# ATTACHMENT II
# MASTER CONTRACT DOCUMENT

**City of San Antonio**

Master Contract Document

for the

San Antonio Professional Fire Fighters Association Bargaining Unit
Health Benefit Program

San Antonio, Texas

Effective April 1, 2020

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# MASTER CONTRACT

## INTRODUCTION

The purpose of the Employee Health Benefit Program is to provide the City of San Antonio Uniform Fire Employees with a family health plan, with coverage and benefits defined herein.

This Master Contract defines and provides for coverage and administration for the benefits common to uniform CITY employees. The variations in coverage applicable to such classes are set forth in specific appendices to this MASTER CONTRACT, including but not limited to FIREFIGHTERS. The coverage provisions applicable to a COVERED PERSON shall collectively be referred to as the Plan, and the provisions of this MASTER CONTRACT and the applicable appendices for any COVERED PERSON shall be referred to as the PLAN DOCUMENT.

This PLAN DOCUMENT does not provide for any premium payment or contributions to the cost of coverage. The obligation and amount of such payments are separately determined from the Ordinances of the City Council or any applicable Collective Bargaining Agreements.

This plan is open to uniform Fire CITY EMPLOYEES.

The benefits provided and defined in this MASTER CONTRACT are self-funded by the City of San Antonio at the time this document was drafted, but the City of San Antonio is entitled to reinsure any portion of its obligations hereunder, and additionally may contract for any carrier acceptable to the City Council to assume and administer coverage and benefits under this document.

Both parties understand and agree the CITY shall provide health care benefits to the extent they are required by law in accordance with HR 3590 “The Patient Protection and Affordable Care Act” and HR 4872 “Health Care and Education Affordability Reconciliation Act of 2010” pursuant to its effective dates.

ANY BENEFITS UNDER THE CITY'S INSURANCE OR SELF FUNDED PROGRAMS ARE SUBJECT TO CHANGE AS DETERMINED BY THE CITY COUNCIL IN ANY BUDGET YEAR, OR BY AMENDMENT OR OTHER LAWFUL CHANGE TO THE APPLICABLE BARGAINING AGREEMENTS.

The City of San Antonio may select a CLAIMS ADMINISTRATOR from time to time, or may elect to administer claims under the plan as an internal function. The CITY’S CLAIM ADMINISTRATOR is not an insurer.

## GENERAL INFORMATION

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|---|---|
| NAME OF PLAN: | Fire Active Employee Health Plan |
| PLAN YEAR: | Effective April 1, 2020 through December 31, 2020.<br>January 1 – December 31 in all future years |
| PLAN SPONSOR: | City of San Antonio<br>P.O. Box 839966<br>San Antonio, Texas 78283 |
| PLAN ADMINISTRATOR: | Employee Benefits Administrator<br>City of San Antonio<br><br>Human Resources Department<br>P.O. Box 839966<br>San Antonio, Texas 78283<br>(210) 207-8705 |

CLAIMS ADMINISTRATOR AND PRESCRIPTION BENEFIT MANAGER:

AS OF THE EFFECTIVE DATE OF THIS AGREEMENT, BUT SUBJECT TO CHANGE OVER THE LIFE OF THE AGREEMENT:

MEDICAL: BLUE CROSS/BLUE SHIELD OF TX

PHARMACY: CVS/CAREMARK

| | |
|---|---|
| EFFECTIVE DATE: | The effective date of this plan for fire uniform CITY employees is April 1, 2020 |

## PLAN AND CLAIMS ADMINISTRATION

Administration and payment of claims under the PLAN DOCUMENTS shall be carried out by the CLAIMS ADMINISTRATOR, under the supervision of the PLAN ADMINISTRATOR. It shall be a principal duty of the PLAN ADMINISTRATOR to see that the PLAN DOCUMENT is carried out as written. The PLAN ADMINISTRATOR shall have full power to administer the Plans and all of their details, and to make all final determinations about coverage on behalf of the City of San Antonio.

The PLAN ADMINISTRATOR will make available for examination, to each COVERED PERSON, his/her heirs, and/or assigns, records that pertain to the COVERED PERSON at a reasonable time during normal business hours as established by the PLAN ADMINISTRATOR.

The PLAN ADMINISTRATOR'S powers shall include, but shall not be limited to, the following:

(a) To make and enforce reasonable rules and regulations as the PLAN ADMINISTRATOR deems necessary or proper for the effective and efficient administration of the PLAN DOCUMENT;

(b) To interpret the contract, including, but not limited to, all questions of coverage and eligibility. The PLAN ADMINISTRATOR'S interpretations thereof in good faith shall be final and conclusive on all persons claiming Benefits under the PLAN DOCUMENT, subject only to the Review and Appeal Process; and

(c) To coordinate with and supervise the CLAIMS ADMINISTRATOR, prepare and handle budgetary and contractual relationships involving the plan, distribute information to COVERED PERSONS under the plan, appoint such agents, counsel, accountants, consultants and actuaries as may be required to assist in administering the PLAN DOCUMENT.

## CHAPTER 1 GENERAL PLAN COVERAGE FOR ELIGIBLE PARTICIPANTS

### ELIGIBILITY REQUIREMENTS

**Eligible Employee**

Full-time CITY employees (authorized full-time equivalent) are eligible to participate in the PLAN on the date their employment begins. Coverage begins on the date of hire, or upon taking office and performing work for the City of San Antonio, whichever occurs later.

**Eligible Dependent**

An Eligible Dependent is:

(1) The Eligible EMPLOYEE'S lawful spouse. A spouse that is legally separated under a court decree under the laws of another state shall not be an eligible dependent,

(2) All natural children including legally adopted, under legal guardianship of the Covered EMPLOYEE and who have not yet reached their twenty-sixth birthday. Foster children are not Eligible Dependents under this Plan, unless there has been an application for adoption accepted by the Texas Department of Human Services. Stepchildren are Eligible Dependents during the marriage between the Eligible EMPLOYEE and the natural parent of the child, so long as (a) they permanently reside in the EMPLOYEE'S household, and (b) are PRINCIPALLY DEPENDENT on the EMPLOYEE.

The term "Eligible Dependent" shall not include anyone who is covered as an Eligible EMPLOYEE. An Eligible Dependent shall not be entitled to any additional benefits or coverage by virtue of the fact that both parents, step parents or guardians are employed by the CITY.

**Incapacitated Dependent**

An Eligible Dependent child who is physically or mentally incapable of self-support upon attaining the age of twenty-six (26) years, shall continue to be an Eligible Dependent while remaining incapacitated, unmarried and continuously covered under the PLAN. An eligible incapacitated dependent must be solely dependent on the EMPLOYEE, and must be incapacitated by a disability that arose while such dependent was a covered dependent. To continue eligibility under this provision, proof of incapacity must be submitted by the EMPLOYEE at least thirty-one (31) days within such child's attainment of age twenty-six (26).

**Effective Date of Coverage**

Coverage does not become effective until the Eligible EMPLOYEE completes the CITY'S health benefit enrollment process.

Newborn infants will be covered from the date of birth as long as the EMPLOYEE is covered under this plan and coverage for the newborn child is requested within 31 days of the child's date of birth. If coverage of a newborn is not requested within 31 days of the child's date of birth, then coverage cannot become effective until the next January 1 of the year following the next open enrollment period.

Eligible Dependents who are enrolled after the EFFECTIVE DATE of this Plan will become covered on the date such dependent is acquired, provided that the covered EMPLOYEE enrolls such dependent within 31 days of the date the dependent is acquired. If coverage of a dependent is not requested within 31 days of the date the dependent was acquired, the coverage cannot become effective until the next January 1 of the year following the next open enrollment period.

### Change of Family Status

If there is a legal change in family status, the EMPLOYEE has thirty-one (31) calendar days to notify the EMPLOYEE Benefits Office in writing or by personally appearing in the Benefits Office and completing a change of dependent coverage form.

If there is no change in family status or if notice is not given for additional coverage within thirty-one (31) days after the legal change in status, no change can become effective until the next January 1 of the year following the next open enrollment period.

A legal change in family status includes: divorce; marriage; birth or adoption of a child, including a child living with the adopting parents during the period of probation; change in employment status for the EMPLOYEE's spouse; or ineligibility of a child due to age, or change in student status.

### Termination of Coverage for Individuals

The coverage of any COVERED PERSON under the PLAN shall terminate on the earliest of the following dates:

(1) The date of termination of the PLAN;

(2) The date employment terminates;

(3) The date all coverage or certain benefits are terminated in a particular class by modification of the PLAN; and

(4) The date an active Eligible EMPLOYEE is covered under any other available alternative health care delivery system for the EMPLOYEE or dependents of the EMPLOYEE.

### Termination of Coverage for Dependents

Coverage with respect to the COVERED PERSON'S dependents shall terminate under the PLAN at the earliest time specified below:

(1) Upon termination of employment for the covered EMPLOYEE;

(2) On the date dependents cease to be eligible as defined in the PLAN.

### Termination of Coverage for Failure to Pay Premium

Coverage with respect to any COVERED PERSON for which a premium or contribution is required shall terminate 31 days after the due date for such premium, or as soon thereafter as otherwise allowed by law.

### Documentation

The PLAN ADMINISTRATOR is entitled to require relevant legal documentation to be furnished with any request for coverage or change in status.

## Pre-Existing Conditions

If the Affordable Care Act is repealed, nullified, or modified, treatment for pre-existing conditions will continue to be provided to the same extent as under the Affordable Care Act.

## CHAPTER 2 COBRA PROVISIONS

### CONTINUATION COVERAGE

On April 7, 1986, a federal law was enacted requiring that most employers sponsoring group health plans offer EMPLOYEES and their families the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the plan would otherwise end. This law is called the Consolidated Omnibus Budget Reconciliation Act of 1985, better known as COBRA. This notice is intended to inform EMPLOYEES, in a summary fashion, of rights and obligations under the continuation coverage provisions of COBRA. The EMPLOYEE and spouse should take the time to read this notice carefully.

**"Qualified Beneficiary**" means:

a. you, as a Covered EMPLOYEE, for termination or reduced hours;
b. your spouse or your dependent child if he/she was a dependent under the PLAN on the day before your Qualifying Event occurred; or
c. a child who is born to a Covered EMPLOYEE during a period of COBRA continuation coverage.

"**Qualifying Event for a Covered Employee**" means a loss of coverage due to:

a. termination of employment for any reason other than gross misconduct; or
b. reduction in hours of employment.

"**Qualifying Event for a Covered Dependent**" means a loss of coverage due to:

a. a Covered EMPLOYEE'S termination of employment for any reason other than a gross misconduct or reduction in hours of employment;
b. a Covered EMPLOYEE'S death; a spouse's divorce or legal separation from a Covered EMPLOYEE;
c. a Covered EMPLOYEE'S entitlement to Medicare; or
d. a dependent child's loss of dependent status under the PLAN.

"**Timely contribution payment**" means contribution payment must be made within 30 days of the due date or within such longer period as applies to or under the PLAN.

**Continuation of Health Coverage**. Continuation of health coverage shall be available to you and/or your Covered Dependents upon the occurrence of a Qualifying Event. To continue health coverage, the PLAN ADMINISTRATOR must be notified of a Qualifying Event by:

(a) the EMPLOYER, within 30 days of such event, if the Qualifying Event is:
    1. for a Covered Dependent, the Covered EMPLOYEE'S death;
    2. the Covered EMPLOYEE'S termination other than for gross misconduct or reduction in hours;
    3. for a Covered Dependent, the Covered EMPLOYEE'S entitlement to Medicare.

(b) you or a Qualified Beneficiary, within 60 days of such event, if the Qualifying Event is:
   1. for a spouse, divorce, or legal separation from a Covered EMPLOYEE; or
   2. for a dependent child, loss of dependent status under the PLAN.

The PLAN ADMINISTRATOR must, within 14 days of receiving such notice, notify any Qualified Beneficiary of his/her continuation right. Notice to a Qualified Beneficiary who is your spouse shall be notice to all other Qualified Beneficiaries residing with such spouse when such notice is given.

