

AN ORDINANCE **91182**

AUTHORIZING THE EXECUTION OF AMENDMENTS TO THE COLLECTIVE BARGAINING AGREEMENT BETWEEN THE CITY OF SAN ANTONIO AND THE SAN ANTONIO PROFESSIONAL FIREFIGHTERS ASSOCIATION (SAPFFA), PASSED AND APPROVED BY ORDINANCE NO. 90594, TO EQUALIZE THE TERMS AND CONDITIONS OF HEALTH BENEFITS BETWEEN THE SAPFFA AND THE SAN ANTONIO POLICE OFFICERS ASSOCIATION (SAPOA). (AMENDS ORD. NO. 90594 DATED SEPT. 30, 1999)

\* \* \* \* \*

**WHEREAS**, Ordinance No. 90594, passed and approved on September 30, 1999, authorized the execution of a Collective Bargaining Agreement between the City of San Antonio and the San Antonio Professional Firefighters Association/ Local 624 International Association of Firefighters ("SAPFFA"); and

**WHEREAS**, the Collective Bargaining Agreement is effective for a period from September 30, 1999, through September 30, 2001, with an evergreen clause through September 30, 2011; and

**WHEREAS**, Article XXV, Benefits, of the Agreement allowed the parties to re-open negotiations for the sole purpose of equalizing the terms and conditions of health benefits enjoyed by members of the San Antonio Police Officers' Association ("SAPOA") and the SAPFFA; and

**WHEREAS**, the City of San Antonio forwarded a copy of the proposed amendments to the SAPFFA on December 20, 1999; and

**WHEREAS**, the amendments were ratified by the SAPFFA members on January 17, 2000, by a vote of 708 to 44; and

**WHEREAS**, these amendments will be effective for a period through September 30, 2001, with an evergreen clause through September 30, 2011; NOW THEREFORE:

**BE IT ORDAINED BY THE CITY COUNCIL OF THE CITY OF SAN ANTONIO:**

**SECTION 1.** The City Manager or his designee is hereby authorized to execute amendments to the Collective Bargaining Agreement with the San Antonio Professional Firefighters Association/ Local 624 International Association of Firefighters ("SAPFFA") to equalize the terms and conditions of health benefits enjoyed by members of the San Antonio Police Officers' Association and the SAPFFA. A copy of the amendments is attached hereto and incorporated herein for all purposes as Attachment I. The terms and conditions set forth in said Amendments are hereby approved.

**SECTION 2.** This ordinance shall be effective on and after the tenth day after passage hereof.

**PASSED AND APPROVED** this 27<sup>th</sup> day of January,  
2000.



M Y O R

Howard W. Peak

**ATTEST:**



City Clerk

**APPROVED AS TO FORM:**



City Attorney

00-04

**MEETING OF THE CITY COUNCIL**

|  |
|--|
| ALAMODOME                              |
| ASSET MANAGEMENT                       |
| AVIATION                               |
| BUDGET & EMPLOYEE SERVICES             |
| BUDGET & EMPLOYEE SERVICES - PERSONNEL |
| BUILDING INSPECTIONS                   |
| BUILDING INSPECTIONS - HOUSE NUMBERING |
| CITY ATTORNEY                          |
| MUNICIPAL COURT PROSECUTORS            |
| RISK MANAGEMENT                        |
| CITY MANAGER                           |
| CITY PUBLIC SERVICE - GENERAL MANAGER  |
| CITY PUBLIC SERVICE - MAPS & RECORDS   |
| CODE COMPLIANCE                        |
| COMMERCIAL RECORDER (PUBLISH)          |
| COMMUNITY INITIATIVES                  |
| COMMUNITY RELATIONS                    |
| PUBLIC INFORMATION OFFICE              |
| CONVENTION & VISITORS BUREAU           |
| CONVENTION CENTER EXPANSION OFFICE     |
| CONVENTION FACILITIES                  |
| COUNCIL OFFICES                        |
| CULTURAL AFFAIRS                       |
| ECONOMIC DEVELOPMENT                   |
| FINANCE DIRECTOR                       |
| FINANCE (ASSESSOR)                     |
| FINANCE (CONTROLLER)                   |
| FINANCE (GRANTS)                       |
| FINANCE (TREASURY)                     |
| FIRE DEPARTMENT                        |
| HOUSING & COMMUNITY DEVELOPMENT        |
| INFORMATION SERVICES                   |
| INTERGOVERNMENTAL RELATIONS            |
| INTERNAL REVIEW                        |
| INTERNATIONAL AFFAIRS                  |
| LIBRARY                                |
| METROPOLITAN HEALTH DISTRICT           |
| MUNICIPAL CODE CORPORATION (PUBLISH)   |
| MUNICIPAL COURTS                       |
| NEIGHBORHOOD ACTION                    |
| PARKS & RECREATION                     |
| PLANNING DEPARTMENT                    |
| DISABILITY ACCESS OFFICE               |
| LAND DEVELOPMENT SERVICES              |
| POLICE DEPARTMENT                      |
| GROUND TRANSPORTATION OFFICE           |
| PUBLIC WORKS DIRECTOR                  |
| CAPITAL PROJECTS                       |
| CENTRAL MAPPING (W/ATTACHMENTS)        |
| ENGINEERING                            |
| ENVIRONMENTAL SERVICES                 |
| PARKING                                |
| REAL ESTATE                            |
| SOLID WASTE                            |
| TRAFFIC ENGINEERING                    |
| PURCHASING & GENERAL SERVICES          |
| SAN ANTONIO WATER SYSTEM               |

AGENDA ITEM NUMBER: \_\_\_\_\_

30  
JAN 27 2000

DATE: \_\_\_\_\_

MOTION: \_\_\_\_\_

91182

ORDINANCE NUMBER: \_\_\_\_\_

RESOLUTION NUMBER: \_\_\_\_\_

ZONING CASE NUMBER: \_\_\_\_\_

TRAVEL AUTHORIZATION: \_\_\_\_\_

| NAME                           | ROLL | AYE | NAY |
|--------------------------------|------|-----|-----|
| BOBBY PEREZ<br>District 1      |      |     |     |
| MARIO SALAS<br>District 2      |      |     |     |
| DEBRA GUERRERO<br>District 3   |      |     |     |
| RAUL PRADO<br>District 4       |      |     |     |
| RICK VASQUEZ<br>District 5     |      |     |     |
| ENRIQUE BARRERA<br>District 6  |      |     |     |
| ED GARZA<br>District 7         |      |     |     |
| BONNIE CONNER<br>District 8    |      |     |     |
| TIM BANNWOLF<br>District 9     |      |     |     |
| DAVID CARPENTER<br>District 10 |      |     |     |
| HOWARD W. PEAK<br>Mayor        |      |     |     |

AMENDS ORD. NO. 91594 OF 930-99

**00-04**

**FILE** "FIREFIGHTERS LOCAL 674"

**CONSISTENT AGENDA**

ATTACHMENT I

**AMENDMENTS TO**  
**THE COLLECTIVE BARGAINING AGREEMENT**

These Amendments to the COLLECTIVE BARGAINING AGREEMENT are entered into by and between the CITY OF SAN ANTONIO (hereinafter referred to as "CITY"), a Texas municipal corporation, acting by and through its City Manager pursuant to Ordinance No. \_\_\_\_\_, passed and approved on \_\_\_\_\_, 2000, and LOCAL 624 INTERNATIONAL ASSOCIATION OF FIREFIGHTERS/SAN ANTONIO PROFESSIONAL FIREFIGHTERS ASSOCIATION (hereinafter referred to as "SAPFFA").

I.

The City and the SAPFFA exercise the option to re-open the COLLECTIVE BARGAINING AGREEMENT (hereinafter referred to as "Agreement"), such option having been granted in Article XXV, Section 9, and Article XXXVI, Section 3 of the Agreement originally entered into by and between the City and the SAPFFA and passed and approved by San Antonio City Ordinance No. 90594 on September 30, 1999. These Amendments provide for equalization of the terms and conditions of health benefits enjoyed by members of the SAPFFA and the San Antonio Police Officers Association (SAPOA).

II.

Article XXV. BENEFITS, is hereby amended and restated to read as follows:

**ARTICLE XXV.**

**BENEFITS**

**Section 1. Active Fire Fighters Health Benefits.**

- A. The City shall provide all active Fire Fighters who are eligible with family medical benefits and shall pay the full cost of said benefits as agreed upon herein. The minimum benefits provided are those as stated in the Master Contract Document for the City of San Antonio Employees Health Benefit Program attached hereto and incorporated herein as Attachment 2 and will be effective January 1, 2000. Provisions and benefits specified in the Master Contract Document shall not be reduced during the life of this Agreement; however, the City reserves the right to change carriers or plan administrators at any time at its discretion. While the City is prohibited from reducing the provisions and benefits specified in the Master Contract Document during the life of this Agreement, a determination of what medical service is medically necessary for a particular patient or any reduction in the usual and customary allowable charge for that medical service will not be construed as a reduction

in benefits; provided that the determination is made in accordance with the procedure and criteria described in the Master Contract Document.

- B. Active and retired Fire Fighters covered under this Agreement shall be granted the option of entering into or exiting from the flexible benefits program as provided for by the City to substitute for the basic program as outlined in this Agreement. Said option must be exercised by the active Fire Fighter during the City's re-enrollment period between the dates of October 1, and December 31, of each calendar year.

## **Section 2. Retired Fire Fighters Health Benefits.**

- A. **Retiree Benefits.** The City shall also provide all retired Fire Fighters who are eligible with medical benefits. Retiree medical benefits shall be supplemental to Medicare benefits, only if the retiree individually qualifies for Medicare. Retirees shall not be required to purchase Medicare coverage if they have not qualified. The benefits provided prior to Medicare eligibility are stated in the Master Contract Document for the City of San Antonio Employees Health Benefit Program. Attached hereto and incorporated herein as Attachment 2.

Provisions and benefits specified in the Master Contract Document shall not be reduced during the life of this agreement; however, the City reserves the right to change carriers or plan administrators at its discretion. While the City is prohibited from reducing the provisions and benefits specified in the Master Contract Document during the life of this agreement, any reasonable determination of what medical service is medically necessary for a particular patient or any reduction in the usual and customary allowable charge will not be construed as a reduction in benefits.

Fire Fighters who retire on or after October 1, 1989 but before or on December 3, 1995, who became eligible for retiree medical benefits under the terms of the Collective Bargaining Agreement executed October 1, 1988, between the City and Union shall continue to receive retiree medical benefits in accordance with that prior Collective Bargaining Agreement. Retiree medical benefits for Fire Fighters, who retire on or after December 4, 1995, shall be determined in accordance with Collectively Bargained Agreements between the City and the Union.

- B. **Contributions.** The City has established a trust fund for prefunded retiree health care benefits for all eligible retired Fire Fighters (hereinafter referred to as "the Fund") and has increased its contribution levels for the purpose of establishing an actuarially sound retiree health benefit fund, evaluated over thirty years. The parties agreed in principle in 1995 that once an actuarially sound fund was established by current contribution levels, the responsibility for future contributions (made necessary by changes in circumstances, the economy, and the medical care system) would be jointly shared by the parties, and would be quantified and allocated by negotiation in future agreements, as necessary. During the life of this agreement the City shall contribute to the Fund a monthly amount equal to 9.4% of base pay plus longevity of all eligible fire fighters. Effective January 1, 2001, each fire

fighter shall contribute to the Fund a monthly amount of \$20.00, each and every month thereafter for the life of this Agreement.

If the Prefunded Retiree Health Care Fund Board ("Board") does not complete an actuarial study on the Fund on or before January 1, 2001, and on or before January 1<sup>st</sup> of each year thereafter, the parties agree to have an actuarial study completed on the Fund for that fund year. The costs of the study shall be paid by the City and deducted from its contribution to the Fund. The study shall be conducted by Towers Perrin Company, if that firm is still being utilized for actuarial services by the Board. If the firm is not being utilized (or if the responsible personnel currently handling those matters are not available with that firm) the City and the Union may select any other recognized actuarial firm with experience in handling self-funded municipal retiree health benefit programs. The study shall evaluate the amount of monthly contributions necessary to provide benefits under the fund for a minimum of thirty (30) years. The City shall provide such accurate and complete information, as the actuary shall require. The assumptions utilized shall be determined by the actuary, provided that any material change in the assumptions shall be preceded by notice to the City and the Union, and an opportunity for input or conferences prior to completion of the study.

The Union or City may request additional studies, revised assumptions, or developed scenarios as it may deem necessary from the same firm, by paying for such additional services. In the event that the study shows a higher contribution to be necessary than provided by the terms of this paragraph, the City and the Union members will increase their contributions during the following budget year to the contribution amounts shown to be necessary (based on the actuarial computation of the normal costs for current employees, together with the additional amounts necessary to amortize the unfunded contingent liability over a 30 year period), with each sharing 50/50 of the amount above the total contribution of: (a) 9.4% of base plus longevity, plus (b) the \$20.00 per member monthly payment provided above, plus (c) an additional \$20.00 per member monthly "match" to be paid by the City, in the event and at such time as the actuarial study shows that the contribution achieved by (a) and (b) are not sufficient.

- C. Upon receipt of the actuarial study to be completed prior to January 1, 2001, the City and Union agree to meet and confer in regards to evaluating the benefits being provided to retired police officers and fire fighters through the PreFund Trust. The parties agree to include the San Antonio Police Officers Association in the discussions. Nothing herein shall prevent the parties from mutually agreeing to a new schedule of benefits based upon actuarial projections or agreeing to transfer to the PreFund Trust the obligation and responsibility of establishing and maintaining a schedule of benefits based on actuarial projections. The Union has obtained this provision to meet and confer on the basis of its commitment and agreement that any change, by contract or legislation, which removes any control over benefits levels from the City Council and vests same in the Board of the Prefund Trust shall establish a defined contribution level to protect the City and its taxpayers from liability for future contribution levels resulting from changes in benefits levels

by the Board. Any such agreement would need to be ratified by the City and the respective Unions.

