NEW BUSINESS

AGENDA ITEM 15.1

August 23, 2011

TO: Mayor and City Council

FROM: Teresia Haase, Director of Human Resources

SUBJECT: **ADOPT SUMMARY PLAN DESCRIPTION AND MONTHLY PREMIUM RATES FOR THE CITY OF STOCKTON EMPLOYEE MODIFIED MEDICAL PLAN EFFECTIVE SEPTEMBER 1, 2011**

RECOMMENDATION

It is recommended that the City Council adopt the attached resolution revising the Summary Plan Description (SPD) to incorporate legally mandated changes and implement plan design changes effective September 1, 2011.

Adopt the monthly premium rates for the City of Stockton Modified Employee Medical Plan, effective September 1, 2011

Summary

In accordance with its action plan for fiscal sustainability, the City has undertaken a comprehensive review of the self-funded medical plan with the assistance of the SEGAL Company (SEGAL), the City's contracted employee benefits plan consultant. The last time the Modified Medical Summary Plan Description was updated was in February, 2008. Since that time numerous legal changes have occurred that have been implemented but not updated in the Plan itself. In their report dated March 22, 2011, SEGAL recommended at the City's request, medical plan design changes, which will result in significant cost savings to the City and bring our health plan benefit levels more in line with the general labor market and into compliance with healthcare reform. The City as the administrator of a self funded medical plan is required to maintain a plan document which provides a description of the benefits, limitations, exclusions and other plan provisions. A new summary Plan description has been developed for the Modified Employee Medical Plan, which has been prepared by SEGAL and is submitted as Exhibit 1. These changes are necessary to improve the fiscal sustainability of the medical plan and to bring the City's medical plan into compliance with the reforms under the Affordable Care Act.

DISCUSSION

Background

The City first established a self-funded medical plan on May 1, 1988 (the Original Employee Medical Plan). Several years later, the plan was reevaluated, and plan design changes were implemented in 1993. Since then, the medical plan has remained essentially the same, with the exception of a few benefit enhancements and language revisions, which were implemented effective February 1, 2008.

The cost of the health plan benefits provided to City employees/retirees has increased significantly over the last few years due to high utilization and the escalating rate of inflation for healthcare. Given the City's current economic situation, the City needs to take action to reduce its health plan expenditures.

In order to address this issue, the City Council authorized the City Manager to enter into an agreement with SEGAL (Council Resolution No. 10-0396), to evaluate the City's current health benefit program. SEGAL is known in the benefits industry for its experience with public sector employee health benefits and retirement plans. They offer actuarial services and assistance in the development and implementation of benefit plan solutions to assist employers and union trust plans.

In their report dated March 22, 2011, SEGAL proposed an alternative medical plan design, which is anticipated to produce a substantial reduction in the City's health plan expenditures. SEGAL's report also included actuarially recommended monthly premium rates for the Modified Employee Medical Plan based upon the proposed plan design changes. Also attached as Attachment A is a summary of the monthly premium rates established by SEGAL for the Modified Medical Plan effective September 1, 2011.

Present Situation

Health benefits provided to employees are established through the collective bargaining process. Redesigning the City's self-funded medical plan is one component of the overall strategy to reduce the City's cost of doing business. The City has nine represented labor groups and one unrepresented group. City labor negotiators met with labor representatives representing the City's bargaining units on the plan design changes and the City Council has previously, in various agenda items since June 21, 2011, adopted the Plan design changes to the Modified Medical Plan either by agreement or via imposition with all groups. These medical plan design changes will also apply to all retirees who have coverage under the City's Employee Modified Medical Plan.

With federal Health Care Reform, several changes are necessary in the City's Summary Plan description in order to be in compliance with those regulations. These include appeal processes that are now mandated. Additionally other federally required changes from the past 10 years have been incorporated in the new revised Summary Plan Description.

The Human Resource Department has provided all employees and retirees a summary of the plan design changes on July 13th. They also, along with the SEGAL, held for all employees and retirees a series of four meetings on July 27th and July 28th to go over the proposed Plan design changes and answer questions related to the plan design

changes. Approximately 500 employees and retirees attended these meetings. One of these sessions was videotaped and is available on the City's Website. A Frequently Asked Question (FAQ) document has also been developed based on questions from the meetings that will be posted on the City's Website.

FINANCIAL SUMMARY

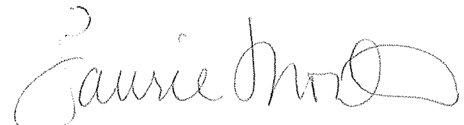
Savings from the modification of benefits is approximately $5.6 million directly to the City and has already been noted in the individual agenda items previously presented to the City Council and has already been incorporated into the City budget that was adopted on June 21, 2011. Additional savings from plan design changes are reflected in the reduced amounts employees will be required to pay for medical insurance over the City maximum contribution that otherwise would not occur.

Respectfully submitted,

TERESIA HAASE
DIRECTOR OF HUMAN RESOURCES

TH:tem

APPROVED



LAURIE MONTES
DEPUTY CITY MANAGER

Attachment A - Summary of Monthly Premium Rates

Monthly Premium Rates with Plan Changes Effective September 1, 2011

	Modified Medical Plan			**Original Plan****	
Rate Tier	Active*	Retiree Under 65	Retiree Over 65	Retiree Under 65	Retiree Over 65
Employee Only	$570.13	$896.61	$297.27	$1,636.41	$544.46
Employee+One	$1,039.19	$1,613.90	$535.09	$2,945.53	$980.03
Employee+Family	$1,381.28	$2,151.88	$713.45	$3,927.39	$1,306.72

* Active Rates include dental and vision benefits

** The Original Plan is a closed plan, covering only retirees. Enrollment is declining and these are currently 56 enrollees.

