



A Foundation Health Systems Company

SUMMARY PLAN DESCRIPTION

FOR

City of Stamford Employees

Open Access Point-of-Service Plan

**EFFECTIVE DATE: On or After January 1, 1998, in accordance with
Applicable Collective Bargaining Agreements**

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INTRODUCTION

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This Summary Plan Description (SPD) is a description of the open access Point-of-Service (POS) plan for City of Stamford Employees. This document is being provided to you to outline the basics of your plan, so please try to read everything in this document.

The City of Stamford open access POS plan provides an extensive network of participating doctors, providers, hospitals and facilities from which to choose. Also, for added flexibility, as an open access POS participant you may choose to see doctors who do not participate within the PHS network.

Your health plan probably isn't something you spend a lot of time thinking about, but when it comes time to use it, you will want to know how it works for you. Here is what you absolutely must know:

- ◆ You must designate a primary care physician (also known as a PCP). Your PCP can be a network internist, a family or general practitioner, or a pediatrician for your children.
- ◆ The words **PHS**, **participating**, and **network** are used interchangeably to describe physicians and other providers who are part of the PHS panel.
- ◆ Wherever the word "participant" appears throughout this document it is referring to you the employee participant and your dependents who are covered under this plan.
- ◆ PHS will cover emergencies treated anywhere. In case of an emergency, try to reach your PCP or treating PHS physician if at all possible. If the situation is life-threatening, go straight to the nearest hospital. Please keep in mind that you will be responsible for the entire cost of any visit to the emergency room that is not considered an emergency based on the symptoms and circumstances pertaining to the diagnosis.
- ◆ You are encouraged to pay any copayments at the time services are received (e.g., at the doctor's office). Please refer to the Benefits Summary for detailed information about your copayment, deductible, and coinsurance requirements.
- ◆ Keep your PHS ID card in your wallet or purse. Whenever you go to the doctor, hospital, etc., please show your card, whether they ask for it or not.
- ◆ You can call the PHS Customer Relations department at **1-800-205-0095** with any questions or concerns about your plan. Representatives are also available to assist our non-English speaking members. For hearing impaired participants, our TTY phone number is 1-888-747-2424.
- ◆ Coverage under the plan will take effect for an employee and designated dependents when the employee and such dependents satisfy any waiting period and all the eligibility requirements set forth in your applicable collective bargaining agreement, along with completing and filing all necessary forms required by the City's Benefits Department.
- ◆ Changes in the plan may occur in any or all parts of the plan including benefit coverage, deductibles, maximums, copayments, exclusions, limitations, definitions, eligibility and the like only pursuant to your collective bargaining agreement. Administrative practices by PHS do not constitute a change in the plan.
- ◆ If the plan is terminated, the right of members are limited to covered charges incurred before termination.

**This SPD is not a contract, but rather an overview of your plan.
If there is specific information you need about your plan benefits, please refer to your
Benefits Summary beginning on page 30, or call PHS Customer Relations.**

DEFINED TERMS

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Following are terms used through this document and are included for your reference. If you have any additional questions regarding terms or language included, please call PHS Customer Relations.

Acupuncture is an original Chinese practice of puncturing the body (as with needles) at specific points to treat disease or relieve pain.

Active Employee is defined in your applicable collective bargaining agreement.

Allowed Amount is the percentage of coinsurance eligible for payment by PHS after the participant has met their applicable deductible. The allowed amount is based upon the Usual, Customary and Reasonable charge (UCR), the provider's Total Charges, or the lesser of the Total Charges or a PHS contracted amount.

Allowable Expense means a necessary, reasonable and customary item of expense for health care when the expense is covered at least in part by one or more plans covering the participant for whom the claim is made. The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an allowable expense under the above definition unless the participant's stay in a private hospital room is medically necessary either in terms of generally accepted medical practice, or as specifically defined in the plan. When a plan provides benefits in the form of services (as this document provides), the reasonable cash value of each service that would be rendered shall be deemed a benefit; any such service actually provided shall be deemed an allowable expense and a benefit paid. Allowable expense does not include coverage for dental care, vision care, prescription drugs or hearing aid appliances, unless specifically provided for in the Schedule of Basic Medical Benefits or Covered Charges.

Ambulatory Procedures are those procedures performed in a physician's office, free-standing surgical center or hospital outpatient department. Please review the pre-certification section in this document to verify whether or not you need PHS pre-certification for these procedures.

Ambulatory Surgical Center is a licensed facility that is used mainly for performing outpatient surgery, has a staff of physicians, has continuous physician and nursing care by registered nurses (RNs) and does not provide for overnight stays. Services performed at these facilities may require PHS pre-certification.

Annual Benefit Limitation is the maximum PHS payment per participant per calendar year for specific services listed in the Schedule of Basic Medical Benefits.

Appropriate Level is the duration, frequency and intensity of medical care which is "medically necessary" for the participant's condition and the treatment setting in which it is provided.

Approved in Advance means authorized as "medically necessary" through the process in which PHS provides participant with a written document, that a plan physician or provider has requested and a copy of which is sent and received by the participant prior to the initiation of treatment requiring such pre-approval, that specifies the services to be covered by PHS. You should not rely on verbal approval as this process is not complete until the participant has received a copy of the approval document.

Benefit Payment. Each calendar year, benefits will be paid for the covered charges of a participant. Payment will be made at the rate shown under percentage payable in the Benefits Summary. No benefits will be paid in excess of the maximum benefit amount or the "Benefit Limits" of the plan.

Calendar year means a period of time beginning January 1st and ending December 31st of the same year.

Certified Independent Social Worker (CISW); Psychiatric Clinical Nurse Specialist (RNCS); Marriage and Family Therapist (MFT) are individuals who provide mental health services. These services are subject to the combined cumulative benefit limits, exclusions and copayment requirements that similarly apply to psychologists and psychiatrists.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Coinsurance is the required participant payment of the percentage of the UCR or the Allowed Amount not payable by PHS for Out-of-Network services. Coinsurance counts towards the participant's out-of-pocket maximum. Charges by a physician or provider that are in excess of UCR are not considered coinsurance, and shall be the participant's financial responsibility and do not count towards the participant's out-of-pocket maximum. Coinsurance does not apply to In-Network services.

Copayment (also see **Copayment Schedule**) is a fixed fee that is payable by the participant for certain services at the time services are rendered as listed in the Benefits Summary.

Copayment Schedule is a schedule that is part of this plan, which sets forth the fees that are to be paid directly by the participant to plan physicians, hospitals, providers or other providers and facilities at the time services covered under this plan are rendered.

Cosmetic Surgery means medically unnecessary surgical procedures, usually, but not limited to, plastic surgery directed toward preserving or creating beauty or correcting scars, burns or disfigurements.

Custodial Care is care (including room and board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of custodial care are, help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication which could normally be self-administered.

Deductible is the amount a participant must pay prior to receiving coverage for Out-of-Network services. Deductible amounts are applied on a calendar year basis. Deductibles count toward the participant's out-of-pocket maximum.

1. The individual deductible is satisfied when a participant has paid for covered services totaling the deductible as specified in the Benefits Summary. The individual deductible applies to a participant whether they have individual or family unit coverage.
2. The family deductible is satisfied when one of the following events occurs:
 - a. One participant of the family has already met the individual deductible and the remaining members of the family unit collectively meet the family contract deductible;
or
 - b. Each participant of a two-party family meets the applicable individual deductible;
or
 - c. No one participant of the family has met an individual deductible, but collectively they meet the family deductible as specified in the Benefits Summary. When the family contract deductible is satisfied, all members of the family unit are eligible for benefits described in the Benefits Summary.

Dependent is an individual who relies on a participant for support or obtains health coverage through a spouse, parent or grandparent who is the eligible person. Please see the eligibility section for further details regarding dependents.

Durable Medical Equipment are items that can withstand repeated use and are intended to serve a medical treatment purpose. Durable medical equipment must be approved in advance by PHS and must be prescribed by a physician or provider.

Effective Date is the date coverage under this plan begins.

Elective Admission is an admission, not caused by a life-threatening situation, to an acute care or rehabilitative hospital or facility that occurs at the direction of a non-hospital staff physician.

Emergency is an unexpected and sudden, serious occurrence requiring immediate medical attention; or a life-threatening situation.

Emergency Admission is an admission caused by a life-threatening situation, to an acute care hospital that occurs through the emergency room and not at the direction of a non-hospital staff physician.

Employee refer to applicable collective bargaining agreement.

Employer is **City of Stamford** or any other entity approved by this City.

Experimental and/or Investigational means services, supplies, care and treatment which do not constitute accepted medical practice properly within the range of appropriate medical treatment under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time services were rendered.

PHS will make an independent evaluation of the experimental/non-experimental standings of specific technologies. PHS and the City shall be guided by a reasonable interpretation of plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. PHS will be guided by the following principles:

1. The medical condition must be life-threatening, desperate, life-shortening or one that leads to paralysis or severe loss of bodily or motor functions.
2. Conventional therapy does not exist or has failed.
3. The risk-benefit ratio of patient outcome must be as favorable as that of established therapies or no treatment at all.
4. The technology must be appropriate, in level of service and intensity, to the nature of the disease or condition being treated.
5. Public policy would support the procedure(s) as a valid and ethical course of treatment.
6. The technology is judged to be reasonably clinically effective according to reports in peer reviewed scientific literature, completed clinical study data and/or preponderant expert medical opinion.

If a technology does not meet the above criteria, in whole or in significant part, it will be deemed experimental and/or investigational. The decisions by PHS may be overruled by the City in extraordinary circumstances.

Drugs are considered experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use.

Family Unit is the covered employee and the family members who are covered as dependents under the plan.

Fiduciary. A fiduciary exercises discretionary authority or control over management of the plan or the disposition of its assets, renders investment advice to the plan or has discretionary authority or responsibility in the administration of the plan.

Generic Drug means a prescription drug which has the equivalency of the brand name drug with the same use and metabolic disintegration. This plan will consider as a generic drug any Food and Drug

Administration-approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

Home Health Care Agency is an agency that meets all of these tests: its main function is to provide home health care services and supplies; it is federally certified as a home health care agency; and it is licensed by the state in which it is located, if licensing is required.

Home Health Care Plan must meet these tests: it must be a formal written plan made by the participant's attending physician which is reviewed at least every 30 days; it must state the diagnosis; it must certify that the home health care is in place of hospital confinement; and it must specify the type and extent of home health care required for the treatment of the participant.

Home Health Care Services and Supplies include: part-time or intermittent nursing care by or under the supervision of a registered nurse (RN); part-time or intermittent home health aide services provided through a home health care agency (this does not include general housekeeping services); physical, occupational and speech therapy; medical supplies; and laboratory services by or on behalf of the hospital.

Hospice Agency is an agency whose main function is to provide hospice care services and supplies and is licensed by the state or Medicare in which it is located, if licensing is required.

Hospice Care Plan is a plan of terminal patient care that is established and conducted by a hospice agency and supervised by a physician.

Hospice Care Services and Supplies are those provided through a hospice agency and under a hospice care plan and include inpatient care in a hospice unit or other licensed facility, home care, and family counseling during the bereavement period.

Hospice Unit is a facility or separate hospital unit, that provides treatment under a hospice care plan and admits at least two unrelated persons who are expected to die within six months.

Hospital is an institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the participant's expense and which fully meets these tests: it is accredited as a hospital by the Joint Commission on Accreditation of Healthcare Organizations; it is approved by Medicare as a hospital; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of physicians; it continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of registered nurses (RNs); and it is operated continuously with organized facilities for operative surgery on the premises.

The definition of "**hospital**" shall be expanded to include the following:

- ◆ A facility operating legally as a psychiatric hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operated.
- ◆ A facility operating primarily for the treatment of substance abuse if it meets these tests: maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; has a physician in regular attendance; continuously provides 24-hour-a-day nursing service by a registered nurse (RN); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of substance abuse.

Injury means an accidental physical injury to the body caused by unexpected external means.

In-Network Services are those services rendered by a PHS participating provider and are subject to In-Network benefit limitations as outlined in the Benefits Summary.

Intensive Care Unit (ICU) is defined as a separate, clearly designated service area which is maintained within a hospital solely for the care and treatment of members who are critically ill. This also includes what is referred to as a “coronary care unit” or an “acute care unit.” It has: facilities for special nursing care not available in regular rooms and wards of the hospital; special life saving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (RN) in continuous and constant attendance 24-hours-a-day.

Lifetime is a word that appears in this plan in reference to benefit maximums and limitations. Lifetime is understood to mean while covered under this plan. Under no circumstances does lifetime mean during the lifetime of the participant.

Maintenance Medications are those medications where either the duration of action or the duration of use is greater than seven to 10 days.

Maximum Benefit Amount. The maximum benefit amount is shown in the Benefits Summary. It is the total amount of benefits that will be paid under the plan for covered charges incurred by a participant.

Medical Care Facility means a hospital, a facility that treats one or more specific ailments or any type of skilled nursing facility.

Medical Emergency means a sudden onset of a condition with acute symptoms requiring immediate medical care and includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

In addition, **medical emergency** includes a mental health or substance abuse condition when the lack of medical treatment could reasonably be expected to result in the participant harming himself or herself and/or other persons.

Medically Necessary care and treatment is recommended or approved by a physician and conforms with PHS or industry standards; is consistent with the participant’s condition or accepted standards of good medical practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the participant or provider; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the participant.

Medical Social Services are those services, excluding services provided by a CISW, which are rendered under the direction of a plan physician by a qualified social worker holding a master’s degree from an accredited school of social work.

Medicare is the health insurance for the aged and disabled program under Title XVIII of the Social Security Act, as amended.

