ADVERTISEMENT
REQUEST FOR PROPOSAL
HEALTH PLAN

CITY OF GRAND ISLAND, NEBRASKA

Sealed proposals will be received by the City Clerk, City Hall, 100 E. First Street, Grand Island, NE 68801 or P O Box 1968 Grand Island, NE until 4:00 p.m. (local time) on April 26, 2012 for furnishing health plan and/or administrative services for the City of Grand Island, Nebraska. Proposals received after the specified time will be returned unopened to sender. Proposals must be based on the City's Request for Proposals. Contact Tami Herald at The City of Grand Island Human Resources Department for further information.

Proposals will be evaluated based upon ability to meet key service criteria described in the Request of Proposal; quality of service provided to plan participants; ability to provide claims management systems and processes, quality of service provided to administrative staff of the City of Grand Island; ability to adapt the plan over time to meet ongoing The City's needs, quality of employee education and materials; client references; fees and insurance costs and, contract terms. Proposals shall remain firm for a period of ninety (90) days after the proposal due date. The City of Grand Island reserves the right to refuse any or all proposals and to select the proposal to be in the City's best interest, at its sole discretion.

RaNae Edwards, City Clerk

Please publish one time on March 22, 2012

Introduction

Strong Financial Resources, Inc. (SFR) has been contracted as the City of Grand Island's Health Plan consultant. We have asked them to coordinate a search and market analysis of Insurance Carriers and Third Party Administrators (TPA's) for our Medical/Rx Health Plan.

Please note we are not in search of an insurance broker or consultant at this time since we are already under contract with (SFR) for their services. Therefore, all proposals submitted should be submitted net of any broker or consultant commissions.

If you are an insurance carrier, or a third party administrator with ability to provide re-insurance proposals as well, you are invited to submit a proposal for these services to the City of Grand Island. The deadline for submission of any proposals will be 4:00pm CST on April 26th, 2012. No proposals will be accepted after this date.

NOTE: **The City of Grand Island is requesting proposal that EXACTLY matches their current coverage, and also a second set of proposals with different options detailed, each prices separately as the City may elect some of all the coverage options. Details at end of RFP**

All questions of items of clarification for the Request for Proposal (RFP) of any ambiguity, inconsistency or errors which a potential vendor may find are to be directed to:

Calvin Strong
Strong Financial Resources, Inc.
1611 10th Street
Aurora, NE 68818

Phone: 402-694-3033
Fax: 402-694-3012
E-mail: cstrong@strongfr.com

OR

Tami Herald
Benefits & Risk Management Coordinator
100 East First Street
P.O. Box 1968
Grand Island, NE 68802-1968
308-385-5444 ext. 199
308-385-5422

All interpretations, corrections and changes made to the specifications will be made in writing. Oral interpretations or changes made to the specifications in any other manner will not be binding on the City, and any vendor shall not rely on any oral interpretations or changes.

We expect that you will treat all information about The City of Grand Island, NE its plan, this Request for Proposal, and any other information as fully confidential.

Delivery of Proposals

Please submit your complete proposal to:

Three (3) copies to:

City Clerk
Grand Island City Hall
P.O. Box 1968
100 East First Street
Grand Island, NE 68802-1968

One (1) copy to:

Calvin Strong
Strong Financial Resources, Inc.
1611 10th Street
Aurora, NE 68818

The proposal delivery to the City Clerk's office serves to complete the legally required portion of the RFP process as set by statute and should be considered the primary delivery location. We request that one (1) additional copy be delivered to the consultant for the City, Calvin Strong, at the address above to assist in making our RFP process as timely and efficient as possible.

Any exhibits, documentation, and collateral materials must be assembled and submitted with the proposal in a single package.

The proposal must be signed by a person authorized to make contract of the scope, terms, specifications, and pricing outlined in the proposal. No oral quotations or modifications of the bound proposal will be accepted. Any modification to the original proposal must be made in writing. All costs and expenses of preparing and submitting a proposal is the responsibility of the firm submitting the proposal.

