessary that he/she do so, the Member is responsible for the difference in rate between the most common semi-private and private accommodations.

(c) In the event of scheduled admissions, the Member must contact the Utilization Review Administrator prior to the admission to confirm notification. In the event the medical condition prevents prior contact, the Member must confirm notification of the admission within twenty-four (24) hours.

(d) In-Patient Hospital Physician Visits, diagnostic and therapeutic radiology, and laboratory procedures are covered.

(e) Anesthesia, Anesthesiologist charges, Maternity Care, and services obtained at a Birthing Center and Surgery/Operating Room charges are covered.

(2) Outpatient Services

(a) Surgery and related diagnostic service received on the same day as the Surgery, whether as Outpatient Treatment or in a Physician's office, including Physician's surgical charges;

(b) Diagnostic testing related to Surgery or Medical Care; and

(c) Services provided in an Ambulatory Surgical Facility.

(3) Pre-Admission Testing: Reasonable and Customary

Expenses Incurred for pre-admission testing that is performed either:

(a) at a Hospital on an outpatient basis or

(b) at an outpatient facility if the test results are accepted by the Hospital to which the patient is admitted

provided that such testing is performed within seven (7) days prior to admission to that Hospital on an in-patient basis for treatment in connection with the Sickness or Injury to which the pre-admission testing relates. No benefits are available pursuant to this subsection if the treatment to which the testing relates is postponed, unless such postponement is Medically Necessary.

(U) Infertility Services (limited to $10,000 per family per lifetime, including pharmacy benefits)

For purposes of this Section, "Infertility" means the inability to conceive after one year of unprotected sexual intercourse or the inability to sustain a successful pregnancy.

Infertility services will be provided upon the recommendation of a Physician, which may include such services as the use of fertility drugs as primary treatment for infertility (covered as deemed necessary by a Participating Physician). Other treatment may be covered as pre-approved by the Utilization Review Administrator, including GIFT, artificial insemination to treat an organic cause of infertility, and In Vitro fertilization.

Except those procedures listed above, experimental procedures/ treatments, Surgery or medication will not be covered by the Plan. Drug therapy for infertility that involves a non-FDA approved medication is not covered.

Health Services and associated expenses for surrogate parenting and Health Services for the birth of an adopted child who is not a qualified dependent at birth are not covered.

(V) Injections and Immunizations

Injections are covered when administered by a Physician or at his/her direction.

(W) Mammograms

One low dose mammography screening per year will be covered for all Covered Persons or Covered Dependents based on age and risk factors. Services received from an In-Network Provider are covered at no cost (100%) and are not subject to any Deductible or Copayment/Coinsurance.

A comprehensive ultrasound screening of an entire breast or breasts if a mammogram demonstrates heterogeneous or dense breast tissue is covered when Medically Necessary as determined by a Physician. Services received from an In-Network Provider are not subject to any Deductible or Copayment/Coinsurance provisions of the Plan. If a Participant does not comply with Plan provisions specific to the use of contracted (In-Network) Providers, plan provisions specific to the use of non-contracted (Out-of-Network) Providers will be applied without distinction for coverage required by this section and shall be at least as favorable as for other radiological examinations covered by the Plan.

(X) Mastectomy

(1) Coverage is provided for inpatient hospitalization following a mastectomy for a length of time determined by the attending Physician to be Medically Necessary and in accordance with protocols and guidelines based on sound scientific evidence and evaluation of the patient and for a post-discharge Physician office visit or in-home nurse visit within 48 hours after discharge.

(2) The following represent benefits for elective breast reconstruction in connection with a mastectomy:

(a) reconstruction of the breast on which the mastectomy has been performed;

(b) surgery and reconstruction of the other breast to produce a symmetrical appearance; and

(c) prostheses and physical complications in all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending Physician and the patient.

(Y) Maternity Care

Notwithstanding any provision herein to the contrary, subject to the limitations on eligibility in Article III and Article IV, Expenses Incurred as a result of the pregnancy will be eligible for benefits the same as any other Sickness under the Plan, except that the following provisions shall be applicable:

(1) A minimum of forty-eight (48) hours of in-patient Hospital care for the mother and newborn child shall be provided following a vaginal delivery.

(2) A minimum of ninety-six (96) hours of in-patient Hospital care for the mother and newborn child shall be provided following a delivery by Cesarean section.

A shorter in-patient Hospital stay may be provided if a Participating Physician licensed to practice medicine in all of its branches determines, in accordance with the protocols and guidelines developed by the American College of Obstetricians and Gynecologists or the American Academy of Pediatrics, that the mother and the newborn child meet the appropriate guidelines for a shorter stay, based upon an evaluation of the mother and newborn child and taking into consideration the availability of a post-discharge visit within forty-eight (48) hours following the discharge with either a Physician in his/her office or with an RN, or LPN supervised by an RN, in the child's home.