Mental Disorder means any disease or condition that is classified as a mental disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

Morbid Obesity is a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight for a person of the same height, age and mobility as the participant.

Naturopathy a system of treatment of disease that avoids drugs and surgery and emphasizes the use of natural agents (as air, water and sunshine) and physical means (as manipulation and electrical treatment).

Network Physician means a doctor of medicine, osteopathy, chiropractic, podiatry, a qualified psychologist, a qualified optometrist and, for purposes of oral surgery only, a doctor of dental surgery or a doctor of medical dentistry, where such plan physician is acting with the scope of his or her licensure, and who has contracted with PHS and is eligible for listing in the PHS Directory of Physicians and Providers, as updated from time to time.

No-Fault Auto Insurance is the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

Non-Participating Pharmacy means a pharmacy which does not have a contract with PHS to furnish prescription drug service to enrolled members.

Non-Plan Provider is any physician, health care provider, registered nurse or facility not listed in the PHS Directory of Physicians and Providers, as updated from time to time. Use of a non-plan provider will be covered under this plan, subject to any applicable deductibles, coinsurance and maximums, unless approved in advance by PHS or when determined to be for emergency services.

Out-of-Network means that unless otherwise specified in this plan, those services provided by any physician, health care provider or facility that has not contracted with PHS to provide services to members, and is **not** listed in the PHS Directory of Physicians and Providers, as updated from time to time.

Out-of-Network Admission is an admission to a non-participating hospital or an admission to a participating hospital by a non-participating physician, unless the admission has been pre-certified by PHS or is due to an emergency.

Out-of-Pocket Maximum is the participant's or dependent's maximum payment liability per calendar year for Out-of-Network services, which have separate maximums. The out-of-pocket maximums are the sum of in-network office and hospital copayments or the sum of all out-of-network coinsurance amounts and deductibles paid by the participant or dependent in a calendar year. The out-of-pocket maximum does **not** include: prescription drug copayments, charges by a physician or provider that are in excess of UCR of the Allowed Amount, or any participant or dependent copayments once the out-of-pocket maximum as listed in the Benefits Summary have been met, PHS will pay 100 percent of the UCR or Allowed Amount, up to the annual benefit limitation for Out-of-Network services.

Outpatient Care is treatment including services, supplies and medicines provided and used at a hospital under the direction of a physician to a person not admitted as a registered bed patient; or services rendered in a physician's office, laboratory or x-ray facility, an ambulatory surgical center, or the participant's home.

Participant is an employee or dependent who is covered under this plan.

Participating Pharmacy means a pharmacy which has contracted with PHS to furnish prescription drug service to enrolled members.

Pharmacy means a licensed establishment where covered prescription drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Physician means a doctor of medicine, osteopathy, chiropractic, podiatry, a qualified psychologist, a qualified optometrist and, for purposes of oral surgery only, a doctor of dental surgery or a doctor of medical dentistry, where such plan physician is acting within the scope of his or her licensure, and who has contracted with PHS and is eligible for listing in the PHS Directory of Physicians and Providers, as updated from time to time.

Plan Participant is any employee or dependent who is covered under this plan.

Plan Hospital is a general or specialty hospital eligible for listing in the PHS Directory of Physicians and Providers, as updated from time to time.

Plan Provider is any physician, health care provider, registered nurse or facility listed in the PHS Directory of Physicians and Providers, as updated from time to time. A provider who has contracted with PHS to provide services to members and dependents.

Plan Physician is a doctor of medicine, osteopathy, podiatry, a qualified psychologist, a registered nurse, a qualified optometrist and, for purpose of oral surgery only, a doctor of dental surgery or a doctor of medical dentistry, where such Plan Physician is acting with the scope of his licensure, and who has contracted with PHS and is eligible for listing in the PHS Directory of Physicians and Providers, as updated from time to time.

Plan Year is the 12-month period beginning on either the effective date of the plan or on the day following the end of the first plan year which is a short plan year.

Pre-Certification or **Pre-Certify** is the process by which the participant must notify PHS in advance of an elective hospital admission to either a plan hospital by an Out-of-Network physician or to an Out-of-Network hospital and for certain elective ambulatory or diagnostic procedures. During this process, PHS provides the participant with a written document, which the participant has requested and received prior to the initiation of treatment requiring such pre-approval, that specifies the services to be covered by PHS. When performed In-Network, the plan physician will notify PHS in advance.

Pregnancy is childbirth and conditions associated with pregnancy, including complications.

Prescription means a request for medication issued by a doctor of medicine, a doctor of podiatry, a doctor of osteopathy, a doctor of dental surgery or a doctor of dental medicine, in the authorized course of his practice, and shall include authorized refills.

Prescription Drugs means drugs, biological and compounded prescriptions which can be dispensed only pursuant to a written prescription, and which are included in the United States Pharmacopoeia, The National Formulary, accepted mental remedies, new drugs and which, by law, are required to bear the legend: Caution — Federal Law prohibits dispensing without prescription; or which are specifically approved by PHS.

Prescription Drug Service means the qualifying prescription drug benefits provided by a participating pharmacist to a participant, upon presentation of valid identification.

Recovery means monies paid to the participant by way of judgment, settlement, or otherwise to compensate for all losses caused by injuries.

Refraction means the process of determining refractive errors of the eye for their correction with lenses which is a basic element of general ophthalmologic or optometric services.

Refund means repayment to the plan for medical or dental benefits that it has paid toward care and treatment of the injury.

Rehabilitative Services are services, including physical, rehabilitative, cardiac and occupational therapies, obtained from a plan provider and rendered under the direction of a plan physician, if significant improvement in the participant's condition is expected to occur within two months of the first date of treatment.

Sickness is a person's illness, disease or pregnancy (including complications). For a newborn child after birth, but before release from a medical facility, sickness also includes a congenital defect, a birth abnormality or a premature birth.

Skilled Nursing Facility is a facility that fully meets all of these tests:

1. It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from injury or sickness. The service must be rendered by a registered nurse (RN) or by a licensed practical nurse (LPN) under the direction of a registered nurse. Services to help restore members to self-care in essential daily living activities must be provided.
2. Its services are provided for compensation and under the full-time supervision of a physician.
3. It provides 24-hour-per-day nursing services by licensed nurses, under the direction of a full-time registered nurse.
4. It maintains a complete medical record on each participant.
5. It has an effective utilization review plan.
6. It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mental retardates, custodial or educational care or care of mental disorders.
7. It is approved and licensed by Medicare.

This term also applies to charges incurred in a facility referring to itself as an extended care facility, convalescent nursing home or any other similar nomenclature.

Spinal Manipulation/Chiropractic Care means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Subrogation means the plan's right to pursue the participant's claims for medical or dental charges against another person.

Substance Abuse is the condition caused by regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs that results in a chronic disorder affecting physical health and/or personal or social functioning. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

Temporomandibular Joint (TMJ) syndrome is the treatment of jaw joint problems including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint when covered. Care and treatment shall include, but are not limited to orthodontics, crowns, inlays, physical therapy and any appliance that is attached to or rests on the teeth.

Total Disability (Totally Disabled) means: In the case of an active employee, the complete inability to perform any and every duty of his or her occupation or of a similar occupation for which the person is reasonably capable due to education and training, as a result of injury or sickness.

In the case of a dependent, it means the complete inability as a result of injury or sickness to perform the normal activities of a person of like age and sex in good health.

Usual, Customary and Reasonable Charge (UCR) is a charge which is not higher than the usual charge made by the provider of the care or supply and does not exceed the usual charge made by most providers of like service in the same geographical area, based on a statistical industry standard. This test will consider the nature and severity of the condition being treated. It will also consider medical complications or unusual circumstances that require more time, skill or experience.

Your Rights. PHS guarantees you specific rights and you should be aware of them. Our goal is to provide you with quality health care, while respecting those rights. You have the right to:

- ◆ Receive information about PHS, its services, its practitioners and providers, and participant rights and responsibilities
- ◆ Be treated with respect and recognition of your dignity and right to privacy
- ◆ Be treated without discrimination regarding your race, age, color, religion, sex, national origin, sexual orientation, or marital status
- ◆ Available and accessible services when medically necessary, including availability of care 24-hours-a-day, seven days a week for urgent or emergency conditions
- ◆ Be given complete and current information regarding your medical condition and treatment in terms you can understand. When it is not medically advisable to give you such information (or when the participant is a minor or not capable of understanding), the information regarding your treatment will be given to an appropriate person whom you designate
- ◆ Be provided with adequate information for you to give informed consent prior to the commencement of treatment
- ◆ Refuse treatment to the extent permitted by law and be informed of the medical consequences of that refusal
- ◆ Participate in decision making regarding your health care with no restrictions on the clinical discussion
- ◆ Request a specialist care coordinator or access to a specialty care center for chronic, life-threatening, or degenerative and disabling conditions
- ◆ Formulate advance directives
- ◆ Know the benefits and limitations set forth in your Benefits Summary
- ◆ Receive a second opinion, if you want one, from a PHS participating physician or specialist
- ◆ Use the reconsideration (grievance) process, or designate someone to represent you, if you disagree with a PHS decision
- ◆ Participate in the development of PHS policies by communicating your concerns and suggestions to Customer Relations

Your Responsibilities. As a PHS participant, you are also responsible for understanding and following certain guidelines regarding your health care coverage.

We encourage you to:

- ◆ Use your PCP for preventive care services and to assist you with referrals to specialists when indicated
- ◆ Keep your scheduled appointments or notify your doctor's office of cancellations or delays. You may be billed for missed appointments
- ◆ Provide all necessary information to physicians, providers, and hospital staff so that these professionals can care for you appropriately
- ◆ Follow treatment recommendations made by your physician(s) and consider the possible consequences if you refuse to comply with recommended treatment
- ◆ Be aware of which medical services are covered and which are not by reviewing this document
- ◆ Pay any applicable copayments when you receive services
- ◆ Protect your PHS ID card from unauthorized use

Employee Coverage.

Eligible classes and Eligibility requirements for employee coverage

Employee eligibility and coverage is defined and set forth in your applicable collective bargaining agreement with the City.

The following Collective Bargaining groups may be participating in this program, if so provided by their Bargaining Agreement:

- International Association of Fire Fighters Local No. 786;
- Stamford Municipal Supervisory Employees Union, AFSCME Local No. 2657;
- City of Stamford Registered Nurses Union, AFSCME Local No. 465;
- Teamsters Local No. 145;
- Stamford Public Health Dental Hygienist Union, AFSCME Local No. 1303-273;
- Stamford Assistant Corporate Counsel's Union, AFSCME Local 1303-191;
- UAW Local No. 2377;
- New England Health Care Employees Union District 1199;
- The Stamford Police Association, Inc.; and
- Custodian and Mechanics Union Local No. 1083

Dependent Coverage.

Dependent is any one of the following persons:

1. A covered employee's (participant's) lawful spouse and unmarried children from birth up to age 19 years of age. However, a dependent child will continue to be covered after age 18, provided the child is a full-time student, at an accredited school, primarily dependent upon the participant for support and maintenance, is unmarried and under age 24. Coverage ends on the last day of the month the child graduates or is no longer enrolled as a full-time student and dependent upon the employee for support, but in no event will coverage be extended beyond the last day of the month of the child's 24th birthday.

The term "spouse" means the legally recognized marital partner of a participant in the State of Connecticut. The administrator may require documentation proving a marital relationship.

The term "children" includes biological children, adopted children or children placed in the participant's home in anticipation of adoption. Step-children who reside in the participant's household, and for whom the participant or spouse is legally responsible for insurance coverage may also be included.

As required by the federal Omnibus Budget Reconciliation Act of 1993 (OBRA), any child of a participant who is an alternate recipient under a qualified medical child support order will be considered as having a right to dependent coverage under this plan.

The phrase "primarily dependent upon" means dependent upon the participant for support and maintenance as defined by the Internal Revenue Code (at least 51%) and the participant must declare the child as an income tax deduction. The administrator may require documentation proving dependency.

2. A dependent child regardless of age who is incapable of self-sustaining employment or supporting themselves financially by reason of mental deficiencies, physical handicap or developmental disability, as defined in the Connecticut Mental Health Law, primarily dependent upon the participant for support and maintenance, unmarried and covered under the plan when reaching the ages of 19 or 24 if a full-time student at an accredited school. PHS or the City may require, at reasonable intervals during the time following the dependent's reaching the limiting age, subsequent proof of the child's disability and

dependency.

Disabled Dependent - To continue coverage for a disabled dependent past the age of which dependent coverage would otherwise terminate, the participant must show proof of such handicap within 31 day of the date on which the child's coverage would have ended if not handicapped. The administrator may require proof the child's continued dependency, but not more than one per year.

The following individuals are not dependents under this plan; (1) individuals living in the participant's home, but who are not eligible; (2) the legally separated or divorced former spouse of the employee; and (3) any person who is on active duty in any military service of any country.

A person may be covered both as an employee and as a dependent under this Plan. A person may be covered as a dependent of no more than two employees under this Plan or related medical plans of the City unless mandated by court order. In both cases, the benefits payable will be subject to **Coordination of Benefits**.

Coverage of an eligible dependent begins when the name is registered with the plan on the form provided for that purpose and made effective by the plan. The PHS and/or the City may require documentation proving dependency.

Newborn children are automatically entitled to coverage for the first 31 days following birth. The child will become a dependent thereafter upon the completion and filing of the necessary forms with the City's Benefits Department.

Effective date of employee coverage. An employee will be covered under this plan as of the date that the employee satisfies all of the following:

1. The eligibility requirement set forth in the applicable collective bargaining agreement.
2. The enrollment requirements of the plan.