Strong Financial Resources, Inc. and the City of Grand Island will endeavor to protect the confidentiality of proprietary information. We will use the information and material only in connection with this client. We will not share your information with any entities that compete with your firm. Any other specific restrictions for your proposal must be clearly stated in your material.

The City of Grand Island reserves the right to accept or reject any and all proposals submitted or to modify any requirements or assumptions stated in the RFP before signing a final agreement with any firm. No firm can make a claim against The City of Grand Island, NE for exercise of any of these rights. The city of Grand Island will choose the firm whose proposal is most advantageous, not necessarily the lowest bidder.

All proposals must be presented with plan and fee structures and insurance costs that are firm for no less than ninety (90) days from the date the proposals are due.

Selections of Firm (Vendor)

The City of Grand Island, NE (The City) will evaluate proposals based on:

- Ability to meet key service criteria described in this RFP
- Quality of service provided to plan participants
- Ability to provide claims management systems and processes
- Quality of service provided to Administrative staff of The City of Grand Island
- Ability to adapt the plan over time to meet ongoing The City's needs
- Quality of employee education and materials
- Client references
- Fees and insurance costs

Upon review of the submitted written proposals, we anticipate choosing multiple firms for on-site interviews. We anticipate notifying these firms the week of May **14th, 2012**. The City of Grand Island will notify all firms of the results in writing. The firms selected for on-site interviews at The City of Grand Island are currently scheduled to be the week of May **21st, 2012**, with the actual date determined later. All interviews will be held the same day.

The City anticipates implementing any plan and/or administrative changes as of October 1st, 2012.

GRATUITIES AND KICKBACKS

City Code states that it is unethical for any person to offer, give or agree to give any City employee or former City employee, or for any City employee or former City employee to solicit, demand, accept, or agree to accept from another person, a gratuity or an offer of employment in connection with any decision, approval, disapproval, recommendation, or preparation of any part of a program requirement or a purchase request, influencing the content of any specification or procurement standard, rendering of advice, investigation, auditing, or in any other advisory capacity in any proceeding or application, request for ruling, determination, claim or controversy, or other particular matter, pertaining to any program requirement or a contract or subcontract, or to any solicitation or proposal therefore. It shall be unethical for any payment, gratuity, or offer of employment to be made by or on behalf of a subcontractor under a contract to the prime contractor or higher tier subcontractor or any person associated therewith, as an inducement for the award of a subcontract or order.

INSURANCE COVERAGE

The proposer shall purchase and maintain at his expense as a minimum insurance coverage of such types and in such amounts as are specified herein to protect proposer and the interest of Owner and others from claims which may arise out of or result from proposer's operations under the Contract Documents, whether such operations be by proposer or by any Subcontractor or anyone directly or indirectly employed by any of them or for whose acts any of them may be legally liable. Failure of proposer to maintain proper insurance coverage shall not relieve him of any contractual responsibility or obligation.

FAIR EMPLOYMENT PRACTICES

Each proposer agrees that they will not discriminate against any employee or applicant for employment because of age, race, color, religious creed, ancestry, handicap, sex or political affiliation.

LB 403

Every public contractor and his, her or its subcontractors who are awarded a contract by the City for the physical performance of services within the State of Nebraska shall register with and use a federal immigration verification system to determine the work eligibility status of new employees physically performing services within the State of Nebraska.

FISCAL YEARS

The City of Grand Island, Nebraska operates on a fiscal year beginning October 1st and ending on the following September 30th. It is understood and agreed that any portion of this agreement which will be performed in a future fiscal year is contingent upon the City Council adopting budget statements and appropriations sufficient to fund such performance.

