**THE CITY OF SAVANNAH**
**EMPLOYEE GROUP MEDICAL PLAN - TCN**
**AMENDMENT #5 TO THE**
**JANUARY 1, 2022 PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION**
**EFFECTIVE: JANUARY 1, 2024**

This Plan is amended to include the following updates: update prescription drug Out-of-Pocket Maximums and remove GoStrong Retail Card Program/Pharmacy; update benefits for bariatric surgery, diagnostic colonoscopy, preventive and diagnostic mammogram (to include 3D), diabetes self-management training/education, diagnostic hearing exam, diagnostic imaging, family planning for men, hearing aids, voluntary sterilization for men, fitness reimbursement and weight loss reimbursement. In addition, the Plan is also amended to revise contact information pertaining to Precertification, Case Management Services, Benefit Inquiries and Claim appeals under this Plan as administered by Quantum Health; any reference to GoStrong is replaced with Comprehensive Diabetes Management Program; any reference to Weigh To GO is replaced with Weight Management. All references to the provisions below that appear in any part of the Plan Document or in any prior amendments are also hereby amended to be consistent with the changes described below.

**The Plan Document and Summary Plan Description are hereby amended as follows:**

## SECTION II. GENERAL INFORMATION:

The **Case Management Services** contact information is hereby **updated** as follows:

| | |
|---|---|
| **Case Management Services:** | Quantum Health<br>5240 Blazer Pkwy<br>Dublin, OH 43017<br>(866) 360-9065<br>www.CityofSavannahHealthPlan.com |

## SECTION IV. SCHEDULE OF MEDICAL BENEFITS:

### BASIC OPTION 1 AND PLUS OPTION 1 PLANS

- The **Prescription Drug Benefit** is hereby **deleted** and **replaced** as follows:

| PRESCRIPTION DRUG BENEFIT – ADMINISTERED BY MAXORPLUS | |
|---|---|
| **Prescription Drug Expense & Mail Order Option**<br><br>**Step Therapy:**<br>Certain prescription drug products are subject to step therapy requirements. In order to receive benefits for such prescription drug products or pharmaceutical products, Covered Persons may be required to use a different prescription drug product(s) or pharmaceutical product(s) first.<br><br>To determine whether a particular prescription drug product or pharmaceutical product is subject to step therapy requirements, call Member Customer Care at the telephone number on your ID card. | **Retail Card Program – You Pay:**<br>(Up to a 30 day supply)<br>$5 Co-payment per generic drug<br>$25 Co-payment per preferred brand name drug<br>$50 Co-payment per non-preferred brand name drug<br>$75 Co-payment per specialty drug<br><br>**Retail Card Pharmacy – You Pay:**<br>(Up to a 90 day supply)<br>$10 Co-payment per generic drug<br>$50 Co-payment per preferred brand name drug<br>$125 Co-payment per non-preferred brand name drug |

| PRESCRIPTION DRUG BENEFIT – ADMINISTERED BY MAXORPLUS | |
|---|---|
| **Prescription Drug Expense & Mail Order Option**<br><br>Substitution of a generic equivalent medication is required; if a Covered Person requests the brand name medication be filled, the Covered Person pays the difference between the brand and generic drug when a generic drug is available. The difference in cost does not apply toward the Prescription Drug Calendar Year Out-of-Pocket Maximum.<br><br>Covered Persons with diabetes can earn reduced Co-payments for diabetic medications and testing supplies by complying with Quantum Health Chronic Condition Management guidelines; *see* Complex Case Management/Alternate Treatment Coverage *for additional information.* | **Mail Order Pharmacy – You Pay:**<br>(Up to a 90 day supply )<br>$10 Co-payment per generic drug;<br>$50 Co-payment per preferred brand name drug;<br>$125 Co-payment per non-preferred brand name drug<br><br>Note: Prescription drug Co-payments accumulate toward the prescription drug Out-of-Pocket Maximums. Once the prescription drug Out-of-Pocket Maximums have been met, prescription drugs are covered at 100% for the balance of the Calendar Year.<br><br>U.S. Food and Drug Administration (FDA) approved contraceptive medications and devices are covered at 100%<br><br>Tobacco cessations products are covered at 100%. |
| **Retail Card/Mail Order Pharmacy Calendar Year Out-of-Pocket Maximums:**<br><br>(Includes all applicable prescription drug Co-payments) | $3,450 per person;<br>$6,900 per two person;<br>$6,900 per family |