ATTACHMENT A

Resolution No. ______

STOCKTON CITY COUNCIL

RESOLUTION BY THE CITY COUNCIL OF THE CITY OF STOCKTON ADOPTING THE SUMMARY PLAN DESCRIPTION AND MONTHLY PREMIUM RATES FOR THE CITY OF STOCKTON EMPLOYEE MODIFIED MEDICAL PLAN EFFECTIVE SEPTEMBER 1, 2011

The City of Stockton (City) has undertaken a comprehensive review of the self-funded medical plan with the assistance of the SEGAL Company, the City's contracted employee benefits plan consultant; and

Due to the current economic situation, the City must reduce the costs of the medical plans offered to employees and retirees through better medical plan management and plan design changes; and

The City is required to maintain a plan document which provides a description of the benefits, limitations, exclusions, and other plan provisions that apply to the Modified Employee Medical Plan; and

The City is required to effectuate plan design changes in compliance with the Affordable Healthcare Act of 2010; and

The City has either reached agreement on or imposed the plan design changes with all bargaining units by previous actions taken on June 21, 2011, July 26, 2011, and August 9, 2011; now, therefore,

BE IT RESOLVED BY THE CITY COUNCIL OF THE CITY OF STOCKTON, AS FOLLOWS:

1. The Modified Employee Medical Plan Summary Plan Document/Summary Plan Description is adopted effective September 1, 2011, a copy of which is attached as Exhibit 1 and incorporated by this reference. This Summary Plan Description supersedes any previous amendments thereto as well as any previous benefit policy memorandum issues and is incorporated by reference into this resolution.

2. The actuarially established premium rates for the Modified Employee Medical Plan, effective September 1, 2011, are incorporated by reference into the resolution and adopted.

City Atty
Review GDP
Date August 16, 2011

3. The City Manager is hereby authorized to take steps that are appropriate to carry out the purpose and intent of this resolution.

PASSED, APPROVED, and ADOPTED ______ August 23, 2011 ________.

____
ANN JOHNSTON, Mayor
of the City of Stockton

ATTEST:

____
BONNIE PAIGE, City Clerk
of the City of Stockton

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City of Stockton

Modified Employee

Medical Plan Document/Summary Plan Description

Restated September 1, 2011

EXHIBIT 1

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INTRODUCTION

This Plan Document/Summary Plan Description provides a description of benefits, limitations, exclusions and other plan provisions that apply to the City of Stockton's Modified Employee Medical Plan as of September 1, 2011. This document replaces and supersedes all other Plan Documents/Summary Plan Descriptions and amendments thereto issued prior to that date.

You should review this document and share it with those members of your family who are or will be covered by the Plan. It will give all of you an understanding of the coverage provided; the procedures to follow in submitting claims; and your responsibilities to provide necessary information to the Plan.

While recognizing the many benefits associated with this Plan, it is also important to note that not every expense you incur for health care is covered by this Plan.

IMPORTANT NOTICE

You or another family member must promptly furnish to the City information regarding change of name, address, marriage, divorce or legal separation, death of any covered Family Member, change in Domestic Partnership status, change in status of a Family Member, Medicare enrollment or disenrollment or the existence of other coverage.

Notify the City's Human Resources Department – Benefits Section in writing no later than 31 days after any of the above noted events. Failure to do so may cause you or a Family Member to lose certain rights under the Plan or may result in your liability to the Plan if any benefits are paid to an ineligible person.

FOR HELP OR INFORMATION

When you need information, please check this document first. If you need further help, call the people listed in the following Quick Reference Chart.

QUICK REFERENCE CHART

Information Needed	Whom to Contact
Plan Administrator • Claim Forms (Medical) • Modified Medical Plan Claims and Appeals • Eligibility for Coverage • Modified Medical Plan Benefit Information • HIPAA Certificate of Creditable Coverage • Medicare Part D Notice of Creditable Coverage • COBRA Information and Enrollment Forms	Delta Health Systems P.O. Box 80 Stockton, CA 95201-3080 (800) 291-0726 www.deltahealthsystems.com
• **City's Human Resources Department – Benefits Section** • Enroll or cancel dependent(s) • Problems with eligibility • Submit Change of Address • Obtain copy of Summary Plan Description • Information on premium contributions	City of Stockton Human Resources Department – Benefits Section 22 East Weber Avenue, Suite 150 Stockton, CA 95202-2317 (209) 937-8233 or 937-8622 http://www.stocktongov.com
PPO Network • Medical Network Provider Directory • Additions/Deletions of Network Providers • (Always check with the Network before you visit a provider to be sure they are still contracted and will give you the discounted price)	Anthem Blue Cross P.O. Box 60007 Los Angeles, CA 90060-0007 (800) 274-7767 www.anthem.com/ca **CAUTION:** Use of a **Non**-Participating Provider could result in you having to pay a substantial balance on the provider's billing. Your lowest out of pocket costs will occur when you use Participating Providers.
Utilization Management (UM) Program • Precertification of Admissions and Medical Services • Second and Third Opinions • Case Management • Appeals of UM decisions	Delta Health Systems P.O. Box 80 Stockton, CA 95201-3080 (800) 291-0726 www.deltahealthsystems.com
Prescription Drug Plan • ID Cards • Retail Network Pharmacies • Mail Order (Home Delivery) Pharmacy • Prescription Drug Information • Formulary of Preferred Drugs • Precertification of Certain Drugs	Medco P.O. Box 14711 Lexington, KY 40512 (800) 711-0917 www.medco.com
Employee Assistance Program (EAP) Professional, confidential information, support and referral to help individuals cope with personal problems that impact their home and work life. EAP counselors can help you with stress, marriage/family/work-related problems, substance abuse, financial and legal problems.	Integrated Behavioral Health 3070 Bristol Street, Suite 350, Costa Mesa, CA 92626 (800) 395-1616 www.ihbcorp.com

OVERVIEW OF THE CITY OF STOCKTON'S MODIFIED MEDICAL PLAN AS OF SEPTEMBER 1, 2011

The following is an overview of the City's Modified Medical Plan provided to eligible active and retired Employees and their eligible Family Members. Since this is only a summary of the benefits, you should refer to the Articles of this document for a more complete description of Plan benefits, limitations and exclusions.