- D. Spouses of retired Fire Fighters shall be eligible to receive the benefits as set forth in the Master Contract Document. Medical benefits shall be supplemental to Medicare benefits once the spouse individually qualifies for Medicare coverage. Spouses of retired Fire Fighters shall pay a portion of the annual health plan to retain coverage at a rate based on the tenure of the Fire Fighter to whom the spouse was married. Beginning with a Fire Fighter, who served 20 years or less, the spousal rate will be 30% of the health plan premium (the COBRA formula premium as enumerated in chapter 2 of the Master Contract Document). From 21 years to 30 years of tenure, for each year of tenure above 20, the spousal rate will decrease by 3% of the health plan premium until it is 0% for a spouse of a Fire Fighter with 30 years of tenure. Once the retired Fire Fighter becomes eligible for Medicare, the spousal rate will become 0% of the annual health plan premium.
- E. Spouses of deceased fire fighters shall be entitled to benefits provided for spouses of retired fire fighters, in the event that the deceased fire fighter died in the line of duty, or was eligible for retirement at the time of death. Line of duty shall mean any occurrence wherein the officer was exercising the power and authority of a certified fire fighter, whether or not scheduled for duty at the time of death. Spouses of fire fighters not eligible for retirement or acting in the line of duty at the time of death shall be entitled to continue coverage by paying the applicable COBRA formula premium (as enumerated in Chapter 2 of the Master Contract Document), until death or remarriage.
- F. Upon retirement, the Fire Fighter may elect to cover any other eligible dependents (other than spouse) in accordance with the Master Contract Document. The retiree shall pay 100% of the health plan premium (the COBRA formula premium as enumerated in Chapter 2 of the Master Contract Document) for each other eligible dependent.

**Section 3.** Medical benefits provided for herein as to retirees and their spouses shall be supplemental to Medicare/Medicaid benefits. Once the spouse is individually eligible for Medicare, each such person is required to apply for, purchase, and maintain Medicare benefits. Upon the death of a retired fire fighter who became a fire fighter on or after October 1, 1988, the plan shall pay the applicable Part B Medicare premium for a surviving spouse until death or remarriage. The Plan Administrator may approve any alternate health care coverage provided by the spouse of a retired or deceased fire fighter, in lieu of Medicare coverage to comply with this requirement. The health plan will serve as supplemental coverage as benefits or coverage levels not otherwise provided by Medicare, to the extent permitted by federal law.

**Section 4.** This agreement, and the Master Contract Document for Health Benefits adopted herein, shall control the available health benefits during the term of this agreement, for active fire fighters. The supplemental insurance coverage provisions for retired fire fighters and spouses shall control available

health benefits during the term of this agreement for retired fire fighters and spouses.

**Section 5.** Health care benefits for active or retired Fire Fighters shall not be terminated, altered, modified or reduced except by amendments or successors to this Agreement.

**Section 6.** It is understood and agreed that the provisions of this agreement and the Master Contract Document for Health Benefits have been drafted in substantial and material reliance upon existing provisions of federal and state law concerning employee health benefits. Any change in federal or state law or regulations which changes the obligations of either party, the applicability or extent of Medicare benefits, or materially alters the assumptions underlying the actuarial analysis relied upon in negotiations shall entitle the City or the Union to reopen negotiations concerning health benefits.

**Section 7. Other Benefits.**

A. **Amounts.** During the term of this Agreement and any extensions hereof, the City will pay a monthly amount for each fire fighter as shown by the schedule below for dental, optical and prepaid legal benefits under any plan or plans selected by the Union. Furthermore, neither the City nor the Union may change the amounts paid or allocated for the respective benefits as shown in the schedule during the term of this Agreement.

For the period prior to October 1, 1999:

|                               | Optical/Dental<br>Plan | Prepaid Legal<br>Plan |
|-------------------------------|------------------------|-----------------------|
| Fire Fighters with dependents | \$89.50                | \$32.00               |
| Fire Fighters w/o dependents  | \$43.50                | \$32.00               |

For the period from October 1, 1999, through September 30, 2001 (two (2) year period):

|                               | Optical/Dental<br>Plan | Prepaid Legal<br>Plan |
|-------------------------------|------------------------|-----------------------|
| Fire Fighters with dependents | \$89.50                | \$30.00               |
| Fire Fighters w/o dependents  | \$43.50                | \$30.00               |

After September 30, 2001 (and any extensions thereafter):

|                               | Optical/Dental<br>Plan | Prepaid Legal<br>Plan |
|-------------------------------|------------------------|-----------------------|
| Fire Fighters with dependents | \$89.50                | \$32.00               |
| Fire Fighters w/o dependents  | \$43.50                | \$32.00               |

- B. **Audits.** The Union shall ensure that all benefits providers will conduct annual independent audits at no additional costs to the City. The Union shall further ensure that all benefit providers shall provide a copy of each annual independent audited financial report to the City within thirty (30) days of the benefit providers receipt and acceptance of the audit.

The City reserves the right, at its sole discretion, to conduct an audit of said benefit plans at the City's expense any time during the term of this Agreement. Should the city decide to conduct such an audit, the Union shall ensure that the benefit providers make available to the city all relevant documentation within a reasonable time.

- C. **Use of Benefits.** With respect to the Prepaid Legal Benefits, it is understood that no fire fighter may use the benefits for the purpose, in whole or in part, of implementing and/or initiating legal action against the City, any of its agents, officers, and/or assigns.
- D. **Change of Benefits Providers.** During the term of this Agreement, the Union may change providers for Supplemental Benefits (Dental/Optical and Legal). In the event that the Union makes a proposal to change benefit providers, the Union shall submit the same in writing to the City. Moreover, should the Union choose to change benefit providers, the Union agrees to join the city in resolving all claims the Union and/or City may have regarding funds held by the previous benefit providers, including, but not limited to, a suit for declaratory judgment.
- E. **Copies of Plan.** Any benefit plan providers under this Article will provide to each fire fighter a summary of the plans and will provide up-to-date copies of the Plan Documents to the Budget and Employee Services Department, the Union Office, and the Fire Department. The Union Office shall make available copies of said plan documents to fire fighters for inspection during normal business hours.

### III.

The MASTER CONTRACT DOCUMENT for the City of San Antonio Employees Health Benefit Program referred to in Article XXV. BENEFITS, as Attachment 2 therein, is hereby amended as provided in Attachment "A," attached hereto and incorporated herein.

IV.

All other terms, conditions, covenants and provisions of the COLLECTIVE BARGAINING AGREEMENT passed and approved by Ordinance No. 90594 on September 30, 1999, are as previously agreed in said Agreement, save and except for Section XXV, BENEFITS, and the Master Contract Document for the City of San Antonio Employees Health Benefits Program, attached to said Collective Bargaining Agreement as Attachment 2 therein, which the undersigned parties agree are hereby amended and restated, and such other provisions as added herein.

EXECUTED this the \_\_\_\_ day of January \_\_\_\_, 2000.

(Effective Date: January 1, 2000)

**FOR THE CITY OF SAN ANTONIO:**

\_\_\_\_\_  
Howard W. Peak  
Mayor

\_\_\_\_\_  
Alexander E. Briseno  
City Manager

Date: \_\_\_\_\_

Date: \_\_\_\_\_

\_\_\_\_\_  
Frank J. Garza  
City Attorney

Date: \_\_\_\_\_

**FOR THE INTERNATIONAL ASSOCIATION OF FIRE FIGHTERS and LOCAL 624:**

\_\_\_\_\_  
John Anderson, Jr.  
Chief Negotiator, Local 624

Date: \_\_\_\_\_

CITY OF SAN ANTONIO  
CITY ATTORNEY'S OFFICE  
INTERDEPARTMENTAL CORRESPONDENCE

**TO:** Mayor and City Council

**FROM:** Robert Ojeda, Fire Chief

**COPIES TO:** Alexander E. Briseño, City Manager; J. Rolando Bono, Assistant City Manager; Frank J. Garza, City Attorney; Terry Brechtel, Budget and Employee Services Director; Octavio Peña, Finance Director; File

**SUBJECT:** Amendments to Fire Collective Bargaining Agreement

**DATE:** January 19, 2000

**SUMMARY AND RECOMMENDATION:**

This Ordinance authorizes amendments to the Collective Bargaining Agreement between the City of San Antonio and the San Antonio Professional Firefighters Association (SAPFFA), passed and approved on September 30, 1999. The proposed amendments equalize the terms and conditions of health benefits between the SAPFFA and the San Antonio Police Officers Association (SAPOA).

The members of the SAPFFA ratified the proposed amendments to the Collective Bargaining Agreement on January 17, 2000 by a vote of 708 to 44.

**BACKGROUND:**

Ordinance Number 90594, passed and approved on September 30, 1999, provided for a new Collective Bargaining Agreement between the City of San Antonio and the San Antonio Professional Firefighters Association (SAPFFA). Effective October 1, 1999, Article XXV, Benefit Plans of the new Agreement allowed the parties to re-open negotiations for the sole purpose of equalizing the terms and conditions of health benefits enjoyed by members of the San Antonio Police Officers' Association (SAPOA) and the SAPFFA. This ordinance approves the amendments to the contract necessary to establish health benefits for members of the SAPFFA that are comparable to those enjoyed by members of the SAPOA.

The amendments to the Collective Bargaining Agreement provide for the following changes in Article XXV, Benefit Plans and the Master Plan Contract :

1. Provides for retiree medical benefits for firefighters retiring on or after December 4, 1995, to be determined in accordance with future collective bargaining agreements between the City and the SAPFFA;
2. Clarifies coverage with respect to organ transplants;

3. Clarifies coverage with respect to hospice treatment;
4. Provides for a cumulative family deductible; and
5. Provides an eligible employee to obtain a physical examination from his own physician.

**Financial Impact:**

No financial impact is associated with this Ordinance.

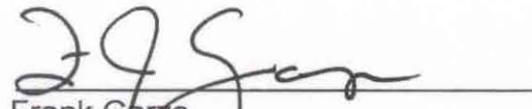
**Supplemental Comments:**

The disclosure requirements mandated by the City's Ethics Code do not apply to this contract amendment.

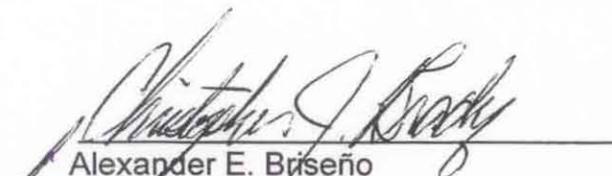
**Coordination:**

This item was coordinated with the City Attorney's Office, the Budget and Employee Services Department and the Finance Department.

  
\_\_\_\_\_  
Robert Ojeda  
Fire Chief

  
\_\_\_\_\_  
Frank Garza  
City Attorney

**APPROVED:**

  
\_\_\_\_\_  
Alexander E. Briseño  
City Manager

ATTACHMENT "A"

**City of San Antonio**

Master Contract Document

for the

City of San Antonio Uniform Officers and Uniform Prefund Retirees  
Health Benefit Program

San Antonio, Texas  
January 1, 2000

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# MASTER CONTRACT

## INTRODUCTION

The purpose of the Employee Health Benefit Program is to provide the City of San Antonio Uniform Employees and Retirees with a family health plan, with coverage and benefits defined herein.

This Master Contract defines and provides for coverage and administration for the benefits common to uniform City employees, and retirees. The variations in coverage applicable to such classes are set forth in specific appendices to this Master Contract, including but not limited to Firefighters and Police Officers. The coverage provisions applicable to a covered person shall collectively be referred to as the Plan, and the provisions of this Master Contract and the applicable appendices for any covered person shall be referred to as the Plan Document.

This Plan Document does not provide for any premium payment or contributions to the cost of coverage. The obligation and amount of such payments are separately determined from the Ordinances of the City Council or any applicable Collective Bargaining Agreements.

This plan is open to uniform City employees and retired uniform City employees.

The benefits provided and defined in this Master Contract are self-funded by the City of San Antonio at the time this document was drafted, but the City of San Antonio is entitled to reinsure any portion of its obligations hereunder, and additionally may contract for any carrier acceptable to the City Council to assume and administer coverage and benefits under this document.

**ANY BENEFITS UNDER THE CITY'S INSURANCE OR SELF FUNDED PROGRAMS ARE SUBJECT TO CHANGE AS DETERMINED BY THE CITY COUNCIL IN ANY BUDGET YEAR, OR BY AMENDMENT OR OTHER LAWFUL CHANGE TO THE APPLICABLE BARGAINING AGREEMENTS.**

The City of San Antonio may select a claims administrator from time to time, or may elect to administer claims under the plan as an internal function. The City's claim administrator is not an insurer.

## GENERAL INFORMATION

NAME OF PLAN: CitiMed

PLAN YEAR: January 1 through December 31.

PLAN SPONSOR: City of San Antonio  
P.O. Box 839966  
San Antonio, Texas 78283

PLAN ADMINISTRATOR: Employee Benefits Administrator  
City of San Antonio  
Budget and Employee Benefits Department  
P.O. Box 839966  
San Antonio, Texas 78283  
(210) 207-8705

CLAIMS ADMINISTRATOR: Benefit Planners, Inc.  
P.O. Box 690930  
San Antonio, Texas 78269  
(210) 691-2479

EFFECTIVE DATE: The effective date of this plan for uniform City employees and uniform prefund retirees is January 1, 2000.

## PLAN AND CLAIMS ADMINISTRATION

Administration and payment of claims under the Plan Documents shall be carried out by the Claims Administrator, under the supervision of the Plan Administrator. It shall be a principal duty of the Plan Administrator to see that the Plan Document is carried out as written. The Plan Administrator shall have full power to administer the Plans and all of their details, and to make all final determinations about coverage on behalf of the City of San Antonio.

The Plan Administrator will make available for examination, to each Covered Person, his heirs, and/or assigns, records that pertain to the Covered Person at a reasonable time during normal business hours as established by the Plan Administrator.

The Plan Administrator's powers shall include, but shall not be limited to, the following:

- (a) To make and enforce reasonable rules and regulations as the Plan Administrator deems necessary or proper for the effective and efficient administration of the Plan Document;
- (b) To interpret the contract, including, but not limited to, all questions of coverage and eligibility. The Plan Administrator's interpretations thereof in good faith shall be final and conclusive on all persons claiming Benefits under the Plan Document, subject only to the Review and Appeal Process; and
- (c) To coordinate with and supervise the Claims Administrator, prepare and handle budgetary and contractual relationships involving the plan, distribute information to Covered Persons under the plan, appoint such agents, counsel, accountants, consultants and actuaries as may be required to assist in administering the Plan Document.

**CHAPTER 1**

**GENERAL PLAN COVERAGE  
FOR ELIGIBLE PARTICIPANTS**

**ELIGIBILITY REQUIREMENTS**

**Eligible Employee**

Full-time City employees (authorized full-time equivalent) are eligible to participate in the Plan on the date their employment begins. Coverage begins on the date of hire, or upon taking office and performing work for the City of San Antonio, whichever occurs later.