If a Covered Person or Covered Dependent becomes pregnant after her Eligibility Date under the Plan, and if delivery occurs while the Plan is in effect, Expenses Incurred as a result of the pregnancy will be eligible for benefits under the Plan. If a Covered Person or Covered Dependent becomes pregnant before her Eligibility Date under the Plan, and if delivery occurs while her coverage under the Plan is in effect, Expenses Incurred as a result of the pregnancy will be eligible for benefits under the Plan. If delivery occurs

after coverage under the Plan has terminated, Expenses Incurred as a result of the pregnancy may be eligible for benefits under the Plan, subject to the limitations on Extension of Benefits prescribed herein.

Maternity benefits shall not be subject to the limitation on Pre-Existing Conditions. Accordingly, Expenses Incurred as a result of pregnancy will be eligible for coverage even if conception occurred prior to the pregnant individual's Eligibility Date.

For all purposes under this Plan, a mother and newborn child are considered separate persons for the purpose of the computation of benefits.

(Z) Medical Supplies

Medically Necessary medical supplies including, but not limited to, dressings, sutures, casts, splints, trusses, crutches, braces (except dental braces), colostomy supplies, mastectomy bras (after mastectomy), continuous glucose monitors and pads, diabetic supplies (such as glucose monitors, needles, lancets and syringes), blood pressure kits and corrective shoes or arch supports (when Medically Necessary) will be considered a covered expense. Charges for these supplies should be filed directly with the Medical Contract Administrator.

(AA) Medical Transport Services

Emergency medical transport services are provided when determined to be Medically Necessary due to accidental Injury to the nearest Hospital, between Hospitals or between a Hospital and a Skilled Nursing Facility (including air-ambulance service when Medically Necessary). Transportation between a Hospital or health care facility and a private home or residence will not be covered. For the purposes of this Section (AA), the term "emergency" means a need for immediate medical attention resulting from a life-threatening condition or situation or a need for immediate medical attention as otherwise reasonably determined by a Physician, public safety official or other emergency medical personnel.

(BB) Mental Health Care, Alcoholism and Substance Abuse

(1) Mental Health Care

(a) Mental Health Care services for short-term treatment and/or crisis intervention are covered as determined necessary and appropriate by a Physician, subject to any applicable deductible, Copayment or Coinsurance as specified in the Summary of Benefits. Benefits are available only if such treatment is rendered in a Hospital, Mental Health Facility or professional office of a Physician, psychiatrist, clinical psychologist or Social Worker and if such service is provided by a Physician, a psychiatrist or Social Worker licensed in the state in which he/she is practicing or a clinical psychologist registered in the state in which he/she is practicing.

(b) What is not covered includes the following:

(i) Psychiatric evaluation or therapy, on court order or as a condition of parole or probation, unless otherwise determined by a Physician to meet the criteria for covered benefits.

(ii) Psychological testing when not Medically Necessary to determine the appropriate treatment of a short-term psychiatric condition.

(iii) Services provided by a non-licensed mental health professional, care in long-term or residential facilities, family retreats and marriage or social counseling are not covered.

(2) Alcoholism and Substance Abuse

(a) Acute inpatient Substance Abuse detoxification is covered if determined by a Physician that outpatient management is not medically appropriate.

(b) Substance Abuse rehabilitation services or treatment are covered for Medically Necessary short-term treatment.

(c) Diagnosis, detoxification and treatment of the medical complications of the abuse or addiction to alcohol or drugs on either an in-patient or outpatient basis are covered, subject to the provisions of this Section.

Benefits are available only if such treatment is rendered in a Hospital, Substance Abuse Treatment Facility or professional office of a Physician, psychiatrist, clinical psychologist or Social Worker and if such service is provided by a Physician, a psychiatrist or Social Worker licensed in the state in which he/she is practicing or a clinical psychologist registered in the state in which he/she is practicing.

(d) What is not covered includes the following:

(i) Psychiatric evaluation or therapy, on court order or as a condition of parole or probation, unless otherwise determined by the Attending Physician to meet the criteria for covered benefits.

(ii) Services provided by a non-licensed mental health professional, care in long-term or residential facilities, family retreats and marriage or social counseling are not covered.

(CC) Organ Transplants

Subject to preapproval by the Utilization Review Administrator, Reasonable and Customary Expenses Incurred for Medically Necessary and appropriate transplants may include the following services received In-Network:

(1) If both the donor and recipient are covered by the Plan, each shall have their benefits computed in accordance with the provisions of their own coverage.

(2) If the recipient is covered by the Plan and the donor has no other source of benefits, benefits for both the donor and the recipient shall be computed in accordance with the provisions governing the recipient's eligibility for benefits under the Plan.

(3) If the donor is covered by the Plan and no benefits are available to the donor from any other source, benefits shall be provided to the donor under the provisions of the Plan, but no benefits shall be provided to the recipient.