Upon termination of employment or reduction in hours, to continue health coverage for 29 months, a Qualified Beneficiary who is determined under Title II or Title XVI of the Social Security Act to be disabled on such date or at any time during the first 60 days of COBRA continuation coverage, must notify the PLAN ADMINISTRATOR of such disability within 60 days from the date of determination and before the end of the 18 month period. If a Qualified Beneficiary entitled to the disability extension has non-disabled family members who are entitled to COBRA continuation coverage, the non-disabled family members are also entitled to the disability extension.

Qualified Beneficiaries who are disabled under Title II or Title XVI of the Social Security Act must notify the PLAN ADMINISTRATOR within 30 days from the date of final determination that they are not longer disabled.

A Qualified Beneficiary must elect Continuation of Health Coverage within 60 days from the later of the date of the Qualifying Event or the date notice was sent by the PLAN ADMINISTRATOR.

A newborn child of a Qualified Beneficiary or a child placed with a Qualified Beneficiary for adoption may be added according to the enrollment requirements for dependent coverage under the Eligibility Requirements of the PLAN.

Any election by you or your spouse shall be deemed to be an election by any other Qualified Beneficiary, though each Qualified Beneficiary is entitled to an individual election of continuation coverage.

Upon election to continue health coverage, a Qualified Beneficiary must, within 45 days of the date of such election, pay all required contribution to date to the PLAN ADMINISTRATOR. All future contribution payments by a Qualified Beneficiary must be made to the PLAN ADMINISTRATOR and are due the first of each month with a 30-day grace period.

A Qualified Beneficiary will be notified by the PLAN ADMINISTRATOR of the amount of the required contribution payment and the contribution payment options available.

**Termination of Coverage**. Coverage will end upon the earliest of the following:

a. termination or reduction of hours;
   1. 18 months from the date of the Qualifying Event; or
   2. 29 months from the date of the Qualifying Event if the Qualified Beneficiary is determined under Title II or Title XVI of the Social Security Act to be disabled on such date or at any time during the first 60 days of COBRA continuation coverage and provides notice as required by law (including, COBRA continuation coverage of non-disabled family members of the Qualified Beneficiary entitled to the disability extension).

b. the day, after the 18 month continuation period, which begins more than 30 days from the date of a final determination under Title II or Title XVI of the Social Security Act that a Qualified Beneficiary, entitled to 29 months, is no longer disabled (including COBRA continuation coverage of non-disabled family members of the Qualified Beneficiary entitled to the disability extension who is no longer disabled).

c. for a Covered Dependent, 36 months from the date of the Qualifying Event if the Qualifying Event is:
   1. the Covered EMPLOYEE's death;
   2. the Covered EMPLOYEE's entitlement to Medicare;
   3. a spouse's divorce or legal separation from a Covered EMPLOYEE; or
   4. a dependent child's loss of dependent status under the Plan.

d. if any of the Qualifying Events listed in (c) occurs during the 18-month period after the date of the initial Qualifying Event listed in (a), coverage terminates 36 months after the date of the Qualifying Event listed in 1.

e. the date on which the EMPLOYER ceases to provide any group health plan to any EMPLOYEE;

f. the date on which a Qualified Beneficiary fails to make timely payment of the required contribution;

g. the date on which a Qualified Beneficiary first becomes (after the date of the election) covered under any other group health plan (as an EMPLOYEE or otherwise) which does not contain any exclusion or limitation with respect to any pre-existing condition of such Qualified Beneficiary;

h. the first day of the month in which a Qualified Beneficiary becomes entitled to Medicare; or

i. the date this PLAN terminates.

Continuation of health coverage under this provision shall not duplicate health care coverage continued under any state or federal law.

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Any questions about COBRA should be directed to the CITY'S Employee Benefits Office, 111 Soledad, San Antonio, Texas 78205, (210) 207-8705.

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## CHAPTER 3 HIPAA PRIVACY

**A. Use and Disclosure of Protected Health Information (PHI)**

The PLAN will use protected health information (PHI) to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Specifically, the PLAN will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations.

Payment includes activities undertaken by the PLAN to determine or fulfill its responsibility for coverage and provision of plan benefits that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:

- determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, plan maximums and COINSURANCE as determined for an individual's claim);
- coordination of benefits;
- adjudication of health benefit claims (including appeals and other payment disputes);
- billing, collection activities and related health care data processing;
- claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments;
- obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);
- medical necessity reviews or review of appropriateness of care or justification of charges;
- utilization review, including pre-certification, preauthorization, concurrent review and retrospective review;
- disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, Social Security number, payment history, account number and name and address of the provider and/or health plan); and
- reimbursement to the PLAN.

*Health Care Operations* include, but are not limited to, the following activities:

- quality assessment;
- population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;
- rating provider and plan performance, including accreditation, certification, licensing or credentialing activities;
- underwriting, premium rating and other activities relating to the creation, renewal of replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance);
- conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
- business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the PLAN, including formulary development and administration, development or improvement of payment methods or coverage policies;

- business management and general administrative activities of the PLAN, including, but not limited to:
  (a) management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements, or
  (b) customer service, including the provision of data analysis for management; and
- resolution of internal grievances.

**B. The PLAN Will Use and Disclose PHI as Required by Law and as Permitted by Authorization of the Participant or Beneficiary**

**C. For Purposes of This Section, the City of San Antonio is the PLAN SPONSOR**

The PLAN will disclose PHI to the PLAN SPONSOR only upon receipt of a certification from the PLAN SPONSOR that the plan documents have been amended to incorporate the following provisions.

**D. With Respect to PHI, the PLAN SPONSOR Agrees to Certain Conditions**

The PLAN SPONSOR agrees to:

- not use or further disclose PHI other than as permitted or required by the PLAN DOCUMENT or as required by law;
- ensure that any agents, including a subcontractor, to whom the PLAN SPONSOR provides PHI received from the PLAN agree to the same restrictions and conditions that apply to the PLAN SPONSOR with respect to such PHI;
- not use or disclose PHI for employment-related actions and decisions unless authorized by an individual;
- not use or disclose PHI in connection with any other benefit or employee benefit plan of the PLAN SPONSOR unless authorized by an individual;
- report to the PLAN any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;
- make PHI available to an individual in accordance with HIPAA's access requirements;
- make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- make available the information required to provide an accounting of disclosures;
- make internal practices, books and records relating to the use and disclosure of PHI received from Plan available to the HHS Secretary for the purposes of determining the PLAN'S compliance with HIPAA; and
- if feasible, return or destroy all PHI received from the PLAN that the PLAN SPONSOR still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

**E. Adequate Separation Between the PLAN and the PLAN SPONSOR Must Be Maintained**

In accordance with HIPAA, only the following employees may be given access to PHI:

- the staff of the Employee Benefits Division of the Human Resources Department
- the staff of the Finance Department assigned to the Self Insurance Fund and
- the staff of Legal Department assigned to the Employee Benefits Division.

**F. Noncompliance Issues**

If the persons described in section E do not comply with this PLAN DOCUMENT, the PLAN SPONSOR shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

# CHAPTER 4 DEFINITIONS

"**ACCIDENTAL INJURY**" means a condition caused by an accidental means which results in traumatic damage to the COVERED PERSON'S body from an external force that is unexpected at the time, but which occurrence was definite as to time and place. Normal and routine human movements and activities shall not be considered accidents, even though unexpected physiological injury or damage may occur as a result thereof. (Such as bending, stooping or lifting resulting in disc injury; or yawning that damages the temporomandibular joint).

"**ACTIVELY AT WORK**" means the active expenditure of time and energy in the service of the EMPLOYER, except that an EMPLOYEE shall be deemed actively at work on each day of a regular paid vacation or on a regular non-working day, provided he was actively at work on the last preceding regular working day.

"**ALLOWABLE EXPENSE**" relates to coordination of benefits, under Chapter 13 of this PLAN DOCUMENT. Allowable expenses shall mean any necessary usual, customary and reasonable expenses incurred while eligible for benefits under the PLAN, part or all of which would be covered under any of the plans, but not including any expenses contained in the Exclusions chapter.

"**AMBULATORY SURGICAL CENTER**" means a specialized facility which is established, equipped, operated and staffed primarily for the purpose of performing surgical procedures on an outpatient basis and which fully meets one of the following two tests:

(a) It is licensed as an ambulatory surgical facility in the state in which it is located; or

(b) Where licensing is not required:

1. it is operated under the full-time supervision of a PHYSICIAN;
2. it permits surgical procedures to be performed only by PHYSICIANS who are privileged to perform the procedure in at least one local HOSPITAL;
3. it requires in all cases, except for those using only local infiltration anesthetics, that a licensed anesthesiologist either administers the anesthetic or supervises an anesthetist who administers it and that the anesthesiologist or anesthetist remains present throughout the surgical procedure;
4. it provides at least one operating room and at least one post-anesthesia recovery room;
5. it is equipped to perform diagnostic x-ray and laboratory examinations or has an arrangement to obtain these services;
6. it has trained personnel and necessary equipment to handle emergencies;
7. it has immediate access to a blood bank or blood supplies;
8. it provides the full-time services of one or more registered graduate nurses (R.N.) for patient care in the operating room and post-anesthesia recovery room; and
9. it maintains an adequate medical record for each patient that contains an admitting diagnosis that includes, except for patients undergoing a procedure under local anesthesia, a preoperative examination report, medical history and laboratory tests and/or x-rays, and operative report and discharge summary.

"**ANNUAL MAXIMUM OUT OF POCKET**" is the sum of all member cost sharing expenses including deductibles, co-pays and COINSURANCE under the PLAN DOCUMENT. It does not include any applicable monthly employee contributions. When the annual out of pocket is reached (which can be for an individual or a family, cumulative) covered expenses incurred during that plan year will be paid at 100%.

Out of Pocket does not include:

* Charges beyond usual & customary fees;

* Penalties resulting from non-compliance with pre-certification;

* Charges not covered under the PLAN.

"**BODY ORGAN**" means the following (a) a kidney; (b) a heart; (c) a heart/lung; (d) a liver, (e) a pancreas, when the condition is not treatable by use of insulin therapy; (f) bone marrow; and (g) a cornea.

"**CALENDAR YEAR**" a period of 12 consecutive months beginning with January 1 through December 31 of the same year. For new EMPLOYEES and dependents, the CALENDAR YEAR is the EFFECTIVE DATE of their coverage through December 31 of the same year.

"**CITY**" means the City of San Antonio.

"**CLAIMS ADMINISTRATOR**" means the Third Party Administrator or any CITY EMPLOYEE or office designated to process claims under the PLAN DOCUMENT.

"**COINSURANCE**" is the COVERED PERSON'S obligation to pay a percentage of the costs of care in accordance with the terms and provisions of this PLAN DOCUMENT. For example, if this plan provides for payment of 80% of eligible medical expense, the remaining 20% is the EMPLOYEE'S obligation, and is referred to as "coinsurance." If the plan provides for out of network payment of 60% of eligible medical expense, the remaining 40% EMPLOYEE obligation is referred to as “coinsurance.” If the plan provides for an in-network prescription payment of 80%, the remaining 20% is the employee’s obligation and is referred to as “co-insurance.

"**COMPLICATIONS OF PREGNANCY**" means:

(a) conditions requiring HOSPITAL confinement (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or caused by pregnancy, such as: acute nephritis; nephrosis; cardiac decompensation; missed abortion; and similar medical and surgical conditions of comparable severity; or

(b) non-elective caesarean section; ectopic pregnancy which is terminated; or spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible.

"Complications of pregnancy" does not mean: false labor; occasional spotting; physician prescribed rest during pregnancy; morning sickness; hyperemesis gravidarum; preeclampsia; or similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy.

**“COPAYMENT OR CO-PAY” -** The fixed dollar amount (or in some cases, a percentage) that you must pay to a health care provider in order to receive a specific service or benefit covered under this Plan.

"**COSMETIC PROCEDURES**" mean any surgical procedure or any portion of a surgical procedure performed primarily to improve physical appearance and does not promote the proper function of the body or treat any illness or injury.

"**COVERED PERSON**" means an eligible EMPLOYEE, retiree, official or eligible Dependent covered under this Plan.