A new employee who is not actively at work because of medical disability will not become covered under the Plan until the date the employee is actively at work.

**Eligible Dependent**

An Eligible Dependent is:

(1) The Eligible Employee's spouse. A spouse that is legally separated under a court decree under the laws of another state shall not be an eligible dependent,

(2) All natural children including legally adopted, under legal guardianship of the Covered Employee and who have not yet reached their twentieth birthday, provided the children have never been married and are principally dependent upon the Eligible Employee, as directed by court order, for support and maintenance. Foster children are not Eligible Dependents under this Plan, unless there has been an application for adoption accepted by the Texas Department of Human Services. Stepchildren are Eligible Dependents during the marriage between the Eligible Employee and the natural parent of the child, so long as (a) they permanently reside in the employee's household, and (b) are principally dependent on the employee.

In addition to the above, children will be considered as Eligible Dependents from age twenty (20) through age twenty-three (23), if they are full-time students, have never been married, and are principally dependent upon the Eligible Employee for support and maintenance.

The term "Eligible Dependent" shall not include anyone who is covered as an Eligible Employee. An Eligible Dependent shall not be entitled to any additional benefits or coverage by virtue of the fact that both parents, step parents or guardians are employed by the City.

**Eligible Retiree**

Any eligible City employee that retires under the rules of the Fire and Police Pension Fund will be eligible for the City's retiree health program.

### **Retired Employee's Dependents**

If you retire and are eligible to receive retirement benefits you may continue your dependents' coverage, subject to the payment of any applicable premiums without lapse. Only Dependents who participate in the Plan at the time of the eligible employee's retirement are eligible. Eligible dependent children shall not include anyone who is covered as an eligible employee under the Plan.

### **Incapacitated Dependent**

An Eligible Dependent child who is physically or mentally incapable of self-support upon attaining the age of twenty (20) years, shall continue to be an Eligible Dependent while remaining incapacitated, unmarried and continuously covered under the Plan. An eligible incapacitated dependent must be solely dependent on the employee, and must be incapacitated by a disability that arose while such dependent was a covered dependent. To continue eligibility under this provision, proof of incapacity must be submitted by the employee at least thirty-one (31) days prior to such child's attainment of age twenty (20).

### **Effective Date of Coverage**

Coverage does not become effective until the Eligible Employee completes the City's enrollment document.

Newborn infants will be covered from the date of birth as long as the employee is covered under this plan and coverage for the newborn child is requested within 31 days of the child's date of birth. If coverage of a newborn is not requested within 31 days of the child's date of birth, then coverage cannot become effective until the next re-enrollment period.

Eligible Dependents who are enrolled after the effective date of this Plan will become covered on the date such dependent is acquired, provided that the covered Employee enrolls such dependent within 31 days of the date the dependent is acquired. If coverage of a dependent is not requested within 31 days of the date the dependent was acquired, the coverage cannot become effective until the next re-enrollment period.

If a new employee is not actively at work, coverage shall take effect on the date the individual returns to work.

If an Eligible Dependent (except a newborn child whose mother was covered under the Plan at the time of the child's birth) is confined in a hospital, residential treatment center, nursing home, convalescent hospital or rehabilitation facility at the time of the Eligible Dependent's effective date, the dependent's coverage shall not become effective until he is no longer confined. Confinement shall be construed to continue when the patient leaves the institution for a temporary period for therapeutic reasons or with a reasonable expectation that the patient will return to the institution to resume treatment.

### **Change of Family Status**

If there is a legal change in family status, the employee has thirty-one (31) calendar days to notify the Employee Benefits Office in writing. The notice may be given by personally appearing in the Benefits Office and completing a change of dependent coverage form.

If there is no change in family status or if notice is not given for additional coverage within thirty-one (31) days after the legal change in status, no change can become effective until the next re-enrollment period, which shall be not less than thirty-one (31) days, occurring during the months of October or November, as the Plan Administrator shall determine, or as otherwise established by the City Council.

A legal change in family status includes: divorce; marriage; birth or adoption of a child, including a child living with the adopting parents during the period of probation; change in employment status for the employee's spouse; or ineligibility of a child due to age, or change in student status.

#### **Termination of Coverage for Individuals**

The coverage of any Covered Person under the Plan shall terminate on the earliest of the following dates:

(1) The date of termination of the Plan;

The date employment terminates;

(3) The date all coverage or certain benefits are terminated in a particular class by modification of the Plan; and

(4) The date an active Eligible Employee is covered under a qualified Health Maintenance Organization (HMO) or any other available alternative health care delivery system for the employee or dependents of the employee.

#### **Termination of Coverage for Dependents**

Coverage with respect to the Covered Person's dependents shall terminate under the Plan at the earliest time specified below:

(1) Upon termination of employment for the covered employee;

(2) On the date dependents cease to be eligible as defined in the Plan.

#### **Termination of Coverage for Failure to Pay Premium**

Coverage with respect to any Covered person for which a premium or contribution is required shall terminate 31 days after the due date for such premium, or as soon thereafter as otherwise allowed by law.

#### **Documentation**

The Plan Administrator is entitled to require relevant legal documentation to be furnished with any request for coverage or change in status.

### Continuation Coverage

On April 7, 1986, a federal law was enacted requiring that most employers sponsoring group health plans offer employees, retirees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the plan would otherwise end. This law is called the Consolidated Omnibus Budget Reconciliation Act of 1985, better known as COBRA. This notice is intended to inform employees and retirees, in a summary fashion, of rights and obligations under the continuation coverage provisions of COBRA. The employee, retiree and spouse should take the time to read this notice carefully.

**"Qualified Beneficiary"** means:

- a. you, as a Covered Employee, for termination or reduced hours;
- b. your spouse or your dependent child if he/she was a dependent under the Plan on the day before your Qualifying Event occurred; or
- c. a child who is born to a Covered Employee during a period of COBRA continuation coverage.

**"Qualifying Event for a Covered Employee"** means a loss of coverage due to:

- a. termination of employment for any reason other than gross misconduct; or
- b. reduction in hours of employment.

**"Qualifying Event for a Covered Dependent"** means a loss of coverage due to:

- a. a Covered Employee's termination of employment for any reason other than a gross misconduct or reduction in hours of employment;
- b. a Covered Employee's death; a spouse's divorce or legal separation from a Covered Employee;
- c. a Covered Employee's entitlement to Medicare; or
- d. a dependent child's loss of dependent status under the Plan.

**"Timely contribution payment"** means contribution payment must be made within 30 days of the due date or within such longer period as applies to or under the Plan.

**Continuation of Health Coverage.** Continuation of health coverage shall be available to you and/or your Covered Dependents upon the occurrence of a Qualifying Event. To continue health coverage, the Plan Administrator must be notified of a Qualifying Event by:

- a. the Employer, within 30 days of such event, if the Qualifying Event is:
  1. for a Covered Dependent, the Covered Employee's death;
  2. the Covered Employee's termination other than for gross misconduct or reduction in hours;
  3. for a Covered Dependent, the Covered Employee's entitlement to Medicare.

- b. you or a Qualified Beneficiary, within 60 days of such event, if the Qualifying Event is:
  - 1. for a spouse, divorce, or legal separation from a Covered Employee; or
  - 2. for a dependent child, loss of dependent status under the Plan.

The Plan Administrator must, within 14 days of receiving such notice, notify any Qualified Beneficiary of his/her continuation right. Notice to a Qualified Beneficiary who is your spouse shall be notice to all other Qualified Beneficiaries residing with such spouse when such notice is given.

Upon termination of employment or reduction in hours, to continue health coverage for 29 months, a Qualified Beneficiary who is determined under Title II or Title XVI of the Social Security Act to be disabled on such date or at any time during the first 60 days of COBRA continuation coverage, must notify the Plan Administrator of such disability within 60 days from the date of determination and before the end of the 18 month period. If a Qualified Beneficiary entitled to the disability extension has non-disabled family members who are entitled to COBRA continuation coverage, the non-disabled family members are also entitled to the disability extension.

Qualified Beneficiaries who are disabled under Title II or Title XVI of the Social Security Act must notify the Plan Administrator within 30 days from the date of final determination that they are not longer disabled.

A Qualified Beneficiary must elect Continuation of Health Coverage within 60 days from the later of the date of the Qualifying Event or the date notice was sent by the Plan Administrator.

A newborn child of a Qualified Beneficiary or a child placed with a Qualified Beneficiary for adoption may be added according to the enrollment requirements for dependent coverage under the Eligibility Requirements of the Plan.

Any election by you or your spouse shall be deemed to be an election by any other Qualified Beneficiary, though each Qualified Beneficiary is entitled to an individual election of continuation coverage.

Upon election to continue health coverage, a Qualified Beneficiary must, within 45 days of the date of such election, pay all required contribution to date to the Plan Administrator. All future contribution payments by a Qualified Beneficiary must be made to the Plan Administrator and are due the first of each month with a 30-day grace period.

A Qualified Beneficiary will be notified by the Plan Administrator of the amount of the required contribution payment and the contribution payment options available.

**Termination of Coverage.** Coverage will end upon the earliest of the following:

- a. termination or reduction of hours;
  - 1. 18 months from the date of the Qualifying Event; or
  - 2. 29 months from the date of the Qualifying Event if the Qualified Beneficiary is determined under Title II or Title XVI of the Social Security Act to be disabled on such date or at any time during the first 60 days of COBRA continuation coverage and provides notice as required by law (including, COBRA continuation coverage of non-disabled family members of the Qualified Beneficiary entitled to the disability extension).

- b. the day, after the 18 month continuation period, which begins more than 30 days from the date of a final determination under Title II or Title XVI of the Social Security Act that a Qualified Beneficiary, entitled to 29 months, is no longer disabled (including COBRA continuation coverage of non-disabled family members of the Qualified Beneficiary entitled to the disability extension who is no longer disabled).
- c. for a Covered Dependent, 36 months from the date of the Qualifying Event if the Qualifying Event is:
  - 1. the Covered Employee's death;
  - 2. the Covered Employee's entitlement to Medicare;
  - 3. a spouse's divorce or legal separation from a Covered Employee; or
  - 4. a dependent child's loss of dependent status under the Plan.
- d. if any of the Qualifying Events listed in (c) occurs during the 18-month period after the date of the initial Qualifying Event listed in (a), coverage terminates 36 months after the date of the Qualifying Event listed in 1.
- e. the date on which the Employer ceases to provide any group health plan to any employee;
- f. the date on which a Qualified Beneficiary fails to make timely payment of the required contribution;
- g. the date on which a Qualified Beneficiary first becomes (after the date of the election) covered under any other group health plan (as an employee or otherwise) which does not contain any exclusion or limitation with respect to any pre-existing condition of such Qualified Beneficiary;
- h. the first day of the month in which a Qualified Beneficiary becomes entitled to Medicare; or
- i. the date this Plan terminates.

Continuation of health coverage under this provision shall not duplicate health care coverage continued under any state or federal law.

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Any questions about COBRA should be directed to the City's Employee Benefits Office,  
115 Plaza De Armas, Suite 10-E, San Antonio, Texas 78205, (210) 207-8705.

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## CHAPTER 3

## DEFINITIONS

**"ACCIDENTAL INJURY"** means a condition caused by an accidental means which results in traumatic damage to the Covered Person's body from an external force that is unexpected at the time, but which occurrence was definite as to time and place. Normal and routine human movements and activities shall not be considered accidents, even though unexpected physiological injury or damage may occur as a result thereof. (Such as bending, stooping or lifting resulting in disc injury; or yawning that damages the temporomandibular joint).

**"ACTIVELY AT WORK"** is considered any day when a covered employee performs in the customary manner all of the regular duties of employment.

**"ALLOWABLE EXPENSE"** relates to coordination of benefits, under Chapter 13 of this Plan Document. Allowable expenses shall mean any necessary usual, customary and reasonable expenses incurred while eligible for benefits under the Plan, part or all of which would be covered under any of the plans, but not including any expenses contained in the Exclusions chapter.

**"AMBULATORY SURGICAL CENTER"** means a specialized facility which is established, equipped, operated and staffed primarily for the purpose of performing surgical procedures on an outpatient basis and which fully meets one of the following two tests:

- (a) It is licensed as an ambulatory surgical facility in the state in which it is located; or
- (b) Where licensing is not required:
  - 1. it is operated under the full-time supervision of a physician;
  - 2. it permits surgical procedures to be performed only by physicians who are privileged to perform the procedure in at least one local hospital;
  - 3. it requires in all cases, except for those using only local infiltration anesthetics, that a licensed anesthesiologist either administers the anesthetic or supervises an anesthetist who administers it and that the anesthesiologist or anesthetist remains present throughout the surgical procedure;
  - 4. it provides at least one operating room and at least one post-anesthesia recovery room;
  - 5. it is equipped to perform diagnostic x-ray and laboratory examinations or has an arrangement to obtain these services;
  - 6. it has trained personnel and necessary equipment to handle emergencies;
  - 7. it has immediate access to a blood bank or blood supplies;
  - 8. it provides the full-time services of one or more registered graduate nurses (R.N.) for patient care in the operating room and post-anesthesia recovery room; and
  - 9. it maintains an adequate medical record for each patient that contains an admitting diagnosis that includes, except for patients undergoing a procedure under local anesthesia, a preoperative examination report, medical history and laboratory tests and/or x-rays, and operative report and discharge summary.

**"ANNUAL OUT OF POCKET"** is the sum of the deductible and any co-insurance under the Plan Document. When the annual out of pocket is reached (which can be for an individual or a family) covered expenses incurred during that plan year will be paid at 100%.

Out of Pocket does not include:

- \* Charges beyond usual & customary fees;
- \* Penalties resulting from non-compliance with pre-certification;
- \* Co-insurance for inpatient or outpatient mental & nervous benefits;
- \* Charges not covered under the Plan.

**"BODY ORGAN"** means the following (a) a kidney; (b) a heart; (c) a heart/lung; (d) a liver, (e) a pancreas, when the condition is not treatable by use of insulin therapy; (f) bone marrow; and (g) a cornea.

**"CALENDAR YEAR"** a period of 12 consecutive months beginning with January 1 through December 31 of the same year. For new employees and dependents, the calendar year is the effective date of their coverage through December 31 of the same year.

**"CITY"** means the City of San Antonio.

**"CLAIMS ADMINISTRATOR"** means the Third Party Administrator or any City employee or office designated to process claims under the Plan Document.