Note: Capitalized terms used in this document have a very precise meaning (for example, "Medically Necessary", "Emergency" and "Allowable Charges"). To be sure you understand the meaning of capitalized terms, please refer to the Definitions contained in Article 1.

Plan Feature	Coverage Amount	
	When Provided by a Participating Provider	**When Provided by a Non-Participating Provider**
Calendar year deductible *(only Allowable Charges for Covered Services in Article 3 of this document can be applied toward the deductible)*	$500 per person; $1,500 maximum per family *(for example: the family deductible is met if 5 Family Members each have $300 applied toward their individual deductibles)*	$1,500 per person; $3,000 maximum per family *(for example: the family deductible is met if 5 Family Members each have $600 applied toward their individual deductibles)*
Calendar year out-of-pocket maximum on Allowable Charges *(only Allowable Charges for Covered Services in Article 3 of this document can be applied toward the out-of-pocket maximum))*	$5,000 per person; $10,000 maximum per family	None
Overall lifetime maximum benefit	None	None
Hospital		
Inpatient confinement	80% of Allowable Charges after a copayment of $75 per admission	50% of Allowable Charges after a copayment of $200 per admission
Outpatient department	80% of Allowable Charges	50% of Allowable Charges
Emergency room	80% of Allowable Charges; 50% of Allowable Charges if it is determined that an Emergency did not exist (refer to Article 1 for the Plan's definition of Emergency)	80% of Allowable Charges; 50% of Allowable Charges if it is determined that an Emergency did not exist (refer to Article 1 for the Plan's definition of Emergency)
Skilled Nursing Facility	80% of Allowable Charges after a copayment of $75 per admission	50% of Allowable Charges after a copayment of $200 per admission

Plan Feature	Coverage Amount	
	When Provided by a Participating Provider	**When Provided by a Non-Participating Provider**
Outpatient therapy *(physical, respiratory, cardiac & speech)*	80% of Allowable Charges	50% of Allowable Charges
Home health care	80% of Allowable Charges	Not covered
Hospice care	80% of Allowable Charges	Not covered
Mental or nervous disorder		
Inpatient confinement	80% of Allowable Charges after a copayment of $75 per admission	50% of Allowable Charges after a copayment of $200 per admission
Outpatient services	80% of Allowable Charges	50% of Allowable Charges
Substance abuse treatment *(Retired Employees and their Family Members are NOT covered for these benefits)*		
Inpatient confinement	80% of Allowable Charges after a copayment of $75 per admission	50% of Allowable Charges after a copayment of $200 per admission
Outpatient services	80% of Allowable Charges	50% of Allowable Charges
Outpatient diagnostic radiology & laboratory	80% of Allowable Charges	50% of Allowable Charges
Radiation therapy, chemotherapy & dialysis treatment	80% of Allowable Charges	50% of Allowable Charges
Physician services		
Office & hospital visits	80% of Allowable Charges	50% of Allowable Charges
Emergency room care	80% of Allowable Charges; 50% of Allowable Charges if it is determined that an Emergency did not exist (refer to Article 1 for the Plan's definition of Emergency)	80% of Allowable Charges; 50% of Allowable Charges if it is determined that an Emergency did not exist (refer to Article 1 for the Plan's definition of Emergency)
Surgery	80% of Allowable Charges	50% of Allowable Charges
Anesthesia and its administration	80% of Allowable Charges	50% of Allowable Charges
Preventive Care *(physical exam, screenings, tests & immunizations as recommended by certain government agencies – refer to the definition of Preventive Care Services in Article 1)*	Not subject to the calendar year deductible; 100% of Allowable Charges	Calendar year deductible applies; 50% of Allowable Charges
Dental treatment	Not covered except 80% of	Not covered except for 50%

Plan Feature	Coverage Amount	
	When Provided by a Participating Provider	**When Provided by a Non-Participating Provider**
	Allowable Charges for treatment of Accidental Injury to natural teeth	of Allowable Charges for treatment of Accidental Injury to natural teeth
Chiropractic services	80% of Allowable Charges	50% of Allowable Charges
Pregnancy & childbirth *(dependent children are not covered by this benefit)*	Covered on the same basis as an illness	Covered on the same basis as an illness
Infertility	80% of Allowable Charges	50% of Allowable Charges
Organ & tissue transplants	Payable on the same basis as any other illness	Payable on the same basis as any other illness
Ambulance service	80% of Allowable Charges	50% of Allowable Charges
Prosthetics & orthotics	80% of Allowable Charges	50% of Allowable Charges
Durable medical equipment	80% of Allowable Charges	50% of Allowable Charges
Hearing aids	No Coverage	No Coverage
Prescription Drug Program ***(no calendar year deductible applies)***	**When Dispensed at a Participating Pharmacy**	**When Dispensed at a Non-Participating Pharmacy**
Retail pharmacy *(30 day supply limit)*	$10 copayment for a generic drug; $35 copayment for a non-generic formulary drug; no coverage for non-formulary drugs	Not covered
Mail service pharmacy *(90 day supply limit)* Mandatory Mail Order for Maintenance Medications	$20 copayment for a generic drug; $70 copayment for a non-generic formulary drug; no coverage for non-formulary drugs	Not covered

Refer to Articles 3 and 4 on how to file a claim, and Article 7 on how to appeal a claim if it has been denied in whole or in part.

ARTICLE 1. DEFINITIONS

The following definitions apply to the terms used in this document.