TITLE VI

The City of Grand Island, in accordance with Title VI of the Civil Rights Act of 1964, 78 Stat. 252, 42 U.S.C 2000d to 2000d-4 and Title 49, Code of Federal Regulations, Department of Transportation, Subtitle A, Office the Secretary, Part 21, Nondiscrimination in Federally assisted programs of the Department of Transportation issued pursuant to such Act, hereby notified all bidden that it will affirmatively insure that in any contact entered into pursuant to this advertisement, minority business enterprises will be afforded full opportunity to submit bids in response to this invitation and will not be discriminated against on the grounds of race, color, or national origin, sex, age and disability/handicap in consideration for an award.

SECTION 504/ADA NOTICE TO THE PUBLIC

The City of Grand Island does not discriminate on the basis of disability in admission of its programs, services, or activities, in access to them, in treatment of individuals with disabilities, or in any aspect of their operations. The City of Grand Island also does not discriminate on the basis of disability in its hiring or employment practices.

This notice is provided as required by Title II of the Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973. Questions, complaints, or requests for additional information or accommodation regarding the ADA and Section 504 may be forwarded to the designated ADA and Section 504 compliance coordinator.

Mary Lou Brown
308-385-5444, extension 140
100 East First Street, Grand Island, NE 68801
Monday through Friday; 8:00 a.m. to 5:00 p.m.

PROPOSAL TERMS AND CONDITIONS

The City will not pay any costs incurred by the firm in preparing or submitting the proposal. The City reserves the right to modify or cancel, in part or in its entirety, this RFP. The City reserves the right to reject any or all proposals, to waive defects or informalities, and to offer to contract with any firm in response to any RFP. This RFP does not constitute any form of offer to contract.

City of Grand Island

Request for Proposal

Health Insurance Plan

Third Party Administrative Services

and Reinsurance

March 2012

Background on Health Insurance Plan

The City of Grand Island has sponsored a Group Health Plan for more than 25 years. The City of Grand Island currently utilizes a self-funded plan with a Specific and Aggregate Stop Loss coverage for the Health Plan. The current administrative and reinsurance carrier is Regional Care, Inc. The Health Plan is priced on a three (3) tier structure, with the tiers being Employee, 2/4 (Employee + Children or Employee + Spouse), and Family coverage. There are **470** employees with coverage in the Health Insurance Plan.

The current plan year is October 1st through September 30th of each following year for the Health Insurance. All plan features such as deductibles, Co-insurance, preventive care, and plan maximums are managed on a calendar year structure.

The City of Grand Island currently utilizes Midlands Choice Premier (PPO) for this plan.

Plan level administration, payroll items, employee changes, etc. are handled by the staff of The City of Grand Island Human Resources department. The City of Grand Island does not want the claim fiduciary responsibility for appeals and expects the firm they select to fulfill this role.

Is has been the practice of The City to enter the RFP process every 3-5 years to perform their due diligence and to make sure the current plan is offering competitive options and pricing, with efficient processing and service. The most recent reviews were done in 1999, 2003, 2006 and 2009. The plan was with Aetna from 1999-2006 at which time they elected to move to Mutual of Omaha. Subsequent to that, Coventry assumed the group business from Mutual of Omaha. In 2009 the City of Grand Island moved to their current medical carrier, Regional Care.

A copy of the current Plan Document is enclosed for your review. All proposals must be based on benefits and services provided in this Plan Document.

Proposal Service Requirements

I. Company Profile and Stability

A. Include history of your firm, along with the current ownership and management team.

B. Include current number of clients and number of employees covered for the last five years.

C. List number of employees for your firm and number of people directly involved with groups such as City of Grand.

D. List current retention rate of existing groups (percentage who renew annually).

II. Claim Payments

A. Detail frequency of claims processing and payments to providers and/or employees.

1. List claim turnaround process and time frames for, including the PPO time frames and method items are transferred between PPO network and your firm (Fax, E-mail, mail, etc.) if outside PPO firm utilized.

2. Detail number of people directly related to this function. List contact Personnel City of Grand Island would deal with daily.

