CITY OF HANNIBAL AND BOARD OF PUBLIC WORKS
SCHEDULE OF BENEFITS EFFECTIVE JANUARY 1, 2019

MEDICAL BENEFITS

All benefits described in this Schedule are subject to the exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator's determination that: care and treatment is Medically Necessary; that charges are Usual and Reasonable; that services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

This document is intended to describe the benefits provided under the Plan but, due to the number and wide variety of different medical procedures and rapid changes in treatment standards, it is impossible to describe all covered benefits and/or exclusions with specificity. Please contact the Plan Administrator if you have questions about specific supplies, treatments or procedures.

Note: The following services must be precertified or reimbursement from the Plan may be reduced.

The attending Physician does not have to obtain precertification from the Plan for prescribing a maternity length of stay that is 72 hours or less for a vaginal delivery or 120 hours or less for a cesarean delivery.

Inpatient Services	
► Elective Admissions ► Emergency Admissions ► Skilled Nursing Facility Admissions ► Rehabilitation Facility Admissions ► LTAC Admissions ► Hospice	► Cervical Spine Surgery ► Lumbar Spine Surgery ► Sacroiliac Joint Fusion ► Transplants ► Computer Navigation for Orthopedic Surgery
Surgical Procedures	
► Blepharoplasty/Blepharoptosis ► Bone-Anchored Hearing Aids ► Breast Procedures ► Cardiac Resynchronization Therapy (CRT) with or without Implantable Cardioverter Defibrillator ► (CRT/ICD) for Treatment of Heart Failure ► Cartilage Transplant Knee ► Cervical Spine Surgery ► Cochlear Implant ► Computer Navigation for Orthopedic Surgery ► Cosmetic and Reconstructive Services of Head, Neck, Trunk and Groin ► Elective Total Hip Arthroplasty ► Elective Total Knee Arthroplasty ► IDET Procedure	► Implantable Cardioverter-Defibrillator (ICD) ► Lumbar Spine Surgery ► Mandibular/Maxillary Surgery (Orthognathic) ► Mastectomy for Gynecomastia ► Nasal Septoplasty ► Panniculectomy and Lipectomy/Diastasis Recti Repair ► Reduction Mammoplasty ► Rhinoplasty ► Sacroiliac Joint Fusion ► Sinus Endoscopy ► Sleep Apnea Surgery - LAUP/UPPP, Nasal, and Uvulopalatoplasty ► Treatment of Varicose Veins (Lower Extremities)
Ancillary Services	
► Air Ambulance ► Botulinum Toxin – Review for Migraine Use Only ► Home Health Services ► Genetic Testing for Breast and/or Ovarian Cancer Syndrome ► Genetic Testing for Inherited Peripheral Neuropathies ► Genetic Testing for PTEN Hamartoma Tumor Syndrome	► Home Hospice ► Home Infusion Services ► Hyperbaric Oxygen Therapy (Systemic/Topical) ► Occupational Therapy ► Physical Therapy ► Private Duty Nursing ► Speech Therapy

Diagnostic Imaging - Ambulatory	
► MRA of the Head and/or Neck ► MRI of the Brain ► MRI of Spine – Cervical, Thoracic, Lumbar, Sacral	► PET Scans ► Coronary CT Angiography (CCTA) ► Coronary MRA ► Cardiac MRI
Durable Medical Equipment	
► Tens Unit ► Neuromuscular Stimulators ► Custom Wheelchairs ► Power Wheelchairs ► Cooling Devices (i.e. Polar Care) ► Infusion Pumps ► Insulin Pumps ► Limb Prosthetics	► Wound Vacs ► Electric Scooters ► Bone Stimulator ► Cardio/External Defibrillator ► LVAD – Reviewed by Transplant ► Myoelectric prosthetics ► CPAP/BIPAP
Specialty Infusion Drugs	
► Azacitidine (Vidaza) ► Bevacizumab (Avastin) – Review for non-eye only ► Bortezomib (Velcade) ► Botulinum Toxin - Review for Migraine Use only ► Etanercept (Enbrel) ► Fulvestrant (Faslodex) ► Immune Globulin (Intravenous)	► Infliximab (Remicade) ► Ipilimumab (Yervoy) ► Nivolumab (Opdivo) ► Paclitaxel (Abraxane only) ► Panitumubab (Vectibix) ► Pembrolizumab (Keytruda) ► Pemetrexed (Alimta) ► Rituximab (RituXan) - Review for non-oncology diagnosis/treatment only)

Please see the Cost Management section in this booklet for details.