"**COVERED PROVIDER**" means an AMBULATORY SURGICAL CENTER, a HOME HEALTH CARE AGENCY, a licensed HOSPICE care center, a HOSPITAL, a PHYSICIAN, a SURGEON, a PSYCHIATRIC DAY TREATMENT FACILITY, a REHABILITATION FACILITY and a SKILLED NURSING FACILITY, or other licensed clinician approved by the PLAN ADMINISTRATOR.

"**CUSTODIAL CARE**" means that type of care or service, wherever furnished and by whatever name called, which is designated primarily to assist a COVERED PERSON, whether or not totally disabled, in the activities of daily living. Such activities include, but are not limited to: bathing, dressing, feeding, preparation of special diets, assistance in walking or in getting in or out of bed, and supervision over medication which can normally be self-administered.

"**DEDUCTIBLE**" means the amount of Covered Medical Expenses a COVERED PERSON must incur and pay each CALENDAR YEAR before benefits are payable under the PLAN.

"**FAMILY DEDUCTIBLE LIMIT**" means that, once the sum of the family deductible has been satisfied by the cumulative Covered Medical Expenses of the eligible EMPLOYEE and one (1) or more of his eligible dependents in a CALENDAR YEAR, no further deductible need be satisfied in that CALENDAR YEAR for any other eligible member of the family.

"**DENTIST**" means a currently licensed dentist practicing within the scope of the license or any PHYSICIAN furnishing dental services which the PHYSICIAN is licensed to perform.

"**DIABETES EQUIPMENT**" means the following:

a. blood glucose monitors, including monitors designed to be used by blind individuals;
b. insulin pumps and associated appurtenances;
c. insulin infusion devices; and
d. podiatric appliances for the prevention of complications associated with diabetes.

**“DIABETES SUPPLIES”** means the following:

a. test strips for blood glucose monitors;
b. visual reading and urine test strips;
c. lancets and lancet devices;
d. insulin and insulin analogs;
e. injection aids; syringes;
f. prescriptive and non-prescriptive oral agents for controlling blood sugar levels; and
g. glucagon emergency kits.

"**DONOR**" means a person who undergoes a surgical operation for the purpose of donating a BODY ORGAN(s) for TRANSPLANT SURGERY.

"**DURABLE MEDICAL EQUIPMENT**" means equipment prescribed by the attending PHYSICIAN which meets each of the following: a) MEDICALLY NECESSARY; b) is not primarily or customarily used for non-medical purposes; c) is designated for prolonged use; and d) serves a specific therapeutic purpose in the treatment of any injury or illness.

“**EFFECTIVE DATE**” when applied to an individual’s coverage under the PLAN, means the first day of the individual’s coverage. The individual’s effective date may or may not be the same as the individual’s enrollment date (as “enrollment date” is defined by the PLAN).

"**ELIGIBLE EXPENSE**" is any expense, which is eligible for payment, in whole or in part under this PLAN DOCUMENT.

**“EMERGENCY SERVICES”** Emergency Services are health care services provided in a Hospital emergency facility or comparable facility to evaluate and stabilize medical conditions, including a behavioral health condition, of a recent onset and severity including, but not limited to, severe pain that would lead a prudent lay person, possessing an average knowledge of medicine and health to believe that his or her condition, Illness, or Injury is of such a nature that failure to get immediate medical care could result in:

1. placing his or her health in serious jeopardy;
2. serious impairment to bodily functions;
3. serious dysfunction of any BODY ORGAN or part;
4. serious disfigurement; or
5. in the case of a pregnant woman, serious jeopardy to the health of the fetus.

This definition is only for purposes of determining whether out of network emergency services will be paid at in-network benefit levels.

"**EMPLOYEE**" means a person who is directly employed by the City of San Antonio and is regularly scheduled for a full shift or schedule in like manner as other similarly situated workers in the department or division. "Employee" shall also include employees on Worker's Compensation, Disability, or Non-Paid status.

"**EMPLOYER**" means the City of San Antonio.

"**FIRE FIGHTER**" means any full time, permanent, paid Employee who:

(a) Is employed by the City's Fire Department;

(b) Has been hired in substantial compliance with Chapter 143 of the Local Government Code;

(c) Has successfully completed the Fire Academy; and

(d) Has received his or her certificate from the Fire Chief.

**“FLEXIBLE SPENDING ACCOUNT (FSA)”** means a tax favored account that allows employees to be reimbursed for qualified medical expenses. FSAs are funded through voluntary salary reduction agreements with the employer. No employment or federal income taxes are deducted from the contribution. The employee must be an eligible individual to qualify for an FSA.

**“HEALTH SAVINGS ACCOUNT (HSA)”** means a tax-exempt trust or custodial account set up with a qualified HSA trustee to pay or reimburse certain medical expenses. The employee must be an eligible individual to qualify for an HSA.

"**HOME HEALTH CARE AGENCY**" means an agency or organization which meets all of the following requirements:

(1) It is licensed and primarily engaged in providing skilled nursing care and other therapeutic services;

(2) It has policies established by a professional group associated with the agency or organization and includes at least one physician and one registered graduate nurse (R.N.) who provide full time supervision of such services;

(3) It maintains complete medical records on each individual;

(4) It has a full time administrator.

"**HOSPICE**" means an agency which:

a. is primarily engaged in providing counseling, medical services or room and board to terminally ill persons;
b. has professional service policies established by a group associated with it. This group must include one (1) PHYSICIAN, one (1) Registered Nurse (RN) and one (1) social service coordinator;
c. has full-time supervision by a PHYSICIAN;
d. has a full-time Administrator;
e. provides services 24 hours a day, seven (7) days a week;
f. maintains a complete medical record of each patient; and
g. is licensed in accordance with state law.

"**HOSPITAL**" means only an institution constituted and operated pursuant to any applicable law, engaged in providing, on an inpatient basis at the patient's expense, diagnostic and therapeutic facilities for the surgical and medical diagnosis, treatment, and care of injured and sick individuals by or under the supervision of a licensed PHYSICIAN or SURGEON and continuously providing 24-hour-a-day services by registered nurses. The term "hospital" shall not include any institution or part thereof which is other than incidentally a place for rest, a residential treatment center, or a nursing home or convalescent hospital.

"**INTENSIVE CARE UNIT OR CARDIAC CARE UNIT**" means a clearly designated service area which is maintained within a hospital and which meets the following tests:

(a) It is solely for the treatment of patients who require special medical attention because of their critical condition;

(b) It provides within such area special nursing care and observation of a continuous and constant nature not available in the regular rooms and wards of the HOSPITAL;

(c) It provides a concentration of special lifesaving equipment immediately available at all times for the treatment of patients confined within such area; and

(d) It provides at least one professional registered nurse who continuously and constantly attends to the patient confined in such area on a twenty-four (24) hour a day basis; or

(e) An alternate hospital that is approved by the PLAN ADMINISTRATOR, as long as the cost of care does not exceed the cost of care at a HOSPITAL that substantially meets subparagraphs (a) through (d) above, in accordance with one or more of the following criteria:

 (i) to facilitate provision of medical services by a particular PHYSICIAN;

(ii) the COVERED PERSON'S physician certifies in writing to the PLAN ADMINISTRATOR before services are rendered that the hospital is equipped to provide needed intensive or cardiac care;

(iii) proximity of the COVERED PERSON'S immediate family members;

(iv) the medical condition of the COVERED PERSON indicates that it would be inadvisable to transfer to another hospital.

"**MASTER CONTRACT**" means and refers to this PLAN DOCUMENT, which sets forth the provisions of universal applicability to the CITY'S various health benefit plans.

"**MEDICALLY NECESSARY**" means any care, treatment, service or supply provided for the diagnosis and treatment of a specific illness, injury or condition which meets all of the following.

(a) The care and treatment is appropriate given the symptoms, and is consistent with the diagnosis, if any. "Appropriate" means that the type, level, and length of service and the setting are needed to provide safe and adequate care and treatment;

(b) It is rendered in accordance with generally accepted medical practice and professionally recognized standards in the United States medical community;

(c) It is not treatment that is generally regarded as experimental, educational or unproven; and

(d) It is specifically allowed by the licensing statutes that apply to the provider that renders the service.

With respect to confinement in a HOSPITAL, "MEDICALLY NECESSARY" further means that the medical condition requires confinement and that safe and effective treatment cannot be provided as an outpatient.

The CLAIMS ADMINISTRATOR may require satisfactory proof in writing, that any type of treatment, service or supply received is MEDICALLY NECESSARY. The CLAIMS ADMINISTRATOR may also specifically require the prescribing physician or consulting board or committee of any facility to provide a written analysis of the necessity and acceptability of the methods, process or procedure under this paragraph, taking into account the criteria set forth above. The fact that a physician may prescribe, order, recommend or approve care, treatment, service or supply does not, in itself, make them MEDICALLY NECESSARY.

Medical necessity specifically does not include any:

(a) Repeated test which would not be necessary if initially done correctly, or is not necessary at current intervals;

(b) Care, treatment, service or supply which is for the psychological support, education or vocational training of the COVERED PERSON;

Criteria used in determining that a procedure is experimental includes:

(a) Whether there is an appropriate rationale for the treatment;

(b) Whether there is evidence that the treatment is effective;

(c) Whether there is evidence that the treatment is harmful;

(d) Whether the benefits justify the immediate and delayed risks of treatment;

(e) Whether the treatment has been endorsed or approved by the appropriate medical authorities, such as the FDA, the AMA or other medical specialty societies or specialists or whether the treatment is covered by Medicare or other public programs;

(f) Whether the device or treatment is the subject of ongoing investigation or research;

(g) Whether the treatment is legal;

(h) Whether controlled medical trials have been carried out that demonstrate the treatment's efficacy.

"**NEWBORN CARE**" charges for the routine care of a newborn child, while HOSPITAL confined, are covered by the PLAN on the same basis as an illness of such newborn child. Such charges will be considered separate from the mother's charges and subject to the DEDUCTIBLE and the applicable benefit percentage payable as shown in the Schedule of Benefits. All such newborn coverage shall include circumcision. Well baby care is covered for three days after birth, before an individual dependent DEDUCTIBLE is applicable to the newborn.

"**OTHER COVERAGE**" means any other contract or policy under which the COVERED PERSON is enrolled, such as:

* Group or blanket insurance;

* Group plans, other employer plans, individual plans offered on a group basis, or other group prepayment coverage;

* Labor management trusteed plans, union welfared plans, employee organization plans, or employee benefit organization plans;

* Government programs, such as Medicare, or coverage required or provided by statute;

* Any group coverage of a child sponsored by, or provided through, any educational institution;

* Group arrangements for members of associations or individuals.

"**OTHER COVERED PROVIDER**" means a certified social worker (CSW) licensed professional counselor (LPC), licensed occupational therapist (LOT), certified nurse midwife, licensed speech therapist, licensed physical therapist, registered nurse, licensed vocational nurse, or licensed practical nurse.

"**PHYSICIAN OR SURGEON**" means any professional practitioner who holds a lawful license authorizing the person to practice medicine or surgery in the locale in which the service is rendered, limited to a Doctor of Medicine (M.D.), a Doctor of Osteopathy (D.O.), a Doctor of Podiatric Medicine (D.P.M.), a Doctor of Dental Surgery (D.D.S.), a Doctor of Chiropractic (D.C.), a Clinical Psychologist (Ph.D), who has met the standards of the National Register of Health Service Providers in Psychology.

"**PLAN**" whenever used herein without qualification means this PLAN DOCUMENT.

"**PLAN ADMINISTRATOR**" means the City of San Antonio's designated Employee Benefits Administrator.

"**PLAN DOCUMENT**" means this Master Contract which provides and defines coverage for particular EMPLOYEES and dependents.

"**PLAN SPONSOR**" means the City of San Antonio.

"**PLAN SUMMARY**" is the information provided to City EMPLOYEES concerning coverage and benefits to assist in understanding and using available benefits. THE PLAN SUMMARY DOES NOT DEFINE COVERAGE, WHICH IS THE SOLE PURPOSE OF THE MASTER CONTRACT. ANY STATEMENT ABOUT COVERAGE IN THE SUMMARY IS A GENERAL INTERPRETATION ONLY, AND IS NOT MADE FOR SPECIFIC APPLICATION TO ANY COVERED PERSON, ILLNESS, OR EXPENSE.