B. Detail funding options available. (i.e., does your firm pay the claims and then bill the clients, do you require a reserve to process the claim payments, etc.)

1. List pricing structure for each option individually.

2. Which methods are acceptable for fund transfer? Are there any additional fees involved in utilizing a different option? If yes, list these fees.

C. Which PPO network does your firm currently utilize?

1. What other networks is your firm contracted with and do they provide any national coverage if your network for Grand Island is a local or regional network?

2. Details the fees and processing times for each of these networks you would propose utilizing and describe how the networks interact with each other.

D. List claim review procedure for appealed/disputed claims. List time frames to review and respond to claims in these categories.

E. List time frames and procedures for claim audits preformed on behalf of the client. Are audits performed on a regular basis or only as requested? Detail additional fees for audits.

F. List average time frames for all claim payments by your firm and the accuracy percentage.

III. Plan Document

A. The City of Grand Island's current plan document is included; is this document adequate for your firm?

1. If yes, will your firm maintain this document?

   a. List annual fees, if any, to maintain this document.
   b. List services provided and the legal advisor(s) that assist in maintaining the plan document.
   c. If the document, during your period of maintaining it, is challenged legally, detail the legal assistance provided by your firm, if any, and the fees.

2. If no, does your firm provide a document?

   a. Is the document pre-approved to meet current legal and regulatory standards? Please include notifications from various governmental agencies detailing approval.
   b. Is there a separate fee for providing the document? If yes, please detail the fee.

   d. Does your firm maintain this plan document to keep it within the legal standards required by governmental regulations? If yes, list any additional fees required for this service.

   e. List programs or formats the revisions would be available in and any fees for different format options.

   f. Does your firm provide Summary Plan Descriptions? If yes, is there any additional charge?

   g. Provide sample copies of your firm's plan document and summary plan description, if any.

   h. What is the process and time frames to implement plan changes desired by The City of Grand Island? Are there any limitations with your computer systems that would limit the ability to make changes or limit any kind of plan changes (i.e. inserting a co pay for allergy injections, smoking cessation programs that limit coverage to 1 time, etc.)?

   i. Is a copy of the plan document maintained on the web site employees have access to for their reference?

IV. Reports

A. Employee Reports

1. Does your firm provide annual usage summaries to employees? At what cost?
2. Is the Explanation of Benefits mailed to the employee's residence? What other options are available (e-mail, etc.) and what fees are associated with those options?
3. What is the time frame for the distribution for EOBs to the employees?
4. Include sample copies of EOBs.

B. Employer Reports

1. Employer reports are provided at what interval?
2. Employer reports available in what formats? Any additional fees for different formats? If yes, please list.
3. Are reports customizable? Any additional fee to customize reports?
4. Time line to receive reports once requested?
5. Include sample copies of employer reports. (Include all formats available.)

C. At what intervals are representatives from your firm meeting with employers to discuss usage trends, effect of any plan changes, and any possible plan changes your firm recommends for The City to implement in the future?

V. Administrative Services

A. List primary contact(s) for each portion of the plan (claims, reports, administration, Pharmacy Benefit Manager, etc.) and number of people involved in each aspect of the plan.

B. Detail time frames to process administrative changes (new enrollments, terminations, status changes, billing questions, customer service response times, any unique abilities to manage claims, customer service structure, etc.).

C. Detail steps utilized to maintain plan compliance items.

D. Describe and include samples of communication materials that may be distributed to plan participants or employees eligible to enroll. Please include any materials available, including enrollment kits and educations materials. List all media that are available for distribution of employee communication information.

E. How are client and employee complaints handled? Is the employer given notice of employee complaints and responses (within HIPPA guidelines)? If yes, on what intervals?

F. Does your firm directly handle pre-certification services?

1. If yes, are there any additional fees?

2. If no, list the firms handling the administrative duties of these of these items and the time frame that your firm has utilized their services. Also, list relationship to your firm (subsidiary, partner, etc.).