(DD) Orthotics

Leg, back, arm and neck braces required due to Sickness or Injury.

(EE) Outpatient Services

Certain outpatient services may require pre-approval by the Utilization Review Administrator. See the Utilization Review section.

(FF) Partial Hospitalization

Treatment in a planned therapeutic treatment program of a Hospital or Substance Abuse Treatment facility in which patients with Mental Illness or Substance Abuse spend days or nights.

(GG) Physical, Occupational and Speech Therapy

(1) Short-term rehabilitative services, including in-patient and outpatient rehab normally provided by a licensed physical therapist, licensed speech therapist, occupational therapist or licensed facility, are provided when such services are determined to be Medically Necessary by a Physician.

(2) Out-patient rehabilitative therapy directed at improving physical functioning of the Member (including, but not limited to, speech therapy, physical therapy and occupational therapy) are covered up to a combined total of not more than sixty (60) treatments per year.

(3) Medically Necessary preventive physical therapy for the treatment of multiple sclerosis is covered when prescribed by a Physician for the purpose of treating parts of the body affected by multiple sclerosis but only where the physical therapy includes reasonably defined goals including, but not limited to, sustaining the level of function the person has achieved with periodic evaluation of the efficacy of the physical therapy against those goals.

(HH) Physician Services

Diagnostic and treatment services provided by Physicians at their office are covered according to accepted medical and surgical practices and standards. Preventive medical services, including periodic health care examinations and well-child care, are covered.

(1) Physician services for surgical procedures (including oral Surgery).

(2) Visits to a Hospital or facility by a Physician.

(3) Anesthetics and their administration by a professional anesthetist or anesthesiologist.

(4) Second surgical opinions, and if the second opinion does not confirm the first opinion, a third opinion is also covered.

(II) Prescription Drugs

Charges for drugs that can be obtained only with the written prescription of a Physician, insulin and disposable needles, pursuant to the terms of the Prescription Drug Card program maintained by the Employer.

(JJ) Preventive Care

Expenses Incurred for the following services are covered and subject to the limitations specified by the Employer:

(1) Adult flu shots for covered City of Springfield employees that are administered at Sangamon County Department of Public Health will be reimbursed up to $30.

(2) Flu shots administered at the City of Springfield Leadwell Clinic will be covered at no charge.

(3) Flu shots for Employees, Retirees, Spouses and Dependents covered on the health plans;

(4) Shingles vaccine for Covered Persons, as recommended by the CDC;

(5) evidence-based supplies or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF);

(6) routine immunizations, as recommended by the Advisory Committee on Immunization Practices of the Centers of Disease Control and Prevention for infants and children through age six (6); children and adolescents age seven (7) through eighteen (18) years and adults age nineteen (19) years and older;

(7) evidence-informed Routine Preventive Care and screenings as provided by the Health Resources Services Administration for infants, children, adolescents and adult women, unless included in the USPSTF recommendations;

(8) Annual routine mammograms for women;

(9) Colonoscopies;

(10) BRCA testing and counseling;

(11) Annual well-woman office visits to obtain preventive care;

(12) Screening for gestational diabetes in a pregnant woman:

(a) Between twenty-four (24) and twenty-eight (28) weeks of gestation; and

(b) At the first prenatal visit for a pregnant woman identified to be at high risk for diabetes.

(13) Human papillomavirus (HPV) DNA testing no more frequently than every three (3) years for a woman age thirty (30) and above;

(14) Annual counseling for sexually transmitted infections for a sexually active woman;

(15) Annual counseling and screening for human immune deficiency virus for a sexually active woman;

(16) FDA approved contraceptive methods, sterilization procedures and patient education and counseling for a woman with reproductive capacity;

(17) Breastfeeding support, supplies and counseling, to include the cost of rental or purchase, whichever is less;

(18) costly, of breastfeeding equipment; and

(19) Annual screening and counseling for interpersonal and domestic violence.

The Plan will apply reasonable medical management techniques to determine the appropriate frequency, method, treatment, or setting for a preventive item or service to the extent that such techniques are not specified in the recommendations or guidelines.

The Plan will not provide coverage for the above referenced routine preventive care/wellness services, immunizations, screenings or supplies until the Plan year that begins on or after one year after the date such recommendation or guideline referenced above is issued.

(KK) Private Duty Nursing

Private duty professional nursing services by a Registered Graduate Nurse or Licensed Practical Nurse, but only:

(1) on an in-patient basis if the Employer determines that services provided are of such a nature or degree of complexity or quantity that they cannot be or are not usually provided by the regular nursing staff of the Hospital or other facility or

(2) in the home if the services provided are of such a nature that they cannot be provided by non-professional personnel.

