

MASTER PLAN DOCUMENT AMENDMENT #1

Effective July 1, 2019, the Master Plan Document and Summary Plan Description for City of San Luis is hereby amended as follows:

SCHEDULE OF COVERAGE, is hereby deleted and replaced with Attachment A

DEFINITIONS OF GENERAL TERMS, EMPLOYEE, is hereby deleted replaced with the following:

EMPLOYEE means an Employee of the Employer who is regularly scheduled to actively perform the principle duties of his/her occupation a minimum of 30 hours per week, and who is enrolled and eligible for coverage under the Plan. Employee also includes Council Members who are working a minimum of 20 hours per month.

Part-time, seasonal, temporary and retired employees are not eligible for coverage under the Plan. Employee does not include the following:

1. a self-employed individual as described in Section 401 (c) of the Code, including, but not limited to, a sole proprietor if the Employer is a sole proprietorship, a person owning more than 2% of the Employer if it is a Subchapter S corporation, a partner of the Employer if it is a partnership, and a member of the Employer if it is a limited liability company and the members are treated as partners for income tax purposes;
2. an employee who is a spouse, child, grandchild, or parent of a person owning more than 2% of the Employer if it is a Subchapter S corporation;
3. any individual included within a unit of employees covered by a collective bargaining unit unless such agreement expressly provides for coverage of the Employee under the Plan;
4. any individual who is a nonresident alien and receives no earned income from the Employer from sources within the United States;
5. any individual who is a leased employee as defined in Section 414(n)(2) of the Code;
6. any individual who performs services for the Employer through, and is paid by, a third-party (including but not limited to an employee leasing or staffing agency) even if such individual is subsequently determined to be a common law employee of the Employer; or
7. any individual who performs services for the Employer pursuant to a contract or agreement (whether verbal or written) which provides that such individual is an independent contractor or consultant, even if such individual is subsequently determined to be a common law employee of the Employer.

PRE-CERTIFICATION, is hereby deleted and replaced with the following:

PRE-CERTIFICATION

PRE-CERTIFICATION IS REQUIRED FOR THE FOLLOWING SERVICES:

- All non-Emergency Hospitalizations (including skilled nursing facility, inpatient rehabilitation and residential treatment facilities)
- Outpatient surgery
- Hospice
- Home Health Care
- Durable Medical Equipment > \$750 or when rental exceeds 4 months
- Inpatient Rehabilitation/Habilitation services

FOR PRE-CERTIFICATION CALL EBSO-REVIEW, AT 1-800-426-9317. Non-compliance reduces benefits. If a Plan Member does not comply with Pre-certification when required, Covered Expenses will be reduced by a penalty of
PPO: \$500 per service or
Non-PPO: 50% of the total cost of the service.

This reduction is in addition to the Deductible.

Please be prepared to supply the following basic information:

1. Patient's name and date of birth
2. Employee's name, address and phone number
3. Physician's name and phone number
4. Name of the Hospital
5. Reason for the hospitalization
6. Date the hospitalization started
7. Employer's I.D. Number.

The following is hereby added:

INCENTIVE PROGRAM FOR PPO PROVIDER SELECTED HOSPITAL/OUTPATIENT FACILITY AKA WIN/WIN INCENTIVE PROGRAM

The Plan receives greater discounts through the PPO Provider Selected Hospital and Outpatient Facility listing below.

As an incentive to use one of the exclusive provider Hospitals and Outpatient facilities listed below, when a Plan Member utilizes one of the exclusive provider Hospitals or Outpatient facilities, the Plan will issue a check to the Employee the

amount of the reimbursement applied to that Covered Expense.

This benefit is subject to the procedure or confinement being a Covered Expense under this Plan. This incentive program applies to the Employee and covered Dependents. The incentive payment shall be issued in the name of the Employee.

The incentive payment will be issued upon the claims administrator's receipt of the claim for the Covered Expense.