"**POST DELIVERY CARE**" means postpartum health care services provided in accordance with accepted maternal and neonatal physical assessments. Post Delivery Care includes parent education, assistance and training in breast-feeding and bottle-feeding, including use of a Certified Lactation Consultant, and the performance of any necessary and appropriate clinical tests.

"**PRINCIPALLY DEPENDENT**" shall have the meaning defined in Sections 151 and 152 of the Internal Revenue Code and the regulations thereunder.

"**PSYCHIATRIC DAY TREATMENT FACILITY**" means an institution which meets all of the following requirements:

(a) It is a mental health facility which: provides treatment for individuals suffering from acute mental, nervous or emotional disorders, in a structured psychiatric program utilizing individualized treatment plans with specific attainable goals and objectives appropriate both to the patient and the treatment modality of the program; and is clinically supervised by a doctor of medicine who is certified in psychiatry by the American Board of Psychiatry and Neurology.

(b) It is accredited by the Program for Psychiatric Facilities or its successor, or the Joint Commission on Accreditation of HOSPITAL; and

(c) Its patients are treated for not more than eight (8) hours in any twenty-four (24) hour period.

"**QUALIFIED INSURED**" means an individual eligible for coverage under the PLAN who has been diagnosed with:

a. insulin dependent or non-insulin dependent diabetes;
b. elevated blood glucose levels induced by pregnancy; or
c. another medical condition associated with elevated blood glucose levels.

"**RECIPIENT**" means an insured person who undergoes a surgical operation to receive a BODY ORGAN transplant.

"**REHABILITATION FACILITY**" means a facility that provides services of acute rehabilitation. All services are provided under the direction of a PHYSICIAN with a specialty in rehabilitation and physical medicine. The facility is staffed around the clock by registered nurses and it does not provide services of a custodial nature. The facility must be Medicare certified, licensed by the State Department of Health as a "special hospital" and accredited by the Joint Commission on Accreditation of Healthcare Organizations. It is also accredited by the Commission on Accreditation of Rehabilitation Facilities.

"**SKILLED NURSING FACILITY**" means a legally operated institution, or a distinct part of an institution, primarily engaged in providing skilled nursing care to patients recovering from injury or illness and which:

(a) Is under the resident supervision of a PHYSICIAN or registered nurse (R.N.);

(b) Provides continuous skilled nursing care for 24 hours of every day;

(c) Requires that the health care of every patient be under the supervision of a PHYSICIAN;

(d) Provides that a PHYSICIAN be available at all times to furnish necessary medical care in emergencies;

(e) Maintains clinical records for each patient;

(f) Has an effective utilization review plan;

(g) Has a transfer agreement with at least one (1) HOSPITAL;

(h) Is not, other than incidentally, a clinic, a place devoted to care of the aged or a place for treatment of mental disorders or mental retardation;

(i) Is not a place for CUSTODIAL CARE.

“**TEMPORARY MECHANICAL EQUIPMENT**" means any non-organic device used in conjunction with the RECIPIENT's own BODY ORGAN for the purpose of sustaining a bodily function for which a transplant has been deemed necessary by the attending physician.

"**TRANSPLANT SURGERY**" means the transfer of BODY ORGAN(s) from a DONOR to a RECIPIENT.

"**USUAL & CUSTOMARY CHARGE**" means charges for MEDICALLY NECESSARY services and supplies which would usually be provided for cases the same as or similar to the one being treated. The Usual and Customary charge is limited to the lesser of:

(a) The fee usually charged by the provider for similar services and supplies; and

(b) The fee usually charged for the same service or supply by other providers who are in the same area. "Area" means a geographical area as determined by the CLAIMS ADMINISTRATOR to be significant enough to establish a representative base of charge for the treatment. The determination of the "usual and customary" charges by the CLAIMS ADMINISTRATOR shall be based on standard profiles and statistical sampling methods accepted in the benefits industry. Usual and customary shall be based on the 85th percentile and updated on a semi-annual basis. All charges above or beyond the "usual and customary" charges so determined are the financial responsibility of the COVERED PERSON. Upon request, the CITY will furnish information or assistance to a COVERED PERSON to enable them to contest excessive charges, in accordance with the policy of the Employee Benefits Office in effect at the time of the request.

## CHAPTER 5 COVERED MEDICAL EXPENSES

Covered Medical Expenses shall be the portion, set forth in the Schedule of Benefits, of the usual and customary charges for the following services, supplies, and treatment when MEDICALLY NECESSARY and when ordered by a licensed PHYSICIAN or SURGEON. Medical expenses exceeding usual and customary expenses covered by this PLAN will be the obligation of the COVERED PERSON.

1. Daily semi-private room charge in a HOSPITAL or REHABILITATION FACILITY.

2. Services and supplies furnished by a HOSPITAL.

3. Treatment by a PHYSICIAN or SURGEON.

4. Treatment by any OTHER COVERED PROVIDER not related by blood or marriage.

5. Anesthesia and its administration.

6. "Surgery in mouth or oral cavity" is limited to:

   (a) removal of non-odontogenic lesions, tumors or cysts;

   (b) incision and drainage of non-odontogenic cellulitis;

   (c) surgery on accessory sinuses, salivary glands and ducts and tongue;

   (d) surgical treatment of fractures and dislocation of the jaw resulting from an ACCIDENTAL INJURY.

7. Diagnostic radiology, radiation therapy and laboratory examinations.

8. Ambulance charges to or from the nearest medically appropriate HOSPITAL by an ambulance service operated in accordance with State law.

9. Medical supplies and equipment as follows:

   (a) drugs and medicines which can be obtained only by numbered prescription for the specified illness or injury for which the patient is being treated;

   (b) birth control pills, injections and medication implants are covered for EMPLOYEES and dependent spouses only. No other contraceptive methods or devices are covered;

   (c) blood and blood plasma;

   (d) charges for drawing and storing autologous blood;

   (e) prosthetic appliances such as artificial limbs or eyes, not including their replacement except when required due to growth or development of a dependent child. After a covered mastectomy, breast implants or prostheses are also covered. Replacement of breast prosthesis is covered only when original prosthesis was required due to a major catastrophic illness or injury;

(f) crutches. The rental (but not to exceed the total cost of purchase) or, at the option of the CLAIMS ADMINISTRATOR, the purchase of DURABLE MEDICAL EQUIPMENT when MEDICALLY NECESSARY and prescribed by a PHYSICIAN for therapeutic use, including wheelchairs, hospital beds, oxygen and equipment for its administration including IPPB (Intermittent Positive Pressure Breathing);

(g) medical supplies such as lancets, autolets, syringes, dextrowash and dextrostix, ostomy supplies, casts, splints, trusses and braces;

(h) orthopedic shoes when prescribed by a PHYSICIAN.

10. Dental treatment for fractured jaw or for injury to sound natural teeth including replacement of such teeth within six months after the date of accident, provided that such accident occurs while the COVERED PERSON is on the PLAN.

11. Expenses incurred for maternity care and services shall be covered on the same basis as for any other illness incurred by the COVERED PERSON or the dependent spouse. There is no coverage for expenses for maternity care and services incurred by a dependent child except for COMPLICATIONS OF PREGNANCY which shall be treated as any other illness.

    The attending PHYSICIAN shall make the determination as to whether a delivery is complicated.

    Under Federal law, group health plans generally may not restrict benefits for any HOSPITAL length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. The 48-hour period (or 96-hour period if applicable) begins at the time a delivery occurs in the HOSPITAL (or in the case of multiple births, at the time of the last delivery) or, if the delivery occurs outside the HOSPITAL, at the time a mother and/or newborn are admitted. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours if applicable) following the delivery.

    If a decision is made to discharge a mother or her newborn child from inpatient care before the expiration of the minimum hours of coverage of inpatient care as provided above, the PLAN will provide coverage for timely POST DELIVERY CARE as defined herein. Such care may be provided to the mother and the child by a PHYSICIAN, registered nurse or other appropriate licensed health care provider and may be provided at the mother's home, a health care provider's office, a health care facility or another location determined to be appropriate under rules adopted by the Commissioner of Insurance.

12. NEWBORN CARE.

13. Services of a licensed speech therapist are covered when therapy is rendered in accordance with PHYSICIAN's specific instructions as to type and duration when speech was present before the illness and/or injury, and for a child born under the plan with developmental disorder or birth defects.

14. Services of a licensed physical therapist are covered only for those services that require the technical medical proficiency and skills of a licensed physical therapist and which are rendered in accordance with a PHYSICIAN'S specific instructions as to type and duration.

15. Acupuncture or hypnosis when performed by a COVERED PROVIDER and in lieu of anesthesia.

16. Psychiatric Conditions – To be treated as any other illness/condition requiring care, as required by the The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).

17. Chemical dependency and substance abuse will be treated as any other illness.

18. Voluntary sterilization is covered.

19. Preventive services:

    a. One routine pap smear (doctor's procedure charge, lab expenses and office visit) per CALENDAR YEAR for female COVERED PERSONS;

    b. One routine mammogram per CALENDAR YEAR for female COVERED PERSONS age thirty-five (35) and over;

    c. One (1) routine physical examination per CALENDAR YEAR for each eligible EMPLOYEE and dependent.

       1. If performed by the EMPLOYEE'S own PHYSICIAN, covered services will be limited to a preventative medical examination, blood chemistry profile, thyroid function (TSH), fecal occult blood, urinalysis, electrocardiogram, body fat measurement, health risk appraisal, stress and personality profile, and nutritional analysis, subject to the DEDUCTIBLE and COINSURANCE as stated herein.

       2. If performed at the Occupational Health Clinic, the PLAN will also cover a complete blood count, cholesterol and glucose screening; blood pressure check; height and weight evaluation; and a health assessment questionnaire at 100%.

    d. A physical examination for the detection of prostate cancer and prostate-specific Antigen test used for the detection of prostate cancer for each male enrolled in the PLAN who is;

       1. at least 50 years of age and asymptomatic; or
       2. at least 40 years of age with a family history of prostate cancer or another prostate cancer risk factor.

20. Immunizations and Vaccines

(a) Gamma globulin injections and the following immunizations for Covered Dependents from birth through the date the child is six (6) years of age shall be covered: (a) DTP, (b) polio (OPV), (c) MMR, (d) meningitis (HIB); (e) hepatitis B (HBV); (f) TB tine; (g) varicella; and (h) any other immunizations as required by Texas law. After age six (6), the aforementioned immunizations will be covered only if the dependent was covered under this PLAN before attaining age six (6). Expenses for all covered immunizations are covered at 100%, deductible waived. Other services provided at the same time as the immunizations, including, but not limited to, office visit charges, shall be subject to the DEDUCTIBLE and COINSURANCE.

(b) Synagis (Palivizumab) administration for the prevention of respiratory syncytial virus (RSV) among high risk infants meeting prescribing criteria set forth by American Academy of Pediatrics (AAP) will be covered at 100%, deductible waived, only if such treatment is determined to be MEDICALLY NECESSARY and prior authorization obtained on or before administration of the first injection.

21. Attention Deficit Disorder- To be treated as any other illness/condition requiring care, as required by the The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).

22. Occupational Therapy.

23. Diabetes. Coverage shall be provided to each QUALIFIED INSURED as defined herein for:

    a. DIABETES EQUIPMENT;
    b. DIABETES SUPPLIES; and
    c. diabetes self-management training programs as defined herein.

    Self-management training programs must be provided by a health care practitioner or provider who is licensed, registered, or certified in Texas to provide appropriate health care services related to diabetes education. Self-management training includes:

    a. training provided to a QUALIFIED INSURED after the initial diagnosis of diabetes in the care and management of that condition, including nutritional counseling and proper use of DIABETES EQUIPMENT and supplies;

    b. additional training authorized by a PHYSICIAN or other health care practitioner of a significant change in the QUALIFIED INSURED'S symptoms or condition that requires changes in the QUALIFIED INSURED'S self-management regime; and

    c. periodic or episodic continuing education training when prescribed by an appropriate health care practitioner as warranted by the development of new techniques and treatments for diabetes.