This Plan has entered into an agreement with certain Hospitals, Physicians and other health care providers, which are called Network Providers. Because these Network Providers have agreed to charge reduced fees to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees.

Therefore, when a Covered Person uses a Network Provider, that Covered Person will receive better benefits from the Plan than when a Non-Network Provider is used. It is the Covered Person's choice as to which Provider to use.

Under the following circumstances, the higher In-Network payment will be made for certain Non-Network services:

If a Covered Person has no choice of Network Providers in the specialty that the Covered Person is seeking within the PPO service area.

If a Covered Person is out of the PPO service area and has a Medical Emergency requiring immediate care.

If a Covered Person receives Physician or anesthesia services by a Non-Network Provider at an In-Network facility.

Additional information about this option, including any rules that apply to designation of a primary care provider, as well as a list of Network Providers, will be given to Plan Participants, at no cost, and updated as needed. This list will include providers who specialize in obstetrics or gynecology.

Deductibles payable by Plan Participants

Deductibles are dollar amounts that the Covered Person must pay before the Plan pays.

A deductible is an amount of money that is paid once a Calendar Year per Covered Person. Typically, there is one deductible amount per Plan and it must be paid before any money is paid by the Plan for any Covered Charges. Each January 1st, a new deductible amount is required. However, Covered Charges incurred in, and applied toward the deductible in October, November and December will be applied to the deductible in the next Calendar Year as well as the current Calendar Year.

MEDICAL BENEFITS SCHEDULE

DESCRIPTION OF MEDICAL BENEFITS	HEALTHLINK		NON-NETWORK PROVIDERS
	OPEN ACCESS III PROVIDERS	PPO PROVIDERS	
Lifetime Maximum	Unlimited		
Calendar Year Deductible			
• Individual	$500	$1,000	$2,000
• Family	$1,000	$2,000	$4,000
Covered expenses for Open Access III Providers and PPO Providers will accumulate to satisfy the Open Access III Providers and PPO Providers deductible amounts simultaneously until the Open Access III Providers and PPO Providers deductible amounts are satisfied. However, only charges made by Non-Network providers will be used to satisfy the Non-Network deductible amounts.			
Calendar Year Out-of-Pocket Maximum (including deductible, coinsurance and medical and prescription drug copays)			
• Individual	$2,500	$3,000	$5,000
• Family	$5,000	$6,000	$7,500
Covered expenses for Open Access III Providers, PPO Providers or Non-Network providers will accumulate to satisfy the Open Access III Providers, PPO Providers or Non-Network Providers out-of-pocket maximums simultaneously until the Open Access III Providers and PPO Providers out-of-pocket maximums are satisfied. However, only charges made by Non-Network providers will be used to satisfy the remainder of the Non-Network out-of-pocket maximum			
Health Reimbursement Account Services rendered at an Open Access III Provider that are more than 50 miles from Hannibal, MO are eligible for a reimbursement of $250 per occurrence with a maximum of $500 per person/$1,000 per family.			
Utilization Review Requirements Please refer to the HealthLink pre-certification list for full details. It is the Employee's responsibility to obtain pre-certification or benefits will be reduced by a $500 penalty. Penalty does not apply toward the Calendar Year deductible or out-of-pocket maximum.			
Hospital Services			
• Inpatient **(See Utilization Review Requirements)**	100% after deductible	80% after deductible	50% after deductible
• Outpatient	100% after deductible	80% after deductible	50% after deductible
• Inpatient Services and Outpatient Surgery performed at any facility owned or operated by **Hannibal Regional, Hannibal Clinic, Blessing Hospital, Midwest Orthopedic Hannibal and Quincy, Blessing Physician Services, Quincy Medical Group, and Northeast MO Ambulatory Surgery Center**. **DOES NOT APPLY TO EMERGENCY SERVICES, MATERNITY SERVICES OR PHYSICIAN OFFICE VISITS.**	$500 copay per occurrence, then 100% after deductible	N/A	N/A
Diagnostic Services			
• Lab and X-Ray performed in the physician office	100% after deductible	80% after deductible	50% after deductible
• MRA, MRI, PET or CT Scans	100% after deductible	80% after deductible	50% after deductible
• MRA, MRI, PET or CT Scans performed at any facility owned or operated by **Hannibal Regional, Hannibal Clinic, Blessing Hospital, Midwest Orthopedic, Blessing Physician Services, and Quincy Medical Group**.	$500 copay per test, then 100% after deductible	N/A	N/A