Section 1.01 The term "**Accidental Injury**" means physical harm or disability which is the result of a specific unexpected incident. The physical harm or disability must have occurred at an identifiable time and place.

Section 1.02 The term "**Active Employee**" means any person who meets the eligibility rules in Section 2.01 A.1.

Section 1.03 The term "**Administrator**" means the organization contracting with the City to perform certain administrative duties with regard to the Plan.

Section 1.04 The term "**Allowed Charge(s)**" means:

A. For charges made by Participating Providers – Allowable Charge is the lesser of the billed charge or the contracted fee agreed upon by the Plan's Preferred Provider Organization and the Participating Provider for the Covered Service.

B. For charges made by Non-Participating Providers – Allowable Charge is the lesser of the billed charge or applicable amount in the schedule that lists the dollar amounts the Plan has determined it will allow for eligible Medically Necessary services or supplies performed by Non-Participating Providers. The Plan's allowed charge amount list is not based on or intended to be reflective of fees that are or may be described as usual and customary (U&C), reasonable and customary (R&C), usual, customary and reasonable charge (UCR), prevailing or any similar term. The Plan reserves the right to have the billed amount of a claim reviewed by an independent medical review firm/provider to assist in determining the amount the Plan will allow for the submitted claim.

With respect to Hospital emergency room services in a Non-Participating Hospital, the Allowable Charge is the greater of:

1. the negotiated median amount for Participating Provider Hospitals, or
2. 100% of the Plan's usual payment (Allowed Charge) formula (reduced for cost-sharing), or
3. When such database is available, the amount that Medicare Parts A or B would pay (reduced for cost-sharing).

All charges in excess of Allowable Charges are not covered by the Plan.

Section 1.05 The term "**Ambulatory Surgical Facility/Center**" means a specialized facility that is established, equipped, operated and staffed primarily for the purpose of performing surgical procedures and which fully meets one of the following two tests:

A. It is licensed as an Ambulatory Surgical Facility/Center by the regulatory authority responsible for the licensing under the laws of the jurisdiction in which it is located; or

B. Where licensing is not required, it meets all of the following requirements:
1. It is operated under the supervision of a licensed Physician (M.D. or D.O.) who is devoting full time to supervision and permits a surgical procedure to be performed only by a duly qualified Physician who, at the time the procedure is performed, is privileged to perform the procedure in at least one Hospital in the area.
2. It requires in all cases, except those requiring only local infiltration anesthetics, that a licensed anesthesiologist administer the anesthetic or supervise an anesthetist who is administering the anesthetic, and that the anesthesiologist or anesthetist remain present throughout the surgical procedure.
3. It provides at least one operating room and at least one post-anesthesia recovery room.
4. It is equipped to perform diagnostic x-ray and laboratory examinations or has an arrangement to obtain these services.
5. It has trained personnel and necessary equipment to handle emergency situations.
6. It has immediate access to a blood bank or blood supplies.
7. It provides the full-time services of one or more registered nurses (RNs) for patient care in the operating rooms and in the post-anesthesia recovery room.
8. It maintains an adequate medical record for each patient, which contains an admitting diagnosis (including, for all patients except those undergoing a procedure under local anesthesia, a preoperative examination report, medical history and laboratory tests and/or x-rays), an operative report and a discharge summary.

An Ambulatory Surgical Facility/Center that is part of a Hospital, as defined in this Article, will be considered an Ambulatory Surgical Facility/Center for the purposes of this Plan.

Section 1.06 The term "Birthing Center" means a specialized facility that is primarily a place for delivery of children following a normal uncomplicated pregnancy and which fully meets one of the two following tests:

A. It is licensed by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or

B. Where licensing is not required, it meets all of the following requirements:
1. It is operated and equipped in accordance with any applicable state law for the purpose of providing prenatal care, delivery, immediate post partum care, and care of a child born at the center.
2. It is equipped to perform routine diagnostic and laboratory examinations, including but not limited to hematocrit and urinalysis for glucose, protein, bacteria and specific gravity, and diagnostic x-rays, or has an arrangement to obtain those services.
3. It has available to handle foreseeable emergencies, trained personnel and necessary equipment, including but not limited to oxygen, positive pressure mask, suction, intravenous equipment, equipment for maintaining infant temperature and ventilation, and blood expanders.
4. It provides at least two beds or two birthing rooms.
5. It is operated under the full-time supervision of a licensed Physician (M.D. or D.O.)or Registered Nurse (R.N.).
6. It has a written agreement with at least one Hospital in the area for immediate acceptance of patients who develop complications.
7. It has trained personnel and necessary equipment to handle emergency situations.
8. It has immediate access to a blood bank or blood supplies.

9. It has the capacity to administer local anesthetic and to perform minor Surgery.
10. It maintains an adequate medical record for each patient that contains prenatal history, prenatal examination, any laboratory or diagnostic tests and a post partum summary.
11. It is expected to discharge or transfer patients within 48 hours following delivery; and
12. Is accredited by the American Association of Birth Centers (AABC).

Section 1.07 The term "**Calendar Year**" means January 1 to December 31 of any given year.

Section 1.08 The term "**Case Management Program**" means a program which coordinates a variety of medical care services needed by a Member with a catastrophic illness or injury or a long-term chronic, high dollar condition.

Section 1.09 The term "**Child**" means a natural child, a legally adopted child or child placed for adoption of either the Employee or the Spouse/Registered Partner. To be eligible for coverage, the Child must be under the age of 26 with the following exception. A covered unmarried dependent Child who is incapable of self-sustaining employment by reason of mental or physical disability and who is chiefly dependent upon the Employee for support, can remain covered beyond age 26 provided that written proof by a Physician of such incapacity and dependency is provided to the City's Human Resources Department within 31 days of the date the Child reached age 26. Proof of continuing dependency and disability may be required at periodic intervals as requested by the Administrator.