24. Temporomandibular Joint. MEDICALLY NECESSARY diagnostic or surgical treatment of conditions affecting the temporomandibular joint (jaw and the craniomandibular joint) resulting from one of the following shall be covered:

    a. an accident;
    b. a trauma;
    c. a congenital defect;
    d. a developmental defect; or
    e. a pathology.

    Such coverage is subject to the same Plan provisions as for any surgical treatment including, but not limited to, the requirements for pre-certification of benefits.

25. Mastectomy. Coverage for inpatient care for a COVERED PERSON is as follows:

    a. 48 hours following a mastectomy; and
    b. 24 hours following a lymph node dissection for the treatment of breast cancer.

    For reconstruction of the breast on which a MEDICALLY NECESSARY mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; prostheses and treatment of physical complications for all stages of the mastectomy, including lymphedemas are covered under this Plan.

    If the COVERED PERSON and the COVERED PERSON's attending PHYSICIAN determine that a shorter period of inpatient care is appropriate, the Plan is not required to provide the minimum hours of coverage of inpatient care stated above.

26. Treatment for Mental and Nervous Conditions shall be covered the same as any other illness/condition requiring care, as required by the The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).

27. HOSPICE Care. HOSPICE Care is an alternative to the Hospital Confinement of a terminally ill person. HOSPICE Benefits are available for COVERED PERSONS with a life expectancy of six (6) months or less provided the attending PHYSICIAN approves the program. Failure to pre-certify will result in no benefit allowances. HOSPICE Care is subject to the DEDUCTIBLES and COINSURANCE as provided in the applicable appendix for each class of CITY EMPLOYEE, retiree, and official.

    Eligible HOSPICE Charges are charges made by a HOSPICE for:

    a. room and board;
    b. private duty nursing care provided by or under the supervision of a Registered Nurse (R.N.);
    c. part-time or intermittent home health aide services which consist primarily of caring for the patient by employees of the HOSPICE;
    d. social work performed by a licensed social worker, routinely provided by the HOSPICE agency;
    e. nutritional services, including, special meals, if included in the per diem;
    f. emotional support services routinely provided by the HOSPICE agency, if included in the per diem;
    g. bereavement counseling sessions for eligible dependents covered under the PLAN, if included in the per diem; and
    h. drugs and medication.

28. Organ Transplants. If covered expenses are incurred as a result of a BODY ORGAN transplant, the PLAN will pay the applicable COINSURANCE percentage of the Covered Expenses, as defined herein, after the DEDUCTIBLE is applied, subject to the LIFETIME MAXIMUM benefit and the following conditions:

    a. Benefits are available for BODY ORGAN transplantation, subject to determination made on an individualized case by case basis in order to establish medical necessity;
    b. Benefits will be provided only when the HOSPITAL and PHYSICIAN customarily charge a transplant RECIPIENT for such care and services;
    c. When only the transplant RECIPIENT is a COVERED PERSON, the benefits of the PLAN will be provided for the DONOR to the extent that such benefits are not provided under any other form of coverage. In no such case under the PLAN will any payment of a "personal service" fee be made to any DONOR. Only the necessary HOSPITAL and PHYSICIAN’S medical care and services expenses with respect to the DONOR will be considered for benefits;
    d. When only the DONOR is a COVERED PERSON, the DONOR will receive benefits for care and services necessary to the extent such benefits are not provided under any coverage available to the RECIPIENT. Benefits will not be provided to any RECIPIENT who is not a COVERED PERSON; and
    e. When the RECIPIENT and the DONOR are both COVERED PERSONS, as provided herein, benefits will be provided for both in accordance with their respective Covered Expenses.

    If the RECIPIENT is the COVERED PERSON and/or pursuant to the conditions set forth above, the following coverage shall be provided:

a. The use of TEMPORARY MECHANICAL EQUIPMENT, pending the acquisition of "matched" BODY ORGAN(s);
b. TRANSPLANT SURGERY of a BODY ORGAN(s) as defined herein;
c. Multiple transplant(s) during one (1) operative session;
d. Replacement(s) or subsequent transplant(s); and
e. Follow-up expenses for covered services, including immunosuppressant therapy.

If the DONOR is a COVERED PERSON and pursuant to the conditions set forth above, the following coverage shall be provided:

a. The acquisition of a BODY ORGAN(s) from the DONOR;
b. The life support of a DONOR pending the removal of a usable BODY ORGAN(s); and
c. Transportation of a BODY ORGAN(s). However, transportation of a BODY ORGAN(s) shall not include transportation of a living DONOR and/or a DONOR on life support.

29. The plan will allow coverage for behavioral services for the treatment of Autism Spectrum Disorder to include Applied Behavioral Analysis (ABA). The Specialist Copay will apply for outpatient treatment. All behavioral services are subject to prior authorization.

30. The plan will provide a travel and lodging reimbursement benefit for cancer treatments if patient lives more than 100 miles from location of authorized treatment. Lodging is covered $50 per day for patient and additional $50 per day for one companion. Travel is covered for coach airfare or ground transportation. Receipts are required for reimbursement and there is a $10,000 lifetime maximum benefit per covered person.

31. The plan will provide programs for diabetes management and second opinion/clinical advocacy to be determined by the City.

## CHAPTER 6 LIMITATIONS

Benefit limitations apply to the following conditions and services:

1. Abortions

Abortions will be covered when the attending PHYSICIAN certifies that the mother's life would be endangered if the fetus were carried to term.

2. Cosmetic Procedure

Elective procedure performed solely to improve appearance is not covered. Nor are the complications that may arise from or are the direct result of such procedure covered. A procedure utilized as treatment of neurosis, psychoneurosis, psychopathy, psychosis, and other mental, nervous and emotional illness will be covered as any other illness/condition requiring care, as required by The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). Additionally, expenses incurred for a cosmetic procedure for the prompt repair or alleviation of damage caused solely by accidental bodily injury, or congenital defects of children, or for the correction of a congenital anomaly in a newborn child, or for the reconstruction of the breast on which a MEDICALLY NECESSARY mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; prostheses and treatment of physical complications for all stages of the mastectomy, including lymphedemas are covered under this PLAN.

3. Treatment in Mouth or Oral Cavity

The care and treatment of the teeth, gums or alveolar process or for dentures, appliances or supplies used in such care and treatment is not covered, except for charges incurred as a result of and within six months after an accident suffered while covered hereunder for treatment of injuries to sound, natural teeth, including replacement of such teeth, or for setting of a jaw fractured or dislocated in such accident; provided, however, that this exclusion shall not be applicable to services and supplies rendered to a newborn child which are necessary for treatment or correction of a congenital defect.

4. Maternity for Dependents

Maternity care and services rendered to a dependent child are limited to treatment of COMPLICATIONS OF PREGNANCY.

5. Mental and Nervous Conditions - shall be covered the same as any other illness/condition requiring care, as required by the The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).

Expenses for treatment in a psychiatric day treatment facility for a mental, nervous or emotional disorder, if the attending physician certifies that such treatment is in lieu of hospitalization, will be covered as if incurred on an inpatient basis. Any benefits so provided shall be determined as if necessary care and treatment in a psychiatric day treatment facility were inpatient care and treatment in a HOSPITAL; each full day or treatment in a psychiatric day treatment facility shall be considered equal to one-half day of HOSPITAL confinement for purposes of determining benefits and benefit maximums under the PLAN.

6. Private Room Limit

When private room accommodations have been used, charges will be reimbursed at the average semi-private room rate in the facility. If a HOSPITAL has private rooms available only, then the maximum eligible charge will be based on the usual and customary semi-private room charge in the community.

7. Chiropractic Care Services

Chiropractic Care Services are limited to in-network coverage subject to the Schedule of Benefits DEDUCTIBLES, COINSURANCE and out of pocket maximums for in-network providers. Out of network chiropractic services are not covered under this plan.

8. Invitro Fertilization

Invitro Fertilization coverage is limited to six (6) attempts per lifetime per covered female subject to the Schedule of Benefits DEDUCTIBLES, COINSURANCE and out of pocket maximums. An attempt is each placement of fertilized embryos in female COVERED PERSONS. The plan will allow coverage for freezing, storage, and thawing of embryos with coverage for storage not to exceed a period of twelve months. All services are subject to prior authorization.

## CHAPTER 7 EXCLUSIONS

No coverage is provided under the PLAN for services and supplies:

1. For which the patient or EMPLOYEE has no legal obligation to pay, or for which no charge would be made if the EMPLOYEE had no health coverage.

2. Any treatment or service rendered by a COVERED PROVIDER related by blood or marriage.

3. Not MEDICALLY NECESSARY for the diagnosis and treatment of an illness or injury or which exceed the USUAL AND CUSTOMARY CHARGES.

4. For intentionally self-inflicted injury, whether sane or insane.

5. For diseases contracted or injuries sustained as a result of service in any branch of the armed forces.

6. For accidental bodily injury or illness which is covered by Workers' Compensation or an Occupational Medical Policy, or any expenses payable under compromise settlement agreements arising from a Workers' Compensation Claim.

7. For marital, family, vocational and other counseling services, except for nutritional counseling for diabetics.

8. For sex transformation surgery and all expenses in connection with such surgery.

9. For reversal or attempted reversal of sterilization.

10. For services, therapy and counseling for sexual dysfunction or inadequacies or for implants or aids to sexual function except due to a disease or injury which is otherwise covered by this PLAN.

11. For family planning, infertility treatment and services including but not limited to: artificial insemination and personal therapy for infertility, except in-vitro coverage as allowed in the Schedule of Benefits

12. For all charges, including but not limited to pregnancy or in-vitro services, associated with surrogacy.

13. For a dependent child's pregnancy except for complication as defined by the PLAN arising from a dependent child's pregnancy.

14. For smoking cessation seminars, services, devices or medications.

15. For the surgery or treatment of obesity, morbid obesity, dietary control, or for weight reduction.

16. For nutritional supplements, including prescription and over the counter vitamins except for "prenatal vitamins" as described in Section 13 under Exclusions and Limitations, and "Medical Food" which shall be defined as follows:

    A "Medical Food" is a food which is formulated to be consumed or administered enterally under the supervision of a physician and which is intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation. A food is subject to this exemption only if:

    (i) It is a specially formulated and processed product (as opposed to a naturally occurring foodstuff used in its natural state) for the partial or exclusive feeding of a patient by means of oral intake or enteral feeding by tube;
    (ii) It is intended for the dietary management of a patient who, because of therapeutic or chronic medical needs, has limited or impaired capacity to ingest, digest, absorb, or metabolize ordinary foodstuffs or certain nutrients, or who has other special medically determined nutrient requirements, the dietary management of which cannot be achieved by the modification of the normal diet alone;
    (iii) It provides nutritional support specifically modified for the management of the unique nutrient needs that result from the specific disease or condition, as determined by medical evaluation;
    (iv) It is intended to be used under medical supervision; and
    (v) It is intended only for a patient receiving active and ongoing medical supervision wherein the patient requires medical care on a recurring basis for, among other things, instructions on the use of the medical food.

    Infant formula shall be included within this exception so long as it meets the above definition of "Medical Food."

17. For exercise equipment or exercise programs.

18. For orthotics (arch supports, etc.) and other supportive devices for feet that are not prescribed by a PHYSICIAN.

19. For air conditioners, filters, humidifiers, dehumidifiers, and purifiers.

20. For eye exercises, visual training (orthoptics), eyeglasses, including contact lenses, hearing aids, or examinations for the purpose of determining visual acuity or level of hearing.

21. For radial keratotomy surgery and orthokeratology.

22. For medical, dental or surgical treatment including associated diagnostic procedures of orthognathic conditions.

23. For vocational therapy.

24. For preparing medical reports or itemized bills.

25. For travel or accommodations, whether or not recommended by a PHYSICIAN.

26. For charges associated with non-emergency HOSPITAL admissions on either a Friday or a Saturday unless a surgical procedure is performed within 24 hours of admission.