INCENTIVE PROGRAM PLAN

Reimbursement for Incentive Program	
Inpatient - Lodging Reimbursement	Up to \$125 per night for up to 4 nights
Outpatient - Lodging Reimbursement	Up to \$125 per night for up to 4 nights
Maximum Out of Pocket (In Network)	\$5,500 + Lodging reimbursements
Hospitalizations for Incentive Program	
Hospitalization and Outpatient	0% + Deductible
Plan Member Pays	
X-rays and Labs	
At Primary Care Provider - Diagnostic, X-ray and Lab	\$15 Copay
At Specialty Care Provider - Diagnostic, X-ray and Lab	\$25 Copay
At Contracted Stand-Alone Provider i.e. Focus Imaging, Sonora Quest and Lab Corp	\$15 Copay
At a Hospital -	20% + Deductible
Complex Imaging – MRI, CT, PET Scan	
At Contracted Stand-Alone Provider i.e. Focus Imaging, Sonora Quest and Lab Corp	\$25 Copay
At a Hospital - Complex, MRI, CT and Pet Scan	20% + Deductible

PPO Provider Selected Hospital and Outpatient Facility list shall include the following providers:

Desert Ridge Outpatient Surgery Center

20940 N Tatum Blvd #370
 PHX 85050
 480-502-4010

Metro Surgery Center

6790 W. Thunderbird Rd
 Peoria, AZ 85381
 623-979-1717

Oasis Hospital

750 N 40th St.
PHX 85008

Canyon Surgery Center

6036 N 19TH Ave #100
PHX 85015

AZ Outpatient Surgery Center

6245 N 16TH St
PHX 85016

The Surgical Hospital of PHX

6501 N 19TH Ave
PHX 85015

Banner Estrella Surgery Center

9301W Thomas Rd
Phoenix, AZ 85037
(623) 388-5700

Phoenix Orthopedic Ambulatory

690 N Cofco Center Ct Ste 150
Phoenix, AZ 85008
(602) 288-4476

Outpatient Surgical Care

1530 W Glendale Ave Ste105
Phoenix, AZ 85021
(602) 995-3395

Peoria Surgery Center

13260 North 94th Drive Suite 200
Peoria, Arizona 85381
Phone: (623) 933-2900

Northwest Tucson Surgery Center AKA Northwest Hospital

(520) 877-6700
6320 N. La Challa Blvd., Suite 100
Tucson, AZ 85741

Oro Valley Hospital

(520) 901-3500
1551E. Tangerine Road
Oro Valley, AZ 85755

Carondelet Foothills Surgery Center

(520) 877-5660

2220 W. Orange Grove Road
Tucson, AZ 85741

Accepted By:

Name:	Title	Date
For: City of San Luis		

SCHEDULE OF COVERAGE

NOTE: THIS IS ONLY A SUMMARY, SPECIFIC SERVICES AND SUPPLIES MAY BE SUBJECT TO OTHER DEDUCTIBLES, COPAYS, PAYMENT PERCENTAGES, MAXIMUM BENEFIT PAYMENTS, AND/OR EXCLUSIONS AND LIMITATIONS.

NOTE: Benefits under this Plan will be paid only if the Plan Administrator decides in his/her discretion that the individual is entitled to them.

COMPREHENSIVE MAJOR MEDICAL PLAN:

DEDUCTIBLE PER COVERAGE YEAR

PPO: \$750 INDIVIDUAL	NON-PPO: \$1,500 INDIVIDUAL
\$1,500 FAMILY	\$3,000 FAMILY

The PPO Deductible and the Non-PPO Deductible shall accumulate independently and shall not be used to satisfy each other.

The family Deductible is the amount contributed toward the Deductible by two or more family members; provided, the amount contributed toward the family Deductible by any one family member cannot be more than the individual Deductible amount.

ANNUAL OUT-OF-POCKET MAXIMUM PER COVERAGE YEAR

PPO: \$5,500 INDIVIDUAL	NON-PPO: \$20,000 INDIVIDUAL
\$11,000 FAMILY	\$40,000 FAMILY

The PPO Annual Out-of-pocket Maximum and the Non-PPO Annual Out-of-pocket Maximum shall accumulate independently and shall not be used to satisfy each other.

The family Annual Out-of-pocket is the amount contributed toward the Annual Out-of-pocket by two or more family members; provided, the amount contributed toward the family Annual Out-of-pocket by any one family member cannot be more than the individual Annual Out-of-pocket amount.

The Annual Out-of-pocket Maximum **includes** the Deductible, Coinsurance, and Copays. The Annual Out-of-pocket Maximum does **NOT** include any charge in excess of the established plan maximums/limitations and penalties for non-compliance with Plan provisions.