Effective date of dependent coverage. Subject to the Deferral Rule, a dependent's coverage will take effect on the day that the eligibility requirement is met; the employee is covered under the plan; and all enrollment requirements are met.

Deferral Rule. If a dependent, other than a newborn child, is a patient in a hospital or other medical care facility on the date coverage would otherwise become effective, coverage will be deferred until the day following the date the dependent is discharged from the facility and able to perform all of the normal activities of a person of the same age and sex.

When employee coverage terminates. Employee coverage will terminate as set forth in your applicable collective bargaining agreement, or on the last day of the month the covered employee ceases to be in one of the eligible classes. This includes death or termination of employment of the covered employee.

When you become a Retiree. As a retiree, the benefits outlined in this booklet may be extended to you and also may be contributory. Please refer to your Collective Bargaining Agreement for the terms and conditions of coverage once retired. If your Collective Bargaining Agreement requires contributions by the retiree to maintain such coverage, you must file an agreement with the City at retirement electing this coverage and agreeing to make the required payments for such coverage.

Coverage will be modified for a retiree or dependent who becomes eligible for Medicare.

If you stop your coverage for any reason as a retiree, you will not be eligible to re-enroll for coverage unless a provision is so provided in your Collective Bargaining Agreement.

Continuation during periods of disability, leave of absence or layoff. A person may remain eligible for a limited time if active, full-time work ceases due to work related injury recognized by Worker's Compensation Law, an approved medical leave of absence or paid leave of absence. This continuance will end on the earlier of (1) the date the covered employer ends the continuance, (2) the maximum period permitted pursuant to applicable law, (3) a date provided in the applicable collective bargaining agreement, or (4) the employee resigns.

While continued, coverage will be that which was in force on the last day worked as an active employee unless modified by the collective bargaining parties, i.e.; if benefits reduce for others in the bargaining group represented currently or formerly of that employee/retiree, they will also reduce for the continued person.

Continuation during family and medical leave. Regardless of the established leave policies mentioned above, this plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor.

During any leave taken under the Family and Medical Leave Act, the employer will maintain coverage under this plan on the same conditions as coverage would have been provided if the participant had been continuously employed during the entire leave period.

When dependent coverage terminates. A dependent's coverage will terminate on the earliest of:

1. The date that the employee's coverage under the plan terminates for any reason including death. *See the COBRA Continuation Option.*
2. The date dependent coverage is terminated under the plan.
3. The date that the dependent ceases to be a dependent as defined by the plan. *See the COBRA Continuation Option.*

Changes to Status

You should always notify your Benefits Department at the City of any changes so that your records will be kept up to date. Any time there are changes regarding your dependents, full-time student status, or marital status, you should notify the City's Benefits Department immediately.

Misrepresentation and Fraud. In the event a participant or his dependent receives benefits, as a result of misleading representation or any type of false information or other fraudulent representations to PHS or the City, such person will be liable to repay all amounts paid by PHS. Fraud includes such person's failure to disclose any other group health coverage in which such person is entitled to receive reimbursement of a claim submitted to PHS for payment along with failure to notify the Benefits Department at the City of any event which affects a family member's status as a covered dependent. The participant or dependent will be prosecuted for fraud and held liable for all costs of collection, including interest and attorney's fees.

Overpayments. If a claim payment is made to a participant or assigned to a provider that is later determined to be an overpayment, PHS or the City may offset future claim payments, in order to recover said overpayment.

There are some occasions when you should contact PHS directly:

- ◆ If you have a baby, you are eligible to participate in the First StepsSM program. First Steps provides new parents with a choice of gifts.
- ◆ If you change your address or phone number.
- ◆ If you change your PCP.

PHS can be reached by mail or phone at:

PHS Customer Relations
One Far Mill Crossing
P.O. Box 904
Shelton, CT 06484-0944
Phone 1-800-205-0095

For all other membership changes, including those described next, get an enrollment application or change form from PHS and send the changes to the address listed on the form.

Coverage for family members. Family members may be added to or deleted from your policy during open periods of enrollment. You may also be able to make changes in your policy any time there has been a marriage, divorce, birth, adoption, or death as long as your employer approves and the change meets PHS eligibility criteria.

Continuing your PHS membership. Check with the City's Benefits Manager if you wish to continue your PHS membership after you leave your job or if you decrease your work schedule to the point where you are no longer eligible for health coverage.

Certain state and federal regulations require most employers to offer a continuation of benefits when employees leave their jobs and/or dependents become ineligible for coverage. This continuation of coverage is arranged through PHS. For complete information on continuing your membership, please call Customer Relations.

Notices Sent To Address of Employee. PHS and the City will give notice by mail to participants of actions taken with respect to eligibility, claims and other important matters. All such notices will be sent to your address as it appears in PHS records. To protect yourself and your rights, you must be sure PHS always has your current address. Any notice sent to you at the address maintained by PHS and the City will be deemed to have been received by you. The time you must reply to notices will not be extended because you did not give PHS and/or the City your current address.

HOW YOUR OPEN ACCESS POS PLAN WORKS

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PHS Physicians and Providers

Your Primary Care Physician. Your PCP is your regular doctor and is there to keep you healthy. Your PCP is the first person you should call if you need medical attention. Since your PCP knows your medical history best, he or she is the best person to help coordinate all of your health care needs. Any dependents who are eligible for coverage under your plan will also need a PCP. To see which doctors and hospitals in your area belong to PHS or to check the location and phone number of a network specialist to whom you've been referred by your PCP, look in your Directory of Physicians and Providers or call Customer Relations. Our representatives can identify network providers close to your work or home and can mail or fax you this list at your request.

Changing PCPs. A good relationship with your doctor develops over time, so it's not a good idea to change PCPs frequently or indiscriminately. However, if you decide to switch, call Customer Relations to advise PHS of the name of your new doctor. Please remember that your PCP must be a family or general practitioner, an internist, or a pediatrician for children.

Making an Appointment. To make an appointment to see any PHS participating physician, we encourage you to first contact your PCP, call the doctor's office directly. When you get to the office, let the receptionist know you are a PHS participant and show your ID card. You should receive no bills for covered services, however, you are responsible for any copayments at the time of service. If the doctor's office sends you a bill, please contact Customer Relations.

If you need medical care that cannot be provided by your PCP, they can refer you to a PHS specialist or you may self-refer. There is no paperwork for you to complete. PHS will only cover services as an In-Network benefit when you receive care from PHS physicians and providers, except in cases of emergency or when you receive prior written approval from the PHS Medical Director.

For covered services provided by physicians and providers who do not participate in the PHS network, coverage will be provided under your Out-of-Network benefits, subject to deductible and coinsurance.

Care at Home. If your PHS doctor believes that it would be best for you not to leave your home to obtain services and you live within the PHS service area, a PHS doctor, a visiting nurse, or other specialist can see you at home. These visits are usually related to post-hospital care and do not include homemaking services or custodial care. If the home visit is medically necessary but you are seen by an Out-of-Network doctor, these services and all associated covered charges will be subject to deductible and coinsurance. Care at home is one of several situations that requires prior approval. A section that fully explains prior approval requirements can be found later in this document.

Point-of-Service Explained

Your open access Point-of-Service (POS) plan allows you to see physicians and providers both in and out of the PHS network. How and from whom you choose to receive the medical care will affect how the services are covered. Take a look at this side-by-side comparison:

In-Network

If you receive covered services from a PHS physician or provider, you are eligible for In-Network benefits. This means your coverage has:

- No deductible
- No coinsurance
- Full coverage, less your copayment responsibility
- No claim forms to complete

Out-of-Network

If you receive covered services from a physician or provider who does not participate with PHS, you are eligible for Out-of-Network benefits. In these situations, your coverage involves:

- Deductible
- Coinsurance
- Submitting medical claims
- Your own pre-certification responsibilities for inpatient admissions and outpatient surgery

As you can see, the open access POS plan provides coverage whether or not you use PHS doctors and other providers. However, by using PHS providers for your care, you can significantly reduce your expenses. Here is an example of what the difference in cost can be for a participant with a \$200 individual deductible and 80/20% coinsurance when elective outpatient surgery is done Out-of-Network rather than In-Network:

In-network costs may be as little as \$10, depending on if there is a copayment. Out-of-network costs for a \$2,000 procedure would be:

Billed amount:	\$2,000.00
Minus:	<u>\$ 200.00</u> (deductible)
	\$1,800.00
	<u>x 80</u> percent
	\$1,440.00 PHS payment

Participant pays \$560.00

Usual, Customary and Reasonable Charges. It is also important to know that payment for covered services Out-of-Network is based on usual, customary and reasonable charges (UCR), except in cases of emergency. UCR is based on data compiled and reviewed by an outside agency, such as Health Insurance Association of America (HIAA), which determines customary charges for services within a certain geographic location. The charges will vary by provider and specific services. UCR allows PHS to keep your premium at an affordable level and is used by almost all insurers for Out-of-Network expenses. UCR represents our “Allowed Amount” or “Allowed Charges” for Out-of-Network services.

Deductible, Coinsurance, and Out-of-Pocket Costs. As a participant of the open access POS plan there may be services that you will receive that involve deductibles, coinsurance and out-of-pocket expenses. Before PHS will make payments for Out-of-Network services, you and/or your eligible dependents must meet the annual deductible dollar amount for your plan. The deductible amount that your employer group selected is listed in your Benefits Summary and is applied on a calendar year basis.

After you meet your deductible, PHS will share the costs for Out-of-Network services. This cost-sharing is called coinsurance. The coinsurance ratio is also selected by your employer, and your payment responsibility includes your coinsurance amount as well as all charges in excess of our allowed charges.

Also listed in your Benefits Summary are your individual and family out-of-pocket maximums. Once your out-of-pocket maximum for deductible and coinsurance is met, PHS will provide full coverage up to our allowed amount for eligible Out-of-Network services. Charges you pay in excess of our allowed amount are not counted toward your deductible or out-of-pocket maximums. Also, penalties applied for failure to pre-certify applicable Out-of-Network services do not count toward deductible, coinsurance, or out-of-pocket maximums.

Submitting Medical Claims. As indicated earlier, you do not need to file claims for medical services provided by doctors, hospitals, and other providers that participate in the PHS network. They will submit them directly to PHS. However, for any non-participating physicians and providers you use, **you the participant** are responsible for ensuring that PHS receives the claim(s). Some Out-of-Network providers may submit the claims directly to PHS, but you should verify that PHS has received them. All other Out-of-Network claim forms given to you should be mailed to PHS. To verify PHS received a claim or for additional Out-of-Network claims forms contact Customer Relations.

Please let PHS know if you have paid in full for the Out-of-Network services, and you can be reimbursed directly. If you assign benefits to the physician or provider, payment will be sent to them and you will have to obtain reimbursement from the provider's office.

Claims must be submitted within fifteen (15) months of the date of service or eighteen (18) months if coordination of benefits applies.

Emergencies and Urgent Situations

No one looks forward to an emergency or urgent medical situation, and there's no way to plan when or where one might happen. PHS understands that these unfortunate situations occur, and we want you to know how your coverage for them works.

Emergencies. A true medical emergency is the sudden and unexpected onset of a condition in which delay in treatment would endanger your health or life. Examples of this include:

- ◆ Difficulty breathing
- ◆ Unconsciousness
- ◆ Severe burns
- ◆ Broken bones
- ◆ Excessive bleeding
- ◆ Suspected heart attack
- ◆ Acute stomach pain
- ◆ Shock

If any of these things happen, go straight to the emergency room or call 911 for an ambulance. PHS will cover emergencies anywhere, but all follow-up care must be provided by your PCP or PHS specialist, if you want to receive In-Network coverage. Remember, you will be responsible for any bills for services provided at an emergency room that are determined not to be true emergencies based by nature of the symptoms and other related factors.

If you are admitted to the hospital directly from the emergency room, the emergency room copayment is waived. If your emergency or urgent problem occurred while you were away from home, send the itemized bill (listing the diagnosis and procedures performed) to PHS along with your PHS ID number and a detailed explanation of the circumstances surrounding the emergency.

Please review your Benefits Summary, or call Customer Relations, for questions about coverage.

Urgent Conditions. An urgent condition is different from an emergency in that it is not as serious, but you still need to speak to a doctor right away. If you should have an urgent problem, call your PCP or treating physician. Your doctor may give you first-aid advice or tell you to go to their office, an urgent care center, or the hospital emergency room.

If you get your doctor's "on-call" service, tell the operator you are a PHS participant. If your call is not returned within a reasonable period of time, seek the appropriate medical treatment.

If your doctor tells you to go to the hospital, bring your PHS ID card and show it when you get there. If you've gone to the hospital without speaking to your doctor, the hospital staff may ask you to call him or her at this time. Please have the hospital admitting office notify PHS as soon as possible if you are admitted to an Out-of-Network hospital, or admitted by an Out-of-Network provider.

Prior Approval Requirements. There are times when PHS needs to be notified by your PCP or PHS specialist about your health care before you receive certain services. Prior approval is necessary in the following situations:

- ◆ A certain procedure or specialist is not available in the PHS service area
- ◆ You or your doctor request a benefit or procedure requiring prior approval or pre-certification
- ◆ You require home care following a hospital stay

Out-of-Network Services. If you or your doctor wants you to see a particular specialist or provider who does not participate with PHS, you may still elect to see the Out-of-Network provider and receive benefits through your Out-of-Network coverage. However, these services will be subject to deductible and coinsurance. Also, if the Out-of-Network services are for outpatient surgery, diagnostic procedures, or inpatient hospital admission (including rehabilitation and skilled nursing facility services), you will need to receive pre-certification from PHS before receiving services.