(LL) Prosthetic Devices

(1) Initial Prosthetic Devices, including surgical implants, terminal surgical implants, terminal devices (artificial limbs, artificial eyes, hands or hooks), prosthetic lenses, cochlear implants, are covered when they replace a part of the body, serve a functional purpose and are Medically Necessary.

(2) Internal cardiac valves, internal pacemakers, paraffin baths, bone screws, bolts, nails, plates and other similar devices are covered.

(3) The Plan will pay for adjustment, repair or replacement of covered prosthetic devices when required because of a change in the patient's medical condition, as Medically Necessary.

(4) What is not covered includes the following:

(a) the replacement and repair of items covered under this benefit that are lost, destroyed or made unusable due to a Member's carelessness, misuse or deliberate actions;

(b) items of an experimental nature such as mechanical hearts or mechanical kidneys; and

(c) dental or vision appliances other than cataract lenses or standard glasses required promptly after, and because of, cataract Surgery.

(MM) Restorative Plastic Surgery

Services are limited to non-cosmetic reconstructive Surgery, which shall mean the repair of a part of the body that was previously altered due to disease, Injury or Surgery, to its approximate original state, when authorized by a Physician. Such services are provided:

(1) to correct a congenital defect or anomaly that has resulted in a functional defect;

(2) to correct a condition resulting from Injury; or

(3) when incidental to Surgery.

Restorative plastic Surgery procedures are provided to newborns to correct congenital or birth deformities.

(NN) Skilled Nursing Facility (Extended Care Facility)

(1) Room and Board, including any charges made by the facility as a condition of occupancy or on a regular daily or weekly basis such as general nursing services;

If private room accommodations are used, benefits available for Room and Board will not exceed the average semi-private rate charged by the facility or a representative cross section of similar institutions in the area.

(2) Medical Services customarily provided by the Extended Care Facility, with the exception of private duty or special nursing services and Physician's fees;

(3) Drugs, biologicals, solutions, dressings and casts furnished for use during the convalescent period, but no other supplies;

(4) Confinement in an Extended Care/Skilled Nursing Facility:

(a) is certified by a Physician as essential for recuperation from Sickness or Injury that caused such Hospital Confinement;

(b) is not incurred for Custodial Care; and

(c) commences within thirty (30) days after a Hospital Confinement for which benefits were payable under the Plan; and

(5) Custodial, intermediate or convalescent confinement or confinement for non-skilled nursing care is not covered.

(OO) Special Treatments

The following treatments are covered, on an inpatient or outpatient basis, if rendered by a Physician or Hospital:

(1) X-ray and Radiation therapy treatments;

(2) Chemotherapy (Coverage of clinical trial phase II or III must be approved by the National Cancer Institute and the Plan);

(3) Shock therapy treatments;

(4) Renal dialysis treatments; and

(5) Allergy shots and allergy surveys.

(PP) Vision Screenings

Treatment or Surgery for eye disease or Injury is covered for all Members if such services are provided by a Physician.

(QQ) Wigs

Wigs following chemotherapy or radiation therapy are covered, subject to the limitations described in the Summary of Benefits.

**10.11 Exclusions/Limitations**

See Section 6.12, General Limitations, the provision of which are hereby made applicable to and a part of this Section.

# HEALTH SAVINGS ACCOUNT

## *ARTICLE XI HEALTH SAVINGS ACCOUNT*

## A. HEALTH SAVINGS ACCOUNT

If you are a participant in the High Deductible Health Plan (HDHP) and otherwise an HSA-Eligible Individual, you may open an individual Health Savings Account (HSA). An HSA allows you to save on a pre-tax basis for future medical expenses.

### 11.1 How an HSA Works

An HSA is an individual custodial account that you establish directly with a bank or other financial institution. You may use the balance in your HSA for reimbursement of qualified medical expenses (as described in Code Section 223). Your contributions to your HSA may be made with pre-tax funds and your qualifying withdrawals will be tax-free. Because your contributions are pre-tax, you may save federal income taxes, state income taxes and FICA (Social Security and Medicare) taxes.

If you do not want to make HSA contributions through pre-tax payroll deductions, you can make tax-deductible lump sum contributions to your HSA at any time up to the IRS maximum allowable amount. Please consult with your tax advisor.

### 11.2 HSA-Eligible Individual

You are eligible to open and contribute to an HSA under Code Section 223 for any month, if on the first day of such month you:

(A) have elected coverage under the HDHP;

(B) are not enrolled in and/or covered by any health plan that is not a High Deductible Health Plan, unless it is a type of permitted limited coverage;

(C) cannot be claimed by another taxpayer (except your spouse) as a dependent on his or her individual income tax return; and

(D) are not eligible for and enrolled in Medicare.

### 11.3 Contributions to an HSA

Federal tax law limits the amount that you and/or anyone else, including the City of Springfield, if applicable, can contribute to your HSA on a tax-favored basis each year. The annual HSA contributions (your contributions plus the City of Springfield's contributions, if applicable) cannot exceed the IRS maximum allowable amount. Please consult with your tax advisor.