G. Does your firm directly handle prescription card services or are they outsourced?

1. If yes, are there any additional fees?

2. If no, list the firm handling the administrative duties of these items and the time frame that your firm has utilized their services. Also list their relationship to your firm (subsidiary, partner, etc.).

3. If there are rebates within the prescription plan are they applied back to the group? Detail how they are handled.

4. Please disclose the model/contract for RX services and pricing. This would include the pricing/discounts for each drug tier (For example: AWP-80% for generic and AWP -18% for Brand)

H. Describe the process for implementing case management on an individual and the fees associated with this service.

VI. Fee Structure

A. Provide at least three (3) years administrative fee history for groups of similar size.

B. What has been the frequency of fee increases for your firm? Please detail the percentage of increase and reason for the increase (new services provided, additional staff, etc.)

C. Detail your standard rate package and the services provided for that fee.

1. Are there any initial takeover fees? If yes, please list.

2. Does your firm have annual charges in addition to the monthly fees for participants? If yes, please detail these separately.

D. Is there any charge for doing employee meetings and/or enrollments? If so, please list. Is there any additional fee for meetings that are early in the morning, evening meetings, or night meetings? If yes, please list fees.

E. Are any of the fees negotiable? For what period of time are the fees guaranteed?

F. List all fees separately (administrative, reinsurance, prescription, utilization review, PPO access fees, case management fees, and any other potential fees that may be charged for services utilized, either directly or indirectly through a third party.)

VII. Computer Items

A. Are employers able to access current information, make changes, etc. via the internet? If not, will this option be available? List the time frame.

B. Are employees able to access current information, track claims, etc. via the internet? If not, will this option be available and when?

C. List any additional computer services available and the costs associated with each option.

VIII. Wellness

A. The City currently has a wellness plan in place with Health Ways, Inc. Does your firm currently work with Health Ways? If so, please detail the interaction between your firm and how your work jointly on the plan.

IX. References

A. Please provide a list of government entities in Nebraska and/or the Midwest that your firm currently works with or has worked with in the last five (5) years and the name of those we may contact.

B. Within the past five (5) years, has there been any litigation or formal complaints against your company resulting from its current or past involvement with any Health Plan? If yes, provide full details and resolutions.

ARTICLE III
SUMMARY OF BENEFITS

3.01 General Limits

Payment for any of the expenses listed below is subject to all Plan exclusions, limitations and provisions. All coverage figures are after the out-of-pocket Deductible has been satisfied. Benefits for Pregnancy expenses, are paid the same as any other Sickness.

Failure to comply with Utilization Management will result in a higher cost to Participants. **"Utilization Management"** includes hospital pre-admission certification, continued stay review, length-of-stay determination and discharge planning. These programs are designed to ensure that Medically Necessary, high-quality patient care is provided and enables maximum benefits under the Plan. See pre-certification requirements in the section entitled "Cost Containment."

The Plan contracts with the medical provider Networks to access discounted fees for service for Participants. Hospitals, Physicians and other Providers who have contracted with the medical provider Networks are called "Network Providers." Those who have not contracted with the Networks are referred to in this Plan as "Non-Network Providers." This arrangement results in the following benefits to Participants:

(1) **The Plan provides different levels of benefits based on whether the Provider Participants use is a Network or Non-Network Provider. Unless one of the exceptions shown below applies, if a Participant elects to receive medical care from the Non-Network Provider, the benefits payable are generally lower than those payable when a Network Provider is used. The following exceptions apply:**

(a) The Network Provider level of benefits is payable when a Participant has no choice of a Network Provider in the specialty that he or she is seeking within the Network service area.

(b) The Network Provider level of benefits is payable when a Participant receives emergency care either Out of Area or at a Non-Network Hospital for an Accidental Bodily Injury or Emergency.