If you have questions about this referral process, including whether your PHS provider has obtained approval for you to see an Out-of-Network provider, call Customer Relations.

Home Care. As explained earlier in this document, care at home is usually related to post-hospital stays and is another instance when your doctor must obtain prior approval from PHS.

PRE-CERTIFICATION SERVICES

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Pre-Certification and Pre-Admission Notification. Pre-certification is a review process PHS conducts to determine the medical necessity of certain surgical and diagnostic procedures. It is a tool that

protects our members' interests by ensuring that the benefits of the planned surgery outweigh the risks. Procedures requiring pre-certification can either be inpatient or outpatient procedures.

Utilization Review. Utilization review is a program designed to help insure that all members receive necessary and appropriate health care while avoiding unnecessary expenses when a hospital confinement is proposed.

The program consists of:

- a. Precertification of the medical necessity for all non-emergency hospital admissions before medical services are provided;
- b. Retrospective review of the medical necessity for all emergency hospital admissions;
- c. Concurrent review, based on the admitting diagnosis, of the number of days of hospital confinement requested by the attending physician; and
- d. Certification of the length of confinement and discharge planning.

The purpose of the program is to determine what is payable by the plan. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending physician or other health care provider.

If a particular course of treatment is not certified, it means that the plan will not consider that course of treatment as appropriate for the maximum reimbursement under the plan.

In order to maximize your plan reimbursements, please read the following provisions carefully.

◆ **Here's how the program works.**

In-Network Pre-Certification. If the plan physician has recommended one of the surgical procedures listed below, they must contact PHS and must receive pre-certification from a PHS nurse reviewer.

- | | |
|--|----------------------------------|
| ◆ Adenoidectomy | ◆ Bunionectomy |
| ◆ Carpal Tunnel Release | ◆ Cataract Extraction |
| ◆ Cholecystectomy | ◆ Colonoscopy |
| ◆ Hammertoe Repair | ◆ Hemorrhoidectomy |
| ◆ Hysterectomy | ◆ Hysteroscopy |
| ◆ Knee Arthroscopy | ◆ Lumbar Laminectomy |
| ◆ Lumbar Spinal Fusion | ◆ Pelvic Laparoscopy |
| ◆ Septoplasty | ◆ Sinus Surgery |
| ◆ Tonsillectomy | ◆ UGI Endoscopy |
| ◆ Carotid Endarterectomy | ◆ Dilation and Curettage (D&C) |
| ◆ Cervical and Lumbosacral Spine Contrast Myelograms,
CAT Scans and MRI Scans | ◆ Tonsillectomy and Adnoidectomy |
| | ◆ Tympanostomy Tub Insertion |

**At the time of publication the procedures shown above constituted a complete list. However, the list of procedures requiring pre-certification is updated periodically. A complete list is available by calling Customer Relations.*

This process will require your physician to contact PHS before they schedule any of these procedures. They will discuss medical information with PHS' medical review staff to ensure that the procedure is appropriate. Also, PHS may contact the patient, or the parents in the case of a child, to ask some questions about the conditions and treatment received.

Next, PHS will send the patient and the physician a letter approving or denying coverage. The physician may have the case reviewed by three clinicians if there is a disagreement regarding the course of treatment. Also, if the patient is dissatisfied with the outcome of the review, he or she may contact PHS Customer Relations to appeal the decision. Should the procedure be done despite the recommendations of the PHS reviewers, the plan will not provide coverage for the procedure or the related hospital and other provider charges.

The utilization review program is set in motion by a telephone call from the participant:

Contact **Physicians Health Services** at (203) 381-6868 or (800) 205-0095 **before** a non-emergency admission. Have the following information available:

- The name of the patient and relationship to the covered employee
- The name, Social Security number and address of the covered employee
- The name of the employer
- The name and telephone number of the attending physician
- The name of the hospital and proposed date of admission
- The diagnosis and/or type of surgery
- The proposed length of hospital stay

If there is an **emergency** admission to the hospital, the patient, patient's family participant, hospital or attending physician must contact PHS as soon as possible. Follow up care should be provided or coordinated by the participant's PCP. Visits for non-emergency situations are not covered.

The utilization review administrator will determine the number of days of hospital confinement authorized for payment. **Failure to follow this procedure will reduce reimbursement received from the plan.**

- ◆ If the participant does not receive authorization as explained in this section, the benefit payment will be reduced by 50%, up to a maximum of \$10,000 per stay.

If the patient elects to receive care from physicians and providers who do not participate with PHS (Out-of-Network providers) he or she is still required to follow certain plan guidelines. If the Out-of-Network physician has recommended elective surgery or a hospital admission, the patient must contact PHS and receive pre-certification.

Out-of-Network. For Out-of-Network services, you must receive pre-certification in advance for elective admissions. The penalty for failure to pre-certify will be 50% of the total cost of the case. PHS will respond within 2 days of receiving complete medical information on the services requested.

If either, or both, the treating physician or the facility hospital where services will be performed do not participate with PHS, pre-certification is required for the following situations.

- ◆ Specific outpatient diagnostic procedures by Out-of-Network providers and/or Out-of-Network hospitals and other facilities. These include, but are not limited to the following:

Tonsillectomy	Cataract Extraction	Lumbar Spinal Fusion
Adenoidectomy	Knee Arthroscopy	Coronary Angioplasty
Septoplasty	Hemorrhoidectomy	Tympanostomy Tube Insertion
Pelvic Laparoscopy	Bunionectomy	Carotid Endarterectomy
Dilation and Curettage (D&C)	Carpal Tunnel Release	Hammertoe Repair
Cholecystectomy	Colonoscopy	UGI Endoscopy

HEALTH CARE BENEFITS

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Covered Charges. Covered charges are the usual and reasonable charges that are incurred for the following items of service and supply. These charges are subject to the “Benefit Limits” of this plan. A charge is incurred on the date that the service or supply is performed or furnished.

1. **Hospital care.** The medical services and supplies furnished by a hospital or ambulatory surgical center. Covered charges for room and board will be payable as shown in the Benefits Summary.
Charges for an intensive care unit stay are payable as an inpatient hospital expense described in the Benefits Summary.
2. **Skilled nursing facility care.** The room and board and nursing care furnished by a skilled nursing facility will be payable if and when:
 - a. the participant is confined as a bed patient in the facility;
 - b. the attending physician certifies that the confinement is needed for further care of the condition that caused the hospital confinement.
3. **Emergency care.** Emergency room services and medical services furnished by a hospital or physician in the event of an unexpected and sudden, serious occurrence requiring immediate medical attention or in the event of life-threatening situation.
4. **Physician care.** The professional services deemed medically necessary of a physician including that of a surgeon, or assistant surgeon.
5. **Private duty nursing care.** The private duty nursing care by a licensed nurse (RN, LPN or LCN). Covered charges for this service will be included to this extent:
 - a. **Inpatient nursing care.** Charges are covered only when care is medically necessary or not custodial in nature and the hospital’s intensive care unit is filled or the hospital has no intensive care unit.
6. **Home health care services and supplies.** Charges for home health care services and supplies, including infusion therapy, are covered only for care and treatment of an injury or sickness when hospital or skilled nursing facility confinement would otherwise be required. The diagnosis, care and treatment must be certified by the attending physician.
Benefit payment for nursing, home health aide and therapy services is subject to the home health care limit shown in the Benefits Summary.
A home health care visit will be considered a periodic visit by either a nurse or therapist, as the case may be, or four hours of home health aide services.
7. **Hospice care services and supplies.** Charges for hospice care services and supplies are covered only when the attending physician has diagnosed the participant’s condition as being terminal, determined that the person is not expected to live more than six months and placed the person under a hospice care plan.
8. **Home and office services.** Charges for medical (non-surgical) services when rendered to a participant in the participant’s home or physician’s office not otherwise specified as a covered service.

9. **Other medical services and supplies.** Covered services and supplies may be limited to those determined medically necessary and appropriate based on professional and industry standards. The following services and supplies are covered expenses by the plan:
- a. Anesthetic; oxygen; blood and blood derivatives that are not donated or replaced; intravenous injections and solutions. Administration of these items is included.
 - b. Diagnostic x-rays including mammographies as outlined in the Benefits Summary.
 - c. Laboratory studies including pathology studies.
 - d. Radiation or chemotherapy and treatment with radioactive substances. The materials and services of technicians are included.
 - e. Rental of durable medical or surgical equipment if deemed medically necessary. These items may be bought rather than rented, but only if agreed to by PHS.
 - f. Medically necessary and emergent professional land or air ambulance service. A charge for this item will be a covered charge only if the service is to the nearest hospital or skilled nursing facility where necessary treatment can be provided unless otherwise approved in advance.
 - g. Surgical dressings, splints, casts and other devices used in the reduction of fractures and dislocations.
 - h. Leg, arm, back and neck braces or trusses which are required as a result of a disabling congenital condition or an injury or sickness that occurred while covered under the plan.
 - i. Artificial legs, arms or eyes required to replace a lost natural body part provided.
 - j. Physical therapy and chiropractic care by a licensed physical therapist or licensed doctor of chiropractic subject to the maximums set forth in the Benefit Summary. The therapy must be in accord with a physician's exact orders as to type, frequency and duration and to improve a body function.
 - k. Speech therapy, when approved in advance by PHS, as limited by the Benefits Summary, required to bring about or restore normal function of the speech mechanism which is impaired due to congenital anomaly, illness or accidental trauma or injury. If significant improvement in speech will not occur within a reasonable period of time, such therapy is not covered.
 - l. Occupational therapy by a licensed occupational therapist.
 - m. Sterilization procedures.
 - n. Prescription drugs (as defined).
 - o. Oral or injectable contraceptives and contraceptive devices, such as diaphragms, intrauterine devices, and cervical caps.
 - p. Electroshock therapy.
 - q. Kidney dialysis.
 - r. Orthoptic training.
10. Foot orthotics when individually fabricated is recognized as a covered charge, subject to an annual maximum benefit of \$200 per calendar year.

Care for Mouth, Teeth and Gums. Charges for the care of the mouth, teeth, gums and alveolar processes will be covered charges under health care benefits only if that care is for the following oral surgical procedures:

1. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
2. Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth when the injuries occurred while covered under the plan.
3. Excision of benign bony growths of the jaw and hard palate.
4. External incision and drainage of cellulitis.
5. Incision of sensory sinuses, salivary glands or ducts.

No charge will be covered under health care benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of, or continued use of dentures unless of a reconstructive nature resulting from an injury/accident.

Mental Health/Substance Abuse Coverage. Just as your plan provides for physical health and wellness, it also provides for mental health and wellness. PHS's Mental Health/Substance Abuse coverage has been designed to ensure that you can obtain medically necessary mental health or substance abuse treatment from a provider who meets your particular needs. Please check your Directory of Physicians and Providers or call Customer Relations if you need help selecting a mental health/substance abuse treatment provider, including psychologist, clinical social worker under the supervision of a physician.

As an open access POS participant, your PCP may refer you, or you may self-refer to any participating mental health/substance abuse provider to receive coverage for outpatient treatment under your In-Network benefits. Since PHS will be reviewing the medical necessity of your treatment, your PHS provider will need to discuss your outpatient mental health treatment with PHS after your **sixth** visit before subsequent visits are recognized as a covered expense. All inpatient/partial day mental health care, as well as all substance abuse care, requires prior approval.

If you choose to use you Out-of-Network benefits for outpatient mental health care, it will be ***your*** responsibility to contact PHS after your sixth visit. Failure to get this prior approval may result in the denial of your claim(s). Members should call PHS at 1-800-205-0095.

PHS recommends that your PCP be notified when you seek mental health/substance abuse services since the doctor coordinates all your health care. In the event you are prescribed medication, your PCP is best able to ensure that any prescription medication you are taking work safely together.

Routine Mammography. Routine mammography services will be paid to the maximum shown in the Benefits Summary.

Spinal Manipulation/Chiropractic Services. Spinal manipulation/chiropractic services will be paid to the maximum shown in the Benefits Summary.

Preventive Care. Routine Adult Physical Examinations. Routine adult physical examinations include care by a physician that is not for an injury or sickness. It includes charges for related x-rays and laboratory tests subject to the limitations shown in the Benefit Summary.

Charges for Well Child Care. Well child care includes routine pediatric care and immunizations by a physician that is not for an injury or sickness subject to the limitations shown in the Benefit Summary.

Organ Transplant Coverage Limits. Charges otherwise covered under the plan that are incurred for the care and treatment due to an organ or tissue transplant are subject to these limits:

1. The transplant must be performed to replace an organ or tissue of the participant.
2. Charges for obtaining donor organs are covered charges under the plan when the recipient is a participant. When the donor has medical coverage, his or her plan will pay first. The benefits under this plan will be reduced by those payable under the donor's plan. Donor charges include those for:
 - a. evaluating the organ;
 - b. removing the organ from the donor; and
 - c. transportation of the organ from within the United States and Canada to the place where the transplant is to take place.

Benefit payments for donor charges are included under the organ transplant maximum benefit limit shown in the Benefits Summary.

3. The plan does not cover charges incurred for obtaining donor organs from the participant.
4. Services and facilities must be approved in advance by PHS and must be performed at a licensed and accredited facility.

Coverage of Maternity and Length of Stay. If PHS is your primary insurance, you must confirm that your obstetrician, pediatrician, and the hospital in which you will deliver the baby all participate with PHS to receive coverage under your In-Network benefits. All your doctor's prenatal and delivery charges should be billed directly to PHS if we are the primary carrier for your health coverage.