Section 1.10 The term "**City**" means the City of Stockton.

Section 1.11 The term "**Consolidated Omnibus Budget Reconciliation Act" (COBRA)** refers to the federal law that requires group health plans to offer a temporary extension of health coverage at group rates in certain instances when coverage would otherwise end.

Section 1.12 The term "**Cosmetic Treatment**" means surgery or medical treatment to improve or preserve physical appearance, but not physical function. Cosmetic Treatment includes, but is not limited to, removal of tattoos, breast augmentation, or other medical/surgical treatment, prescription drugs and dental treatment intended to restore or improve physical appearance, as determined by the Plan Administrator or its designee.

Section 1.13 The term "**Covered Service(s)**" means the services and supplies as specified in Article 3, Section 3.06, which are certified by the attending Physician and determined by the Plan to be Medically Necessary.

Section 1.14 The term "**Custodial Care**" means care and services given mainly for personal hygiene or to perform the activities of daily living. Some examples of Custodial Care are helping patients get in and out of bed, bathe, dress, eat, use the toilet, prepare food, walk (ambulate), or take drugs or medicines that can be self-administered. These services are Custodial Care regardless of where the care is given or who recommends, provides, or directs the care. Custodial Care can be given safely and adequately (in terms of generally accepted medical standards) by people who are not trained or licensed medical or nursing personnel. Custodial Care may be payable by this Plan under certain circumstances such as when Custodial Care is provided during a covered period of hospice care.

Section 1.15 The term "**Day Care Center**" means an outpatient psychiatric facility which is part of or affiliated with a Hospital. It must be licensed according to state and local laws to provide outpatient care and treatment of Mental and Nervous Disorders under the supervision of a psychiatrist.

Section 1.16 The term **"Emergency**" means a sudden unexpected onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or in the case of a pregnant woman, the health of her unborn child) in serious jeopardy, serious impairment to bodily functions or serious dysfunction/impairment of any bodily organ or part. For psychiatric conditions, the lack of the treatment could reasonably be expected to result in the patient harming himself or herself and/or other persons.

Section 1.17 The term "**Employee**" means each eligible Active Employee or each Retired Employee.

Section 1.18 The term "**Employee Assistance Program" (EAP)** means a program provided through an organization which has entered into an agreement with the City to provide mental health services for assessment, counseling, or referral to Active Employees and their eligible Family Members.

Section 1.19 The term "**Experimental" and/or "Investigational"** means if, in the opinion of the Plan Administrator or its designee, based on the information and resources available at the time the service was performed or the supply was provided, any of the following conditions were present with respect to one or more essential provisions of the service or supply:

A. The service or supply is described as an alternative to more conventional therapies in the protocols (the plan for the course of medical treatment that is under investigation) or consent document (the consent form signed by or on behalf of the patient) of the health care provider that performs the service or prescribes the supply.

B. The prescribed service or supply may be given only with the approval of an Institutional Review Board as defined by federal law.

C. In the opinion of the Plan Administrator or its designee, there is either an absence of authoritative medical, dental or scientific literature on the subject, or a preponderance of such literature published in the United States; and written by experts in the field; that shows that recognized medical, dental or scientific experts: classify the service or supply as experimental and/or investigational; or indicate that more research is required before the service or supply could be classified as equally or more effective than conventional therapies.

D. With respect to services or supplies regulated by the US Food and Drug Administration (FDA), FDA approval is required in order for the service and supply to be lawfully marketed; and it has not been granted at the time the service or supply is prescribed or provided; or a

current investigational new drug or new device application has been submitted and filed with the FDA.

E. In determining if a service or supply is or should be classified as Experimental and/or Investigational, the Plan Administrator or its designee will rely only on the following specific information and resources that are available at the time the service or supply was performed, provided or considered:

1. Medical or dental records of the covered person;
2. The consent document signed, or required to be signed, in order to receive the prescribed service or supply;
3. Protocols of the Physician that renders the prescribed service or prescribes or dispenses the supply;
4. Authoritative peer reviewed medical or scientific writings that are published in the United States regarding the prescribed service or supply for the treatment of the covered person's diagnosis, including, but not limited to "United States Pharmacopeia Dispensing Information"; and "American Hospital Formulary Service";
5. The published opinions of: the American Medical Association (AMA) or specialty organizations recognized by the AMA; or the National Institutes of Health (NIH); or the Center for Disease Control (CDC); or the Office of Technology Assessment; or the published screening criteria of national insurance companies such as Aetna and CIGNA, or Milliman Care Guidelines or, the American Dental Association (ADA), with respect to dental services or supplies;
6. Federal laws or final regulations that are issued by or applied to the FDA or Department of Health and Human Services regarding the prescribed service or supply;
7. The latest edition of "The Medicare National Coverage Determinations Manual."

Section 1.20 The term **"Family"** means all enrolled Members of the same family unit.

Section 1.21 The term "**Family Member**" means each enrolled Child or other person eligible and enrolled by virtue of a relationship with the Employee (e.g. a child for whom the Employee is legal guardian) .

Section 1.22 The term "**Home Health Agencies**" and "**Visiting Nurse Associations**" are home health care providers which are licensed according to state and local laws to provide skilled nursing, hospice care and other services on a visiting basis in the Member's home. They must be recognized as home health care providers under Medicare.

Section 1.23 The term "**Hospital**" means a medical care facility which provides diagnosis, treatment, and care of persons who need acute inpatient Hospital care under the supervision of Physicians, and to which a Member is admitted pursuant to arrangements made by a Physician. It must be licensed as a general acute care hospital according to state and local laws and meet the accreditation standards of the Joint Commission on Accreditation of Hospitals.

Section 1.24 The term "**Incurred**" means the date a service or supply given rise to a charge is rendered or obtained. A Hospital or Skilled Nursing Facility confinement will be considered Incurred on the date of admission.