(2) **If the charge billed by a Non-Network Provider for any covered service is higher than the Usual and Customary Fees determined by the Plan, Participants are responsible for the excess unless the Provider accepts assignment of benefits as consideration in full for services rendered. Since Network Providers have agreed to accept a negotiated discounted fee as full payment for their services, Participants are not responsible for any billed amount that exceeds that fee.**

(3) **To receive benefit consideration, Participants must submit claims for services provided by Non-Network Providers to the Third Party Administrator. Network Providers have agreed to bill the Plan directly, so that Participants do not have to submit claims themselves.**

(4) **Benefits available to Network Providers are limited such that if a Network Provider advances or submits charges which exceed amounts that are eligible for payment in accordance with the terms of the Plan, or are for services or supplies for which Plan coverage is not available, or are otherwise limited or excluded by the Plan, benefits will be paid in accordance with the terms of the Plan.**

3.02 Claims Audit

In addition to the Plan's Medical Record Review process, the Plan Administrator may use its discretionary authority to utilize an independent bill review and/or claim audit program or service for a complete claim. While every claim may not be subject to a bill review or audit, the Plan Administrator has the sole discretionary authority for selection of claims subject to review or audit.

The analysis will be employed to identify charges billed in error and/or charges that are not Usual and Customary and/or Medically Necessary and Reasonable, if any, and may include a patient medical billing records review and/or audit of the patient's medical charts and records.

Upon completion of an analysis, a report will be submitted to the Plan Administrator or its agent to identify the charges deemed in excess of the Usual and Customary and Reasonable amounts or other applicable provisions, as outlined in this Plan Document.

Despite the existence any agreement to the converse, the Plan Administrator has the discretionary authority to reduce any charge to a Usual and Customary and Reasonable charge, in accord with the terms of this Plan Document.

3.03 Primary Care Providers

A current list of PPO providers is available, without charge, through the Third Party Administrator's website (located at www.regionalcare.com). If you do not have access to a computer at your home, you may access this website at your place of employment. If you have any questions about how to do this, contact the Human Resources Department.

Each Participant has a free choice of any physician or surgeon, and the physician-patient relationship shall be maintained. The Participant, together with his or her Physician, is ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the Plan will pay for all or a portion of the cost of such care. The PPO providers are merely independent contractors; neither the Plan nor the Plan Administrator make any warranty as to the quality of care that may be rendered by any PPO provider.

3.04 Lifetime Maximum Benefit

The following lifetime maximums apply to each Participant:

Lifetime Maximum Benefits for: (In-Network and Out-of-Network Combined)	
Jaw Joint/TMJ	$2,500
Wig after Chemotherapy	One (1) wig up to $250

3.05 Calendar Year Maximum Benefit

The following calendar year maximums apply to each Participant:

Calendar Year Maximum Benefits for: (In-Network and Out-of-Network Combined)	
Skilled Nursing Facility	60 days
Home Health Care	60 visits
Occupational and Physical Therapy	60 visits
Speech Therapy	30 visits
Spinal Manipulation/Chiropractic	20 visits

3.06 Summary of Medical Benefits

The following benefits are per Participant per calendar year:

	NETWORK	NON-NETWORK
Deductible (Through December 31, 2010)		
Individual	$300	$600
Family Unit	$600	$1,200
Maximum Out-of-Pocket (Through December 31, 2010)		
Individual	$1,600	$2,250
Family Unit	$3,600	$4,500
Deductible (Effective January 1, 2011)		
Individual	$500	$1,000
Family Unit	$1,000	$2,000