COVERAGE YEAR MAXIMUM PAYMENT AMOUNT Unlimited

PRE-CERTIFICATION IS REQUIRED FOR THE FOLLOWING SERVICES:

- All non-Emergency Hospitalizations (including skilled nursing facility, inpatient rehabilitation and residential treatment facilities)
- Outpatient surgery
- Hospice
- Home Health Care
- Durable Medical Equipment > \$750 or when rental exceeds 4 months
- Inpatient Rehabilitation/Habilitation services

FOR PRE-CERTIFICATION CALL EBSO-REVIEW, AT 1-800-426-9317. Non-compliance reduces benefits. If a Plan Member does not comply with Pre-certification when required, Covered Expenses will be reduced by a penalty of

**PPO: \$500 per service or
Non-PPO: 50% of the total cost of the service.**

This reduction is in addition to the Deductible.

THE PPO IS ADMINISTERED BY: BCBS of Arizona
Multiplan wrap
In Mexico, SIARMED

The Plan will at all times be in compliance with PPACA rules and regulations. PPACA requires that benefits that are offered by the Plan that are “Essential Health Benefits” as defined by the United States Department of Health And Human Services may not be restricted to less than a certain annual amount. If a major medical benefit of the Plan has a plan maximum below that amount, the Plan will continue to pay benefits for the Essential Health Benefit components of that benefit even though such payments would exceed the plan maximum for that benefit, but only until the Coverage Year Maximum Payment Amount of the Plan is paid.

This plan may provide a greater discounts / reimbursement for services received through the PPO Provider Selected Hospital and Outpatient Facility. Refer to the **INCENTIVE PROGRAM FOR PPO PROVIDER SELECTED HOSPITAL/OUTPATIENT FACILITY AKA WIN/WIN INCENTIVE PROGRAM** for more information and a list of providers.

Benefit Description	PPO Plan pays	Non-PPO Plan pays	Additional Limitations and Explanations
Acupuncture	80% after Deductible	60% after Deductible	LIMITED to a maximum of 26 visits per Coverage Year.
Ambulance Services -Air and Ground	80% after Deductible	80% after Deductible	
Amino acid-based formula	25% after Deductible	25% after Deductible	LIMITED to supplies not covered under the Prescription Drug Card Benefit. The maximum annual benefit for amino acid based formula to treat eosinophilic gastrointestinal disorder is \$20,000 per Plan Member per Coverage Year.
Chiropractic Care	100% after a \$15 Copay per visit (Deductible waived)	60% after Deductible	Includes x-rays, manipulations, supportive care, and maintenance care. LIMITED to a maximum of 20 visits per Coverage Year.
Dental Hospitalization and Dental Services Office Visits	80% after Deductible	60% after Deductible	Diagnostic procedures & treatment of TMJ are LIMITED to a Lifetime maximum benefit payment of \$300.
Durable Medical Equipment, Prosthetics, Orthotics and Disposable Supplies	80% after Deductible	60% after Deductible	Hearing aids are LIMITED to one per Coverage Year.
Emergency Services and Urgent Care Services			In an Emergency, as defined by the Plan, Non-PPO Covered Expenses will be paid at the PPO level.
Emergency visit	80% (Deductible waived).	80% (Deductible waived).	
Urgent Care	100% after a \$30 Copay per visit (Deductible waived)	60% after Deductible	

Benefit Description	PPO Plan pays	Non-PPO Plan pays	Additional Limitations and Explanations
Home Health Care	80% after Deductible	60% after Deductible	LIMITED to a maximum of 60 visits per Coverage Year.
Hospice Care	80% after Deductible	60% after Deductible	Bereavement Counseling is LIMITED to a Lifetime maximum benefit payment of \$300 per family.
Inpatient Hospital Services (Non-Emergency), Outpatient Hospital, or Ambulatory Surgical Center Services At Selected PPO providers All others	100% after Deductible 80% after Deductible	60% after Deductible 60% after Deductible	
Inpatient and Outpatient Physician Services Primary Care Physician Office Visits (includes lab and X-ray) Specialist Office Visits (includes lab and X-ray) Inpatient Visit Surgery (Physician's office) Surgery (other) Physician Services – Pathology, Anesthesiology, or Radiology	100% after a \$15 Copay per visit (Deductible waived) 100% after a \$25 Copay per visit (Deductible waived) 100% after a \$15 Copay per visit (Deductible waived) 100% after a \$15 Copay per visit (Deductible waived) 80% after Deductible 80% after Deductible	60% after Deductible 60% after Deductible 60% after Deductible 60% after Deductible 60% after Deductible	
Maternity Prenatal visits Hospital Services	100% (Deductible and Copays waived) 80% after Deductible	60% after Deductible 60% after Deductible	