Section 1.25 The term "**Medically Necessary**" means a medical or dental service or supply if it meets the following requirements as determined by the Plan Administrator or its designee:

A. is provided by or under the direction of a Physician who is authorized to provide or prescribe it; and

B. is determined by the Plan Administrator or its designee to be necessary in terms of generally accepted American medical and dental standards; and

C. is determined by the Plan Administrator or its designee to meet all of the following requirements:

1. It is consistent with the symptoms or diagnosis and treatment of an illness or injury; and
2. It is not provided solely for the convenience of the patient, Physician, Hospital or other person or entity; and
3. It is an "Appropriate" service or supply given the patient's circumstances and condition; and
4. It is a "Cost-Efficient" supply or level of service that can be safely provided to the patient; and
5. It is safe and effective for the illness or injury for which it is used.

D. A medical or dental service or supply will be considered to be "Appropriate" if:

1. It is a diagnostic procedure that is called for by the health status of the patient, and is as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both with respect to the illness or injury involved and the patient's overall health condition.
2. It is care or treatment that is as likely to produce a significant positive outcome as and no more likely to produce a negative outcome than any alternative service or supply, both with respect to the illness or injury involved and the patient's overall health condition.

E. A medical or dental service or supply will be considered to be "Cost-Efficient" if it is no more costly than any alternative appropriate service or supply when considered in relation to all health care expenses incurred in connection with the service or supply.

F. The fact that your Physician may provide, order, recommend or approve a service or supply does not mean that the service or supply will be considered to be Medically Necessary for the medical or dental coverage provided by the Plan.

G. A Hospitalization or confinement to a facility will not be considered to be Medically Necessary if the patient's illness or injury could safely and appropriately be diagnosed or treated while not confined.

H. A medical or dental service or supply that can safely and appropriately be furnished in a Physician's office or other less costly facility will not be considered to be Medically Necessary if it is furnished in a Hospital or other more costly facility.

I. The non-availability of a bed in another facility, or the non-availability of a health care practitioner to provide medical services will not result in a determination that continued confinement in a Hospital or other facility is Medically Necessary.

J. A medical or dental service or supply will not be considered to be Medically Necessary if it does not require the technical skills of a Physician or if it is furnished mainly for the personal comfort or convenience of the patient, the patient's family, any person who cares for the patient, any health care practitioner, Hospital or other facility.

Section 1.26 The term "**Member**" means each Employee, Spouse or Domestic Partner and each enrolled Child or other person eligible and enrolled by virtue of a relationship with the Employee (e.g. a child for whom the Employee is legal guardian) .

Section 1.27 The term "**Mental, Nervous, and Substance Abuse Disorders**" are those conditions, including drug or alcohol dependence, which are listed in the International Classification of Diseases as diagnostic codes 290 to and including 319. One or more of these conditions may be specifically excluded in the Plan.

Section 1.28 The term "**Non-Participating Provider**" (Out-of-Network) means a Hospital, Physician, pharmacy, laboratory, or other provider which does not have an agreement in effect with the City under the Preferred Provider Organization at the time its services are rendered.

Section 1.29 The term "Participating Provider" (In-Network) means a Hospital, Physician, pharmacy, laboratory, or other provider which has an agreement in effect with the City under the Preferred Provider Organization and which is applicable to this Plan at the time that the provider provides services covered under this Plan.

Section 1.30 The term "**Physician**" means:

A. A doctor of Medicine (M.D.) or a doctor of Osteopathy (D.O.) who is licensed to practice medicine in the state in which care is provided, or

B. One of the following providers, but only when the provider is licensed to practice where the care is provided, is rendering a service within the scope of that license and is providing a service for which benefits are specified in this Plan; and when benefits would be payable if the services were provided by a Physician as defined in A. above:

1. Dentist (D.D.S.)
2. Podiatrist or Chiropodist (D.P.M., D.S.P., or D.S.C.)
3. Chiropractor (D.C.)
4. Psychologist
5. Clinical Social Worker (C.S.W. or L.C.S.W.)
6. Marriage, Family and Child Counselor (M.F.C.C.)
7. Mental Health Nurse
8. Physical Therapist (P.T. or R.P.T.)

9. Speech Pathologist
10. Occupational Therapist (O.T.R.)*
11. Optometrist
12. Dispensing Optician
13. Respiratory Therapist*
14. Acupuncturist

Note: The providers indicated by one asterisk (*) are covered only by referral of a Physician as defined in A. above.

Section 1.31 The term "**Plan**" means the medical plan provided through the City of Stockton, also known as the "Modified Employee Medical Plan."

Section 1.32 The term "**Preferred Provider Organization**" means a program whereby Hospitals, Physicians, pharmacies, laboratories, and other providers contract with an organization which has a contract with the City to provide necessary hospitalization and medical services to Family Members payable on the basis of a negotiated rate, approved by the City and amended from time to time.

Section 1.33 The term **"Preventive Care Services"** mean services with an "A" or "B" rating from the U.S. Preventive Services Task Force (USPSTF), immunizations recommended by the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices (ACIP), and with respect to infants, children, and adolescents, and women, additional preventive care and screenings provided for in guidelines supported by the Health Resources and Services Administration (HRSA). An office visit to a Physician shall be considered a Preventive Care Service if the primary purpose for the visit is the delivery of a Preventive Care Service and no separate charge is made for the Preventive Care Service provided during the visit.

Section 1.34 The term "**Psychiatric Health Facility**" means a health facility which provides 24-hour inpatient care for mentally disordered, incompetent, or other persons as described in Division 5 (commencing with Section 5000) or Division 6 (commencing with section 6000) of the Welfare and Institutions Code or Department of Health Services.

