MASTER PLAN DOCUMENT AMENDMENT #2A

Effective March 1, 2022, the Master Plan Document and Summary Plan Description for City of San Luis is hereby amended as follows:

SCHEDULE OF COVERAGE, **Amendment 1A**, is hereby deleted and replaced with Attachment A

COVERED EXPENSES, Item 20.t., page 77, is hereby deleted and replaced with the following:

t. Hearing aids (***LIMITED*** as shown in the Schedule of Coverage).

Accepted By:

Maria Sabori Benefits Trust Board Secretary 3/3/22

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 $1,500 FAMILY		**NON-PPO:**	$1,500 INDIVIDUAL $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:	$4,500 INDIVIDUAL $9,000 FAMILY		**NON-PPO:**	$20,000 INDIVIDUAL $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)**
- **Complex Imaging services: CT/PET/MRI/MRA/SPECT**
- **Outpatient surgery**
- **Hospice**
- **Home Health Care**
- **Durable Medical Equipment > $750 or when rental exceeds 4 months**
- **Inpatient Rehabilitation/Habilitation services**

FOR PRE-CERTIFICATION CALL 90 DEGREE BENEFITS 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.

This plan may provide a higher reimbursement for services received through the Exclusive Surgeries Solutions LLC (ESurgeries) Surgical Management Program (surgery and complex imaging procedures.)

Benefit Description	**PPO Plan pays**	**Non-PPO Plan pays**	**Additional Limitations and Explanations**
Acupuncture	80% after Deductible	50% 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)	50% 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	50% after Deductible	Diagnostic procedures & treatment of TMJ are ***LIMITED*** to a Lifetime maximum benefit payment of $300.
COVID-19 tests and vaccine administration	100% (Deductible waived	100% (Deductible waived	Includes testing, related services, and vaccine administration to the extent required by law.

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Benefit Description	PPO Plan pays	Non-PPO Plan pays	Additional Limitations and Explanations
Durable Medical Equipment, Prosthetics, Orthotics and Disposable Supplies	80% after Deductible	50% after Deductible	
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)	50% after Deductible	
ESurgeries Procedures	100% (Deductible waived)	Not applicable	
Hearing Aids	100% (Deductible waived	Not covered	***LIMITED*** to 1 per ear, up to a maximum payment of $1,500 in a 3 calendar year period.
Home Health Care	80% after Deductible	50% after Deductible	***LIMITED*** to a maximum of 60 visits per Coverage Year.
Hospice Care	80% after Deductible	50% 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			
ESurgeries providers	100% (Deductible waived).	Not Applicable	
All others	80% after Deductible	50% after Deductible	

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Benefit Description	PPO Plan pays	Non-PPO Plan pays	Additional Limitations and Explanations
Inpatient and Outpatient Physician Services			
Primary Care Physician Office Visits (includes lab and X-ray performed in office)	100% after a $15 Copay per visit (Deductible waived)	50% after Deductible	
Specialist Office Visits (includes lab and X-ray performed in office)	100% after a $25 Copay per visit (Deductible waived)	50% after Deductible	
Inpatient Visit	100% after a $15 Copay per visit (Deductible waived)	50% after Deductible	
Surgery (Physician's office)	100% after a $15 Copay per visit (Deductible waived)	50% after Deductible	
Surgery (other) – ESurgeries	100% (Deductible waived).	Not Applicable	
Surgery (other)	80% after Deductible	50% after Deductible	
Physician Services – Pathology, Anesthesiology , or Radiology	80% after Deductible	50% after Deductible	
Maternity			
Prenatal visits	100% (Deductible and Copays waived)	50% after Deductible	
Hospital Services	80% after Deductible	50% 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	80% after Deductible	50% after Deductible	
Outpatient treatment	100% after a $15 Copay per visit (Deductible waived)	50% after Deductible	
Outpatient Diagnostic Tests			
Complex - MRI, MRA, CT, PET, SPECT			
Through ESurgeries providers	100% (Deductible waived).	Not Applicable	
Standalone providers, including BCBS AZ	100% after a $25 Copay per visit (Deductible waived)	50% after Deductible	
Hospital	80% after Deductible	50% after Deductible	
Other X-rays and Laboratory tests			
Through ESurgeries providers	100% (Deductible waived).	Not Applicable	
Standalone providers, including BCBS AZ	100% after a $25 Copay per visit (Deductible waived)	50% after Deductible	
Hospital	80% after Deductible	50% after Deductible	
Primary care office visit	Included in office visit copay	50% after Deductible	Services provided in the physician's office are included with the applicable office visit copay. For services referred to a hospital or other facility, see above.
Specialist care office visit	Included in office visit copay	50% after Deductible	

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Benefit Description	PPO Plan pays	Non-PPO Plan pays	Additional Limitations and Explanations
Preventive Care Services Pediatric and Adult Preventive Care Immunizations, inoculations, vaccinations Sterilization – limited to Employee and covered Spouse only	 100% (Deductible waived) 100% (Deductible waived) 100% (Deductible waived)	 80% after Deductible 100% after a $20 Copay per visit (Deductible waived) 80% after Deductible	Refer to benefit section for more information on Preventive Services. Preventive Services not listed will be payable as any other covered illness, subject to applicable cost sharing. 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.
Rehabilitation and Habilitation Services Physical, Speech, Occupational Therapy All Other	 100% after a $30 Copay per visit (Deductible waived) 80% after Deductible	 50% after Deductible 50% after Deductible	Physical, Occupational and Speech therapy are ***LIMITED*** to a maximum of 60 Outpatient visits per Coverage Year, combined.
Skilled Nursing Facility	80% after Deductible	50% after Deductible	***LIMITED*** to a maximum of 90 days per Coverage Year.
Therapy services – Chemotherapy, Dialysis, Radiology	80% after Deductible	50% after Deductible	
Transplants Hospitalization Associated Office Visits	 80% after Deductible 100% after a $15 Copay per visit (Deductible waived)	 50% after Deductible 50% after Deductible	
All other Covered Expenses	80% after Deductible	50% 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