**"COINSURANCE"** is the Covered Person's obligation to pay a percentage of the costs of care in accordance with the terms and provisions of this Plan document. For example, if this plan provides for payment of 80% of eligible medical expense, the remaining 20% is the employee's obligation, and is referred to as "coinsurance."

**"COPAYMENT"** is the covered person's obligation to pay a fixed dollar amount for the services rendered, e.g., \$10 for prescription medications.

**"COMPLICATIONS OF PREGNANCY"** means:

- (a) conditions requiring hospital confinement (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or caused by pregnancy, such as: acute nephritis; nephrosis; cardiac decompensation; missed abortion; and similar medical and surgical conditions of comparable severity; or
- (b) nonelective caesarean section; ectopic pregnancy which is terminated; or spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible.

"Complications of pregnancy" does not mean: false labor; occasional spotting; physician prescribed rest during pregnancy; morning sickness; hyperemesis gravidarum; preeclampsia; or similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy.

**"COSMETIC PROCEDURES"** mean any surgical procedure or any portion of a surgical procedure performed primarily to improve physical appearance and does not promote the proper function of the body or treat any illness or injury.

**"COVERED PERSON"** means an eligible Employee, retiree, official or eligible Dependent covered under this Plan.

**"COVERED PROVIDER"** means an ambulatory surgical center, a home health care agency, a licensed hospice care center, a hospital, a physician, a surgeon, a psychiatric day treatment facility, a rehabilitation facility and a skilled nursing facility.

**"CUSTODIAL CARE"** means that type of care or service, wherever furnished and by whatever name called, which is designated primarily to assist a covered person, whether or not totally disabled, in the activities of daily living. Such activities include, but are not limited to: bathing, dressing, feeding, preparation of special diets, assistance in walking or in getting in or out of bed, and supervision over medication which can normally be self-administered.

**"DEDUCTIBLE"** means the amount of Covered Medical Expenses a Covered Person must incur and pay each calendar year before benefits are payable under the Plan. **"FAMILY DEDUCTIBLE LIMIT"** means that, once the sum of the family deductible has been satisfied by the cumulative Covered Medical Expenses of the eligible employee and one (1) or more of his eligible dependents in a Calendar Year, no further deductible need be satisfied in that Calendar Year for any other eligible member of the family.

For example:

|                                |               |                                     |
|--------------------------------|---------------|-------------------------------------|
| Employee                       | \$ 85.00      |                                     |
| Spouse                         | 200.00        | Satisfied the Individual Deductible |
| Child                          | 90.00         |                                     |
| Child 2                        | <u>50.00</u>  |                                     |
| Total submitted                | \$ 425.00     |                                     |
| Family Deductible Accumulation | <u>400.00</u> |                                     |
|                                | \$ 25.00      | reimbursed at coinsurance level     |

Where a City employee, by virtue of his relationship to another City employee, would be considered an eligible dependent but for his employment with the City, the higher of the two (2) family deductibles of these two (2) City employees need only be satisfied.

**"DENTIST"** means a currently licensed dentist practicing within the scope of the license or any physician furnishing dental services which the physician is licensed to perform.

**"DIABETES EQUIPMENT"** means the following:

- a. blood glucose monitors, including monitors designed to be used by blind individuals;
- b. insulin pumps and associated appurtenances;
- c. insulin infusion devices; and
- d. podiatric appliances for the prevention of complications associated with diabetes.

**"DIABETES SUPPLIES"** means the following:

- a. test strips for blood glucose monitors;
- b. visual reading and urine test strips;
- c. lancets and lancet devices;
- d. insulin and insulin analogs;
- e. injection aids; syringes;
- f. prescriptive and non-prescriptive oral agents for controlling blood sugar levels; and
- g. glucagon emergency kits.

**"DONOR"** means a person who undergoes a surgical operation for the purpose of donating a body organ(s) for transplant surgery.

**"DURABLE MEDICAL EQUIPMENT"** means equipment prescribed by the attending physician which meets each of the following: a) medically necessary; b) is not primarily or customarily used for non-medical purposes; c) is designated for prolonged use; and d) serves a specific therapeutic purpose in the treatment of any injury or illness.

**"ELIGIBLE EXPENSE"** is any expense, which is eligible for payment, in whole or in part under this plan document.

**"EMPLOYEE"** means a person who is directly employed by the City of San Antonio and is regularly scheduled for a full shift or schedule in like manner as other similarly situated workers in the department or division. "Employee" shall also include employees on Worker's Compensation, Disability, or Non-Paid status.

**"EMPLOYER"** means the City of San Antonio.

**"FIRE FIGHTER"** means any full time, permanent, paid Employee who:

- (a) Is employed by the City's Fire Department;
- (b) Has been hired in substantial compliance with Chapter 143 of the Local Government Code;
- (c) Has successfully completed the Fire Academy; and
- (d) Has received his or her certificate from the Fire Chief.

**"FULL TIME STUDENT"** means a participant's dependent child who is enrolled in and regularly attending an accredited college, university or institution on a full time basis as determined by the institution attended by the student. Evidence of the child's status as a full time student satisfactory to the claims administrator must be furnished by the covered person in the event of a claim or enrollment. A person ceases to be a full time student at the end of the month during which the person graduates or otherwise ceases to be enrolled and in attendance at the institution on a full time basis. A person continues to be a full time student during periods of vacation established by the institution, unless the person does not continue as a full time student immediately following the period of vacation.

**"HOME HEALTH CARE AGENCY"** means an agency or organization which meets all of the following requirements:

- (1) It is licensed and primarily engaged in providing skilled nursing care and other therapeutic services;
- (2) It has policies established by a professional group associated with the agency or organization and includes at least one physician and one registered graduate nurse (R.N.) who provide full time supervision of such services;
- (3) It maintains complete medical records on each individual;
- (4) It has a full time administrator.

**"HOSPICE"** means an agency which:

- a. is primarily engaged in providing counseling, medical services or room and board to terminally ill persons;
- b. has professional service policies established by a group associated with it. This group must include one (1) Physician, one (1) Registered Nurse (RN) and one (1) social service coordinator;
- c. has full-time supervision by a Physician;
- d. has a full-time Administrator;
- e. provides services 24 hours a day, seven (7) days a week;
- f. maintains a complete medical record of each patient; and
- g. is licensed in accordance with state law.

**"HOSPITAL"** means only an institution constituted and operated pursuant to any applicable law, engaged in providing, on an inpatient basis at the patient's expense, diagnostic and therapeutic facilities for the surgical and medical diagnosis, treatment, and care of injured and sick individuals by or under the supervision of a licensed physician or surgeon and continuously providing 24-hour-a-day services by registered nurses. The term "hospital" shall not include any institution or part thereof which is other than incidentally a place for rest, a residential treatment center, or a nursing home or convalescent hospital.

**"INTENSIVE CARE UNIT OR CARDIAC CARE UNIT"** means a clearly designated service area which is maintained within a hospital and which meets all of the following tests:

- (a) It is solely for the treatment of patients who require special medical attention because of their critical condition;
- (b) It provides within such area special nursing care and observation of a continuous and constant nature not available in the regular rooms and wards of the hospital;
- (c) It provides a concentration of special lifesaving equipment immediately available at all times for the treatment of patients confined within such area; and
- (d) It provides at least one professional registered nurse who continuously and constantly attends to the patient confined in such area on a twenty-four (24) hour a day basis; or
- (e) An alternate hospital that is approved by the Plan Administrator, as long as the cost of care does not exceed the cost of care at a hospital that substantially meets subparagraphs (a) through (d) above, in accordance with one or more of the following criteria:
  - (i) to facilitate provision of medical services by a particular physician;
  - (ii) the covered person's physician certifies in writing to the Plan Administrator before services are rendered that the hospital is equipped to provide needed intensive or cardiac care;
  - (iii) proximity of the covered person's immediate family members;
  - (iv) the medical condition of the covered person indicates that it would be inadvisable to transfer to another hospital.

**"LIFETIME MAXIMUM"** is the cumulative maximum amount payable during the lifetime of the covered person, during periods of eligibility, as set forth in the Schedule of Benefits.

**"MASTER CONTRACT"** means and refers to this Plan Document, which sets forth the provisions of universal applicability to the City's various health benefit plans.

**"MEDICALLY NECESSARY"** means any care, treatment, service or supply provided for the diagnosis and treatment of a specific illness, injury or condition which meets all of the following.

- (a) The care and treatment is appropriate given the symptoms, and is consistent with the diagnosis, if any. "Appropriate" means that the type, level, and length of service and the setting are needed to provide safe and adequate care and treatment;
- (b) It is rendered in accordance with generally accepted medical practice and professionally recognized standards in the United States medical community;
- (c) It is not treatment that is generally regarded as experimental, educational or unproven; and
- (d) It is specifically allowed by the licensing statutes that apply to the provider that renders the service.

With respect to confinement in a hospital "medically necessary" further means that the medical condition requires confinement and that safe and effective treatment cannot be provided as an outpatient.

The Claims Administrator may require satisfactory proof in writing, that any type of treatment, service or supply received is Medically Necessary. The Claims Administrator may also specifically require the prescribing physician or consulting board or committee of any facility to provide a written analysis of the necessity and acceptability of the methods, process or procedure under this paragraph, taking into account the criteria set forth above. The fact that a physician may prescribe, order, recommend or approve care, treatment, service or supply does not, in itself, make them Medically Necessary.

Medical necessity specifically does not include any:

- (a) Repeated test which would not be necessary if initially done correctly, or is not necessary at current intervals;
- (b) Care, treatment, service or supply which is for the psychological support, education or vocational training of the Covered Person;

Criteria used in determining that a procedure is experimental includes:

- (a) Whether there is an appropriate rationale for the treatment;
- (b) Whether there is evidence that the treatment is effective;
- (c) Whether there is evidence that the treatment is harmful;
- (d) Whether the benefits justify the immediate and delayed risks of treatment;
- (e) Whether the treatment has been endorsed or approved by the appropriate medical authorities, such as the FDA, the AMA or other medical specialty societies or specialists or whether the treatment is covered by Medicare or other public programs;
- (f) Whether the device or treatment is the subject of ongoing investigation or research;

- (g) Whether the treatment is legal;
- (h) Whether controlled medical trials have been carried out that demonstrate the treatment's efficacy.

**"NEWBORN CARE"** charges for the routine care of a newborn child, while hospital confined, are covered by the Plan on the same basis as an illness of such newborn child. Such charges will be considered separate from the mother's charges and subject to the deductible and the applicable benefit percentage payable as shown in the Schedule of Benefits. All such newborn coverage shall include circumcision. Well baby care is covered for three days after birth, before an individual dependent deductible is applicable to the newborn.

**"OTHER COVERAGE"** means any other contract or policy under which the Covered Person is enrolled, such as:

- \* Group or blanket insurance;
- \* Group practice, group Blue Cross, group Blue Shield, individual practice offered on a group basis, or other group prepayment coverage;
- \* Labor management trustee plans, union welfare plans, employee organization plans, or employee benefit organization plans;
- \* Government programs, such as Medicare, or coverage required or provided by statute;
- \* Any group coverage of a child sponsored by, or provided through, any educational institution;
- \* Group arrangements for members of associations or individuals.

**"OTHER COVERED PROVIDER"** means a certified social worker (CSW) licensed professional counselor (LPC), licensed occupational therapist (LOT), certified nurse midwife, licensed speech therapist, licensed physical therapist, registered nurse, licensed vocational nurse, or licensed practical nurse.

**"PHYSICIAN OR SURGEON"** means any professional practitioner who holds a lawful license authorizing the person to practice medicine or surgery in the locale in which the service is rendered, limited to a Doctor of Medicine (M.D.), a Doctor of Osteopathy (D.O.), a Doctor of Podiatric Medicine (D.P.M.), a Doctor of Dental Surgery (D.D.S.), a Doctor of Chiropractic (D.C.), a Clinical Psychologist (Ph.D), who has met the standards of the National Register of Health Service Providers in Psychology.

**"PLAN"** whenever used herein without qualification means this Plan Document.

**"PLAN ADMINISTRATOR"** means the City of San Antonio's designated Employee Benefits Administrator.

**"PLAN DOCUMENT"** means this Master Contract and any Addendum, which collectively provide and define coverage for particular employees and dependents.

**"PLAN SPONSOR"** means the City of San Antonio.

**"PLAN SUMMARY"** is the information provided to City employees concerning coverage and benefits to assist in understanding and using available benefits. THE PLAN SUMMARY DOES NOT DEFINE COVERAGE, WHICH IS THE SOLE PURPOSE OF THE MASTER CONTRACT. ANY STATEMENT ABOUT COVERAGE IN THE SUMMARY IS A GENERAL INTERPRETATION ONLY, AND IS NOT MADE FOR SPECIFIC APPLICATION TO ANY COVERED PERSON, ILLNESS, OR EXPENSE.

**"POLICE OFFICER"** means any full time, permanent, paid employee who:

- (a) Is employed by the City's Police Department;
- (b) Has been hired in substantial compliance with Chapter 143 of the Local Government Code;
- (c) Has successfully completed the Police Academy; and
- (d) Has received his or her certificate from the Police Chief.

**"POST DELIVERY CARE"** means postpartum health care services provided in accordance with accepted maternal and neonatal physical assessments. Post Delivery Care includes parent education, assistance and training in breast-feeding and bottle-feeding and the performance of any necessary and appropriate clinical tests.

**"PRINCIPALLY DEPENDENT"** shall have the meaning defined in Sections 151 and 152 of the Internal Revenue Code and the regulations thereunder.

**"PSYCHIATRIC DAY TREATMENT FACILITY"** means an institution which meets all of the following requirements:

- (a) It is a mental health facility which: provides treatment for individuals suffering from acute mental, nervous or emotional disorders, in a structured psychiatric program utilizing individualized treatment plans with specific attainable goals and objectives appropriate both to the patient and the treatment modality of the program; and is clinically supervised by a doctor of medicine who is certified in psychiatry by the American Board of Psychiatry and Neurology.
- (b) It is accredited by the Program for Psychiatric Facilities or its successor, or the Joint Commission on Accreditation of Hospital; and
- (c) Its patients are treated for not more than eight (8) hours in any twenty-four (24) hour period.

**"QUALIFIED INSURED"** means an individual eligible for coverage under the Plan who has been diagnosed with:

- a. insulin dependent or non-insulin dependent diabetes;
- b. elevated blood glucose levels induced by pregnancy; or
- c. another medical condition associated with elevated blood glucose levels.