Section 1.35 The term "**Registered Domestic Partner**" refers to the Employee's partner of the same sex. This term can also refer to the Employee's partner of the opposite sex if one or both are over the age of 62, and have filed a Declaration of Domestic Partnership (in accordance with Family Code Section 298), with the California Secretary of State.

Section 1.36 The term "**Retired Employee**" means any person who meets the eligibility rules in Section 2.01 A.2.

Section 1.37 The term "**Skilled Nursing Facility**" means a public or private facility, licensed and operated according to law, that primarily provides skilled nursing and related services to people who require medical or nursing care and that rehabilitates injured, disabled or sick people, and that meets all of the following requirements:

A. It is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as a Skilled Nursing Facility or is recognized by Medicare as a Skilled Nursing Facility; and

B. It is regularly engaged in providing room and board and continuously provides 24 hour-a-day Skilled Nursing Care of sick and injured persons at the patient's expense during the convalescent stage of an Injury or Illness, maintains on its premises all facilities necessary for medical care and treatment, and is authorized to administer medication to patients on the order of a licensed Physician (M.D. or D.O.); and

C. It provides services under the supervision of Physicians (M.D. or D.O.); and

D. It provides nursing services by or under the supervision of a licensed Registered Nurse (RN), with one licensed Registered Nurse on duty at all times; and

E. It maintains a daily medical record of each patient who is under the care of a licensed Physician (M.D.or D.O.); and

F. It is not (other than incidentally) a home for maternity care, rest, domiciliary (non-skilled/custodial) care, or care of people who are aged, alcoholic, blind, deaf, drug addicts, mentally deficient, mentally ill; and

G. It is not a hotel or motel.

A Skilled Nursing Facility that is part of a Hospital, as defined in this document, will be considered a Skilled Nursing Facility for the purposes of this Plan.

Section 1.38 The term "**Special Care Units**" means special areas of a Hospital which have highly skilled personnel and special equipment for acute conditions that require special treatment and observation.

Section 1.39 The term "**Spouse**" means the Employee's spouse under a legally valid marriage between the Employee and a person of the opposite sex.

Section 1.40 The term "**Substance Abuse Treatment Center**" means a facility licensed by the state in which it practices as a Chemical Dependency Recovery Hospital. The term shall also include a center for the treatment of alcoholism, drug addiction or drug abuse which is licensed by the proper governmental authority to provide detoxification, counseling and rehabilitative services.

Section 1.41 The term "**Totally Disabled Active Employee**" means an Active Employee who, because of illness or injury, is unable to work for income in any job for which he or she is qualified or for which he or she can reasonably become qualified by training or experience, and who is in fact unemployed.

Section 1.42 The term "**Totally Disabled Family Member**" means a Family Member other than an Active Employee who is unable to perform all the activities usual for a person of that age.

Section 1.43 The term "**Utilization Review Organization" (URO)** means an organization, under contract with the City, which is responsible for administering the Plan's utilization review program as described in Article III of this document.

ARTICLE 2. ELIGIBILITY FOR BENEFITS

Section 2.01 Eligibility Rules for Employees and their Family Members

A. Eligible Employees

The following persons are eligible for enrollment as Employees in the Plan:
1. Active Employees

Full-time employees and eligible regular part-time employees of the City, some elected officials, or individuals who occupy a position which, according to the Memorandum of Understanding, management compensation plan, or other employment/contract, is entitled to benefits.

2. Retired Employees

Retired employees of the City who are entitled to benefits for a period of time, according to the provisions of the Memorandum of Understanding in effect at the time of their retirement. Retired employees eligible for Medicare are required to enroll in Medicare Parts A and B.

B. Eligible Family Members

The following persons may be enrolled as eligible Family Members of the Employee:

1. The Employee's Spouse, or
2. The Employee's Registered Domestic Partner.
3. Child of the Employee or the Spouse or Registered Domestic Partner of the Employee.

   A child is "Placed for Adoption" with you on the date you first become legally obligated to provide full or partial support of the child whom you plan to adopt.

   Disabled Child(ren). A covered unmarried dependent Child who is incapable of self-sustaining employment by reason of mental or physical disability and who is chiefly dependent upon the Employee for support, can remain covered beyond age 26 provided that written proof by a Physician of such incapacity and dependency is provided to the City of Stockton Human Resources Department within 31 days of the date the Child reached age 26. Proof of continuing dependency and disability may be required periodically as requested by the Administrator.

4. Legal Guardianship. The Plan will cover a minor child as a dependent on the Plan, who does not meet the definition of Child, until he/she reaches age 18, provided the following conditions are met:
   a. A Legal Guardian Statement form is completed and submitted certifying the minor child is under the legal guardianship of the Employee.
   b. A copy of the Letter of Guardianship is provided to the Plan.
   c. The minor child must reside with the Employee full-time.

d. The minor child must be claimed as a dependent on the Employee's Income Taxes. (A copy of the first page of the tax return reflecting the minor child as a dependent shall be required annually.)
e. The minor child must be enrolled in the Medi-Cal program. A copy of the minor child's Medi-Cal identification card must be provided to the Plan.

5. Qualified Medical Child Support Orders (QMCSOs).

This Plan will provide benefits to a child named as an "alternate recipient" under a Qualified Medical Child Support Order (QMCSO). In this document the term QMCSO is used and includes compliance with a National Medical Support Notice. According to federal law, a Qualified Medical Child Support Order is a judgment, decree or order (issued by a court or resulting from a state's administrative proceeding) that creates or recognizes the rights of a child, also called the "alternate recipient," to receive benefits under a group health plan, typically the non-custodial parent's plan. The QMCSO typically requires that the plan recognize the child as a dependent even though the child may not meet the plan's definition of dependent. A QMCSO usually results from a divorce or legal separation and typically:

a. Designates one parent to pay for a child's health plan coverage;
b. Indicates the name and last known address of the parent required to pay for the coverage and the name and mailing address of each child covered by the QMCSO;
c. Contains a reasonable description of the type of coverage to be provided under the designated parent's health care Plan or the manner in which such type of coverage is to be determined;
d. States the period for which the QMCSO applies; and
e. Identifies each health care plan to which the QMCSO applies.