It's important to select a pediatrician before the birth of your baby because your newborn will require a pediatric evaluation following his or her birth and care during the hospital stay. Please verify with your doctor that he or she has privileges at the hospital you plan to deliver your baby. You should also check your Benefits Summary or call Customer Relations to see if you have a copayment for hospitalization. If you do, you should be prepared to pay that copayment when you are discharged.

If you select a non-participating pediatrician, any services your baby receives will be covered under your Out-of-Network benefits, subject to your deductible and coinsurance.

The expected length of stay following delivery is 48 hours for a normal vaginal delivery and 96 hours for a cesarean section. If your doctor says that a longer stay is medically necessary, you will be covered for the additional time period. If you choose to leave the hospital earlier than the expected length of stay (i.e., 24-hours for a vaginal delivery), you will be eligible for our maternity home care benefit. Please call Customer Relations or speak with your network doctor for more information.

Once you are home, remember that adding your newborn to your plan does not happen automatically. You must submit a PHS Changes Form to PHS within 31 days of your newborn's birth. This form can be obtained from the Customer Relations department.

To be certain there are no questions or gaps in coverage, you should also advise your employer benefits office within 31 days of the birth of your new baby.

Charges for Routine Nursery Care. Routine nursery care for well-born or sick-born child is room, board and other normal care for which a hospital makes a charge.

The usual and reasonable charge made by the hospital for routine nursery care provided while the mother is hospital confined after birth will be considered as covered charges under the plan.

The benefit is limited to the usual and reasonable charges made by a physician for the newborn child while hospital confined as a result of the child's birth.

Diabetic Coverage. If you need to purchase diabetic medications, and related supplies, PHS will cover the following in full when purchased from a participating pharmacy:

- ◆ alcohol swabs
- ◆ glucose test strips
- ◆ glucose-elevating agents
- ◆ insulin
- ◆ lancets and lancet devices
- ◆ oral hypoglycemic agents
- ◆ syringes

You can use your PHS ID card at a participating pharmacy or through the PCS Mail Service Program to receive your diabetic medications and supplies. The exception is equipment such as insulin pumps and blood glucometers. These items must be purchased through a durable medical equipment (DME) vendor or directly from the manufacturer, and are also covered in full.

Prescription Coverage. Participating pharmacies have contracted with PHS to charge members an amount equal to the wholesale price of their prescription drugs, less a discount. However, in some instances, a pharmacy's cash price might be lower than our discounted price. PCS is the administrator of the pharmacy drug plan.

Copayment - The copayment is applied to each covered pharmacy drug charge and is shown in the Benefits Summary. The copayment amount is not applied to your in-network or out-of-network out of pocket maximums. A participating pharmacy may only dispense a maximum 30 day supply of any prescription. You may however, obtain a 90-day supply by utilizing the PCS Mail Service program.

If a drug is purchased from a non-participating pharmacy, or a participating pharmacy when the participant's ID card is not used, the plan will reimburse up to the amount it would have paid at a participating pharmacy or when the participant's ID card was used. Any excess amount will become the financial responsibility of the participant.

The PHS Maintenance Drug Prescription Plan. If you take prescription drugs for an ongoing medical condition, you can obtain this maintenance medication in larger quantities than is normally allowed under PHS prescription benefit and often at a lower cost, up to the maximum coverage defined by your plan.

Through the PCS Mail Service program, PHS will cover up to a 90-day supply of medically necessary maintenance prescription drugs for a single copayment, if applicable, rather than the 30-day supply normally permitted. Copayments for prescription drugs are not recognized toward your out-of-pocket maximum. Your doctor has the option of prescribing up to three refills, which will entitle you to a maximum of a 12-month supply, resulting in considerable savings in time and money.

Limits to this benefit. This benefit applies only when a participant incurs a covered prescription drug charge. The covered drug charge for any one prescription will be limited to:

1. Refills only up to the number of times specific by a physician.
2. Refills up to one year from the date of order by a physician.

How to use this plan:

- ◆ To obtain prescription envelopes, call PHS or call the PCS Mail Service Pharmacy at 1-800-966-5772.
- ◆ Notify your physician of any allergies to medications.
- ◆ Ask your physician to prescribe a 90-day supply of medically necessary medications with the option of three refills. To ensure prompt processing, make sure the physician's name and address, the participant's name, and the exact daily dosage are clearly indicated on the prescription.
- ◆ Complete the prescription envelope information requested, including your PHS ID number.

Enclose your prescription(s) and check or money order for the appropriate copayment, if applicable, in the prescription envelope and send to:

PCS Mail Service
P.O. Box 961066
Fort Worth, Texas 76161-9854

MEDICAL MANAGEMENT SERVICES

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Concurrent stay review, discharge planning. Concurrent stay review and discharge planning are parts of the utilization review program. The utilization review administrator will monitor the participant's hospital stay and coordinate with the attending physician, hospital and participant to either release the participant from the hospital as scheduled, or obtain an extension.

Large Case Management. When a catastrophic condition, such as a spinal cord injury, a degenerative sickness, or a neurological paralytic disease occurs, a person will require long-term, perhaps lifetime, care. After the person's condition is stabilized in the hospital, he or she might be able to be moved out of the hospital and into another type of care setting — even to his or her home.

Sometimes, specialized care or adaptations to the home are required, but are not covered under the plan. The large case management program was initiated for those situations in which there would be a large cash outlay for non-covered expenses for catastrophic conditions. It is a way in which these non-covered expenses can be paid by the plan.

Large case management occurs in the following situations:

1. The catastrophic injury or sickness must have occurred while the participant was covered and the injury or sickness must have been covered under the plan.
2. The participant has been hospitalized and the attending physician feels the condition is stabilized.
3. The participant must continue to require an acute level of care, but that care need not be in a hospital.
4. Moving the participant to the new care setting must entail expenditures that are not reimbursable under the plan.

5. The case manager will coordinate and implement the large case management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan.
6. PHS, attending physician, participant and participant's family must all agree to the alternate treatment plan.
7. Once agreement has been reached, PHS will direct the plan to reimburse for expenses as stated in the treatment plan, even if these expenses normally would not be paid by the plan.

Note: This is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate.

BENEFITS SUMMARY DESCRIPTION

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**PHYSICIANS HEALTH SERVICES, INC.
OPEN ACCESS POINT-OF-SERVICE PLAN
CITY OF STAMFORD HEALTH PLAN**

The open access POS offers you the opportunity to use either PHS network or non-network health care providers each time you seek medical care, and still receive benefits for covered services.

Open access POS gives you a powerful new choice. You can work within the PHS provider network (there are thousands of participating physicians and dozens of hospitals in the Tri-State network) or "opt out" choosing a provider not affiliated with PHS. Care delivered both within and outside the network is recognized as a managed care benefit. Outside the network, care is subject to deductibles, coinsurance, and claim forms typical of indemnity plans.

Out-of-Network Providers:

Participant deductible, per calendar year	\$200.00
Family unit deductible, per calendar year	\$400.00

In-Network Copayment Maximum: All of your in-network copayments will be applied to the annual in-network copayment maximum of \$400 per participant or \$800 per family per calendar year exclusive of prescription drug benefit.

Out-of-Network Benefits: When using Out-of-Network benefits pre-certification is required for all inpatient admissions and certain outpatient procedures. To pre-certify, please contact the PHS Customer Relations Department at 1-800-205-0095. A flat penalty of 50% of the initial \$10,000.00 of covered expenses of the cost of the case per each non-certification occurrence is applicable to Out-of-Network reimbursement when the participant does not complete the pre-certification process.

General Exclusions: You are not covered for physical exams for employment, insurance, school, premarital requirements or summer camp (unless substituted for a normal physical exam); prescription drugs and some injectables dispensed by a physician in his or her office; dental services including oral surgery (unless services required as a result of an accident); routine eye exams (no illness or injury diagnosed), eyeglasses, or contact lenses; hearing aids; routine foot care; some transplant procedures; cosmetic or reconstructive surgery, unless medically necessary; custodial services; injury or sickness caused by war or service in the armed forces; services of a person who is a member of your immediate family; services of a person who resides in your

home; services of volunteers or persons who do not normally charge for their services; services given by a licensed pastor counselor or member of congregation provided in course of normal duties; weight-reduction programs; marriage counseling; or long-term psychiatric treatment.

PHS will not duplicate any benefits to which members are entitled under Workers' Compensation, No-Fault, Medicare, or other group health insurance coverage.

The services, exclusions and limitations listed above do not constitute a contract and are a summary only. If you have any questions, please call the PHS Customer Relations Dept. at 1-800-205-0095.

Please Note: For any services listed for which a visit or dollar limit is indicated, In-Network and Out-of-Network Services count collectively toward the limit.

**SCHEDULE OF BASIC MEDICAL BENEFITS
CITY OF STAMFORD**

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Benefit Costshares		
	\$10 office visit copayment \$100 hospital admission copayment Out-of-pocket maximum: \$400 ind. /\$800 fam.	Deductible: \$200/\$400 Coinsurance: 80% of first \$5,000 Out-of-pocket maximum: \$1,200 ind. /\$2,400 fam.
	Out of pocket maximum exclusive of prescription drug benefit charges, excess R&C*, non covered services, and supplies and charges in excess of maximum visits.	
Preventive Care		
Pediatric Well Care	\$10 copayment	Subject to deductible, coinsurance, and R&C
	Monthly - birth to 5 months of age Every other month - 6 months to 11 months of age Every 3 months - 12 months to 23 months of age Every 6 months - 24 months to 35 months of age Once per calendar year - age 3 through age 17	
Adult Routine Physical Examinations	\$10 copayment	Subject to deductible, coinsurance, and R&C
	Every 3 calendar years - age 18 to 29 Every other calendar year - age 30 to 49 Every calendar year - on or after age 50	
Gynecological Routine Examinations	\$10 copayment	Subject to deductible, coinsurance, and R&C
	Once per calendar year In addition - as medically necessary	
Mammographic Services	\$10 copayment	Subject to deductible, coinsurance, and R&C
	Age 35 to 39 - one baseline mammography Age 40 and over-once every calendar year or as medically necessary	
Hearing Examinations	\$10 copayment	Subject to deductible, coinsurance, and R&C
Medical Services		
Medical Office Visit	\$10 copayment	Subject to deductible, coinsurance, and R&C
Outpatient - Occupational, Physical and Speech Therapy	\$10 copayment	Subject to deductible, coinsurance, and R&C
	Combined 30 visit maximum per calendar year	

* R&C - Reasonable and Customary Allowance

**SCHEDULE OF BASIC MEDICAL BENEFITS
CITY OF STAMFORD**

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Chiropractic Therapy	\$10 copayment	Subject to deductible, coinsurance, and R&C
	30 visit maximum per calendar year	
Allergy Services	\$10 copayment Allergy shots including bee venom extract	Subject to deductible, coinsurance, and R&C
	Office visit and allergy shots combined subject to one copayment	
Diagnostic Lab & X-Ray and Chemotherapy Services	100% of covered expenses	Subject to deductible, coinsurance, and R&C
Inpatient - Medical Services	100% of covered expenses \$100 copayment per admission	Subject to deductible, coinsurance, and R&C
	Precertification required for certain procedures	
Surgery Fees	100% of covered expenses	Subject to deductible, coinsurance, and R&C
	Precertification required for certain procedures	
Office Surgery	\$10 copayment	Subject to deductible, coinsurance, and R&C
	Precertification required for certain procedures	

**SCHEDULE OF BASIC MEDICAL BENEFITS
CITY OF STAMFORD**

Mental Health and Substance Abuse	IN-NETWORK	OUT-OF-NETWORK
Inpatient Hospital Psychiatric Biologically Based	100% of covered expenses \$100 copayment per admission	Subject to deductible, coinsurance, and R&C
Outpatient Mental Health Biologically Based	\$10 copayment	Subject to deductible, coinsurance, and R&C
Inpatient Hospital Psychiatric Non-Biologically Based	100% of covered expenses \$100 copayment per admission	Subject to deductible, coinsurance, and R&C
	60 Inpatient day maximum or substitution for 120 partial hospitalization days per calendar year	
Outpatient Mental Health Non-Biologically Based	\$20 copayment	50% R&C
	30 Outpatient Visits per calendar year	
Inpatient Hospital Substance Abuse and / or Alcoholism	100% of covered expenses \$100 copayment per admission	Subject to deductible, coinsurance, and R&C
Outpatient Substance Abuse and / or Alcoholism	\$10 copayment	Subject to deductible, coinsurance, and R&C
	Combine inpatient and outpatient maximum of 45 days per calendar year	
Emergency Care		
Emergency Room	\$50 copayment Waived if admitted	\$50 copayment Waived if admitted
After Hours Urgent Care Center	\$10 copayment	\$10 copayment
Walk-In Center	\$10 copayment	\$10 copayment
Ambulance	100% of covered expenses	100% of covered expenses
	When determined medically necessary	

Biologically-based mental illnesses include: Schizoaffective Disorder, Major Depressive Disorder, Bi-Polar Disorder, Paranoia and other Psychotic Disorders, Obsessive-Compulsive Disorder, Panic Disorder, Pervasive Development Disorder, or Autism.