### 11.4 Contributions Are Vested

Any contributions that you make to your HSA are fully vested and are not forfeitable. Contributions will remain in your HSA for your use in future years, even when your employment with the City of Springfield ends.

In addition to making contributions up to the IRS maximum allowable amount, if you are age 55 or older, you may also elect to make an annual catch-up contribution to your HSA ($1,000 each year). If you elect to make a catch-up contribution for a given year, your contributions will be prorated per pay period for the number of months remaining in the calendar year in which you are eligible to contribute to an HSA.

You cannot make catch-up (or any) HSA contributions if you are eligible for and enrolled in Medicare.

### 11.5 Changing Your HSA Contribution Amount

The City of Springfield will make payroll changes to HSA contributions once a month. Payroll changes will be made on a prospective basis for the remainder of the year, in accordance with the Plan's administrative procedures for processing election changes and subject to the statutory limits.

### 11.6 Withdrawals From Your HSA

You must keep track of and request reimbursement from your HSA for the payments you make for qualified medical expenses (whether before or after termination of employment). Reimbursements and all other matters relating to maintaining your HSA are not part of the Plan and are to be handled by you and your bank or other financial institution. The bank or the financial institution with which you establish your HSA will provide you with instructions on how to request reimbursement or withdraw money from your HSA for qualified medical expenses.

Reimbursements from your HSA for qualified medical expenses for you or your dependents are not taxable under federal law, even if at the time of the reimbursement you are no longer eligible to contribute to the HSA. However, reimbursements for expenses that are not qualified medical expenses result in taxable income to you, regardless of when the reimbursement is made, and may be subject to an additional 20% penalty.

### 11.7 Tax implications

You may save federal income taxes, state income taxes and FICA (Social Security and Medicare taxes) by contributing to your HSA. Refer to your bank or other financial institution for more information regarding:

(A) the tax ramifications of participating in an HSA;

(B) the terms and conditions of your HSA;

(C) your rights and responsibilities with respect to your HSA;

(D) the terms of eligibility;

(E) what constitutes a High Deductible Health Plan; and

(F) contributions to and distributions from your HSA.

Also, see IRS Publication 969, "Health Savings Accounts and Other Tax-Favored Health Plans," which is available from the IRS by calling (800) 829-3676. Or, you can download a copy of the publication from the IRS Web site at www.irs.gov.

### 11.8 Reporting Issues

The City of Springfield will report its contributions to your HSA and your pre-tax HSA contributions on your "W-2 Form." You are responsible for all other reporting requirements relating to contributions to and distributions from your HSA in connection with filing your individual federal, state and local tax returns. The manager of your individual custodial account has a reporting requirement to the IRS.

### 11.9 Claims

Claims for reimbursement from your HSA are administered by your bank or other financial institution in accordance with the HSA custodial agreement between you and your bank or other financial institution.

# PRESCRIPTION DRUG CARD BENEFITS

## *ARTICLE XII PRESCRIPTION DRUG CARD PLAN*

### 12.1 Prescription Drug Card Overview

The City has contracted with a Pharmacy Benefit Manager (referred to in this document as the Prescription Drug Card Administrator) to provide Pharmacy benefits to its Members. The City's Prescription Drug Card Plan allows participating Members to obtain prescriptions in two (2) different ways, depending upon the need.

### 12.2 Eligibility

(A) Eligibility Requirements

You and your Dependents will be eligible to participate in the Benefit when you and your Dependents have satisfied the eligibility requirements for benefits under the terms of the City of Springfield Health Benefit Plan (see Sections 3.1 and 4.1).

(B) Participation

You and your Dependents will begin participation on the first day in which you and your Dependents have met the eligibility requirements. When you become a Participant in the Plan, the Employer will issue you an Identification Card. You must present your Identification Card at the time you purchase Covered Drugs at a participating Network Pharmacy in order to take advantage of the Plan's benefits. This benefit is available only as secondary coverage if you or your Covered Dependents have other primary prescription drug coverage.

### 12.3 How Your Prescription Drug Coverage Works

If you meet the Plan's eligibility requirements and you enroll in the medical plan, you have prescription drug coverage through the Prescription Drug Card Administrator.

Certain drugs require prior authorization to verify medical necessity. If you continue using one of these drugs without prior approval, you may be required to pay the full cost. For a full list of drugs requiring prior approval, visit the Prescription Drug Card Administrator's website.

(A) Primary/Preferred Drug List

The Primary/preferred Drug List is a guide within select therapeutic categories for plan members and health care providers. Generics should be considered the first line of prescribing. If there is no generic available, there may be more than one brand-name medicine to treat a condition.