**"RECIPIENT"** means an insured person who undergoes a surgical operation to receive a body organ transplant.

**"REHABILITATION FACILITY"** means a facility that provides services of acute rehabilitation. All services are provided under the direction of a physician with a specialty in rehabilitation and physical medicine. The facility is staffed around the clock by registered nurses and it does not provide services of a custodial nature. The facility must be Medicare certified, licensed by the State Department of Health as a "special hospital" and accredited by the Joint Commission on Accreditation of Healthcare Organizations. It is also accredited by the Commission on Accreditation of Rehabilitation Facilities.

**"SKILLED NURSING FACILITY"** means a legally operated institution, or a distinct part of an institution, primarily engaged in providing skilled nursing care to patients recovering from injury or illness and which:

- (a) Is under the resident supervision of a physician or registered nurse (R.N.);
- (b) Provides continuous skilled nursing care for 24 hours of every day;
- (c) Requires that the health care of every patient be under the supervision of a physician;
- (d) Provides that a physician be available at all times to furnish necessary medical care in emergencies;
- (e) Maintains clinical records for each patient;
- (f) Has an effective utilization review plan;
- (g) Has a transfer agreement with at least one (1) hospital;
- (h) Is not, other than incidentally, a clinic, a place devoted to care of the aged or a place for treatment of mental disorders or mental retardation;
- (i) Is not a place for custodial care.

**"TEMPORARY MECHANICAL EQUIPMENT"** means any non-organic device used in conjunction with the recipient's own body organ for the purpose of sustaining a bodily function for which a transplant has been deemed necessary by the attending physician.

**"TRANSPLANT SURGERY"** means the transfer of body organ(s) from a donor to a recipient.

**"USUAL & CUSTOMARY CHARGE"** means charges for Medically Necessary services and supplies which would usually be provided for cases the same as or similar to the one being treated. The Usual and Customary charge is limited to the lesser of:

- (a) The fee usually charged by the provider for similar services and supplies; and
- (b) The fee usually charged for the same service or supply by other providers who are in the same area. "Area" means a geographical area as determined by the Claims Administrator to be significant enough to establish a representative base of charge for the treatment. The determination of the "usual and customary" charges by the Claims Administrator shall be based on standard profiles and statistical sampling methods accepted in the benefits industry. Usual and customary shall be based on the 85th percentile and updated on a semi-annual basis. All charges above or beyond the "usual and customary" charges so determined are the financial responsibility of the Covered Person. Upon request, the City will furnish information or assistance to a Covered Person to enable them to contest excessive charges, in accordance with the policy of the Employee Benefits Office in effect at the time of the request.

## CHAPTER 4

## COVERED MEDICAL EXPENSES

Covered Medical Expenses shall be the portion, set forth in the Schedule of Benefits, of the usual and customary charges for the following services, supplies, and treatment when medically necessary and when ordered by a licensed physician or surgeon. Medical expenses exceeding usual and customary expenses covered by this plan will be the obligation of the Covered Person.

1. Daily semi-private room charge in a hospital or rehabilitation facility.
2. Services and supplies furnished by a hospital.
3. Treatment by a physician or surgeon.
4. Treatment by an other covered provider not related by blood or marriage.
5. Anesthetic and its administration.
6. "Surgery in mouth or oral cavity" is limited to:
  - (a) removal of non-odontogenic lesions, tumors or cysts;
  - (b) incision and drainage of non-odontogenic cellulitis;
  - (c) surgery on accessory sinuses, salivary glands and ducts and tongue;
  - (d) surgical treatment of fractures and dislocation of the jaw resulting from an accidental injury.
7. Diagnostic radiology, radiation therapy and laboratory examinations.
8. Ambulance charges to or from the nearest medically appropriate hospital by an ambulance service operated in accordance with State law.
9. Medical supplies and equipment as follows:
  - (a) drugs and medicines which can be obtained only by numbered prescription for the specified illness or injury for which the patient is being treated;
  - (b) birth control pills, injections and medication implants are covered for employees and dependent spouses only. No other contraceptive methods or devices are covered;
  - (c) blood and blood plasma;
  - (d) charges for drawing and storing autologous blood;

- (e) prosthetic appliances such as artificial limbs or eyes, not including their replacement except when required due to growth or development of a dependent child. After a covered mastectomy, breast implants or prostheses are also covered. Replacement of breast prosthesis is covered only when original prosthesis was required due to a major catastrophic illness or injury;
  - (f) crutches. The rental (but not to exceed the total cost of purchase) or, at the option of the Claims Administrator, the purchase of durable medical equipment when medically necessary and prescribed by a physician for therapeutic use, including wheelchairs, hospital beds, oxygen and equipment for its administration including IPPB (Intermittent Positive Pressure Breathing);
  - (g) medical supplies such as lancets, autolets, syringes, dextrowash and dextrostix, ostomy supplies, casts, splints, trusses and braces;
  - (h) orthopedic shoes when prescribed by a physician.
10. Dental treatment for fractured jaw or for injury to sound natural teeth including replacement of such teeth within six months after the date of accident, provided that such accident occurs while the insurance is in force as to the covered person.
11. Expenses incurred for maternity care and services shall be covered on the same basis as for any other illness incurred by the covered person or the dependent spouse. There is no coverage for expenses for maternity care and services incurred by a dependent child except for complications of pregnancy which shall be treated as any other illness.

Coverage for inpatient care for a mother and her newborn child in a health care facility shall be as follows:

- a. 48 hours following an uncomplicated vaginal delivery; and
- b. 96 hours following an uncomplicated delivery by cesarean section.

The attending physician shall make the determination as to whether a delivery is complicated.

If a decision is made to discharge a mother or her newborn child from inpatient care before the expiration of the minimum hours of coverage of inpatient care as provided above, the Plan will provide coverage for timely Post Delivery Care as defined herein. Such care may be provided to the mother and the child by a physician, registered nurse or other appropriate licensed health care provider and may be provided at the mother's home, a health care provider's office, a health care facility or another location determined to be appropriate under rules adopted by the Commissioner of Insurance.

12. Newborn care.
13. Services of a licensed speech therapist are covered only when there has been a partial or total loss of functional speech due to illness or injury, when normal speech was present before the illness or injury, and when therapy is rendered in accordance with a physician's specific instructions as to type and duration.
14. Services of a licensed physical therapist are covered only for those services that require the technical medical proficiency and skills of a licensed physical therapist and which are rendered in accordance with a physician's specific instructions as to type and duration.
15. Acupuncture or hypnosis when performed by a covered provider and in lieu of anesthesia.

16. **Psychiatric Treatment.** Serious mental illness includes the following; (1) schizophrenia; (2) paranoia and other psychotic disorders; (3) bipolar disorders (mixed, manic, depressive, and hypomanic); (4) major depressive disorders (single episode or recurrent); (5) schizo-affective disorders (bipolar or depressive); (6) pervasive developmental disorders; (7) obsessive-compulsive disorders; and (8) depression in childhood and adolescence. Treatment of the above-listed serious mental illnesses is limited to 45 days of inpatient treatment per calendar year and 60 visits for outpatient treatment, including group and individual outpatient treatment, per calendar year. Coverage for such treatment does not include addiction to a controlled substance or marihuana that is used in violation of law or mental illness resulting from the use of a controlled substance or marihuana in violation of law. The above-listed serious mental illnesses will be covered as any other illness subject to applicable deductibles, coinsurance, limits and exclusions, pre-certification and non-pre-certification penalties. Any diagnosis other than those listed in the sub-paragraph will be subject to the current Plan design in each program.
17. Chemical dependency and substance abuse will be treated as any other illness.
18. Voluntary sterilization is covered.
19. Preventive services:
  - (a) One routine pap smear (doctor's procedure charge, lab expenses and office visit) per calendar year for female covered persons;
  - (b) One routine mammogram per calendar year for female covered persons age thirty-five (35) and over;
  - (c) One (1) routine physical examination per calendar year for an eligible employee only. The Plan will cover 100% of the costs of such physical examination if done at the Occupational Health Clinic, 401 W. Commerce, Suite 326, or the eligible employee's own physician, subject to the deductible and coinsurance as state herein.
  - (d) A physical examination for the detection of prostate cancer and prostate-specific Antigen test used for the detection of prostate cancer for each male enrolled in the Plan who is;
    1. at least 50 years of age and asymptomatic; or
    2. at least 40 years of age with a family history of prostate cancer or another prostate cancer risk factor.
20. Gamma globulin injections and the following immunizations for Covered Dependents from birth through the date the child is six (6) years of age shall be covered: (a) DTP, (b) polio (OPV), (c) MMR, (d) meningitis (HIB); (e) hepatitis B (HBV); (f) tb tine; (g) varicella; and (h) any other immunization as required by Texas law. After age six (6), the aforementioned immunizations will be covered only if the dependent was covered under this Plan before attaining age six (6). Expenses for all covered immunizations are covered at 100%, deductible waived. Other services provided at the same time as the immunizations, including, but not limited to, office visit charges, shall be subject to the deductible and coinsurance.
21. Expenses for Attention Deficit Disorder.
22. Occupational Therapy

23. **Diabetes.** Coverage shall be provided to each Qualified Insured as defined herein for:

- a. diabetes equipment;
- b. diabetes supplies; and
- c. diabetes self-management training programs as defined herein.

A health care practitioner or provider who is licensed, registered, or certified in Texas to provide appropriate health care services must provide diabetes self-management training. Self-management training includes:

- a. training provided to a Qualified Insured after the initial diagnosis of diabetes in the care and management of that condition, including nutritional counseling and proper use of diabetes equipment and supplies;
- b. additional training authorized on the diagnosis of a physician or other health care practitioner of a significant change in the Qualified Insured's symptoms or condition that requires changes in the Qualified Insured's self-management regime; and
- c. periodic or episodic continuing education training when prescribed by an appropriate health care practitioner as warranted by the development of new techniques and treatments for diabetes.

24. **Temporomandibular Joint.** Medically necessary diagnostic or surgical treatment of conditions affecting the temporomandibular joint (jaw and the craniomandibular joint) resulting from one of the following shall be covered:

- a. an accident;
- b. a trauma;
- c. a congenital defect;
- d. a developmental defect; or
- e. a pathology.

Such coverage is subject to the same Plan provisions as for any surgical treatment including, but not limited to, the requirements for pre-certification of benefits.

25. **Mastectomy.** Coverage for inpatient care for a Covered Person is as follows:

- a. 48 hours following a mastectomy; and
- b. 24 hours following a lymph node dissection for the treatment of breast cancer.

If the Covered Person and the Covered Person's attending physician determine that a shorter period of inpatient care is appropriate, the Plan is not required to provide the minimum hours of coverage of inpatient care stated above.

26. **Treatment for Mental and Nervous Conditions**

- a. There is a limit of 30 days on the number of days for hospital confinement (20% coinsurance applies).
- b. There is a limit of 60 days on the number of days for treatment at psychiatric day treatment facility (20% coinsurance applies).
- c. Psychiatric counseling will be paid at 50% of usual and customary.

27. **Hospice Care.** Hospice care is an alternative to the Hospital Confinement of a terminally ill person. Hospice Benefits are available for Covered Persons with a life expectancy of six (6) months or less provided the attending Physician approves the program. Failure to pre-certify will result in no benefit allowances. Hospice care is subject to the deductibles and co-insurance as provided in the applicable appendix for each class of City employee, retiree, and official.

Eligible Hospice Charges are charges made by a Hospice for:

- a. room and board;
  - b. private duty nursing care provided by or under the supervision of a Registered Nurse (R.N.);
  - c. part-time or intermittent home health aide services which consist primarily of caring for the patient by employees of the Hospice;
  - d. social work performed by a licensed social worker, routinely provided by the Hospice agency;
  - e. nutritional services, including, special meals, if included in the per diem;
  - f. emotional support services routinely provided by the Hospice agency, if included in the per diem;
  - g. bereavement counseling sessions for eligible dependents covered under the Plan, if included in the per diem; and
  - h. drugs and medication.
28. **Organ Transplants.** If covered expenses are incurred as a result of a body organ transplant, the Plan will pay the applicable co-insurance percentage of the Covered Expenses, as defined herein, after the deductible is applied, subject to the lifetime maximum benefit and the following conditions:
- a. Benefits are available for body organ transplantation, subject to determination made on an individualized case by case basis in order to establish medical necessity;
  - b. Benefits will be provided only when the hospital and physician customarily charge a transplant recipient for such care and services;
  - c. When only the transplant recipient is a Covered Person, the benefits of the Plan will be provided for the donor to the extent that such benefits are not provided under any other form of coverage. In no such case under the Plan will any payment of a "personal service" fee be made to any donor. Only the necessary hospital and physician's medical care and services expenses with respect to the donor will be considered for benefits;
  - d. When only the donor is a Covered Person, the donor will receive benefits for care and services necessary to the extent such benefits are not provided under any coverage available to the recipient. Benefits will not be provided to any recipient who is not a Covered Person; and
  - e. When the recipient and the donor are both Covered Persons, as provided herein, benefits will be provided for both in accordance with their respective Covered Expenses.

If the recipient is the Covered Person and/or pursuant to the conditions set forth above, the following coverage shall be provided:

- a. The use of temporary mechanical equipment, pending the acquisition of "matched" body organ(s);
- b. Transplant surgery of a body organ(s) as defined herein;
- c. Multiple transplant(s) during one (1) operative session;
- d. Replacement(s) or subsequent transplant(s); and
- e. Follow-up expenses for covered services, including immunosuppressant therapy.

If the donor is a Covered Person and pursuant to the conditions set forth above, the following coverage shall be provided:

- a. The acquisition of a body organ(s) from the donor;
- b. The life support of a donor pending the removal of a usable body organ(s); and
- c. Transportation of a body organ(s). However, transportation of a body organ(s) shall not include transportation of a living donor and/or a donor on life support.

## **CHAPTER 5                    LIMITATIONS**

Benefit limitations apply to the following conditions and services:

1.            **Abortions**

Abortions will be covered when the attending physician certifies that the mother's life would be endangered if the fetus were carried to term.

2.            **Cosmetic Procedure**

Elective procedure performed solely to improve appearance is not covered. Nor are the complications that may arise from or are the direct result of such procedure covered. A procedure utilized as treatment of neurosis, psychoneurosis, psychopathy, psychosis and other mental, nervous and emotional illnesses is not covered. However, expenses incurred for a cosmetic procedure for the prompt repair or alleviation of damage caused solely by accidental bodily injury sustained while benefits are in force, or congenital defects of children born while covered under this Plan and the defects repaired while covered under this Plan are covered, or for the correction of a congenital anomaly in a newborn child covered under this Plan from birth.