**SCHEDULE OF BASIC MEDICAL BENEFITS
CITY OF STAMFORD**

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Inpatient Hospital		
General/Medical/Surgical/ Maternity (semi-private)/ Intensive Care	100% of covered expenses \$100 copayment per admission	Subject to deductible, coinsurance, and R&C
	Subject to non-emergency precertification	
Ancillary Services (medication, supplies)	100% of covered expenses	Subject to deductible, coinsurance, and R&C
Outpatient Hospital		
Outpatient - Surgery, Facility Charges	100% of covered expenses	Subject to deductible, coinsurance, and R&C
Diagnostic Lab & X-Ray	100% of covered expenses	Subject to deductible, coinsurance, and R&C
Pre-Admission Testing	100% of covered expenses	Subject to deductible, coinsurance, and R&C
Other Services		
Rehabilitation	100% of covered expenses	Subject to deductible, coinsurance, and R&C
	45 day maximum or substitution for hospitalization	
Skilled Nursing Facility	100% of covered expenses	Subject to deductible, coinsurance, and R&C
	60 day maximum per calendar year	
Hospice	100% of covered expenses	100% of covered expenses
	Individuals with life expectancy of 6 months or less	
Durable Medical Equipment	80% coinsurance	50% coinsurance
	\$10,000 maximum per calendar year	
Prosthetics	100% of covered expenses	Subject to deductible, coinsurance, and R&C
	\$5,000 maximum for prosthetic Calendar year replacement parts maximum \$500	
Home Health Care	Covered 100% of covered expenses with prior approval	Subject to deductible, coinsurance, and R&C
Prescription Drugs	\$5 generic \$10 brand \$5 mail order (90-day supply) No maximum	Emergency pharmacy services only
Dependent/Student Eligibility	Child to age 19 Child to age 23 if full time student	

Preventive Services Covered by PHS

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For Adult Women and/or Adult Men

Service	Purpose	Women	Men	Frequency
Gynecological exam (pelvic and breast)	to check for problems	yes	no	yearly
Pap smear (part of gynecological exam)	to check cervix for irregular cells	yes	no	yearly
Routine (well) exam	to promote preventive care and general well-being	yes	yes	from ages 19-29, once every three years; from ages 30-49, once every two years; from age 50 on, once a year
Complete Blood Count (CBC)	to check for anemia and infection	yes	yes	during every routine exam
Urinalysis	to check kidney and bladder function	yes	yes	during every routine exam
Chemistry profile	to check the function of various organs	yes	yes	during every routine exam
Lipid profile	to check fat storage	yes	yes	every five years from age 19-49; every three years after age 50
Electrocardiogram (EKG)	to check heart function	yes	yes	every five years from ages 30-39; every four years from ages 40-49; every three years from ages 50-59; every two years after age 60
Stool screening (three specimen test)	to check for hidden bleeding	yes	yes	every two years from ages 40-49; yearly after age 50
Chest X-ray	to check lungs	yes	yes	once between the ages of 35-45 for smokers; once every five years after age 46 for smokers
Sigmoidoscopy	to check lower bowel for growths	yes	yes	every three years after age 50 after two consecutive years with negative results
Mammography	to check for irregularities in breast tissue	yes	no	baseline between the ages of 35-39; from age 40 on, once a year
Prostate exam	to test for prostate irregularity	no	yes	every routine exam after age 40, with specific blood testing if appropriate

Preventive Services Covered by PHS for Children and Adolescents

Service	Purpose	Ages Birth to 24 Months	Ages 2-6	Ages 7-12	Ages 13-18
Routine (well) exam	to promote preventive care and general well-being	monthly to age 5 months; every 2 months to age 11 months; every 3 months to age 24 months	once every 6 months to age 3; once a year to age 6	once a year	once a year
DPT vaccine	to prevent Diphtheria, Tetanus and Pertussis	ages 2 months, 4 months, 6 months, and 15 months	once between the ages of 4 and 6 (before school entry)		
Polio vaccine	to prevent polio	ages 2 months, 4 months, and 15 months	once between the ages of 4 and 6 (before school entry)		
MMR vaccine	to prevent measles, mumps, and rubella	once around the age of 15 months; cannot be given before first birthday		a second dose of measles vaccine is required no later than entry into seventh grade	
Hib vaccine	to prevent meningitis caused by the Hemophilus influenza organism	the four-dose series should be given at 2, 4, 6, and 15 months; the three dose-series should be given at 2,4, and 12 months			
HBV vaccine	to prevent Hepatitis B	should be given at birth, between 2 and 4 weeks, and between 6 and 18 months			
Varicella vaccine (chicken pox)	to prevent chicken pox	once between the ages of 12 months through 12 years if there is no reliable history of having had chicken pox			Two doses 4 to 8 weeks apart for individuals over age 13 if there is no reliable history of having had chicken pox
TB skin test	to evaluate tuberculosis status	once before the age of 12 months	once between the ages of 1 and 7 (if previously negative)	once between the ages of 7 and 12 (if previously negative)	once between the ages of 12 and 18 (if previously negative)
Cholesterol level test	to determine cholesterol level		once at age 2 <i>if at high risk</i>		
Urinalysis	to check kidneys and bladder	once between birth and 1 year of age	once a year as part of routine exam	once every two years as part of routine exam	once every two years as part of routine exam
Lead level test	to check for high levels	once between birth and 1 year of age	once between the ages of 1 and 7		
Hematocrit or hemoglobin	to check for anemia	once between birth and 1 year	once between the ages of 1 and 4, and once between 4 and 7		

For all benefits shown in the Benefits Summary, charges for the following are NOT covered:

1. Charges excluded or limited by the plan design as mentioned in this document.
2. Charges incurred for which the plan has no legal obligation to pay; including covered charges paid by another group plan pursuant to the coordination of benefit provisions described on pages 41 - 43.
3. Care and treatment of an injury or sickness that, in either case, is occupational — that is, arises from work for wage or profit including self-employment.
4. Care and treatment, services or supplies not recommended and approved by a physician; or treatment, services or supplies when the participant is not under the regular care of a physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the injury or sickness.
5. Care and treatment for which there would not have been a charge if no coverage had been in force (incurred before your coverage began).
6. Care and treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law.
7. Care and treatment that is either experimental/investigational or not medically necessary.
8. Medical treatments or procedures unless proven to be safe, efficacious, scientifically-established therapies; or unless found to have a demonstrable benefit for a particular illness or disease. Ineffective or experimental surgical or medical treatments or procedures, research studies or other experimental health care procedures under continued scientific testing and research with questions to safety and efficacy are not covered.
9. The part of an expense for care and treatment of an injury or sickness that is in excess of the usual and reasonable charge.
10. Charges for services received as a result of injury or sickness caused by or contributed to by engaging in an illegal act or occupation; by committing or attempting to commit any crime, criminal act, assault or other felonious behavior; or by participating in a riot or public disturbance.
11. Any charge that is due to a declared or undeclared act of war.
12. Any charge due to an intentionally self-inflicted injury, while sane or insane.
13. Professional services performed by a person who ordinarily resides in the participant's home or is related to the participant as a spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.
14. Care and treatment provided for cosmetic reasons, including but not limited to liposuction, etc. Reconstructive surgery will be covered when medically necessary and approved in advance or as may be required to approximate a participant's previous external appearance immediately following sickness, trauma, accidental injury or because of congenital disease or anomaly of a dependent child, which has resulted in a functional defect.
15. Radial keratotomy or other eye surgery to correct near-sightedness. Also, lenses for the eyes and exams for their fitting.
16. Charges for routine or periodic examinations, screening examinations, evaluation procedures, preventive medical care, or treatment or services not directly related to the diagnosis or treatment of a specific injury, sickness or pregnancy-related condition which is known or reasonably suspected, unless such care is specifically covered in the Benefits Summary.
17. Charges for routine foot care including, treatment or supplies for the feet; treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions, except open cutting operations; and treatment of corns, calluses or toenails, unless needed in treatment of a metabolic or peripheral-vascular disease.

18. Replacement of braces of the leg, arm, back, neck, artificial arms, legs, eyes or lenses for the eyes, unless there is sufficient change in the participant's physical condition or due to normal wear requiring replacement, rendering the original device no longer functional.
19. Professional services billed by a physician or nurse who is an employee of a hospital or skilled nursing facility and paid by the hospital or facility for the service.
20. Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, allergy-free pillows, blanket or mattress covers, electric heating units, swimming pools, orthopedic mattresses, exercising equipment, vibratory equipment, elevators or stair lifts, blood pressure instruments, stethoscopes, clinical thermometers, scales, elastic bandages or stockings, non-prescription drugs and medicines, first-aid supplies and non-hospital adjustable beds.
21. Care and services or treatment for transsexualism (sex-change), gender dysphoria or sexual reassignment or change, including medications, implants, hormone therapy, surgery, medical or psychiatric treatment.
22. Care and treatment for reversal of surgical sterilization.
23. Care and treatment for hair loss including wigs (excluding cancer patient care), hair transplants or any drug that promises hair growth, whether or not prescribed by a physician.
24. Care and treatment for smoking cessation programs.
25. The following exclusions as related to prescription drug coverage:
 - a. A charge excluded under medical plan exclusions.
 - b. A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin.
 - c. Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device.
 - d. Immunization agents or biological sera; blood or blood plasma; or oxygen, including its administration.
 - e. A drug or medicine labeled: "Caution — limited by federal law to investigational use" unless approved by PHS.
 - f. Experimental drugs and medicines, even though a charge is made to the participant.
 - g. Any charge for the administration of a covered prescription drug.
 - h. Any drug or medicine that is consumed or administered at the place where it is dispensed.
 - i. A drug or medicine that is to be taken by the participant, in whole or in part, while hospital confined. This includes being confined in any institution that has a facility for the dispensing of drugs and medicines on its premises.
 - j. A charge for prescription drugs which may be properly received without charge under local, state or federal programs.
 - k. A charge for allergens.
 - l. A charge for prescription drugs for smoking cessation (i.e., nicotine gum or nicotine patches).
 - m. A charge for antibacterial soaps/detergents, shampoos, toothpastes/gels and mouthwashes/rinse.
 - n. A charge for vaccines and allergenic extracts, except as covered under this plan.
 - o. A charge for prescription drugs used in connection with drug addiction.
 - p. A charge for infertility medication.
 - q. A charge for smoking deterrent patches.
 - r. A charge for hypodermic syringes and/or needles, injectables or any prescription directing administration by injection (other than insulin).
 - s. A charge for prescription drugs used in connection with weight reduction, smoking cessation and treatment of baldness.

- t. A charge for experimental drugs.
- 26. Hypnosis/hypnotherapy.
- 27. Charges for travel or accommodations, whether or not recommended by a physician, except for ambulance charges as defined as a covered expense.
- 28. Care or treatment for injury or sickness resulting from the voluntary taking of or while under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a physician.
- 29. Meals, personal comfort items, social services, housekeeping services, custodial care and protective or companion services.
- 30. Services rendered for bed rest, custodial care or convenience reasons.
- 31. Services required by third parties unless otherwise covered, including but not limited to employment, insurance, school, summer camp and premarital exams.
- 32. Artificial insemination, in vitro fertilization, immunotherapy, embryo transfer, or amniocentesis.
- 33. Services provided for obesity or weight reduction except when medically necessary and approved in advance by PHS. This exclusion includes specialized medical programs and surgical programs (including the excision of fatty tissue) for controlling obesity as a risk factor of other medical conditions.
- 34. Care for conditions the state or local law requires to be treated in a public facility.
- 35. Orthognathic surgery, unless medically necessary as may be required as a result of neoplasm, trauma, or significant unilateral asymmetry. Surgery to reposition the maxilla and/or mandible is otherwise not covered.
- 36. Scleral therapy as the initial treatment for the diagnosis of varicose veins involving the greater and lesser saphenous veins, unless medically necessary and approved in advance by PHS.
- 37. Court-ordered treatment unless deemed medically necessary by PHS and approved in advance.
- 38. Dental treatment for temporomandibular joint dysfunction (TMJ) syndrome and related conditions. Examples of non-covered services include: biofeedback, occlusal appliances (splints) or other oral prostheses and their adjustments, and prosthodontic therapy such as bridgework, crowns and occlusal adjustments.
- 39. Auto-transfusion and storage of blood, except autologous blood preparation and transfusion as listed in this plan.
- 40. Disposable medical equipment.
- 41. The use of interferon for treatment of condylomata acuminata (venereal warts) and extracorporeal shock wave lithotripsy (ESWL) for treatment of gallstones unless approved in advance.
- 42. Artificial heart, isolated pancreas and all other transplants not specifically covered under this plan.
- 43. Maintenance medications, except as provided in this plan.
- 44. Reconstructive surgery, except as covered under this plan.
- 45. Oral or injectable contraceptives and contraceptive devices, such as diaphragms, intrauterine devices, and cervical caps, regardless of the reason for their use.
- 46. Medical, surgical and diagnostic procedures for which pre-certification is required and not obtained.
- 47. Adaptational, functional, educational or vocational testing.
- 48. Biofeedback when not in conjunction with other medical services that have been approved in advance.
- 49. Laser therapy for the purpose of ameliorating or modifying snoring unless significant associated sleep apnea has been demonstrated and the procedure has been approved in advance.
- 50. Oral surgery to remove an impacted tooth or any other procedures on gums or mouth tissue to treat disease unless of a reconstructive nature required as a result of an accidental injury. (Please refer to your separate Dental program).
- 51. Dentures or other dental procedures. (Please refer to your separate Dental program).
- 52. Eyeglasses and/or contact lenses. (Refer to separate Vision program).

53. Education and/or training programs, including visual training, speech therapy, diagnosis and treatment of learning disabilities unless otherwise specifically described as a covered health care benefit.

COORDINATION OF BENEFITS

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Coordination of the benefit plans. Coordination of benefits sets out rules for the order of payment of covered charges when two or more plans — including Medicare — are paying. When a participant is covered by this plan and another plan, or the participant’s spouse is covered by this plan and by another plan or the couple’s covered children are covered under two or more plans, the plans will coordinate benefits when a claim is received.

The plan that pays first, according to the rules will pay if there were no other plans involved. The secondary and subsequent plans will pay the balance due up to 100% of the total allowable expenses.