(B) Prescription Drug

A prescription drug, brand or generic drug, medicine, or medication covered by the plan is a Federal Legend Drug (a drug that requires a prescription) as defined by the Food and Drug Administration (FDA). Experimental drugs or substances/products that are not

approved by the FDA for production, distribution or marketing are not covered by the plan.

(C) Drugs Not Covered

The following drugs, drug classes or drug categories are not covered:

(1) Over-the-Counter Drugs or Products

(2) Botox / Myobloc

(3) Hair Growth Stimulants

(4) Hair Removal Agents

(5) Injectable Nutritional Supplements

(6) Vaccines / Toxoids, unless specifically listed as covered elsewhere in the Plan

(7) Device Contraceptives, unless specifically listed as covered elsewhere in the Plan

(8) Smoking Cessation Gum or Patches, unless specifically listed as covered elsewhere in the Plan

(9) Respiratory Therapy Supplies

(D) Your Prescription Drug ID Card

After you enroll for medical plan coverage, an ID card will be mailed to you. Present your ID card at participating retail pharmacies, and you will be charged the applicable copayment. Your plan will cover the rest.

Once you receive your ID card, you can register as a member to access the Prescription Drug Card Administrator's website. To register, you will need your Participant/ Cardholder ID number from your ID card. You will then be able to access a variety of information including claim and mail-order forms, your mail-order status, set refill reminders, sign up for automatic refills, access the Primary/Preferred Drug List, and much more.

(E) Filling Your Prescription at a Participating Retail Pharmacy

To find a participating pharmacy near you, visit the Prescription Drug Card Administrator's website or call the Prescription Drug Card Administrator.

(1) Day Supply Limit

You can get up to a 34-day supply of medication and a 90-day supply each time you have a prescription filled at a participating retail pharmacy. Ask your doctor

or other prescriber to write a prescription for up to 90-day supply plus refills, when clinically appropriate.

(2) Refill Limit

You may get as many refills of your maintenance medications at a participating retail pharmacy as your prescription allows. There are no refill limits under your prescription benefit plan. *Note: Regardless of the day-supply limit, the 35-90 day supply copays will apply for the fourth and all subsequent retail prescription fills; therefore, for maintenance prescriptions for long-term use, it is beneficial to obtain a 90-day supply from your prescriber.*

(F) Filling Your Prescription through the Mail Service Pharmacy

Please contact your Prescription Drug Card Administrator.

Convenient Home Delivery: Please allow 7-10 days for delivery from the time your order is placed. Your package will include a new mail service order form and an invoice, if applicable. You will also receive the same type of information about any prescription medication that you would receive from a retail pharmacy.

(1) Day Supply Limit

You can get up to a 90-day supply of medication when you get a prescription filled through the Mail Service Pharmacy. Ask your doctor or other prescriber to write a prescription for up to a 90-day supply plus refills, when clinically appropriate.

*Please Note: By Law, the Prescription Drug Card Administrator must fill your prescription for the exact quantity of medication prescribed by your doctor or other prescriber, up to the 90-day supply limit. "30-days plus two refills" does not equal one prescription written for "90-days."*

(2) Payment Options for Mail Order Service

While checks and money order are accepted, the preferred methods of payment are by Electronic Check, Bill Me Later® or credit card. For credit card payments, simply include your Visa®, Discover®, MasterCard® or American Express® number and expiration date in the space provided on the mail service order form.

(G) Specialty Pharmacy Program

Certain chronic and/or genetic conditions require special pharmacy products, often in the form of injected or infused medications. Specialty Pharmacy is a comprehensive pharmacy program that provides these products directly to covered individuals along with the supplies, equipment and care coordination needed. In the ongoing effort to manage your prescription benefits effectively, clinical guidelines are included and evaluated under the Plan.

To take advantage of the Specialty Pharmacy benefits and obtain the necessary Prior Authorization, call the Prescription Drug Card Administrator who will work with your physician to conduct the necessary clinical review.

(H) Immunosuppressant Drugs to Prevent Organ or Tissue Rejection

(1) A prescription for an immunosuppressant drug to prevent rejection of a transplanted organ or tissue, which indicates "may not substitute" on the prescription, must be filled as written. However, a substitution may be made, provided the prescribing Physician and the patient (or parent or guardian if the patient is a child) or the spouse of a patient who is authorized to consent to the treatment of the person:

(a) has been properly notified, and

(b) documented consent is received.

(2) Any applicable Copayment, Deductible, Coinsurance or other charge shall remain the same for the Plan Year, unless another drug or formulation has been interchanged.

(3) The Covered Person or Covered Dependent and his/her Physician shall be notified, in writing, at least sixty (60) days prior to any formulary change that alters the terms of coverage or the discontinuance of coverage for a prescribed immunosuppressant drug that a patient is receiving. The written notification may be provided when the patient requests a refill along with a sixty (60) day supply of the immunosuppressant drug under the same terms as previously allowed.