3.            **Treatment in Mouth or Oral Cavity**

The care and treatment of the teeth, gums or alveolar process or for dentures, appliances or supplies used in such care and treatment is not covered, except for charges incurred as a result of and within six months after an accident suffered while covered hereunder for treatment of injuries to sound, natural teeth, including replacement of such teeth, or for setting of a jaw fractured or dislocated in such accident; provided, however, that this exclusion shall not be applicable to services and supplies rendered to a newborn child which are necessary for treatment or correction of a congenital defect.

4.            **Maternity for Dependents**

Maternity care and services rendered to a dependent child are limited to treatment of Complications of Pregnancy.

5.            **Mental and Nervous Conditions**

Subject to the applicable percentage payable as stated in the Schedule of Benefits, charges for services provided by a physician (M.D., D.O., clinical psychologist, certified social worker or licensed professional counselor) including group therapy, and collateral visits with members of the patients immediate family for the treatment of mental, nervous, emotional, drug or substance abuse illness or disorders of any type are payable as follows:

Covered physician charges provided on an inpatient basis are covered at the applicable percentage rate stated in the Schedule of Benefits.

No coverage is provided for physical or psychological therapy in an in or out patient setting where art, play, music, drama, reading, nutrition, massage, education, home economics or recreational activities is the method of treatment.

Psychological testing, evaluation or assessment is covered at the applicable percentage rate listed in the Schedule of Benefits.

Expenses for treatment in a psychiatric day treatment facility for a mental, nervous or emotional disorder, if the attending physician certifies that such treatment is in lieu of hospitalization, will be covered as if incurred on an inpatient basis. Any benefits so provided shall be determined as if necessary care and treatment in a psychiatric day treatment facility were inpatient care and treatment in a hospital; each full day or treatment in a psychiatric day treatment facility shall be considered equal to one-half day of hospital confinement for purposes of determining benefits and benefit maximums under the Plan.

#### 6. Private Room Limit

When private room accommodations have been used, charges will be reimbursed at the average semi-private room rate in the facility. If a hospital has private rooms available only, then the maximum eligible charge will be based on the usual and customary semi-private room charge in the community.

## CHAPTER 6

## EXCLUSIONS

No coverage is provided under the Plan for services and supplies:

1. For which the patient or employee has no legal obligation to pay, or for which no charge would be made if the employee had no health coverage.
2. Any treatment or service rendered by a Covered Provider related by blood or marriage.
3. Not medically necessary for the diagnosis and treatment of an illness or injury or which exceed the usual and customary charges.
4. For intentionally self-inflicted injury, whether sane or insane.
5. For diseases contracted or injuries sustained as a result of service in any branch of the armed forces.

6. For accidental bodily injury or illness which is covered by Workers' Compensation or an Occupational Medical Policy, or any expenses payable under compromise settlement agreements arising from a Workers' Compensation Claim.
7. For marital, family, vocational and other counseling services, except for nutritional counseling for diabetics.
8. For sex transformation surgery and all expenses in connection with such surgery.
9. For reversal or attempted reversal of sterilization.
10. For services, therapy and counseling for sexual dysfunction or inadequacies or for implants or aids to sexual function except due to a disease or injury which is otherwise covered by this plan.
11. Family planning, infertility treatment and services including but not limited to: artificial insemination and personal therapy for infertility.
12. For a dependent child's pregnancy except for complication as defined by the Plan arising from a dependent child's pregnancy.
13. For smoking cessation seminars, services, devices or medications.
14. For the surgery or treatment of obesity, morbid obesity, dietary control, or for weight reduction.
15. For nutritional supplements, including prescription and over the counter vitamins.
16. For exercise equipment or exercise programs.
17. For orthotics (arch supports, etc.) and other supportive devices for feet that are not prescribed by a physician.
18. For air conditioners, filters, humidifiers, dehumidifiers, and purifiers.
19. For eye exercises, visual training (orthoptics), eyeglasses, including contact lenses, hearing aids, or examinations for the purpose of determining visual acuity or level of hearing.
20. For radial keratotomy surgery and orthokeratology.
21. For medical, dental or surgical treatment including associated diagnostic procedures of orthognathic conditions.
22. For vocational therapy.
23. For preparing medical reports or itemized bills.
24. For travel or accommodations, whether or not recommended by a physician.
25. For charges associated with non-emergency hospital admissions on either a Friday or a Saturday unless a surgical procedure is performed within 24 hours of admission.
26. For special education, counseling or care for learning deficiencies or behavioral problems whether or not associated with a manifest mental disorder or other disturbance.

27. For care in a health resort, rest home, nursing home, residential treatment center, or any institution primarily providing convalescent, or custodial care.
28. For custodial care.
29. For any claims filed more than one (1) year from the month the covered service or supply was provided.
30. For admissions aimed at primarily overcoming the after effects of a specific episode of drug abuse (detoxification), or to keep the patient from access to drugs (maintenance care).
31. For sales tax, transportation, tariffs, immigration fees for international travel, or federal excise taxes are not covered under this plan document.
32. For routine physical examinations for eligible dependents and for eligible employees not covered in Chapter 4, paragraph 19(c).
33. No coverage is provided for services and supplies for routine or preventative immunizations or vaccinations except for gamma globulin injections and child immunizations.
34. Coverage for **Hospice Care** does not include the following charges:
  - a. nutritional services, including special means not included in the per diem;
  - b. emotional support services not routinely provided by the Hospice agency and/or not included in the per diem;
  - c. bereavement counseling sessions for eligible dependents covered under the Plan not included in the per diem;
  - d. funeral arrangements;
  - e. pastoral counseling; and
  - f. financial or legal counseling.
35. Coverage for **Organ Transplant Surgery** does not include the following charges:
  - a. Experimental treatment for new procedures, and treatments, services or supplies which are still considered experimental or investigational and not "generally accepted" by the medical profession. The judgment whether a procedure, treatment, service or supply is experimental is based upon all of the relevant facts and circumstances, including, but not limited to:
    1. Approval by the U.S. Food and Drug Administration, the American Medical Association or the appropriate Medical Specialty Society;
    2. Medical and scientific literature;
    3. Scientifically demonstrated health benefits;
    4. Safety and effectiveness compared to alternatives; and
    5. Safety, effectiveness and benefits when used outside of a research setting;
  - b. Any animal organ or mechanical equipment, mechanical device, or mechanical organ(s), except as provided herein;
  - c. Any financial consideration to the donor other than for a covered service or supply which is incurred in the performance of or in relation to transplant surgery; and
  - d. Transportation of a donor, except as provided herein.

**CHAPTER 7****PRE-EXISTING CONDITIONS**

With respect to any Covered Person, a pre-existing condition is an injury, illness or condition that has been diagnosed, whether or not treatment has been rendered or prescribed, or for which the individual received treatment or services or took prescribed drugs or medicines within the six (6) month period immediately prior to becoming covered by this Plan. No benefits will be paid for expenses incurred as a result of a pre-existing condition during the first six (6) months a person is covered by this Plan.

This provision does not apply to Covered Persons if their current coverage is effective on the date the Plan becomes effective.

This limit shall apply to any new dependents.

**CHAPTER 8****SUPPLEMENTAL ACCIDENT BENEFITS**

This provision provides you and your dependents with supplemental benefits for hospital and medical expenses resulting from an Accidental Injury occurring while you are covered by this Plan.

Covered medical expenses directly related to the accident and incurred within the first ninety (90) calendar days of the date of the accident, are covered at 100% up to a maximum of \$500. Deductible does not apply.

## **CHAPTER 9**

## **PRE-ADMISSION TESTING**

If a Covered Person who is scheduled for inpatient surgery in a hospital, has preoperative testing relating to this surgery performed within ten (10) days prior to the scheduled surgery and the testing is performed at a physician's office, diagnostic laboratory, ambulatory surgery center or on a hospital outpatient basis, the Plan will pay pre-operative testing at 100% provided:

1. The charge for the surgery is a covered expense;
2. The tests would have been covered had the patient been confined as a hospital inpatient;
3. The tests are not repeated when the patient is confined for the surgery;
4. The test results are a part of the patient's medical record;
5. The surgery is performed in a hospital;
6. The service is identified as pre-admission or preoperative testing.

The deductible does not apply.

## **CHAPTER 10 HOSPITAL PRE-CERTIFICATION**

Certification of ALL admissions to a hospital including admissions for rehabilitation, treatment of mental or nervous condition, drug, alcohol or substance abuse and maternity is required prior to or on the day of admission as an inpatient. Emergency admissions must be verified within forty-eight (48) hours following admissions. Confirmation of the admission or an extension beyond the period originally authorized will be provided by the Utilization Review Nurse to the Covered Person, the hospital and the physician.

Certification of all outpatient surgery, performed in an ambulatory surgery center or hospital outpatient facility, is required prior to or on the day of the surgery. Emergency outpatient surgery must be certified within forty-eight (48) hours following the surgery. Confirmation of the outpatient surgery will be provided by the Utilization Review Nurse to the Covered Person, the outpatient facility and the physician.

The Covered Person is responsible for the certification of hospital admission and outpatient surgery.

For all hospital admissions and outpatients surgeries:

The patient, a family member, the physician or the hospital must call the City of San Antonio's Utilization Review Nurse for:

For regular admissions and outpatient surgery:

Call prior to the scheduled admission or surgery date.

For emergency admissions and outpatient surgery:

Call within forty-eight (48) hours of admission or surgery. The number to call for precertification is listed on the back of the Plan identification card provided by the Claims Administrator.

If Pre-Certification Authorization is not obtained the maximum benefit paid for the doctor and hospital will be fifty percent (50%) of the usual and customary charges. The fifty percent (50%) not reimbursed by the Plan will not count toward satisfaction of the Plan year out-of-pocket maximum.

Pursuant to State law, the Plan will not restrict benefits for any hospital length of stay in connection with a mastectomy or lymph node dissection of less than 48 hours following a mastectomy or less than 24 hours following a lymph node dissection or require that a provider obtain authorization from the Plan for prescribing a length or stay within the above periods. Certification is required for a length of stay, which is in excess of the above periods.

Pursuant to State law, the Plan will not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child of less than 48 hours following an uncomplicated vaginal delivery or less than 96 hours following an uncomplicated cesarean section, or require that a provider obtain authorization from the Plan for prescribing a length of stay within the above periods. Certification is required for a length of stay, which is in excess of the above periods.

## **CHAPTER 11 PREFERRED PROVIDER NETWORK**

### **Preferred Provider Network**

The City of San Antonio participates in a Preferred Provider Network of hospitals, physicians and other providers that are contracted to furnish, at negotiated costs, medical care for the City employees and their dependents. The use of a Preferred Provider may result in reduced out of pocket expenses to the Covered Person.

A current listing of the Preferred Provider Network contracting hospitals, physicians and other providers is available in the Employee Benefits Office. A Covered Person may choose any health care provider.

The City reserves the right to terminate or modify the Preferred Provider Network program, or any portion thereof, at any time.

## **CHAPTER 12 EMPLOYEE SELF-AUDIT PROGRAM**

On inpatient hospital bills under \$3,000.00 the Plan will make a cash presentation to any employee who (1) detects a billing overcharge made by a hospital as a result of an inpatient confinement to any covered family member and (2) receives a billing adjustment and (3) the Plan realizes a savings.

Upon discharge from the hospital, simply review the bill. If there is any error, it may be in one of the following area:

### **A Calculation Error**

A charge for service the patient did not receive.

The patient received a service but not in the quantity indicated.

Remember, take the original bill and obtain a corrected bill and present both to the City Claims Administrator for review and determination. The Plan will pay the employee 25% of the savings or maximum of \$500, whichever is less. As an example, if an employee detects an incorrect charge of \$1,200 and this is confirmed, the employee will receive a check for 25% of the savings, or \$300 from the Plan.

## **CHAPTER 13 COORDINATION OF BENEFITS (COB)**

The COB provision is designed to correct over coverage which occurs when a person has health coverage for the same expenses under two (2) or more of the plans listed below. Should this type of duplication occur, the benefits under this Plan will be coordinated with those of the other plans so that the total benefits from all plans will not exceed the expenses actually incurred.

If a Covered Person's benefits under another health plan are reduced due to cost containment provisions, such as a second surgical opinion, pre-certification, HMO or preferred provider arrangements, the amount of the reduction shall not be considered as an allowable expense under this Plan.

The benefits provided by the plans listed below are considered in determining duplication of coverage:

1. This Plan;
2. Any other group insurance or prepayment plan, Health Maintenance Organizations (HMOs); Blue Cross/Blue Shield;

3. Any labor-management trustee plan, union welfare plan, employer organization plan or employee benefit organization plan;
4. Any government plan or statute providing benefits for which COB is not prohibited by law.

#### **Order of Benefit Determination**

Certain rules are used to determine which of the plans will pay benefits first. This is done by using the first of the following rules which applies:

1. A plan with no COB provision will determine its benefits before a plan with a COB provision;
2. A plan that covers a person other than as a Dependent will determine its benefits before a plan that covers such person as a Dependent;
3. Any labor-management trustee plan, union welfare plan, employer organization plan or employee benefit organization plan will determine its benefits before this plan;
4. When a claim is made for a dependent child who is covered by more than one (1) plan:
  - (a) the benefits of the plan of the parent whose birthday falls earlier in the year will be determined before the benefits of the plan of the parent whose birthday falls later in that year; but
  - (b) if both parents have the same birthday, the benefits of the plan which covered the parent longer will be determined before those of the plan which covered the other parent for a shorter period of time.

This method of determining the order of benefits will be referred to as the "Birthday Rule." The Birthday Rule will be used to determine the order of benefits for dependent children in all cases except those described below.

- (c) if the other plan does not have the Birthday Rule, then the plan which covers the child as a dependent of the male parent will pay its benefits first.
- (d) if the parents are legally separated or divorced, benefits for the child will be determined in this order:
  - (i) first, the plan of the parent with custody of the child will pay its benefits;
  - (ii) then, the plan of the spouse of the parent with custody of the child will pay its benefits; and
  - (iii) finally, the plan of the parent not having custody of the child will pay its benefits.

However, if there is a court decree stating which parent is responsible for the health care expenses of the child, then a plan covering the child as a dependent of that parent will determine its benefits before any other plan.