Benefit plan. This provision will coordinate the medical and dental benefits of a benefit plan. The term benefit plan means this plan or any one of the following plans:

1. Group coverage or group-type coverage, whether covered or uncovered. This includes prepayment, group practice or individual practice coverage.
2. Coverage under a governmental plan or coverage that is required or provided by law. This does not include a state plan under Medicaid (Title XIX, grants to states for medical assistance programs, of the United States Social Security Act as amended from time to time). It also does not include any plan when, by law, its benefits are excess to those of any private insurance program or other non-governmental program.
3. Health care benefits coverage of group, group-type and individual “no-fault” and traditional automobile “fault” contracts. The term “plan” shall be construed separately for:
 - a. each policy or other arrangement for benefits; and
 - b. that portion of any such plan which reserves the right to consider the benefits of other plans in determining its benefits and that portion which does not.

Applicability:

1. This Coordination of Benefits (“COB”) provision applies when a participant has health care coverage under more than one plan.
2. PHS shall coordinate benefits for all medically necessary covered services defined as an allowable expense of the Benefits Summary, and according to the terms set forth in this document, which are provided by a physician or arranged by a physician and approved in advance by PHS.
3. If the participant is covered by this plan and another plan, the Coordination of Benefit Determination Rules of the Benefits Summary determine which plan is the primary plan. The sum of this plan’s reduced obligations, and all the benefits payable under all other plans, shall not exceed the total of such allowable expenses.

Automobile Limitations. With respect to services for which a participant is entitled to the basic reparation of benefits under any automobile no-fault policy as required by law, PHS shall be entitled to charge:

1. the insurer for the dollar value of those benefits to which the participant is entitled,
2. the participant for such value, to the extent he has received payment therefor, or
3. withdraw payment from a provider (e.g., physician, hospital, etc.) to the extent a participant is entitled to the basic reparation of benefits under any automobile no-fault policy.

According to the state law where you reside, the automobile insurance carrier may pay for medical expenses associated with an automobile accident before PHS does.

Job-Related Medical Claims. If you have an injury or illness related to your job, you should submit the claim(s) to your employer for coverage through Workers' Compensation.

Benefit Plan Payment Order. When two or more plans provide benefits for the same allowable charge, benefit payment will follow these rules.

1. Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.
2. This plan determines its benefits using the first of the following rules which apply:
 - a. Participant/dependent — The benefit plan that covers the participant as an employee or participant will be considered before a benefit plan that covers the participant as a dependent.
 - b. Active/Inactive employee — The benefits of a benefit plan which covers a person as an employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or retired employee. The benefits of a benefit plan which covers a person as a dependent of an employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a dependent of a laid-off or retired employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

When a child is covered as a dependent and the parents are not separated or divorced, these rules will apply:

1. The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;
2. If both parents have the same birthday, the benefits of the benefit plan which has covered the participant for the longer time are determined before those of the benefit plan which covers the other parent.

If the other benefit plan does not have the rule described immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other benefit plan will determine order of benefits.

When a child's parents are divorced, these rules apply:

1. If the parent with custody of the child has not remarried, then the benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.
 2. If the parent with custody of the child has remarried, then the benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a dependent will be considered next. The benefit plan of the parent without custody will be considered last.
 3. If the terms of a court decree state which parent is financially responsible for health care benefits of the child, the benefit plan of that parent will be considered before other plans that cover the child as a dependent.
 4. If the terms of a court decree does not state the order of responsibility, then the order of responsibility shall be that stated in #2 above.
- c. If there is still a conflict after these rules have been applied, the benefit plan which has covered the participant for the longer time will be considered first. If a court decree states the parents are equally responsible, the benefit plan which has covered the child longer will be considered first.
3. Medicare will pay last to the extent stated in federal law. When Medicare pays first, this plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts.

Claims determination period. Benefits will be coordinated on a calendar year basis. This is called the claims determination period.

Right to receive or release necessary information. To make this provision work, this plan may give or obtain needed information from another insurer or any other organization of person. This information may be given or obtained without the consent of or notice to any other person. A participant will give this plan the information it asks for about other plans and their payment of allowable charges.

Facility of payment. This plan may repay other plans for benefits paid that PHS determines it should have paid. That repayment will count as a valid payment under this plan.

Right of recovery. This plan may pay benefits that should be paid by another benefit plan. In this case, this plan may recover the amount paid from the other benefit plan or the participant. That repayment will count as a valid payment under the other benefit plan.

Further, this plan may pay benefits that are later found to be greater than the allowable charge. In this case, this plan may recover the amount of the overpayment from the source to which it was paid.

CONFIDENTIALITY

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Information from participant and dependent medical records and from providers to hospitals incident to the doctor-patient or hospital-patient relationship may be accessed by PHS staff and its affiliates and shall be kept confidential. Except as necessary for use in administering by the plan, for use in bona fide medical research

and education, medical and financial auditing, and/or as authorized by law; medical information about a participant or dependent will not be disclosed without the written consent of the participant or dependent (or, if the participant or dependent is a minor or incapable, by the participant's or dependent's parent or legal representative).

COBRA CONTINUATION OPTIONS

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Federal law gives certain persons the right to continue their health care benefits beyond the date that they might otherwise terminate. The entire cost (plus a reasonable administration fee) must be paid by the continuing person. Coverage will end if the covered individual fail to make timely payments of contributions or premiums (within a maximum of 30 days). This law is referred to as "COBRA," which stands for Consolidated Omnibus Budget Reconciliation Act of 1985. Generally, COBRA applies to employers with 20 or more full and/or part-time employees.

Benefits affected by COBRA. There are two categories of benefits that may be continued under COBRA:

1. "Core benefits" are medical benefits. Any COBRA continuance option must include core benefits for which the person was covered just prior to the COBRA "qualifying event" (an event which qualifies a person for continued coverage under COBRA).
2. "Non-core benefits" include dental benefits, vision care benefits and flexible spending accounts under Section 125 (Cafeteria-type) plans.

If the "qualified beneficiary" (a person eligible for COBRA continuance) was covered by these non-core benefits prior to termination, the individual may, but is not required to, continue them under COBRA. Which non-core benefits, if any, are to be continued, will be indicated by the qualified beneficiary at the time of COBRA enrollment.

Life insurance, accidental death and dismemberment benefits and weekly income or long term disability benefits (if a part of the employer's plan) are not considered for continuance under COBRA.

Maximum Time Periods. Continuation will be available for a qualified beneficiary up to the maximum time period shown in items 1 and 2 below.

1. Up to 18 months for a participant and his covered dependents when coverage terminates due to a reduction of hours worked or termination of employment for reasons (other than gross misconduct.)
NOTE: An individual who is disabled on the date of the qualifying event described in the preceding sentence may have COBRA coverage extended (and an extra fee charged) from 18 months to 29 months provided that:
 - a. the individual is determined as being disabled for Social Security purposes on the date of the qualifying event; and
 - b. the individual notifies the Plan Administrator within 60 days of the qualifying event or Social Security Administration's determination of disability, and before the disabled individual's 18-month coverage period ends.
 - c. If a covered dependent elects to continue coverage due to the employee's termination of employment or reduction in hours, the dependent will be entitled to additional coverage - up to 36 months from the date the employee originally lost coverage - if during the first 18 months, the employee dies, is divorced or becomes legally separated or if covered child ceases to be an eligible dependent.
2. Up to 36 months for:
 - a. a covered child who ceases to be an eligible dependent;
 - b. a covered dependent of a deceased employee; or

c. a former covered spouse whose coverage ceases due to divorce or legal separation.

Continued coverage will cease before the end of the maximum period on the earliest of:

1. the date that the qualified beneficiary first becomes, after the date of election, (a) covered under any other group health plan (as an employee or otherwise), or (b) entitled to benefits under Medicare. However, a qualified beneficiary who becomes covered under a group health plan which has a pre-existing condition limit must be allowed to continue COBRA coverage for the length of a pre-existing condition or to the COBRA maximum time period, if less.
2. Continued coverage will also cease if an individual receiving coverage beyond the original 18-month period due to a disability is no longer disabled. The individual must notify the Plan Administrator within 30 days of a final determination that the individual is no longer disabled.

Notice Requirements. When coverage terminates due to a participant's death or termination, the employer has 30 day in which to notify the Plan Administrator of the qualifying event.

When coverage terminates due to divorce or change of dependent status, the qualified beneficiary has 60 days from the qualifying event in which the notify the Plan Administrator that the qualifying event has occurred.

Complete instructions on how to elect continuation will be provided by the Plan Administrator within 14 days of receiving notice of the qualifying event. Qualified beneficiaries then have 60 days in which to elect continuation. the 60-day period is measure from the later of the date coverage terminates or the date the person receives notice of the right to continue. If continuation is not elected in that 60-day period, then the right to elect continuation coverage ceases.

RESPONSIBILITIES FOR PLAN ADMINISTRATION [<<Index](#)

Plan Administrator. The City of Stamford Employee Benefits Plan is the benefit plan of the City of Stamford, PHS, also called the plan sponsor.

PHS shall administer this plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. The Plan Administrator shall rely upon PHS but has the absolute discretionary authority (only exercised in rare and unusual circumstances to override PHS) to construe and interpret the terms and provisions of the plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to participant's rights, and to decide questions of plan interpretation and those of fact relating to the plan. The decisions of the Plan Administrator supported by PHS standard practice will be final and binding on all interested parties.

Duties of the Plan Administrator (PHS)

1. To administer the plan in accordance with its terms.
2. To decide disputes which may arise relative to a participant's rights.
3. To keep and maintain the plan documents and all other records pertaining to the plan.
4. To appoint a Claims Administrator to pay claims.

Plan is not an Employment Contract. The plan is not to be construed as a contract for or of employment.

Clerical Error. Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error delay is discovered.

Amending and Terminating the Plan. If the plan is terminated, the rights of the participants are limited to expenses incurred before termination.

THIRD PARTY RECOVERY PROVISIONS

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Rights of Subrogation and Refund

Please see Defined Terms beginning on page 4 for definitions of “Recovery,” “Subrogation” and “Refund.”

When this provision applies. The participant may incur medical or dental charges due to injuries for which benefits are paid by the plan. The injuries may be caused by the act or omission of another person. If so, the participant may have a claim against that other person for payment of the medical or dental charges. The plan will be subrogated to all rights the participant may have against that other person.

The participant must:

1. assign to the plan his or her rights to recovery when this provision applies; and
2. repay to the plan out of the recovery made from the other person or the other person’s insurer.

Amount subject to subrogation or refund. Only the amount recovered for medical or dental charges will be subject to subrogation or refund. In no case will the amount subject to subrogation or refund exceed the amount of medical or dental benefits paid for the injury or sickness under the plan.

When a right of recovery exists, the participant will execute and deliver all required instruments and papers as well as doing whatever else is needed to secure the right of subrogation. In addition, the participant will do nothing else to prejudice the right of the plan to subrogate.

Recovery from another plan under which the participant is covered. This right of refund also applies when a participant recovers under an uninsured or underinsured motorist plan, homeowner’s plan, renter’s plan or any liability plan.

ANSWERS TO FREQUENTLY ASKED QUESTIONS

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Our staff of well-trained and experienced Customer Relations representatives has come up with this list of the most frequently asked questions. Some of the answers may apply to questions you have about PHS.

Q. I want to change my Primary Care Physician - What do I do?

A. We want you to be happy with your PCP. An ongoing, positive relationship with him or her is vital. If you decide that you want to change your PCP, just call Customer Relations and let us know the name of your new doctor. If you need help selecting a doctor, our representatives can identify network providers close to your work or home and can mail or fax you this list at your request. You do not have to notify the City’s Benefits Department to select or change your PCP.

Q. I need to see a specialist. How do I select one?

A. Your PCP is the best person to assist you, because he or she knows your health history best and can make a referral to the proper network specialist. If you prefer, you may self-refer to a specialist from our Directory of Physicians and Providers and still receive In-Network benefits for covered services. If you choose to see a specialist who does not participate in the PHS network, any covered services you receive would be paid under your Out-of-Network benefits.

Q. I lost my membership card. What should I do?

A. Give us a call, and we'll send you a new one. Be sure when you get it to put it in your purse or wallet, where it's safe and convenient. Remember, each time you go to the doctor or receive any medical treatment, you'll need to show your ID card. In the meantime, if you are encouraged to see a PHS physician, he or she can verify your membership with PHS by calling us.

Q. My PCP wants me to see a Specialist not in this PHS network. Will you cover my visits to him or her?

A. While in the Connecticut, New York and Northern New Jersey area you need to see a specialist and one is not participating in PHS's network, contact your PCP. Your PCP will submit an Out of Network Referral Request in your name to a PHS Medical Director. You will receive a determination that if there is no specialist who could provide the same services in the network, your claim will be processed as an in-network benefit. There may be limitations to the kind of services PHS will cover under this exception.

If the services requested by your PCP are not approved because they can be provided by an In-Network physician, you may still choose to see the Out-of-Network doctor and be covered under your Out-of-Network benefits.

Q. It's 2 a.m., and my child is running a high fever. What should I do?

A. Call your child's PCP. This is one reason why a good relationship with a PCP is important—so you can feel comfortable calling at any time. All doctor's offices have answering services that can immediately contact your PCP or another doctor who is on call. He or she will call you back, regardless of what time it is, and let you know what you should do for your child.

Q. The PHS plan I am enrolled in includes a prescription plan. I received my ID card but am unsure how to use it when I purchase prescriptions. Can you explain this to me?