DESCRIPTION OF MEDICAL BENEFITS	HEALTHLINK		NON-NETWORK PROVIDERS
	OPEN ACCESS III PROVIDERS	PPO PROVIDERS	
Emergency Room Services	100% after deductible	100% after deductible	100% after deductible
Hospital Pre-Admission Testing Within 7 days prior to admission.	100% after deductible	80% after deductible	50% after deductible
Second Surgical Opinion Voluntary	100% no deductible	100% no deductible	100% no deductible
Physician Office Visits	100% after deductible	80% after deductible	50% after deductible
Other Physician Services • Hospital visits • Surgeon and assistant surgeon • Anesthesiologist • Radiologist and pathologist • Emergency room Physician	100% after deductible	80% after deductible	50% after deductible
Note: Services of radiologists, anesthesiologists, pathologists and emergency room Physicians will be reimbursed at the same benefit level as the facility where the services are performed.			
Outpatient X-ray and Laboratory Services	100% after deductible	80% after deductible	50% after deductible
Maternity	100% after deductible	80% after deductible	50% after deductible
Well Newborns Well newborn expenses for Hospital, Physician visits and circumcision while mother and baby are confined are paid as part of mother's claim.	100% after deductible	80% after deductible	50% after deductible
Wellness Care			
• Well Child Care, including office visits, routine examinations and laboratory tests as recommended by the American Academy of Pediatrics for up to age 6.	100% no deductible	100% no deductible	50% after deductible
• Immunizations:			
- Birth through 18	100% no deductible	100% no deductible	50% after deductible
• Routine Care – ages 6 and above as follows: - Mammogram – one per Calendar Year unless recommended more frequently by a Physician - Pap smear, including exam – one per Calendar Year - Prostate screening, including exam and any required tests - one per Calendar Year - Colorectal cancer screening and related tests - one per Calendar Year - Flu shot – one per Calendar Year - Screening colonoscopies in accordance with AMA guidelines.	100% no deductible	100% no deductible	50% after deductible