27. For special education, counseling or care for learning deficiencies or behavioral problems whether or not associated with a manifest mental disorder or other disturbance.

28. For care in a health resort, rest home, nursing home, residential treatment center, or any institution primarily providing convalescent, or CUSTODIAL CARE.

29. For CUSTODIAL CARE.

30. For any claims filed more than one (1) year from the month the covered service or supply was provided.

31. For admissions aimed at primarily overcoming the after effects of a specific episode of drug abuse (detoxification), or to keep the patient from access to drugs (maintenance care).

31. For sales tax, transportation, tariffs, immigration fees for international travel, or federal excise taxes.

32. For routine physical examinations for eligible dependents and for eligible EMPLOYEES not covered in Chapter 1.

33. No coverage is provided for services and supplies for routine or preventative immunizations or vaccinations except for gamma globulin injections and child immunizations.

34. Coverage for HOSPICE Care does not include the following charges:

    (a) nutritional services, including special meals not included in the per diem;
    (b) emotional support services not routinely provided by the HOSPICE agency and/or not included in the per diem;
    (c) bereavement counseling sessions for eligible dependents covered under the PLAN not included in the per diem;
    (d) funeral arrangements;
    (e) pastoral counseling; and
    (f) financial or legal counseling.

36. Coverage for Organ TRANSPLANT SURGERY does not include the following charges:

    (a) Experimental treatment for new procedures, and treatments, services or supplies which are still considered experimental or investigational and not "generally accepted" by the medical profession. The judgment whether a procedure, treatment, service or supply is experimental is based upon all of the relevant facts and circumstances, including, but not limited to:

        1. Approval by the U.S. Food and Drug Administration, the American Medical Association or the appropriate Medical Specialty Society;
        2. Medical and scientific literature;
        3. Scientifically demonstrated health benefits;
        4. Safety and effectiveness compared to alternatives; and
        5. Safety, effectiveness and benefits when used outside of a research setting;

    (b) Any animal organ or mechanical equipment, mechanical device, or mechanical organ(s), except as provided herein;
    (c) Any financial consideration to the DONOR other than for a covered service or supply which is incurred in the performance of or in relation to TRANSPLANT SURGERY; and
    (d) Transportation of a DONOR, except as provided herein.

## CHAPTER 8 PRE-ADMISSION TESTING (Value Plan Only)

If a COVERED PERSON who is scheduled for inpatient surgery in a HOSPITAL, has preoperative testing relating to this surgery performed within ten (10) days prior to the scheduled surgery and the testing is performed at a PHYSICIAN's office, diagnostic laboratory, ambulatory surgery center or on a HOSPITAL outpatient basis, the PLAN will pay pre-operative testing at 100% provided:

1. The charge for the surgery is a covered expense;
2. The tests would have been covered had the patient been confined as a HOSPITAL inpatient;
3. The tests are not repeated when the patient is confined for the surgery;
4. The test results are a part of the patient's medical record;
5. The surgery is performed in a HOSPITAL;
6. The service is identified as pre-admission or preoperative testing.

The DEDUCTIBLE does not apply.

**Coverage is not available in the Fire CDHP Plan.**

# CHAPTER 9 HOSPITAL PRE-CERTIFICATION

Certification of ALL non-network admissions to a HOSPITAL including admissions for rehabilitation, treatment of mental or nervous condition, drug, alcohol or substance abuse and maternity is required prior to or on the day of admission as an inpatient. Emergency admissions must be verified within forty-eight (48) hours following admissions. Information for precertification must be provided to the CLAIMS ADMINISTRATOR.

Certification of all non-network outpatient surgery, performed in an ambulatory surgery center or HOSPITAL outpatient facility, is required prior to or on the day of the surgery. Emergency outpatient surgery must be certified within forty-eight (48) hours following the surgery.

The COVERED PERSON is responsible for the certification of hospital admission and outpatient surgery.

If Pre-Certification Authorization is not obtained the maximum benefit paid for the doctor and HOSPITAL will be fifty percent (50%) of the usual and customary charges. The fifty percent (50%) not reimbursed by the PLAN will not count toward satisfaction of the Plan year out-of-pocket maximum.

Pursuant to State law, the PLAN will not restrict benefits for any HOSPITAL length of stay in connection with a mastectomy or lymph node dissection of less than 48 hours following a mastectomy or less than 24 hours following a lymph node dissection or require that a provider obtain authorization from the PLAN for prescribing a length or stay within the above periods. Certification is required for a length of stay, which is in excess of the above periods.

Pursuant to State law, the PLAN will not restrict benefits for any HOSPITAL length of stay in connection with childbirth for the mother or newborn child of less than 48 hours following an uncomplicated vaginal delivery or less than 96 hours following an uncomplicated cesarean section, or require that a provider obtain authorization from the PLAN for prescribing a length of stay within the above periods. Certification is required for a length of stay, which is in excess of the above periods.

## CHAPTER 10 PREFERRED PROVIDER NETWORK

### PREFERRED PROVIDER NETWORK

The City of San Antonio participates in a Preferred Provider Network of HOSPITALS, PHYSICIANS and other providers that are contracted to furnish, at negotiated costs, medical care for the CITY EMPLOYEES and their dependents. The use of a Preferred Provider may result in reduced out of pocket expenses to the COVERED PERSON.

A current listing of the Preferred Provider Network contracting HOSPITALS, PHYSICIANS and other providers is available from the CLAIMS ADMINISTRATOR by phone or internet. A COVERED PERSON may choose any health care provider.

The CITY reserves the right to terminate or modify the Preferred Provider Network program, or any portion thereof, at any time. In the event the CITY changes the PPO provider, the CITY will ensure that the EMPLOYEES will not be substantially affected by a disruption of available in-network providers.

The "In-Network Benefit" level will be paid if a COVERED PERSON receives services from a Non-Participating Provider only in the following situations:

1. EMERGENCY SERVICES.
2. Court-Ordered Dependents. If your court-ordered Eligible Dependent lives outside the service area, and no Out-of-Area Participating Providers are reasonably available to treat the Eligible Dependent. Contact the Employee Benefits Office for details.
3. Continuity of Care if Participating Provider Leaves the PPO Network. If your Participating Provider leaves the PPO Network, a covered person may continue to see that Provider and receive PPO Benefits under “special circumstances.”
4. “Special circumstance” means a condition such that a covered person’s Participating Provider reasonably believes discontinuation of care could cause harm to that person, such as a Disability, an acute condition, a life-threatening illness or a pregnancy that is past the 24$^{th}$ week. If a COVERED PERSON’S Participating Provider makes such a request and special circumstances exist, In-Network Benefits will continue:

   (a) In the case of a COVERED PERSON who is past the 24$^{th}$ week of pregnancy, through the delivery of the child, immediate postpartum care, and the follow-up checkup within the first six (6) weeks of delivery;
   (b) In the case of other special circumstances, (e.g. terminally ill), for 90 days;
   (c) If a Participating Provider, including a facility or a specialist is not available to a COVERED PERSON within the service area to provide MEDICALLY NECESSARY services covered by the PLAN, the CLAIMS ADMINISTRATOR, approves the coverage in advance.

# CHAPTER 11 PRESCRIPTION DRUG COVERAGE

## Obtaining Covered Prescriptions In-Network

Retail Pharmacy - Up to a 30-day Supply

The retail network of pharmacies is available for prescriptions you need right away or for a short time only (such as antibiotics). You can obtain up to a 30-day supply of medication from thousands of participating retail network pharmacies nationwide. A small number of medications may be limited to a 30-day or less supply.

## Mail Service Pharmacy

Prescriptions for maintenance medications or chronic long-term health conditions can be ordered through mail order. Ordering through the mail is both a safe and easy way to receive prescriptions and save money.

## Covered Items

The pharmacy coverage is as outlined in the CVS Value formulary or its equivalent if a new PBM is selected during the contract term.

## Exclusions and Limitations [See Chapter 7]

- Drugs used for cosmetic purposes, including but not limited to certain anti-fungals, hair loss treatments and those used for pigmenting/depigmenting and reducing wrinkles
- Diabetic alcohol swabs
- Fluoride supplements
- Nutritional/Dietary Supplements
- Over-the-counter medications and other over the counter items
- Vitamins, with the exception of pre-natal vitamins prescribed by a Doctor certifying: 1) the existence of factors of a high risk pregnancy; 2) the reasons for the "High Risk" classification; and that the vitamins being prescribed are to assist in avoiding serious health conditions for the child(ren).
- Miscellaneous medical supplies
- Anti-obesity drugs
- Smoking cessation medications
- Experimental or Investigational drugs or for drugs labeled "Caution – limited by federal law to Investigational use"
- Immunization agents, allergens, serums, blood or blood plasma
- Therapeutic devices or appliances, support garments or other non-medical appliances, except those listed as covered drugs

- Coverage for prescription drug products for an amount which exceeds the supply limit (days supply or quantity limit)
- Prescription drug products for any condition, injury, sickness or mental illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws
- Drugs purchased during time of no coverage
- Drugs for any treatment or condition which is listed under expenses not covered in the medical plan
- Charges to administer or inject any drug
- Prescription drugs that are not MEDICALLY NECESSARY
- Charges for delivering any drugs, except through the mail order benefit. Express or over night delivery is at the member's expense.
- Experimental or Investigational medications
- Prescription drugs purchased from an institutional pharmacy for use while the member is an in-patient in that institution regardless of the level-of-care
- Reimbursement for prescription drugs purchased outside of your prescription drug benefit is subject to review under the Direct Member Reimbursement Process and reimbursement may be limited to contract rate less COINSURANCE
- Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a HOSPITAL, extended care facility, or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals.
- Off labeled drugs
- Penlac
- Any other exclusions as determined in the CVS Value Formulary or its equivalent.

**Formulary Management**

A Formulary is a list of medications that have received FDA approval as safe and effective, and have been chosen for inclusion on the Formulary by a committee of PHYSICIANs and pharmacists from the Pharmacy Benefit Management (PBM) vendor selected by the CITY to administer the prescription drug plan. The Formulary drug list can help the member and PHYSICIAN to maximize benefits while minimizing overall prescription drug costs to the member and the PLAN.

The PBM's vendor committee evaluates clinical efficacy and safety of each drug and votes the drug into one of three categories:

- Therapeutically Unique – Clinical effectiveness of the drug is superior to existing drugs with an acceptable safety profile prompting automatic addition to the Formulary
- Therapeutically Equivalent – Clinical effectiveness and safety profile are comparable to existing drugs
- Therapeutically Inferior – Clinical effectiveness of the drug is no greater than existing drugs and the safety profile is less favorable prompting automatic non-Formulary status

Products classified by the PBM's vendor committee as therapeutically equivalent are further evaluated from an economic perspective to determine which clinically appropriate drugs are most cost-effective for

clients. The PBM's vendor committee evaluation is based solely on clinical criteria. It is only after the PBM's vendor committee clinical assessment is made that the economics of the drug are considered.
The formulary to be used in this plan is the CVS Value Formulary or its equivalent if another PBM is selected during the contract term.

The most up-to-date Formulary guide is available on the pharmacy benefit management vendor's website.

Additions to the Formulary are made on a quarterly basis throughout the year with deletions most often occurring annually.

Note: Drugs listed on the Formulary may not be covered as they are subject to the City of San Antonio's specific plan coverages, exclusions, and limitations.

**Prior Authorizations**

Certain prescriptions require step therapy, "clinical prior authorization" or approval from your PLAN before they will be covered. The pharmacy benefit management vendor administers the clinical prior authorization process on behalf of the City of San Antonio.

If the prior authorization request is APPROVED, the pharmacy benefit management vendor's Clinical Service Representative contacts the person who initiated the request and enters an override into the pharmacy benefit management vendor's processing system for a limited period of time. The pharmacy will then process your prescription.

If the prior authorization request is DENIED, the pharmacy benefit management vendor's Clinical Call Center pharmacist contacts the person who initiated the request and sends a denial letter explaining the denial reason. This includes denials due to PHYSICIAN non-response. The letter will include instructions for appealing the denial.