An order is not a QMCSO if it requires the Plan to provide any type or form of benefit or any option that the Plan does not otherwise provide, or if it requires an employee who is not covered by the Plan to provide coverage for a dependent child, except as required by a state's Medicaid-related child support laws. For a state administrative agency order to be a QMCSO, state statutory law must provide that such an order will have the force and effect of law, and the order must be issued through an administrative process established by state law.

If a court or state administrative agency has issued an order with respect to health care coverage for any dependent child of the Employee, the Plan Administrator or its designee will determine if that order is a QMCSO as defined by federal law. That determination will be binding on the Employee, the other parent, the child, and any other party acting on behalf of the child. The Plan Administrator or its designee will notify the parents and each child if an order is determined to be a QMCSO and, if the Employee is covered by the Plan, advise them of the procedures to be followed to provide coverage of the dependent child(ren).

If the Employee is a Plan participant, the QMCSO may require the Plan to provide coverage for the Employee's dependent child(ren) and to accept contributions for that coverage from a parent who is not a Plan participant. The Plan will accept special enrollment of the dependent child(ren) specified by the QMCSO from either the Employee or the custodial parent. Coverage of the dependent child(ren) will become effective as of the date the enrollment is received by the Plan and will be subject to all terms and provisions of the Plan.

No coverage will be provided for any dependent child under a QMCSO unless the applicable Employee contributions for that dependent child's coverage, if any, are paid and all of the Plan's requirements for coverage of that dependent child have been satisfied.

Coverage of a dependent child under a QMCSO will terminate when coverage of the Employee-parent terminates for any reason, including failure to pay any required

contributions, subject to the dependent child's right to elect COBRA continuation coverage, if that right applies.

<u>Note regarding Imputed Income</u>

Please note that if you add a child for coverage, and the child does not qualify as a tax dependent under IRC § 152 or where a state law definition of a dependent does not match with the federal law definition of a dependent, the City must include in your gross income the fair market value of the coverage provided to the adult child. This is known as "imputed income." This will likely increase both the employee's taxable income and tax liability.

C. Application for Enrollment

Employees must file a written application with the City Human Resources Department – Benefits Section, within 31 days of becoming eligible for coverage hereunder and as to Family Members, within 31 days of marriage or the acquiring or birth of a Child.

Refer to Article 9 for Special Enrollment rights that may apply if you do not enroll within 31 days of becoming eligible.

D. Effective Date of Coverage

After the Employee has met the provisions of sub-section 2.01 C. of this Article 2, and if payment of any required premiums to the City have been made, coverage shall commence as follows:

1. For a Member enrolled on the Effective Date of this Plan, coverage shall commence as of the Effective Date of this Plan.

2. For an Active Employee enrolled subsequent to the Effective Date, coverage shall commence on the first day of the month following 30 days active employment. The 30 day waiting period is waived for Active Employees who reinstate within 6 months from the date of termination.

3. For a Retired Employee, the first day of the month following the date of retirement.

4. For a Family Member, other than a newborn Child, who becomes eligible after the Employee has been enrolled, coverage shall commence on the first day of the following month, provided written application for the addition of such Family Member is filed with the City's Human Resources Department – Benefits Section, and any required premiums are paid within 31 days of marriage or the acquiring of the Child.

5. For a Child born while the Employee is covered hereunder, coverage shall commence from the date of birth, provided written application for the addition of such Child is filed with the City's Human Resources Department – Benefits Section, and any required premiums are paid within 31 days of the date of birth.

E. Termination of Eligibility

A Member's eligibility will terminate on the first day of the month following any of the following events:

1. Failure of the Employee or Family Member to meet the Plan's eligibility requirements.

2. Failure of the Employee to pay any required premiums on or before the due date for such payment.

3. Date of separation from employment, unless the Employee is eligible for retiree medical benefits per the Memorandum of Understanding in effect at the time of their retirement.

If an Employee fails to notify the Plan that a Family Member is no longer eligible for coverage, and the Plan pays claims for that ineligible Family Member, the Plan shall seek reimbursement for any expenses paid.

4. Coverage shall cease immediately upon termination of the Plan.

> Prohibition on Rescission
>
> In accordance with the requirements in the Affordable Care Act, the Plan will not retroactively cancel coverage except when contributions are not timely paid, or in cases of fraud or intentional misrepresentation of material fact.

F. HIPAA Certification Of Creditable Coverage When Coverage Ends

When your coverage ends under the Plan, the Plan Administrator will automatically provide you and/or your covered Family Members (free of charge) with a Certificate of Coverage that indicates the period of time you and/or they were covered under the Plan. If your coverage under this Plan ends, and you and/or your covered Family Members become eligible for coverage under another group health plan, or if you buy, for yourself and/or your covered Family Members, a health insurance policy, you may need this certificate (to prove that you did not have a break in coverage of 63 consecutive days or more) in order to reduce any exclusion for Pre-Existing Conditions that may apply to you and/or your covered Family Members in that new group health plan or health insurance policy. The certificate will indicate the period of time you and/or they were covered under this Plan, and certain additional information that is required by law.

The certificate will be sent to you (or to any of your covered Family Members) by first class mail shortly after your (or their) coverage under this Plan ends. This certificate will be in addition to any certificate provided to you after your pre-COBRA group health coverage terminated. In addition, a certificate will be provided to you and/or any covered Dependent upon receipt of a written request for such a certificate if that request is received by the Plan Administrator within two years after the later of the date your coverage under this Plan ended or the date COBRA coverage ended. See Article 9, Section 9.01.C. for the procedure for requesting a certificate of coverage.