5. A plan that covers a person as:
  - (a) a laid off employee; or

(b) a retired employee; or

(c) a dependent of such employee;

will determine its benefits after the plan that does not cover such person as:

(a) a laid off employee; or

(b) a retired employee; or

(c) a dependent of such employee.

If one of the plans does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule will not apply.

6. If one of the above rules establishes the order of payment, a plan under which the person has been covered for the longer time will determine its benefits before a plan covering that person for a shorter time.

Two successive plans of the same group will be considered one plan if the person was eligible for coverage under the new plan within twenty-four (24) hours after the old plan terminated. A change in the amount or scope of benefits, or a change in the carrier, or a change from one type of plan to another (e.g., single employer plan to multiple employer plan) will not constitute the start of a new plan.

When the COB provision reduces the benefits payable under this Plan:

(a) each benefit will be reduced proportionately; and

(b) only the reduced amount will be charged against any benefit limits under the Plan.

The COB provision is applied throughout the calendar year. If there is any reduction of the benefits provided under a specific Benefit Provision of this Plan because of duplicate coverage, similar benefits may be payable later in that year if more Allowable Expenses are incurred under the same Benefit Provision of this Plan because of duplicate coverage, similar benefits may be payable later in that year if more Allowable Expenses are incurred under the same Benefit Provision. "Allowable Expense" means any necessary, usual and customary item of expense at least part of which is covered under at least one of the plans covering the person for who claim is made or service provided, in no event will Allowable Expense include the difference between the cost of a private hospital room and a semi-private hospital room unless the patient's stay in a private hospital room is Medically Necessary.

Benefits under a governmental plan will be taken into consideration without expanding the definition of "Allowable Expense" beyond the hospital, medical and surgical benefits as may be provided by such governmental plan.

When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be deemed to be both an Allowable Expense and a benefit paid.

The Plan has the right to release to, or obtain from, any other organization or person any information necessary for the administration of this provision and to pay to any organization any amounts necessary to satisfy the intent of this provision.

If the Plan has paid any amounts in excess of those necessary to satisfy the intent of this provision, it has the right to recover such excess from the person, to or for whom, such payments were made or from an insurance company or organization.

When you claim benefits under the Plan, you must furnish information about other coverage, which may be involved in applying this coordination provision.

A payment made under another Plan may include an amount which should have been paid under this Plan. If it does, the Claims Administrator may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under this Plan. The Claims Administrator will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

### **Medicare**

This Plan covers most of the same kinds of expenses as Medicare, which has two parts (Part A, hospital insurance, and Part B, medical insurance). Mutually provided benefits are coordinated under the double coverage provision.

This Plan will pay 80% after Medicare has paid as primary (which requires that the Covered Person is entitled to or has elected parts A and B of Medicare coverage) and after the deductible under this Plan has been met.

Generally, whether Medicare is the primary payor of benefits is determined under Federal law and regulations. Certain retirees will have coverage supplemental to Medicare benefits, as provided in the Appendix applicable to those retirees. For information on this subject, you may consult the Employee Benefits Office or your Social Security Office.

If a Covered Person has other primary medical insurance other than Medicare, benefits will be paid at 80% of usual and customary charges under this plan, after the deductible is paid. Once the employee or retiree is eligible for Medicare such person is required to apply for and maintain Medicare benefits. Once Medicare is effective, the health plan would coordinate, as secondary coverage to Medicare whereby retirees would meet the health plan's deductible before expenses are covered at 80%, to the extent permitted by federal law and regulations.

Once the retiree or spouse is individually eligible for Medicare, such person is required to apply for and maintain Medicare benefits. Once Medicare is effective, this health plan provides coverage supplemental to Medicare. The covered person must meet this plan's deductible before expenses are covered at 80%.

### **Compliance with Cost Containment Health Plan Provisions**

If the Covered Person's benefits are reduced by a health plan that has cost containment provisions, such as a second surgical opinion, HMO, pre-certification or preferred provider arrangements, the amount of such reduction shall not be an allowable expense.

## CHAPTER 14 SUBROGATION/THIRD PARTY CLAIMS

### PROVISION FOR SUBROGATION AND RIGHT OF RECOVERY

A third party may be liable or legally responsible for expenses incurred by a Covered Person for an illness or a bodily injury.

Benefits may also be payable under the Plan for such expenses. When this happens, the Plan may, at its option:

1. Take over the Covered Person's right to receive payment of the benefits from the third party. The Covered Person will:
  - (a) transfer to the Plan any rights he may have to take legal action against the third party with respect to benefits paid by the Plan which are subject to this provision; and
  - (b) cooperate fully with the Plan in asserting its right to subrogate. This means the Covered Person must supply the Plan with all information and sign and return all documents reasonably necessary to carry out the Plan's right to recover from the third party any benefits paid under the Plan which are subject to this provision.
2. Recover from the Covered Person any benefits paid under the Plan which the Covered Person is entitled to receive from the third party. The Plan will have a first lien upon any recovery, whether by settlement, judgment or otherwise, that the Covered Person received from:
  - (a) the third party; or
  - (b) the third party's insurer or guarantor; or
  - (c) the Covered Person's uninsured motorist insurance.

This lien will be for the amount of benefits paid by the Plan for the treatment of illness or bodily injury for which the third party is liable or legally responsible. If the Covered Person:

- (a) makes any recovery as set forth in this provision; and
- (b) fails to reimburse the Plan fully for any benefits paid under this provision; then he will be personally liable to the Plan to the extent of such recovery up to the amount of the first lien. The Covered Person must cooperate fully with the Plan in asserting its right to recover.

## CHAPTER 15

## GENERAL PROVISIONS

### 1. Proof of Loss

Written proof of loss must be furnished to the Claims Administrator within one (1) year after the month such loss was incurred. Failure to furnish proof within the time required shall not invalidate or reduce any claim if it was not reasonably possible to give proof within such time, provided proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the Covered Person, later than one (1) year from the month care, treatment, service or supply was first provided for the illness or injury.

### 2. Legal Actions

No action at law or in equity shall be brought to recover on the Plan unless the employee or retiree has exhausted administrative remedies provided in the review and appeal process in Chapter 16.

### 3. Examination

The Claims Administrator shall have the right and opportunity to have the Covered Person examined whose injury or illness is the basis of a claim when and so often as it may reasonably require during pendency of a claim.

### 4. Conformity with Federal Statutes

Any provision of this Plan, which on its effective date is in conflict with federal statutes, is hereby amended to conform to the minimum requirements of such federal statutes.

### 5. Choice of Physician

The Covered Person shall have free choice of any physician, as defined in this Plan, practicing legally. Benefits may vary depending on the physician's participation in the City's Preferred Provider Network.

### 6. Entire Contract

The Plan Document constitutes the entire contract of coverage between the Plan Sponsor and the Covered Person.

### 7. Effect of Changes

All changes to the Plan shall become effective as of a date established by the Plan Administrator, except that:

No increase or reduction in benefits shall be effective with respect to covered expenses incurred prior to the date a change was adopted by the Plan Sponsor, regardless of the effective date of the change; and

8. Written Notice

Any written notice required under the Plan shall be deemed received by a Covered Person sent by regular mail, postage prepaid, to the last address of the Covered Person on the records of the Employer.

9. Clerical Errors/Delay

Clerical errors made on the records of the Plan Sponsor, Plan Administrator or Claims Administrator and delays in making entries on records shall not invalidate covered or cause coverage to be in force or to continue in force. Rather, the effective dates of coverage shall be determined solely in accordance with the provisions of the Plan regardless of whether any contributions with respect to Covered Persons have been made or have failed to be made because of such errors or delays. Upon discovery of an error or delay, an equitable adjustment of any contributions will be made.

10. Workers' Compensation

The Plan is not in lieu of and does not affect any requirement for coverage by Workers' Compensation insurance.

11. Statements

(a) Not Representations

Statements made by or on behalf of any person to obtain coverage under the Plan shall be deemed representations and not warranties.

(b) Misstatements on Enrollment or Claim Form

If any relevant material fact has been misstated by or on behalf of any person to obtain coverage under the Plan, the true fact shall be used to determine whether coverage is in force and the extent, if any, of coverage. Upon the discovery of any misstatement, an equitable adjustment of any benefit payments will be made.

(c) Time Limit for Misstatement

No misstatement made to obtain coverage under the Plan will be used to void the coverage of any person which has been in force for a period of two (2) years or to deny a claim for a loss incurred or disability commencing after the expiration of the two (2) year period. The provisions of this paragraph shall not apply if any misstatement has been made fraudulently.

(d) Use of Statements

No statement made by or on behalf of any person will be used in any context unless a copy of the written instrument containing the statement has been or is furnished to any person or to any person claiming a right to receive benefits with respect to the person.

12. Identification Cards

Identification card(s) will be issued, which indicate coverage by the City of San Antonio Health Benefits Program. Upon request, the Claims Administrator or the City's Employee

Benefits Office will verify coverage of Covered Persons. Identification cards will be for identification of Covered Persons only and do not constitute a guarantee of coverage.

13. Protection Against Creditors

No benefit payment under this Plan shall be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind, and any attempt to accomplish same shall be void. If the City finds that such an attempt has been made with respect to any payment due or to become due to any covered person, the City in its sole discretion may terminate the interest of such covered person or former covered person in such payment. And in such case the City shall apply the amount of such payment to or for the benefit of such covered person or former covered person, his/her spouse, parent, adult child, guardian or a minor child, brother or sister, or other relative of a dependent of such covered person or former covered person, as the City may determine, and any such application shall be a complete discharge of all liability with respect to such benefit payment. However, at the discretion of the City, benefit payments may be assigned to health care providers.

## CHAPTER 16 CLAIM FILING AND CLAIM PAYMENT

1. Claim Filing

- (a) Medical claims (doctor's visits, prescription drugs, exams, hospital, etc.) shall be filed on a claim form available from the Employee Benefits Office or Claims Administrator.
- (b) The claim form shall include medical bills (itemized only) and the explanation of benefit statement (EOB) from other health insurance policies, if any. The bill should contain the following:
  - (i) the official letterhead of the hospital, doctor, clinic, pharmacy, etc.;
  - (ii) type of service;
  - (iii) date of service received;
  - (iv) amount charged;
  - (v) name of patient; and
  - (vi) diagnosis.
- (c) Only one (1) detailed claim form must be completed per person per year, even for different claims and/or diagnoses. Any additional claims throughout the year may be filed on a short claim form available through the Employee Benefits Office. If a claim is for an accidental injury, then a detailed claim form must be completed for each accident occurrence. All items on the front of the detailed claim form must

be completed. It is not necessary to complete the back of the form. The blocked section regarding secondary insurance coverage must be completed.

- (d) The original claim form with the attached bills shall be mailed to the City's claims administrator.

## 2. Limitation of Liability

The Plan Sponsor shall not be obligated to pay any benefits under the Plan for any claim that is not timely filed.

## 3. Time of Claims Processing

Benefits for incurred medical expenses which are covered under the Plan will be processed immediately upon receipt of proper written proof of loss by the Claims Administrator. Any benefits payable will be made within twenty (20) working days.

Periodic Payment: Payment of accrued periodic payments for continuing losses which are covered under the Plan will be made immediately upon receipt of proper proof of loss by the Claims Administrator and at the applicable time period.

## 4. Payment of Benefits

All benefits under the Plan are payable to the Covered Employee whose illness or injury or whose covered dependent's illness or injury is the basis of a claim.

In the event of the death or incapacity of a Covered Employee and in the absence of written evidence to the Plan of the qualification of a guardian for his estate, the Plan may, in its sole discretion, make any and all payments to the individual or institution which, in the opinion of the Plan Administrator, is or was providing the care and support of the employee.

Benefits for medical expenses covered under the Plan may be assigned by a Covered Employee to the person or institution rendering the services for which the expenses were incurred. No assignment will bind the Plan Sponsor unless it is in writing and unless it has been received by the Claims Administrator prior to the payment of the benefit assigned. The Claims Administrator will not be responsible for determining whether any assignment is valid. Payment of benefits which have been assigned will be made directly to the assignee unless a written request not to honor the assignment signed by the Covered Employee and the assignee has been received before the proof of loss is submitted.

## 5. Discharge of Liability

Any payment made in accordance with the provisions of this section will fully discharge the liability of the Plan Sponsor to the extent of payment.

## 6. Recovery of Payments

If the following circumstances apply, the Plan Sponsor reserves the right to deduct from any benefits properly payable under the Plan or recover from the Covered Employee or assignee who received the payment:

- (a) the amount of any payment which has been made in error; or
- (b) pursuant to a misstatement contained in a proof of loss; or

- (c) pursuant to a misstatement made to obtain coverage under the Plan within two (2) years after the date coverage commences.

## **CHAPTER 17 REVIEW & APPEAL PROCESS**

### **Review Process for Disputed Claims**

The review process for disputed claims shall include the following:

1. The Employee or Retiree may request a review by writing the Claims Administrator and stating the basis for the disputed claim.
2. This request must be made within ninety (90) calendar days after the receipt of the original explanation of benefits.
3. Upon receipt of the request, the claim will be reviewed by the Claims Administrator who will either affirm the original claim determination in writing, pay the disputed claim amount, or request additional information necessary to make a determination.
4. The Claims Administrator's decision will be sent within thirty (30) calendar days to the Employee or Retiree along with supporting documentation setting out the basis on which the decision is made.
5. Either the Employee/Retiree or the Claims Administrator may request a review by Claims Review Committee in accordance with paragraph six (6) below. The Employee/Retiree's request must be made within fifteen (15) calendar days after the Claims Administrator's decision is mailed.
6. A review may be made within fifteen (15) calendar days by a Claims Review Committee upon the request of the Plan Administrator only if new claims information is provided by the Employee or Retiree which was not considered before by the Claims Administrator. The Committee shall consist of the Plan Administrator, a representative of the Claims Administrator who was not directly involved in processing the initial claim, the medical director of the Claims Administrator and the City's Utilization Review Nurse. The decision of the Committee will be made within fifteen (15) calendar days, mailed to the Employee/Retiree and will be deemed final and binding.