The categories/medications that require prior authorization are as specified in the Value Formulary.
The criteria for the Clinical Prior Authorization programs are based on nationally recognized guidelines; FDA approved indications and accepted standards of practice.

Please have the information listed below when initiating your request for a clinical prior authorization:

- Name of your Medication
- PHYSICIAN'S Name
- PHYSICIAN'S Phone Number
- PHYSICIAN'S Fax Number, if available
- Member ID number (from your card)
- City of San Antonio Group Number

**Age and Quantity Limitations**

Some medications are subject to age and quantity limits. Your prescription will be denied at time of purchase if it exceeds these limitations. Limitations are based on criteria developed with guidelines from various national medical agencies and in conjunction with the pharmacy benefit management vendor's clinical review process.

**Age Limitations**

Certain medications having an age limitation include but are not limited to, the following health conditions:

- Topical Acne
- Attention Deficit Hyperactivity Disorder (ADHD)
- Narcolepsy

If your prescription is "denied" due to age limitations, but you and your PHYSICIAN believe it is MEDICALLY NECESSARY for you to take the medication to treat one of the above conditions, you may request a clinical prior authorization. Refer to the previous section titled "Prior Authorizations" for details.

Quantity Limitations
Certain medications having quantity limitations include but are not limited to, the following health conditions and medications:

- Impotency
- Insomnia
- Migraine
- Butorphanol
- Oral Antiemetics
- Diflucan 150mg

If your prescription is "denied" due to quantity limitations, and you and your PHYSICIAN believe it is MEDICALLY NECESSARY for you to take a larger quantity of the medication, you may request a clinical prior authorization. Refer to the previous section titled "Prior Authorizations" for details.

## Specialty Pharmacy

Specialty Pharmacy provides convenient, dependable access to medications for people living with complex health conditions. The programs and services focus on injectibles and medication therapies involving strict compliance requirements, special storage/handling/delivery, complex administration methods, and education /monitoring/ ongoing support. These drugs are limited to a 30-day supply regardless if dispensed at a retail pharmacy or at mail service

Certain classifications of specialty pharmacy medications will require prior authorization or approval before they will be covered by your PLAN

## Direct Member Reimbursement

There may be instances where you need to fill a prescription but are unable to have your claim processed through a network retail pharmacy due to situations such as an emergency situation, or a new member whose enrollment has not been processed. In these instances, you will be required to pay the full retail cost of the covered medication, and then file for reimbursement.

You can receive reimbursement for covered prescriptions you've paid for under the PLAN by following these steps:

- Pay the pharmacist the full amount of your prescription. Keep your receipt(s).
- Obtain and complete a claim form available from the COSA Employee Benefits Office.

- Send your completed form and itemized receipts to the pharmacy benefit management vendor.

Please note that the pharmacy benefit management vendor will reimburse you according to the PLAN'S guidelines.

**Drug Utilization Alerts at Time of Purchase**

Drug Utilization Review (DUR) is an effective tool in monitoring drug use to assure that it is appropriate, safe, and effective. At the time of purchase, the pharmacy benefit management's vendor DUR program monitors claim submissions across all pharmacies and PHYSICIANS, compares each claim with the active prescriptions of individual members, and sends "flags" back to the pharmacists should any drug utilization alerts occur. The DUR system adheres to the National Council for Prescription Drug Products (NCPDP) DUR guidelines and monitors every prescription for numerous conditions. Examples of some of the DUR alerts are listed below.

**Drug/Drug Interaction**

A drug/drug interaction is a potentially harmful result that can occur when a patient is taking two or more drugs at the same time. The possible results of the interaction may include the increase or decrease in drug effectiveness or an increase in the adverse effects of one or both of the drugs.

When these occur, the pharmacy benefit management vendor's system advises the dispensing pharmacist that the drug he/she is about to dispense may have a potentially harmful interaction with a drug the patient is currently taking. This allows the pharmacist to use professional judgment to intervene, if necessary, to prevent the patient from being harmed.

**Over Utilization**

The submission of prescription drug claims across all contracted pharmacies is monitored. When a pharmacy claim request is received, the pharmacy benefit management vendor's system reviews each patient's drug profile, searching for a previous prescription for the same drug or its generic equivalent. The system then applies any other parameters that have been defined to reject a claim if the request for the medication is being submitted sooner than the PLAN recognizes as appropriate.

**Therapeutic Duplication Monitoring**

Duplicate therapy monitoring informs the dispensing pharmacist that the newly prescribed drug may duplicate the therapeutic effects of another drug already prescribed for the patient. This duplication can occur even when the two drugs are prescribed for different medical conditions.

When a duplication of therapy is detected, the pharmacy benefit manager vendor will transmit information back to the dispensing pharmacist, including the name of the drug that is duplicating the therapy, for further evaluation and intervention.

# CHAPTER 12 EMPLOYEE SELF-AUDIT PROGRAM

On inpatient HOSPITAL bills under $3,000.00 the PLAN will make a cash presentation to any EMPLOYEE who (1) detects a billing overcharge made by a HOSPITAL as a result of an inpatient confinement to any covered family member and (2) receives a billing adjustment and (3) the PLAN realizes a savings.

Upon discharge from the HOSPITAL, simply review the bill. If there is any error, it may be in one of the following areas:

**A Calculation Error**

A charge for service the patient did not receive.

The patient received a service but not in the quantity indicated.

Remember, take the original bill and obtain a corrected bill and present both to the CITY CLAIMS ADMINISTRATOR for review and determination. The PLAN will pay the EMPLOYEE 25% of the savings or maximum of $500, whichever is less. As an example, if an EMPLOYEE detects an incorrect charge of $1,200 and this is confirmed, the EMPLOYEE will receive a check for 25% of the savings, or $300 from the PLAN.

# CHAPTER 13 COORDINATION OF BENEFITS (COB)

The COB provision is designed to correct over coverage which occurs when a person has health coverage for the same expenses under two (2) or more of the plans listed below. Should this type of duplication occur, the benefits under this PLAN will be coordinated with those of the other plans so that the total benefits from all plans will not exceed the expenses actually incurred.

If a COVERED PERSON'S benefits under another health plan are reduced due to cost containment provisions, such as a second surgical opinion, pre-certification, HMO or preferred provider arrangements, the amount of the reduction shall not be considered as an allowable expense under this PLAN.

The benefits provided by the plans listed below are considered in determining duplication of coverage:

1. This Plan;
2. Any other group insurance or prepayment plan, Health Maintenance Organizations (HMOs); etc;
3. Any labor-management trusteed plan, union welfare plan, employer organization plan or employee benefit organization plan;
4. Any government plan or statute providing benefits for which COB is not prohibited by law.

## Order of Benefit Determination

Certain rules are used to determine which of the plans will pay benefits first. This is done by using the first of the following rules which applies:

1. A plan with no COB provision will determine its benefits before a plan with a COB provision;
2. A plan that covers a person other than as a Dependent will determine its benefits before a plan that covers such person as a Dependent;
3. Any labor-management trusteed plan, union welfare plan, employer organization plan or employee benefit organization plan will determine its benefits before this plan;
4. When a claim is made for a dependent child who is covered by more than one (1) plan:
    (a) the benefits of the plan of the parent whose birthday falls earlier in the year will be determined before the benefits of the plan of the parent whose birthday falls later in that year; but
    (b) if both parents have the same birthday, the benefits of the plan which covered the parent longer will be determined before those of the plan which covered the other parent for a shorter period of time.

This method of determining the order of benefits will be referred to as the "Birthday Rule." The Birthday Rule will be used to determine the order of benefits for dependent children in all cases except those described below.

(c) if the other plan does not have the Birthday Rule, then the plan which covers the child as a dependent of the male parent will pay its benefits first.

(d) if the parents are legally separated or divorced, benefits for the child will be determined in this order:

(i) first, the plan of the parent with custody of the child will pay its benefits;
(ii) then, the plan of the spouse of the parent with custody of the child will pay its benefits; and
(iii) finally, the plan of the parent not having custody of the child will pay its benefits.

However, if there is a court decree stating which parent is responsible for the health care expenses of the child, then a plan covering the child as a dependent of that parent will determine its benefits before any other plan.

5. A plan that covers a person as:

(a) a laid off employee; or

(b) a retired employee; or

(c) a dependent of such employee;

will determine its benefits after the plan that does not cover such person as:

(a) a laid off employee; or

(b) a retired employee; or

(c) a dependent of such employee.

If one of the plans does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule will not apply.

6. If one of the above rules establishes the order of payment, a plan under which the person has been covered for the longer time will determine its benefits before a plan covering that person for a shorter time.

Two successive plans of the same group will be considered one plan if the person was eligible for coverage under the new plan within twenty-four (24) hours after the old plan terminated. A change in the amount or scope of benefits, or a change in the carrier, or a change from one type of plan to another (e.g., single employer plan to multiple employer plan) will not constitute the start of a new plan.

When the COB provision reduces the benefits payable under this Plan:

(a) each benefit will be reduced proportionately; and

(b) only the reduced amount will be charged against any benefit limits under the Plan.

The COB provision is applied throughout the CALENDAR YEAR. If there is any reduction of the benefits provided under a specific Benefit Provision of this PLAN because of duplicate coverage, similar benefits may be a payable later in that year if more ALLOWABLE EXPENSES are incurred under the same Benefit Provision of this PLAN because of duplicate coverage, similar benefits may be payable later in that year if more ALLOWABLE EXPENSES are incurred under the same Benefit Provision. "ALLOWABLE EXPENSE" means any necessary, usual and customary item of expense at least part of which is covered under at least one of the plans covering the person for who claim is made or service provided, in no event will ALLOWABLE EXPENSE include the difference between the cost of a private HOSPITAL room and a semi-private HOSPITAL room unless the patient's stay in a private HOSPITAL room is MEDICALLY NECESSARY.

Benefits under a governmental plan will be taken into consideration without expanding the definition of "ALLOWABLE EXPENSE" beyond the HOSPITAL, medical and surgical benefits as may be provided by such governmental plan.

When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be deemed to be both an ALLOWABLE EXPENSE and a benefit paid.

The PLAN has the right to release to, or obtain from, any other organization or person any information necessary for the administration of this provision and to pay to any organization any amounts necessary to satisfy the intent of this provision.

If the PLAN has paid any amounts in excess of those necessary to satisfy the intent of this provision, it has the right to recover such excess from the person, to or for whom, such payments were made or from an insurance company or organization.

When you claim benefits under the PLAN, you must furnish information about OTHER COVERAGE, which may be involved in applying this coordination provision.

A payment made under another Plan may include an amount which should have been paid under this PLAN. If it does, the CLAIMS ADMINISTRATOR may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under this PLAN. The CLAIMS ADMINISTRATOR will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

## Compliance with Cost Containment Health Plan Provisions

If the COVERED PERSON’S benefits are reduced by a health plan that has cost containment provisions, such as a second surgical opinion, HMO, pre-certification or preferred provider arrangements, the amount of such reduction shall not be an ALLOWABLE EXPENSE.

# CHAPTER 14 SUBROGATION/THIRD PARTY CLAIMS

## PROVISION FOR SUBROGATION AND RIGHT OF RECOVERY

A third party may be liable or legally responsible for expenses incurred by a COVERED PERSON for an illness or a bodily injury.

Benefits may also be payable under the PLAN for such expenses. When this happens, the PLAN may, at its option:

1. Take over the COVERED PERSON'S right to receive payment of the benefits from the third party. The COVERED PERSON will:

   (a) transfer to the PLAN any rights he may have to take legal action against the third party with respect to benefits paid by the PLAN which are subject to this provision; and

   (b) cooperate fully with the PLAN in asserting its right to subrogate. This means the COVERED PERSON must supply the PLAN with all information and sign and return all documents reasonably necessary to carry out the PLAN's right to recover from the third party any benefits paid under the PLAN which are subject to this provision.

2. Recover from the COVERED PERSON any benefits paid under the PLAN which the COVERED PERSON is entitled to receive from the third party. The PLAN will have a first lien upon any recovery, whether by settlement, judgment or otherwise, that the COVERED PERSON received from:

   (a) the third party; or

   (b) the third party's insurer or guarantor; or

   (c) the COVERED PERSON'S uninsured motorist insurance.