## 12.4 Penalties for Improper Use

Eligible Persons may not intentionally use their Identification Cards to obtain Covered Drugs after receiving notice of termination of their benefits under the Plan. Any Eligible Person who makes an improper use of the Identification Card may be guilty of a Class C misdemeanor in accordance with the provisions of Section 512-8(c) of the Illinois Insurance Code and shall be liable to the Prescription Drug Card Administrator for amounts that were paid as a result of improper use.

The Prescription Drug Card Administrator may request such amounts be paid immediately, and if not paid when due, may take appropriate action to recover such amounts.

## 12.5 Coordination of Benefits

The prescription drug card will be valid at a participating Pharmacy if the City of Springfield is the secondary plan. The participant must provide all valid Prescription Drug Cards to the Pharmacy. It is the responsibility of the participant to inform the Pharmacy which plan is primary.

## *ARTICLE XIII HIPAA COMPLIANCE AND CERTIFICATION*

The Contract Administrator, pursuant to the reasonable exercise of its discretion or incident thereto, may release to, or obtain from, any other company, organization or person, without consent of, or notice to, any person, any information regarding any person that the Plan Administrator or Contract Administrator deems necessary to carry out the provisions of the Plan, or to determine how, or if, they apply. To the extent that this information is Protected Health Information as described in 45 C.F.R. 164.500, et seq., or other applicable law, the Plan Administrator or Medical Contract Administrator may only use or disclose such information for treatment, payment or health care operations as allowed by such applicable law. Any claimant under the Plan shall furnish to the Medical Contract Administrator such information as may be necessary to carry out this provision.

The only employees or other persons under the direct control of the Plan Sponsor who are allowed access to the Protected Health Information of other individuals are those employees or persons with direct responsibility for the control and operation of the Plan and only to the extent necessary to perform the duties as Plan Administrator as determined pursuant to the reasonable exercise of discretion of the Plan Administrator.

The employees or classes of employees that will be permitted access to Protected Health Information as set forth in this paragraph are employees within the following areas:

(A) the City of Springfield Office of Human Resources;

(B) the Office of Budget and Management;

(C) the Office of Corporate Counsel; and

(D) Third Party (Contract) Administrators.

In addition, the Plan Sponsor hereby certifies and agrees that it will:

(A) not use or further disclose the information other than as permitted or required by the Plan or as required by law;

(B) implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic Protected Health Information that it creates, receives, maintains or transmits on behalf of the Plan;

(C) ensure that any agents (including subcontractors) to whom it provides Protected Health Information received from the Plan agree in writing to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;

(D) not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;

(E) report to the appropriate representative of the Plan Administrator any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;

(F) make available Protected Health Information in accordance with 45 C.F.R. 164.524;

(G) make health information for amendment and incorporate any amendments to Protected Health Information in accordance with 45 C.F.R. 164.526;

(H) make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. 164.528;

(I) make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with the privacy requirements of 45 C.F.R. 164.500, et seq.;

(J) if feasible, return or destroy all Protected Health Information received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

(K) ensure that the adequate separation between the Plan and the Plan Sponsor is established and maintained pursuant to 45 C.F.R. 164.504(f)(2)(iii) and is supported by reasonable and appropriate security measures.

The use of Protected Health Information by the Plan shall be in accordance with the privacy rules established by 45 C.F.R. 164.500, et seq. Any issues of noncompliance with the provisions of this Section shall be resolved by the privacy officer of the Plan Administrator.

## ADDENDUM A — NOTICE OF PRIVACY PRACTICES

**City of Springfield**
**(We, Us, Our)**
**NOTICE OF PRIVACY PRACTICES**

Effective date of this notice: March 1, 2014

### Our Commitment to Protecting Your Privacy

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

YOU DO NOT NEED TO RESPOND TO THIS NOTICE IN ANY WAY.

### B.1 Our Responsibilities and Privacy Commitment

We understand the importance of protecting your private information. Our highest priority is to maintain your trust and confidence. We will maintain our commitment to safeguarding your information now and in the future.

We are required by law to:

(A) Maintain the privacy of your personal information.

(B) Provide you with certain rights with respect to your personal information.

(C) Provide you with a copy of this Notice of our legal duties and privacy practices with respect to your personal information.

(D) Follow the terms of the Notice that is currently in effect.

We are guided by our respect for the confidentiality of your personal information. We are providing you with this notice in accordance with privacy laws and because we want you to know that we value your privacy.

### B.2 Information We Collect

Personal Information is any information we obtain about you in the course of issuing insurance and/or providing services. The information we may obtain includes, but is not limited to, your past, present, or future physical or mental health or condition, the provision of health care to you, payment for the provision of health care to you, your Social Security number, employment history, credit history, income information, and bank or credit card information.

We obtain this information from several sources, including but not limited to applications or other forms you complete, your business dealings with us and other companies, and consumer reporting agencies.