A. At home or away from the service area, your prescriptions must be obtained at a participating pharmacy to be covered under your plan. You can present your ID card at any PCS pharmacy. The pharmacist will be able to automatically determine whether you have met your deductible (if applicable) and how much money needs to be paid by you. It is very important that you present your card at the pharmacy each time you purchase prescriptions.

Q. I was in the hospital recently and had some blood work done in the lab there. I know the hospital is a participating hospital, but I got a bill for the lab work. Why?

A. Although the hospital is participating for inpatient and outpatient surgical procedures, some ancillary services, including, but not limited to physical therapy, occupational therapy, and blood work, are not always covered. PHS will only cover under your In-Network benefits blood tests or other services performed at PHS participating labs or other providers. If you use a lab that does not participate in the PHS network, coverage will be subject to your Out-of-Network benefits. To find out whether a specific lab or provider participates with PHS, check your PHS Directory of Physicians and Providers or call Customer Relations.

Q. My son fell and broke his arm. I rushed him to the emergency room where they took care of it. Will PHS pay for these services?

A. Yes. A broken arm is a true emergency and is covered by PHS. You are only responsible for a copayment for this visit to the emergency room. Any follow up care after the emergency room visit should be provided by your PHS doctor or specialist in order to receive In-Network coverage. If appropriate, your PCP can refer you to a PHS specialist for the follow-up care. Also, remember that you will be responsible for the entire cost of any visit to the emergency room that is not a true emergency.

Q. I'm planning a trip overseas next month. What if I have a medical emergency while I'm there?

A. PHS covers true medical emergencies anywhere in the world. If you have an emergency while you are away from the PHS service area, by all means get medical attention. As with a medical emergency at home, there is a copayment for approved emergency room services, but if you're admitted to the hospital directly from the emergency room, the copayment is waived. However, depending on the PHS plan you have, you may be responsible for a hospital admission copayment. If you are admitted, you, a spouse or other relative, or the facility should notify PHS as soon as possible. And before you leave, be sure to get an itemized bill (with diagnosis and procedures) for any charges from the hospital or doctor. When you get back home, you'll need to submit this bill, along with an explanation of the emergency, to PHS. Also, you'll want to call your PCP to advise him or her about your medical emergency. Your PCP can help determine what follow-up care is appropriate. If PHS determines that it was not a true emergency, you will be covered under your Out-of-Network benefits.

Q. I just brought my new baby home from the hospital, but it's not re-enrollment time at my office. Will PHS cover my baby?

A. Yes. It's very important that you notify both your employer and PHS within 31 days of the birth. The way to do this is to fill out a PHS Changes Form and send it to the address listed on the form. Normally, your PHS obstetrician will advise PHS of your admission to the hospital or birthing center, and we will send out an introductory "First Steps" package that includes the enrollment form. Adding another person to your policy may increase your premium, so check with your employer about any premium questions you have.

Q. My husband gets PHS coverage for both of us through his job. My employer also provides both of us with health coverage through a different carrier. My insurance carrier just sent me an Explanation of Benefits form for treatment I received from a PHS doctor. What should I do with the Explanation of Benefits?

A. The insurance you have through your job is considered your primary coverage. In your case, PHS is your secondary coverage. You must send the explanation of benefits directly to the PHS doctor you saw. Include a note, with your PHS ID number, stating that PHS is your secondary carrier. The PHS doctor will do the necessary paperwork and submit it to PHS for processing.

Q. In order to improve my health, my doctor has recommended that I lose weight. Will PHS cover a weight-reduction program?

A. Although PHS does not cover the cost of weight-reduction programs, we have arrangements with a variety of agencies, such as Weight Watchers and local fitness centers, for discounts for PHS members. Please call Customer Relations to find out what is available in your area.

Q. Suppose my doctor wants to admit me to the hospital for surgery or schedules me for an outpatient procedure. What do I need to do for PHS?

A. You may not need to do anything. Your PHS doctor needs to get approval from PHS before admitting you to the hospital. Also, some surgical and diagnostic procedures require pre-certification from PHS before coverage will be provided. Your PHS doctor is familiar with the procedure for doing this. If the hospital admission or outpatient procedure will be done by a doctor other than your PCP, please make sure that your PCP has made the appropriate referral for these services. If the admission or procedure is done by an Out-of-Network physician, ***you the participant*** must contact PHS to schedule the pre-certification. Otherwise, you will be subject to a significant reduction in covered charges.

Q. My daughter will be needing a physical exam for school this fall. Will PHS cover it?

A. PHS does not cover services that are required by third parties, such as schools, summer camps, employers, etc.. However, if your daughter is entitled to a physical exam this year, PHS will cover it and she can use it to satisfy the school's requirements.

Q. What if she needs medical attention while she is at college? She's going out of the state, and she won't be able to get to her PCP if there's something wrong.

A. That's no problem. College students who are covered dependents under your policy have many of the same benefits as covered dependents who still live at home. If your college student has a true medical emergency that is life-threatening or requires immediate care, he or she should seek care at a local hospital emergency room. If the student needs to see a doctor urgently, but the situation is not life-threatening, he or she may be seen at the college infirmary. If none is available or more specialized treatment is needed, a walk-in center or local physician would be appropriate. Any routine care should be done by your child's PCP when he or she is home on break.

Q. What if... ?

A. Sometimes this question is the most important one to you, and only you know how the question ends. So please call Customer Relations with your questions. We're here to help you!

RECONSIDERATION (GRIEVANCE) PROCESS

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INTRODUCTION:

PHS medical management staff follow the procedures outlined below to determine whether medical services or supplies (including experimental or investigational) meet the standards for medical necessity adopted by PHS. Examples of medical necessity determinations include, but are not limited to:

- Concurrent Review (inpatient or other ongoing treatment)
- Prior Approval (diagnostic and surgical procedures, behavioral health, home health care, DME, etc.)

INITIAL REVIEWS:

Concurrent Review:

Once PHS has received all pertinent clinical information regarding a concurrent review, a medical necessity determination will be made as soon as possible, but will take no longer than **one (1)** business day.

Prior Review:

Once PHS has received all pertinent clinical information regarding a prior review, a medical necessity determination will be made as soon as possible, but will not take longer than **two (2)** business days.

Expedited Reviews (FOR CONNECTICUT ONLY):

An Expedited Review is a review that is completed by PHS within **three (3) hours** of PHS receipt of pertinent medical information necessary to make a medical necessity determination. An attending physician, on behalf of a participant that is admitted to an acute care hospital, may request an Expedited Review if the physician determines that the participant's life will be endangered or other serious injury could occur if the patient is discharged or if treatment is delayed. The Connecticut Insurance Department has provided each acute care hospital with a PHS telephone and fax number that a physician should use to initiate an Expedited Review. An Expedited Review will be deemed approved if PHS does not respond within **three (3) hours** of its receipt of pertinent information. This **three (3) hour** deemer will apply only to requests initiated between 8:00 a.m. and 6:00 p.m., eastern standard time.

Approvals:

PHS Care Managers are authorized to certify that services and/or supplies meet the medical necessity standards adopted by PHS. Notification of an approval to a provider and/or participant may be verbal but must include a confirmation/approval number. Written documentation of the approval must follow promptly thereafter.

Denials:

In cases where the Care Manager believes that the proposed care does not meet PHS's medical necessity standards, the case is referred to a Medical Director or physician designee to make the medical necessity determination. Only a PHS Medical Director or a physician designee is permitted to determine that a medical service and/or supply is not medically necessary ("Adverse Determination"). Notification of a denial must be made in writing to the provider and the participant and must include the clinical rationale for the denial as well as instructions on how to appeal the denial. In addition, a denial cannot be issued on the basis of insufficient information unless additional information has been requested from the provider and/or participant in writing.

APPEALS:

Either a participant or a treating provider, on the participant's behalf, may appeal an Adverse Determination. The appeal will be conducted in accordance with the following appeals procedure. There are urgent appeals and non-urgent appeals. Urgent appeals are cases indicating that urgent or emergent care is required. Non-urgent appeals are all cases that are not urgent. There are also two levels of appeal. The initial appeal provides an opportunity for a participant or participant's provider to discuss the Adverse Determination with the Medical Director or physician designees ("Stage I"). The Stage I appeal may be initiated by telephone or in writing. PHS will accept written information relating to proposed care via a designated PO Box for appeals, overnight mail or designated fax. If the Stage I appeal upholds an Adverse Determination, a second appeal is available ("Stage II") by a panel made up of at least three (3) health care professionals ("Panel").

Stage I Appeal

1. A Stage I appeal is an informal review that is available whenever PHS has notified a participant or participant's provider of an Adverse Determination. A Stage I appeal may be requested by the participant or the participant's provider via telephone or mail.
2. A Stage I appeal will provide a participant or the treating provider, on the participant's behalf, with an opportunity to discuss and appeal an Adverse Determination with a PHS Medical Director or physician designee who was not previously involved in the case.
3. A Stage I appeal will be completed as soon as possible (as indicated by the medical circumstances). For an urgent appeal, the Panel will complete its review no later than **two (2) business days** of receipt of pertinent medical information. For a non-urgent appeal, the Panel will complete its review no later than **five (5) business days** of receipt of pertinent medical information. When a Stage I appeal is completed, the Medical Director or physician designee will verbally inform the participant and/or the participant's provider of the decision. If there is an Adverse Determination, a written notice will be sent to the participant and the participant's provider that includes the clinical rationale for the decision and an explanation of how to proceed to a Stage II appeal.
4. A participant or participant's provider will have sixty (60) days from the date the participant or provider received PHS's notice of an Adverse Determination to file a Stage I appeal. A request for a Stage I appeal will not be accepted or considered by PHS after such sixty (60) day time period has elapsed.

Stage II Appeal

1. A Stage II appeal is a formal review that may be requested via telephone, fax or mail by the participant or the participant's provider. A complete file of medical information related to the case ("Medical File") must be provided to PHS in order for a Stage II appeal to proceed. A Stage II Appeal will only be available if a Stage I Appeal has concluded with an Adverse Determination.
2. Stage II appeals will be conducted by a panel of at least three (3) health care professionals ("Panel"). No Panel member will have been previously involved in the case under review. Upon request, a participant or participant's provider may appear before the Panel. An appeal will include a review by a physician who is a specialist in the field related to the condition. **(For New Jersey only - a participant or provider may request that the specialist participate in the panel's review of the case.)**
3. PHS will acknowledge receiving the Stage II appeal material within ten (10) days of its receipt. The information received will be reviewed to determine if it includes all of the information appropriate to conduct the appeal. If necessary, PHS will follow-up for additional information.
4. The Panel will conduct a review of the case as soon as possible (as indicated by the medical circumstances). For an urgent appeal, the Panel will conclude its Stage II appeal as soon as possible, but no later than **two (2) business days** after receipt of the Medical File. For a non-urgent appeal, the Panel will conclude its review within **twenty (20) business days** of receipt of the Medical File.

5. A PHS Panel will meet on a scheduled basis as necessary to review Stage II appeals in accordance with the time frames specified above. However, if determined necessary, a Panel may be convened to conduct an unscheduled review.
6. Upon concluding a Stage II appeal, PHS will send the participant and the participant's provider a written notice of the Panel's decision. If the Panel has decided to uphold the Adverse Determination, PHS will send the participant and participant's provider written notice of its decision and the clinical reasons for such decision.
7. A Stage II Appeal must be initiated within sixty (60) days from the date that the participant and participant's provider received PHS's notification of its Stage I appeal decision. A request for a Stage II appeal will not be accepted or considered by PHS after such sixty (60) day time period has elapsed.

GENERAL PLAN INFORMATION

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Type of Administration

The plan is a self-funded welfare plan and the administration is provided through PHS.

Plan Name:	City of Stamford Health Care Plan
PHS Plan Number::	505
Tax ID Number:	06-6001536
Plan Effective Date:	January 1, 1998 or later pursuant to collective bargaining agreement for class of employees
Plan Year Ends:	December 31
Employer Information:	City of Stamford P.O. Box 9310 Stamford, CT 06904-9310
Agent for Service of Legal Process:	City of Stamford P.O. Box 9310 Stamford, CT 06904-9310
Claims Administrator:	Physicians Health Services, Inc. One Far Mill Crossing, PO Box 904 Shelton, CT 06484-0944 (203) 381-6400 1-800-205-0095

HOW TO SUBMIT A CLAIM

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When you have a claim to submit for payment that you must:

1. For plan reimbursements, attach bills for service rendered. ALL BILLS MUST SHOW:
 - ◆ Name of Plan
 - ◆ Group number of Plan
 - ◆ Employee's name

- ◆ Name of participant
- ◆ Name, address, telephone number of the provider of care
- ◆ Diagnosis
- ◆ Type of services rendered, with diagnosis and/or procedure codes
- ◆ Date of services
- ◆ Charges

2. Send the above to the Claims Administrator at the following address, which is designated specifically for Out of Network Claims:

Physicians Health Services
Out of Network
P.O. Box 7090
Bridgeport, CT 06601-7090
(203) 381-6400
1-800-205-0095

Claims must be submitted within twelve (12) months of the date of service or eighteen (18) months if coordination of benefits applies.

3. If you disagree with the amount reimbursed for a claim or have been denied in whole or in part services, the PHS Grievance Process is described on pages 52 through 54, and you should contact the following to initiate an appeal:

PHS Customer Relations Department
P.O. Box 904
One Far Mill Crossing
Shelton, CT 06484-0944

BY THIS AGREEMENT, City of Stamford Employee Benefits Plan is hereby adopted as shown.

IN WITNESS WHEREOF, this instrument is executed for The City of Stamford on or as of the day and year written below.

By: _____
City of Stamford

Date: _____

Witness: _____

Date: _____