Benefit Description	PPO Plan pays	Non-PPO Plan pays	Additional Limitations and Explanations
Medical Foods	50% after Deductible	Not covered except in an Emergency. In an Emergency, covered expenses will be paid at PPO level.	LIMITED to supplies not covered under the Prescription Drug Card Benefit. The maximum annual benefit for medical food to treat an Inherited Metabolic Disorder is \$5,000 per Plan Member per Coverage Year.
Mental/Nervous Disorders and/or Substance Abuse Inpatient treatment Outpatient treatment	80% after Deductible 100% after a \$15 Copay per visit (Deductible waived)	60% after Deductible 60% after Deductible	
Outpatient Diagnostic Tests Complex - MRI, CT, PET Scans At contracted Stand-Alone provider(i.e. Sonora Quest, Lab Corp, Focus Imaging) Other providers: Other X-rays and Laboratory tests – Contracted Stand-Alone Provider (i.e. Sonora Quest, Lab Corp) Other X-rays and Laboratory tests – primary care Other X-rays and Laboratory tests – Specialist care	100% after a \$25 Copay per visit (Deductible waived) 80% after Deductible 100% after a \$15 Copay per visit (Deductible waived) 100% after a \$15 Copay per visit (Deductible waived) 100% after a \$25 Copay per visit (Deductible waived)	60% after Deductible 60% after Deductible 60% after Deductible 60% after Deductible	

Benefit Description	PPO Plan pays	Non-PPO Plan pays	Additional Limitations and Explanations
<p>Preventive Care Services</p> <p>Pediatric and Adult Preventive Care</p> <p>Immunizations, inoculations, vaccinations</p> <p>Sterilization – limited to Employee and covered Spouse only</p>	<p>100% (Deductible waived)</p> <p>100% (Deductible waived)</p> <p>100% (Deductible waived)</p>	<p>80% after Deductible</p> <p>100% after a \$20 Copay per visit (Deductible waived)</p> <p>80% after Deductible</p>	<p>Refer to benefit section for more information on Preventive Services. Includes prescription contraceptives, unless covered under the Prescription Drug Card Benefit. Cost sharing will apply to a brand name contraceptive if a generic version is available and just as effective and safe.</p>
<p>Rehabilitation and Habilitation Services</p> <p>Physical, Speech, Occupational Therapy</p> <p>All Other</p>	<p>100% after a \$30 Copay per visit (Deductible waived)</p> <p>80% after Deductible</p>	<p>60% after Deductible</p> <p>60% after Deductible</p>	<p>Physical, Occupational and Speech therapy are LIMITED to a maximum of 60 Outpatient visits per Coverage Year, combined.</p>
Skilled Nursing Facility	80% after Deductible	60% after Deductible	LIMITED to a maximum of 90 days per Coverage Year.
Therapy services – Chemotherapy, Dialysis, Radiology	80% after Deductible	60% after Deductible	
Transplants			
<p>Hospitalization</p> <p>Associated Office Visits</p>	<p>80% after Deductible</p> <p>100% after a \$15 Copay per visit (Deductible waived)</p>	<p>60% after Deductible</p> <p>60% after Deductible</p>	
All other Covered Expenses	80% after Deductible	60% after Deductible	

PRESCRIPTION DRUG CARD EXPENSE BENEFIT

NOTE: Copays may not apply to certain preventive prescription and over-the-counter medications. Contact the Prescription Drug Card Administrator for more information. Note: the brand name copay will apply to a brand name contraceptive if a generic version is available and just as effective and safe.

Prescriptions must be obtained through Magellan Rx, except in an emergency. Prior authorization is required for some prescription drugs.

Retail (30 day supply)

Formulary Generic/Diabetes syringes or lancets	\$5 Copay
Formulary Brand	\$35 Copay
Non-Formulary Brand	\$55 Copay
Diabetic insulin (2 vials) or test strips	\$25 Copay

Magellan Rx Mail Service Program (90 day supply)

Formulary Generic/Diabetes syringes or lancets	\$15 Copay
Formulary Brand	\$75 Copay
Non-Formulary Brand	\$135 Copay
Diabetic insulin (6 vials) or test strips	\$75 Copay

THE PRESCRIPTION DRUG CARD EXPENSE BENEFIT IS ADMINISTERED BY: Magellan Rx