### B.3 Our Privacy and Security Procedures

Our employees who have access to this information are those who must have it to provide products or services to you. Below are some examples of our guidelines for protecting information.

(A) Paper copies, when used, are viewed, discussed, and retained in private surroundings.

(B) Individuals viewing information stored in a computer must have passwords to gain access. Passwords are provided only to individuals who must have access to provide products or services to our insureds.

(C) Our business associates use information only for the purpose provided. Business associates sign a contract agreeing to follow our privacy procedures.

### B.4 Information We Use or Disclose

We will not use or disclose any Personal Information about you, except as allowed by law, including the Fair Credit Reporting Act. We may share all of the information we collect with insurance companies, agents, companies that help us to conduct our insurance business, companies that are self-insured, or others as permitted by law. Below are examples of the times we may share information for business purposes.

(A) Underwriting (but not Personal Information that consists of the genetic information of an individual);

(B) Premium rating;

(C) Submitting claims;

(D) Reinsuring risk;

(E) Assessing quality;

(F) Business management and planning; and

(G) Sales, transfer, merger or consolidation of the business.

Your information may also be shared:

(A) For purposes of treatment, payment, and health care operations, including assessment of eligibility, case management activities, coordination of care, collection of premium, payment of benefits, and other claims administration.

(B) With a regulatory, law enforcement, or other government authority as required by law. This may include finding or preventing criminal activity, fraud, material misrepresentation or material nondisclosures in connection with an insurance issue.

(C) In response to an administrative or judicial order, including a search warrant or subpoena.

(D) With a medical care institution or professional, to verify coverage, conduct an audit of their activities, discuss a medical problem of which the insured may not be aware, discuss drug and disease management approaches, and other purposes permitted or required by law.

(E) To conduct actuarial or research studies. In this case, individuals are not identified in the use or disclosure of Personal Information.

(F) With our business associates for use in auditing services or operations, auditing marketing services, performing various functions on our behalf, or to provide certain services.

(G) With a group policyholder for reporting claims experience, or for conducting an audit of our operations or services.

(H) To consult with outside health care providers, consultants and attorneys, and other health related services.

(I) As otherwise permitted or required by law.

We require those with whom we share information to implement appropriate safeguards regarding your Personal Information, as they are also governed by the federal privacy and security law. We share only that which is minimally necessary to accomplish a task. Information that we get from a report made by a company that assists us to conduct insurance business may be retained by that company and used for other purposes. We are prohibited from using or disclosing Personal Information that is genetic information of an individual for underwriting purposes.

Your written authorization is required for uses and disclosures of Personal Information for purposes other than those described above, including disclosure of Personal Information containing psychotherapy notes (except as necessary for treatment, payment, and healthcare operating purposes) and for many marketing purposes. We will not sell your Personal Information without obtaining your written authorization to do so. If you provide us authorization to use or disclose your Personal Information, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose information for the specific purpose contained in the authorization. We are required to retain any records we may have containing your Personal Information for the periods specified in document retention laws. If you revoke your authorization for payment or health care operations, you may jeopardize the administration of the benefits under your health plan.

### B.5 Your Rights

Upon written request, you have the right to:

(A) Inspect and copy certain Personal Information. We may charge a reasonable fee for the costs of copying or mailing.

(B) Receive confidential communication of Personal Information.

(C) Receive an electronic copy of your Personal Information when it is maintained electronically.

(D) Request restrictions on certain uses and disclosures of your Personal Information, although we are not required to agree to a requested restriction.

(E) Request an amendment to your Personal Information, although we are not required to agree to an amendment.

(F) Receive an accounting of certain Personal Information disclosures or disclosures made in compliance with federal law (or state regulations, if applicable) for which an accounting is required.

(G) Be notified of a breach of unsecured Personal Information, unless there is a low probability that your Personal Information has been compromised.

We will respond to your request in a timely manner. The written request must reasonably describe the information. The information requested must be reasonably locatable and retrievable.

### B.6 How to File a Complaint Regarding the Use and Disclosure of Personal Information

If you believe your privacy rights have been violated, you should let us know immediately. We will take steps to remedy any violations of this notice. You may file a complaint with us, your respective state insurance department, or with the Secretary of Health and Human Services. All complaints must be in writing.

You may not be retaliated against for filing a complaint.

### B.7 How to Contact Us

You may contact our representative at the following address:

James Kuizin – Privacy Officer
City of Springfield
Human Resources
300 S. 7th Street
Springfield, IL 62701
Email – jim.kuizin@springfield.il.us

Notification of a revised privacy notice will be provided through one of the following:

(A) U.S. Postal Service

(B) Revised Plan Document

(C) Internet E-mail

Any right a consumer, claimant, or beneficiary may have under this notice is not limited by any other privacy notice used by City of Springfield, IL or its subsidiaries and affiliates.