This lien will be for the amount of benefits paid by the PLAN for the treatment of illness or bodily injury for which the third party is liable or legally responsible. If the COVERED PERSON:

(a) makes any recovery as set forth in this provision; and

(b) fails to reimburse the PLAN fully for any benefits paid under this provision; then he will be personally liable to the PLAN to the extent of such recovery up to the amount of the first lien. The COVERED PERSON must cooperate fully with the PLAN in asserting its right to recover.

## CHAPTER 15 GENERAL PROVISIONS

1. Proof of Loss

Written proof of loss must be furnished to the CLAIMS ADMINISTRATOR within one (1) year after the month such loss was incurred. Failure to furnish proof within the time required shall not invalidate or reduce any claim if it was not reasonably possible to give proof within such time, provided proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the COVERED PERSON, later than one (1) year from the month care, treatment, service or supply was first provided for the illness or injury.

2. Legal Actions

No action at law or in equity shall be brought to recover on the PLAN unless the EMPLOYEE or retiree has exhausted administrative remedies provided in the review and appeal process in Chapter 19.

3. Examination

The CLAIMS ADMINISTRATOR shall have the right and opportunity to have the COVERED PERSON examined whose injury or illness is the basis of a claim when and so often as it may reasonably require during pendency of a claim.

4. Conformity with Federal Statutes

Any provision of this PLAN, which on its EFFECTIVE DATE is in conflict with federal statutes, is hereby amended to conform to the minimum requirements of such federal statutes.

5. Choice of PHYSICIAN

The COVERED PERSON shall have free choice of any PHYSICIAN, as defined in this PLAN, practicing legally. Benefits may vary depending on the PHYSICIAN'S participation in the City's Preferred Provider Network.

6. Entire Contract

The PLAN DOCUMENT constitutes the entire contract of coverage between the PLAN SPONSOR and the COVERED PERSON.

7. Effect of Changes

All changes to the PLAN shall become effective as of a date established by the PLAN ADMINISTRATOR, except that:

No increase or reduction in benefits shall be effective with respect to covered expenses incurred prior to the date a change was adopted by the PLAN SPONSOR, regardless of the effective date of the change; and

8. Written Notice

Any written notice required under the PLAN shall be deemed received by a COVERED PERSON sent by regular mail, postage prepaid, to the last address of the COVERED PERSON on the records of the EMPLOYER.

9. Clerical Errors/Delay

Clerical errors made on the records of the PLAN SPONSOR, PLAN ADMINISTRATOR or CLAIMS ADMINISTRATOR and delays in making entries on records shall not invalidate covered or cause coverage to be in force or to continue in force. Rather, the EFFECTIVE DATES of coverage shall be determined solely in accordance with the provisions of the PLAN regardless of whether any contributions with respect to COVERED PERSONS have been made or have failed to be made because of such errors or delays. Upon discovery of an error or delay, an equitable adjustment of any contributions will be made.

10. Workers' Compensation

The PLAN is not in lieu of and does not affect any requirement for coverage by Workers' Compensation insurance.

11. Statements

(a) Not Representations

Statements made by or on behalf of any person to obtain coverage under the PLAN shall be deemed representations and not warranties.

(b) Misstatements on Enrollment or Claim Form

If any relevant material fact has been misstated by or on behalf of any person to obtain coverage under the PLAN, the true fact shall be used to determine whether coverage is in force and the extent, if any, of coverage. Upon the discovery of any misstatement, an equitable adjustment of any benefit payments will be made.

(c) Time Limit for Misstatement

No misstatement made to obtain coverage under the PLAN will be used to void the coverage of any person which has been in force for a period of two (2) years or to deny a claim for a loss incurred or disability commencing after the expiration of the two (2) year period. The provisions of this paragraph shall not apply if any misstatement has been made fraudulently.

(d) Use of Statements

No statement made by or on behalf of any person will be used in any context unless a copy of the written instrument containing the statement has been or is furnished to any person or to any person claiming a right to receive benefits with respect to the person.

12. Identification Cards

Identification card(s) will be issued, which indicate coverage by the City of San Antonio Health Benefits Program. Upon request, the CLAIMS ADMINISTRATOR or the City's Employee Benefits Office will verify coverage of COVERED PERSONS. Identification cards will be for identification of COVERED PERSONS only and do not constitute a guarantee of coverage.

13. Protection Against Creditors

No benefit payment under this PLAN shall be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind, and any attempt to accomplish same shall be void. If the CITY finds that such an attempt has been made with respect to any payment due or to become due to any covered person, the CITY in its sole discretion may terminate the interest of such COVERED PERSON or former COVERED PERSON in such payment. And in such case the CITY shall apply the amount of such payment to or for the benefit of such COVERED PERSON or former COVERED PERSON, his/her spouse, parent, adult child, guardian or a minor child, brother or sister, or other relative of a dependent of such COVERED PERSON or former COVERED PERSON, as the CITY may determine, and any such application shall be a complete discharge of all liability with respect to such benefit payment. However, at the discretion of the CITY, benefit payments may be assigned to health care providers.

## CHAPTER 16 CLAIM FILING AND CLAIM PAYMENT

1. Claim Filing

   (a) Medical claims (doctor's visits, prescription drugs, exams, HOSPITAL, etc.) shall be filed on a claim form available from the Employee Benefits Office or CLAIMS ADMINISTRATOR.

   (b) The claim form shall include medical bills (itemized only) and the explanation of benefit statement (EOB) from other health insurance policies, if any. The bill should contain the following:

      (i) the official letterhead of the HOSPITAL, doctor, clinic, pharmacy, etc. including address, phone number and tax ID;

      (ii) type of service;

      (iii) date of service received;

      (iv) amount charged;

      (v) name of patient; and

      (vi) diagnosis.

   (c) Only one (1) detailed claim form must be completed per person per year, even for different claims and/or diagnoses. Any additional claims throughout the year may be filed on a short claim form available through the Employee Benefits Office. If a claim is for an ACCIDENTAL INJURY, then a detailed claim form must be completed for each accident occurrence. All items on the front of the claim form must be completed. The blocked section regarding secondary insurance coverage must be completed.

   (d) The original claim form with the attached bills shall be mailed to the City's CLAIMS ADMINISTRATOR.

2. Limitation of Liability

The PLAN SPONSOR shall not be obligated to pay any benefits under the PLAN for any claim that is not timely filed.

3. Time of Claims Processing

Benefits for incurred medical expenses which are covered under the PLAN will be processed immediately upon receipt of proper written proof of loss by the CLAIMS ADMINISTRATOR. Any benefits payable will be made within twenty (20) working days.

Periodic Payment: Payment of accrued periodic payments for continuing losses which are covered under the PLAN will be made immediately upon receipt of proper proof of loss by the CLAIMS ADMINISTRATOR and at the applicable time period.

4. Payment of Benefits

All benefits under the PLAN are payable to the Covered EMPLOYEE whose illness or injury or whose covered dependent's illness or injury is the basis of a claim.

In the event of the death or incapacity of a Covered EMPLOYEE and in the absence of written evidence to the PLAN of the qualification of a guardian for his estate, the PLAN may, in its sole discretion, make any and all payments to the individual or institution which, in the opinion of the PLAN ADMINISTRATOR, is or was providing the care and support of the EMPLOYEE.

Benefits for medical expenses covered under the PLAN may be assigned by a Covered EMPLOYEE to the person or institution rendering the services for which the expenses were incurred. No assignment will bind the PLAN SPONSOR unless it is in writing and unless it has been received by the CLAIMS ADMINISTRATOR prior to the payment of the benefit assigned. The CLAIMS ADMINISTRATOR will not be responsible for determining whether any assignment is valid. Payment of benefits which have been assigned will be made directly to the assignee unless a written request not to honor the assignment signed by the Covered EMPLOYEE and the assignee has been received before the proof of loss is submitted.

5. Discharge of Liability

Any payment made in accordance with the provisions of this section will fully discharge the liability of the PLAN SPONSOR to the extent of payment.

6. Recovery of Payments

If the following circumstances apply, the PLAN SPONSOR reserves the right to deduct from any benefits properly payable under the PLAN or recover from the Covered EMPLOYEE or assignee who received the payment:

(a) the amount of any payment which has been made in error; or

(b) pursuant to a misstatement contained in a proof of loss; or

(c) pursuant to a misstatement made to obtain coverage under the PLAN within two (2) years after the date coverage commences.

## CHAPTER 17 REVIEW & APPEAL PROCESS

### REVIEW PROCESS FOR DISPUTED CLAIMS

The review process for disputed claims shall include the following:

1. The Employee may request a review by writing the CLAIMS ADMINISTRATOR and stating the basis for the disputed claim.

2. This request must be made within ninety (90) calendar days after the receipt of the original explanation of benefits.

3. Upon receipt of the request, the claim will be reviewed by the CLAIMS ADMINISTRATOR who will either affirm the original claim determination in writing, pay the disputed claim amount, or request additional information necessary to make a determination.

4. The CLAIMS ADMINISTRATOR's decision will be simultaneously mailed and emailed-within thirty (30) calendar days to the EMPLOYEE along with supporting documentation setting out the basis on which the decision is made.

5. Either the Employee or the CLAIMS ADMINISTRATOR may request a review by Claims Review Committee in accordance with paragraph six (6) below. The Employee's request must be made within twenty (20) calendar days after the date upon which the CLAIMS ADMINISTRATOR's decision is simultaneously mailed and emailed receipt of to the Employee. Should the twentieth (20$^{th}$) calendar day fall on a weekend or holiday, the time shall be tolled until the first subsequent business day. Alternatively, an employee may elect to forego the review of the claim by the Claims Review Committee and instead appeal the decision of the CLAIMS ADMINISTRATOR through the Grievance Procedure, set forth in Article 30 of the Collective Bargaining Agreement. The EMPLOYEE shall have thirty (30) days from the date upon which the CLAIMS ADMINISTRATOR's decision is simultaneously mailed and emailed of receipt of the Claims Administrator's decision to initiate the grievance process. Once the grievance process is initiated, all applicable deadlines as set forth in the Grievance Procedure shall be applicable to the employee.

6. A review may be made within fifteen (15) calendar days by a Claims Review Committee upon the request of the PLAN ADMINISTRATOR only if new claims information is provided by the EMPLOYEE which was not considered before by the CLAIMS ADMINISTRATOR. The Committee shall consist of the PLAN ADMINISTRATOR, a representative of the CLAIMS ADMINISTRATOR who was not directly involved in processing the initial claim, and an independent licensed medical reviewer of the CLAIMS ADMINISTRATOR. The decision of the Committee will made within fifteen (15) calendar days, mailed to the EMPLOYEE and will be deemed final and binding. The employee shall have thirty (30) days from the date the Claims Review Committee decision is simultaneously mailed and emailed to the Employee to initiate the grievance process as set forth in Article 30 of the Collective Bargaining Agreement. Once the grievance process is initiated, all applicable deadlines as set forth in the Grievance Procedure shall be applicable to the Employee.

# CHAPTER 18 AMENDMENT OR TERMINATION OF PLAN

The CITY may amend the provisions of this PLAN, from time to time, as the need arises in order to assure the fair and equitable administration of Benefits to be provided eligible EMPLOYEES in compliance with the terms of the respective Collective Bargaining Agreements.

The CITY may terminate the provisions of the PLAN only during negotiations over the terms to be contained in Collective Bargaining Agreements with Local 624 of the International Association of Firefighters in regard to FIRE FIGHTERS for any period covered by a Collective Bargaining Agreement.

Nothing in the Document or any related Bargaining Agreements between the City and the Bargaining Agents of the FIRE FIGHTERS is intended to imply vesting or irrevocable Benefits for current, active FIRE FIGHTERS beyond the provisions of the Collective Bargaining Agreement between the City and Local 624 of the International Association of Firefighters, in regard to FIRE FIGHTERS.

Termination, continuance, alteration, or any related activity on the PLAN will be determined by the provisions of future Collective Bargaining Agreements between the CITY and Local 624 of the International Association of Firefighters, in regard to FIRE FIGHTERS.