**CHAPTER 18 APPENDICES-SUMMARY OF ACCIDENT AND HEALTH BENEFITS**

**APPENDIX A-** Specific Provisions Applicable to Fire & Police Active Employees. (Cadets are covered under the Flex Plan Document as those provisions apply to Non-Uniform City Employees)

**SCHEDULE OF BENEFITS**

**Deductible**

|  |       |
|--|-------|
| Maximum per individual per calendar year ..... | \$200 |
| Maximum per family per calendar year .....     | \$400 |
| Coinsurance .....                              | 80%   |

**No deductible**

|  |      |
|--|------|
| Supplemental accident benefits .....   | 100% |
| up to \$500. No deductible   |      |
| Immunizations for Covered Dependents from birth through the date the child is six (6) years of age (other services provided at the same time as the immunizations, including, but not limited to, office visit charges will be subject to the deductibles and co-insurance ..... | 100% |
| Generic prescriptions .....  | 100% |

**Out of pocket (including deductible)**

|  |             |
|--|-------------|
| Maximum per individual per calendar year .....             | \$700       |
| Maximum per family per calendar year .....                 | \$1,900     |
| Lifetime maximum per individual (medical) .....            | \$1,500,000 |
| Lifetime maximum per individual (mental and nervous) ..... | \$25,000    |

The following provisions apply to the Fire and Police Active Employees as stated herein:

1. Review and Appeal Process.

The review and appeal process in Chapter 17 shall not be construed to supersede, and is in addition to, any grievance procedure set forth in the Collective Bargaining Agreements between the City and the San Antonio Police Officers' Association, in regard to Police Officers and Local 624 of the International Association of Fire Fighters, in regard to Fire Fighters.

2. Amendment or Termination of Plan

The City may amend the provisions of this Plan, from time to time, as the need arises in order to assure the fair and equitable administration of Benefits to be provided eligible Employees in compliance with the terms of the respective Collective Bargaining Agreements.

The City may terminate the provisions of the Plan only during negotiations over the terms to be contained in Collective Bargaining Agreements with Local 624 of the International Association of Firefighters in regard to Fire Fighters and the San Antonio Police Officers' Association, in regard to Police Officers, for any period covered by a Collective Bargaining Agreement.

Nothing in the Document or any related Bargaining Agreements between the City and the Bargaining Agents of the Fire Fighters and Police Officers is intended to imply vesting or irrevocable Benefits for current, active or retired Fire Fighters and Police Officers beyond the provisions of the 1998-2001 Collective Bargaining Agreement between the City and Local 624 of the International Association of Firefighters, in regard to Fire Fighters and the provisions of the 1998-2002 Collective Bargaining Agreement between the City and the San Antonio Police Officers' Association, in regard to Police Officers.

Termination, continuance, alteration, or any related activity on the Plan will be determined by the provisions of future Collective Bargaining Agreements between the City and the San Antonio Police Officers' Association, in regard to Police Officers and Local 624 of the International Association of Firefighters, in regard to Fire Fighters.

**APPENDIX B-** Specific Provisions Applicable to Fire and Police Prefund Retirees. (Fire and Police Retirees who retired prior to October 1, 1989, are covered under the Flex Plan Document as those provisions apply to Regular Retirees)

**SCHEDULE OF BENEFITS**

THE BENEFITS SET FORTH IN THIS SCHEDULE ARE THE TOTAL BENEFITS PAYABLE BY MEDICARE, PARTS A AND B, AS SUPPLEMENTED BY THE PROVISIONS OF THIS PLAN FOR THE RETIREES. IF YOU ARE A RETIRED POLICE OFFICER OR FIREFIGHTER COVERED BY THIS SCHEDULE, AND YOU ARE ELIGIBLE FOR MEDICARE, THE BENEFITS AND SERVICES PROVIDED BY MEDICARE WILL BE PAID BEFORE THE BENEFITS DESCRIBED IN THIS APPENDIX AND THE MASTER CONTRACT ARE PAID. THIS WILL ALSO APPLY TO YOUR HUSBAND OR WIFE WHO IS ELIGIBLE FOR MEDICARE.

**Deductible**

|  |       |
|--|-------|
| Maximum per individual per calendar year ..... | \$200 |
| Maximum per family per calendar year .....     | \$400 |
| Coinsurance .....                              | 80%   |

**No deductible.**

|  |      |
|--|------|
| Supplemental accident benefits .....   | 100% |
| up to \$500. No deductible.  |      |
| Immunizations for Covered Dependents from birth through the date the child is six (6) years of age (other services provided at the same time as the immunizations, including, but not limited to, office visit charges will be subject to the deductibles and co-insurance ..... | 100% |
| Generic prescriptions .....  | 100% |

**Out of pocket (including deductible)**

|  |             |
|--|-------------|
| Maximum per individual per calendar year .....             | \$700       |
| Maximum per family per calendar year .....                 | \$1,900     |
| Lifetime maximum per individual (medical) .....            | \$1,500,000 |
| Lifetime maximum per individual (mental and nervous) ..... | \$25,000    |

**PROVISIONS APPLICABLE TO ALL RETIREES**

RETIREES AND SPOUSES SHALL BE ENTITLED TO BASIC COVERAGE UNDER THE CITY'S MASTER PLAN DOCUMENT FROM THE DATE OF RETIREMENT UNTIL THE DATE OF ELIGIBILITY FOR MEDICARE. UPON REACHING THE AGE AND ESTABLISHED CRITERIA FOR MEDICARE ELIGIBILITY, BENEFITS UNDER THIS PLAN AS PRIMARY COVERAGE SHALL NO LONGER BE APPLICABLE, AND THIS COVERAGE SHALL CONVERT TO SUPPLEMENTAL COVERAGE ONLY, IN ACCORDANCE WITH THE PROVISIONS SET FORTH HEREINAFTER.

A RETIREE'S SPOUSE WILL BE COVERED IF ELECTED AT THE TIME OF THE EMPLOYEE'S RETIREMENT, SUBJECT TO THE PAYMENT OF ANY REQUIRED PREMIUM. IF THE RETIREE DIES, THEN A PREVIOUSLY COVERED SPOUSE SHALL BE ELIGIBLE FOR CONTINUED COVERAGE, SUBJECT TO THE PAYMENT OF ANY REQUIRED PREMIUM.

A SURVIVING SPOUSE WHO OBTAINS COVERAGE UNDER THIS PLAN SHALL BE ELIGIBLE FOR CONTINUED COVERAGE UNTIL RE-MARRIAGE OR DEATH, SUBJECT TO PAYMENT OF ANY APPLICABLE PREMIUM.

ONLY PREVIOUSLY COVERED DEPENDENTS ELECTED ON THE RETIREE ENROLLMENT FORM FOR THE RETIREMENT PLAN AT THE TIME OF THE EMPLOYEE'S RETIREMENT ARE ELIGIBLE FOR COVERAGE.

ELIGIBLE DEPENDENT SHALL NOT INCLUDE ANYONE WHO IS COVERED AS AN ELIGIBLE EMPLOYEE UNDER THE CITY'S BENEFIT PROGRAMS. IF AND WHEN SUCH DEPENDENT TERMINATES EMPLOYMENT AND LOSES EMPLOYEE COVERAGE UNDER THE CITY'S PLANS, THE RETIREE MAY ELECT TO COVER ANY SUCH ELIGIBLE DEPENDENT UNDER THE RETIREE PLAN.

ONCE THE COVERED PERSON IS ELIGIBLE FOR MEDICARE, THE COVERED PERSON IS REQUIRED TO APPLY FOR, PURCHASE AND MAINTAIN MEDICARE BENEFITS. THE PLAN ADMINISTRATOR MAY APPROVE ANY ALTERNATE HEALTH CARE COVERAGE PROVIDED BY THE ELIGIBLE SPOUSE OF A RETIRED OR DECEASED POLICE OFFICER, IN LIEU OF MEDICARE COVERAGE, TO COMPLY WITH THIS REQUIREMENT. AFTER THE DATE OF MEDICARE ELIGIBILITY, RETIREES SHALL BE ENTITLED TO SUPPLEMENTAL BENEFITS ONLY. THIS PLAN WILL SUPPLEMENT AVAILABLE MEDICARE COVERAGE AND BENEFITS AS DEFINED IN THIS ADDENDUM AND THE SCHEDULE OF BENEFITS FOR RETIREES, NOT TO EXCEED THE BENEFITS OTHERWISE APPLICABLE UNDER THE SAN ANTONIO MASTER CONTRACT DOCUMENT.

THE SURVIVING SPOUSE, UPON THE DEATH OF THE COVERED EMPLOYEE A FIRE FIGHTER OR POLICE OFFICER WHO MEETS ALL THE PRESCRIBED PROVISIONS FOR RETIREMENT ELIGIBILITY AFTER SEPTEMBER 30, 1989, AS DEFINED IN THE FIRE FIGHTER AND POLICE OFFICER PENSION PLAN DOCUMENT, BUT WHO DIES PRIOR TO ACTUAL RETIREMENT, BECOMES ELIGIBLE TO PARTICIPATE IN THE BENEFITS OF THIS PLAN, UPON PAYMENT OF ANY REQUIRED PREMIUM, IF THE FOLLOWING CRITERIA ARE MET:

1) THE DECEASED FIRE FIGHTER OR POLICE OFFICER MUST HAVE MET, AT THE TIME OF HIS OR HER DEATH, ALL OF THE PRESCRIBED PROVISIONS FOR MINIMUM RETIREMENT ELIGIBILITY IN EXISTENCE AFTER SEPTEMBER 30, 1989, AS DEFINED IN THE FIRE FIGHTER AND POLICE OFFICER PENSION PLAN;

2) A SURVIVING SPOUSE WHO IS COVERED UNDER ANOTHER HEALTH PLAN SHALL BE COVERED AS A DEPENDENT FOR PURPOSES OF COORDINATION OF BENEFITS UNDER THIS PLAN;

3) SURVIVING SPOUSE IS DEFINED AS A SPOUSE WHO HAS BEEN CONTINUOUSLY MARRIED TO THE DECEASED FIRE FIGHTER OR POLICE OFFICER AT LEAST ONE (1) YEAR PRIOR TO THE DEATH OF SAID FIRE FIGHTER OR POLICE OFFICER, AND REMAINED MARRIED TO THE SAID PERSON UNTIL THE TIME OF DEATH;

4) A SURVIVING SPOUSE HEREUNDER SHALL BE ELIGIBLE FOR CONTINUED COVERAGE UNTIL RE-MARRIAGE OR DEATH, PROVIDED THAT THERE IS NO LAPSE OF COVERAGE FOR NON-PAYMENT OF APPLICABLE PREMIUMS;

5) A SURVIVING SPOUSE HEREUNDER HAS NO RIGHT TO ELECT ANY DEPENDENT COVERAGE.

UPON RETIREMENT, A FIRE FIGHTER OR POLICE OFFICER MAY ELECT TO CONTINUE COVERAGE FOR ANY OTHER PREVIOUSLY COVERED ELIGIBLE DEPENDENT (OTHER THAN SPOUSE AT ONE HUNDRED PERCENT (100%) OF THE ACTUAL CLAIMS COST FOR THE RETIREE DEPENDENT MEDICAL BENEFITS ACCOUNT FOR THE PRIOR YEAR, ADJUSTED AS DETERMINED BY THE CITY'S ACTUARY, WHOSE DETERMINATION SHALL BE FINAL. THIS COST, ANALOGOUS TO A PREMIUM PAYMENT, SHALL BE ESTIMATED ANNUALLY AND PAID BY PAYROLL DEDUCTION OR IN CASH, PAID MONTHLY.

A RETIREE WHO IS REEMPLOYED BY THE CITY AND IS THERE BY FURNISHED BENEFITS UNDER THE CURRENT EMPLOYEE PLAN, TEMPORARILY SUSPENDS STATUS IN THE RETIREE PLAN, WILL BE ALLOWED TO RE-ENROLL IN THE RETIREE PLAN WHEN HE TERMINATES SUCH CITY EMPLOYMENT. ALL SERVICE TIME WITH THE CITY WILL BE COMBINED TO DETERMINE THE TOTAL NUMBER OF SERVICE YEARS TOWARD PREMIUMS IF APPLICABLE TO THE EMPLOYEE/RETIREE. (THIS PROVISION CURRENTLY APPLIES ONLY TO THOSE CITY EMPLOYEES RETIRED BEFORE OCT. 1, 1989.)

|   |               |   |  |  |          |
|---|---------------|---|--|--|----------|
| DO NOT TYPE IN THIS SPACE   |               | <b>CITY OF SAN ANTONIO</b>              |  | For CMO use only                                 |          |
| Approval  |               | <b>Request For Ordinance/Resolution</b> |  | Date Considered                                  |          |
| Finance   | Budget        |   |  | Consent <input type="checkbox"/> Individual      |          |
| Legal   | Coordinator   |   |  | <input type="checkbox"/> <i>SP</i>               |          |
|   |               |   |  | Item No.   | Ord. No. |
| Date:<br>Wednesday, January 19,   |               | Department:<br>Fire                     |  | Contact Person/Phone #:<br>Robert Ojeda 207-8408 |          |
| Date Council Consideration<br>Requested: Thursday, January 27,<br>2000  |               | Deadline for Action:                    |  | Dept. Head Signature<br><i>Robert Ojeda</i>      |          |
| <b>SUMMARY OF ORDINANCE</b>   |               |   |  |  |          |
| This Ordinance authorizes amendments to the Collective Bargaining Agreement between the City of San Antonio and the San Antonio Professional Firefighters Association (SAPFFA), passed and approved by Ordinance Number 90594 on September 30, 1999. The proposed amendments equalize the terms and conditions of health benefits between the SAPFFA and the San Antonio Police Officers Association (SAPOA). |               |   |  |  |          |
| Council Memorandum Must be Attached To Original   |               |   |  |  |          |
| Other Depts., Boards, Committees Involved (please specify):<br>City Attorney's Office, Department of Budget and Employee Services and Department of Finance.  |               |   |  |  |          |
| Contract signed by other party<br>Yes <input type="checkbox"/> No <input type="checkbox"/>  |               |   |  |  |          |
| <b>FISCAL DATA (If Applicable)</b>  |               |   |  |  |          |
| Fund No.  | Amt. Expended | Funds/Staffing Budgeted                 | Yes <input type="checkbox"/>   | No <input type="checkbox"/>                      |          |
| Activity No.  | SID No.       | Positions Currently Authorized          |  |  |          |
| Index Code  | Project No.   | Impact of future O & M                  |  |  |          |
| Object Code   |               |   |  |  |          |
| Comments:   |               |   | If positions added, specify class and no.  |  |          |
|   |               |   |  |  |          |
|   |               |   |  |  |          |
|   |               |   | Coordinator - White<br>Legal - Green<br>Budget - Canary<br>Finance - Pink<br>Originator - Gold |  |          |