	NETWORK	NON-NETWORK
Maximum Out-of-Pocket (Effective January 1, 2011)		
Individual	$1,800	$2,950
Family Unit	$3,600	$5,900
The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.		
The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%. Cost containment penalties Out-of-Network Organ and Tissue Transplants		
Covered Medical Expenses:		
Allergy		
Allergy Testing	100% after $35 copayment ($50 copayment for a Specialist)	70% after deductible
Allergy Serum and Injections	80% after deductible	70% after deductible
Ambulance Service	80%, no deductible	80%, no deductible
Durable Medical Equipment	80% after deductible	70% after deductible
Emergency Services		
Hospital	80% after deductible	80% after deductible
Physician	80% after deductible	80% after deductible
Urgent Care Facility	100% after $35 copayment	70% after deductible
Home Health Care	80% after deductible 60 visit Calendar Year maximum	70% after deductible 60 visit Calendar Year maximum
Hospice Care	80% after deductible	70% after deductible
Bereavement Counseling	100%, no deductible	100%, no deductible
Hospital Services (Inpatient)		
Room and Board	80% after deductible the semi-private room rate (unless Hospital only has private rooms available then the private room rate will be allowed)	70% after deductible the semi-private room rate (unless Hospital only has private rooms available then the private room rate will be allowed)
Intensive Care Unit (ICU)	80% after deductible Hospital's ICU Charge	70% after deductible Hospital's ICU Charge
Nursery	80% after deductible	70% after deductible
Inpatient Ancillary	80% after deductible	70% after deductible
Hospital Services (Outpatient)		
Surgery	80% after deductible	70% after deductible
Radiology/Lab	80% after deductible	70% after deductible
Outpatient Services	80% after deductible	70% after deductible
High Tech Radiology (e.g. MRI's, CT, PET or CAT Scans) services are covered at the Outpatient Hospital or Office Services level of benefits. **Pre-certification is required for High Tech Radiology.**		
Jaw Joint/TMJ	80% after deductible $2,500 Lifetime maximum	70% after deductible $2,500 Lifetime maximum
LabCard Services (Outpatient)	100%, no deductible	Not Available
The use of the LabCard program is strictly voluntary. If a Plan Participant uses the services of LabCard, the Plan will pay 100% of the Covered Charges a Plan Participant incurs for outpatient laboratory services, and will waive any of this Plan's deductible and coinsurance requirements which otherwise would have applied to such charges.		
Mental Disorders	Same as any other Illness	Same as any other Illness
Orthotics	80% after deductible	70% after deductible
Occupational and Physical Therapy	80% after deductible 60 visit Calendar Year maximum	70% after deductible 60 visit Calendar Year maximum

	NETWORK	NON-NETWORK
Organ and Tissue Transplants	80% after deductible	50%, no deductible
This Plan contains a separate Organ and Tissue Carve-Out Transplant policy. The benefits listed above apply to Covered Charges not reimbursable under the Transplant Policy and for Covered Charges incurred after the benefits under the Policy have been exhausted. Non-Network Organ and Tissue Transplant charges do not apply to the Out-of-Pocket Maximum and will never be paid at 100%.		
Physician Services		
Inpatient Visits	80% after deductible	70% after deductible
Hospital Inpatient / Outpatient Surgery	80% after deductible	70% after deductible
Radiologist	80% after deductible	70% after deductible
Pathologist	80% after deductible	70% after deductible
Anesthesiologist	80% after deductible	70% after deductible
High Tech Radiology (e.g. MRI's, CT, PET or CAT Scans) services are covered at the Outpatient Hospital or Office Services level of benefits. **Pre-certification is required for High Tech Radiology.**		
Physician Office Services		
Office Visits	100% after $35 copayment	70% after deductible
Specialist Office Visits	100% after $50 copayment	70% after deductible
Office Surgery	80% after deductible	70% after deductible
Office Services	80% after deductible	70% after deductible
Laboratory services that are received when the LabCard benefit is not used will be applied towards the Office Visit copayment. Diagnostic x-ray and laboratory services which are ordered on the same day as the office visit, but performed or read at a later date and/or at another facility will be considered as part of the office visit. High Tech Radiology (e.g. MRI's, CT, PET or CAT Scans) services are covered at the Outpatient Hospital or Office Services level of benefits. **Pre-certification is required for High Tech Radiology.**		
Pregnancy	80% after deductible	70% after deductible
Preventive Care		
Routine Well Care (Newborns through Adults)	100%, no deductible	70% after deductible
Routine Mammograms (Age 35 and over)	100%, no deductible	70%, no deductible
Routine Pap Smears	100%, no deductible	70% after deductible
Routine Colonoscopies (Over age 50)	100%, no deductible	70% after deductible
Prostate Antigen Test Services (PSA) (Over age 40)	100%, no deductible	70% after deductible
Immunizations	100%, no deductible	70% after deductible
Human Papillomavirus (HPV) Vaccine	100%, no deductible	100%, no deductible
The Patient Protection and Affordable Care Act (the Affordable Care Act) outlines the following Preventive Services: • Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (Task Force) with respect to the individual involved. • Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and		