DESCRIPTION OF MEDICAL BENEFITS	HEALTHLINK		NON-NETWORK PROVIDERS
	OPEN ACCESS III PROVIDERS	PPO PROVIDERS	
Mental/Nervous Disorders			
• Inpatient treatment - Hospital **(See Utilization Review Requirements)** - Partial Hospitalization – two partial days equals one Inpatient day. - Residential treatment facility - Physician - Inpatient Services at **Hannibal Regional and Blessing Hospital**	100% after deductible $500 copay per occurrence, then 100% after deductible	80% after deductible N/A	50% after deductible N/A
• Outpatient treatment - Psychotherapy. - Medicine checks, Diagnostic Charges, etc.	100% after deductible	80% after deductible	50% after deductible
Alcoholism and Drug Abuse			
• Inpatient treatment - Hospital **(See Utilization Review Requirements)** - Partial Hospitalization – two partial days equals one Inpatient day. - Residential treatment facility - Physician - Inpatient Services at **Hannibal Regional and Blessing Hospital**	100% after deductible $500 copay per occurrence, then 100% after deductible	80% after deductible N/A	50% after deductible N/A
- Outpatient treatment	100% after deductible	80% after deductible	50% after deductible
Skilled Nursing Facility Must be within 14 days of a 3-day Hospital or Skilled Nursing Facility confinement, up to a maximum of 70 days per Calendar Year.	100% after deductible	80% after deductible	50% after deductible
Home Health Care Limited to a maximum of 100 visits per Calendar Year. One visit equals 4 hours.	100% after deductible	80% after deductible	50% after deductible
Hospice Care Limited to a Lifetime maximum of 70 days, Inpatient or Outpatient.	100% after deductible	80% after deductible	50% after deductible
Physical, Speech & Occupational Therapy Limited to a combined maximum of 90 visits per Calendar Year	100% after deductible	80% after deductible	50% after deductible
Ambulance	100% after deductible	100% after deductible	100% after deductible
Durable Medical Equipment	100% after deductible	80% after deductible	50% after deductible
Chiropractic Care Limited to a maximum of 26 visits per Calendar Year, including Diagnostic Charges.	100% after deductible	80% after deductible	50% after deductible
Temporomandibular Joint (TMJ) Syndrome Limited to a maximum of $5,000 per Calendar Year	100% after deductible	80% after deductible	50% after deductible

DESCRIPTION OF MEDICAL BENEFITS	HEALTHLINK		NON-NETWORK PROVIDERS
	OPEN ACCESS III PROVIDERS	PPO PROVIDERS	
Organ Transplants	100% after deductible	80% after deductible	50% after deductible
Donor expenses limited to a maximum of $10,000 per transplant	100% after deductible	80% after deductible	50% after deductible
• Reasonable lodging, meals and transportation expenses for the covered recipient and one other individual, limited to $150 per day and $10,000 per transplant.	100% after deductible	100% after deductible	100% after deductible
All Other Covered Charges	100% after deductible	80% after deductible	50% after deductible
Note: Covered expenses rendered by a Non-Network provider: • for a Covered Person while traveling outside the Network service area; • for a Full-Time Student attending school outside the Network service area; • for a Covered Person residing outside the Network service area; will be reimbursed at the Non-Network level of benefits.			

DESCRIPTION OF PRESCRIPTION DRUG BENEFITS	PRESCRIPTION DRUG PROGRAM PAYS
Drugs available only through the Prescription Drug Program	
Retail (greater of 34 day supply or 100 unit dose)	100% after 25% Copay – Generic 25% Copay – Brand Name 25% Copay – Brand Name Non-Preferred Drug
Mail Order (greater of 90 day supply or 300 unit dose)	100% after 25% Copay – Generic 25% Copay – Brand Name 25% Copay – Brand Name Non-Preferred Drug
Specialty Medications	100% after 25% Copay and with a $2,500 out-of-pocket maximum Per Calendar Year

Prescription drug coverage for members is administered by TrueRx, which is a pharmacy benefits manager. TrueRx provides a nationwide network of participating pharmacies and also provides a drug formulary. The TrueRx prescription drug formulary is divided into "tiers." The presence of a drug on this formulary does not guarantee coverage. The drugs listed on the TrueRx formulary are subject to change. To find out if a medication you are prescribed is covered under the Plan, visit our Member Page at www.True-Rx.com or call 1-877-232-3811 for the most current formulary information.

Coverage for generic and name brand medications above $350 and specialty medications are only applicable if patient advocacy fails to provide a patient assistance program. Patient assistance comes from a variety of sources, including manufacturer assistance programs, copay cards, grants, and mail order pharmacies. The plan may cover the cost of patient assistance options so that your out of pocket cost will not exceed the cost under the pharmacy benefit. The plan may also allow for a 60-day grace period for urgent medications to allow time to complete the patient assistance process. Prior authorization is required on all specialty medications.