Prevention (Advisory Committee) with respect to the individual involved. A recommendation of the Advisory Committee is considered to be "in effect" after it has been adopted by the Director of the Centers for Disease Control and Prevention. A recommendation is considered to be for routine use if it appears on the Immunization Schedules of the Centers for Disease Control and Prevention.

- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).
- With respect to women, evidence informed preventive care and screening provided for in comprehensive guidelines supported by HRSA (not otherwise addressed by the recommendations of the Task Force).

The complete list of recommendations and guidelines that are required to be covered can be found at: www.HealthCare.gov/center/regulations/prevention.html.

Prosthetics	80% after deductible	70% after deductible
Skilled Nursing Facility	80% after deductible; the facility's semiprivate room rate; within 14 days of a 3 day stay 60 day Calendar Year maximum	70% after deductible; the facility's semiprivate room rate; within 14 days of a 3 day stay 60 days Calendar Year maximum
Speech Therapy (Refer to page 72 under the Medical Benefits section to for coverage information.)	80% after deductible 30 visit Calendar Year maximum	70% after deductible 30 visit Calendar Year maximum
Spinal Manipulation / Chiropractic	100% after $35 copayment 20 visit Calendar Year maximum	Not Available
Substance Abuse	Same as any other Illness	Same as any other Illness
Wig After Chemotherapy	100%, no deductible One (1) wig up to $250 Lifetime maximum	100%, no deductible One (1) wig up to $250 Lifetime maximum

3.07 Summary of Prescription Drug Benefits

The following benefits are per Participant:

COVERED PRESCRIPTION DRUG EXPENSES	
Pharmacy Option (includes MedTrak 90):	
Generic Drugs	$10 copayment
Formulary Brand Name Drugs	$25 copayment
Non-Formulary Brand Name Drugs	$40 copayment
Specialty Drugs	$50 + 20% copayment Up to an Out-of-Pocket Maximum of $100
Diabetic Testing Supplies	
Retail – Formulary Brand Name	$5 copayment
MedTrak 90 – Formulary Brand Name	$15 copayment
Mail Order – Formulary Brand Name	$12.50 copayment
Mail Order Prescription Drug Option (90 day supply):	
Formulary Brand Name Drugs	$62.50 copayment
Non-Formulary Brand Name Drugs	$100 copayment
Non-Network Pharmacy Claims: A Participant who purchases a Prescription Drug from a Non-Network pharmacy, he or she must pay 100% of the cost of the prescription at the time of purchase and a submit a claim for reimbursement. Reimbursement will be 50% of the cost of the drug.	

Step Therapy Program

Step Therapy is designed to promote responsible use of medications by the use of first step medications before second step medications are used.

Step Therapy will save you money as you will pay a lower prescription copayment for your medication and encourages you to be actively involved in your health care needs and begin discussions early with your doctor when prescriptions are prescribed.

The following list reflects classes of drugs that are included in the Step Therapy Program:

Anti-Inflammatory Agents
Antidepressants
Antihypertensive Agents
Bisphosphonates
Lipid-Lowering Agents
Nasal Steroids
Proton Pump Inhibitors
Sedatives & Hypnotics