- The following services are hereby **deleted** and **replaced** in their entirety with the following:

| PREVENTIVE CARE | IN-NETWORK PROVIDERS | OUT-OF-NETWORK PROVIDERS |
|---|---|---|
| The preventive care services marked below with ** are provided according to the terms prescribed by the regulations issued under the Patient Protection and Affordable Care Act of 2010, as may be amended from time to time. Please see the Medical Benefits section for additional details about the preventive coverage provided. | | |
| Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services rendered to a Covered Person on an inpatient or outpatient basis in an In-Network Hospital or facility, provided the Covered Person has not validly waived the applicability of the NSA. | | |
| ** **Breast Cancer Screening including Routine Mammograms and BRCA testing (Including 3D mammograms)**<br><br>Up to one (1) per person, per Calendar Year | 100% (Deductible waived) | Not Covered |

| HOSPITAL SERVICES – OUTPATIENT | IN-NETWORK PROVIDERS | OUT-OF-NETWORK PROVIDERS |
|---|---|---|
| **Case Management Services and Precertification are administered by Quantum Health – Providers should contact Quantum Health at 866-360-9065 regarding precertification requirements. Failure to obtain precertification will result in a $500 reduction in benefits.** | | |
| Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for emergency services rendered for "Emergency Care" as defined in the section titled "Definitions"; and Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services rendered to a Covered Person on an inpatient or outpatient basis in an In-Network Hospital or facility, provided the Covered Person has not validly waived the applicability of the NSA. | | |
| **Outpatient Surgery in Hospital, Ambulatory Surgical Center, etc.** | 80% (after Deductible)<br><br>Diagnostic colonoscopies for Covered Persons with personal or family history of colon cancer (including removal of polyps during the procedure):<br>100% (Deductible waived), up to one (1) procedure per Person, per Calendar Year with no cost sharing; subsequent diagnostic colonoscopies are subject to cost sharing shown above | 50% Allowed Amount (after Deductible) |

| OTHER SERVICES & SUPPLIES | IN-NETWORK PROVIDERS | OUT-OF-NETWORK PROVIDERS |
|---|---|---|
| **Case Management Services and Precertification are administered by Quantum Health – Providers should contact Quantum Health at 866-360-9065 regarding precertification requirements. Failure to obtain precertification will result in a $500 reduction in benefits.** | | |
| Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services rendered to a Covered Person on an inpatient or outpatient basis in an In-Network Hospital or facility, provided the Covered Person has not validly waived the applicability of the NSA. | | |
| **Bariatric Surgery**<br>*(Precertification for Medical Necessity required; see* Medical Benefits *section for other limitations)*<br><br>Up to one (1)* surgical procedure per person, per lifetime | Wellstar MCG Health:<br>80% (after Deductible) | $500 Co-payment per admission, then 50% Allowed Amount (after Deductible) |
| **Diabetes Self-Management Training and Education and/or Nutritional Counseling**<br><br>**(Comprehensive Diabetes Management Program; contact Quantum Health for details)** | St. Joseph's/Candler Center:<br>100% (Deductible waived)<br><br>All Other Providers:<br>Not Covered | Not Covered<br><br>Not Covered |
| **Diagnostic Hearing Exam** | 80% (Deductible waived) | 50% Allowed Amount (after Deductible) |

| OTHER SERVICES & SUPPLIES | IN-NETWORK PROVIDERS | OUT-OF-NETWORK PROVIDERS |
|---|---|---|
| **Case Management Services and Precertification are administered by Quantum Health – Providers should contact Quantum Health at 866-360-9065 regarding precertification requirements. Failure to obtain precertification will result in a $500 reduction in benefits.** | | |
| Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services rendered to a Covered Person on an inpatient or outpatient basis in an In-Network Hospital or facility, provided the Covered Person has not validly waived the applicability of the NSA. | | |
| **Diagnostic Imaging**<br>(MRI, MRA, PET and PET-CT Scans)<br><br>(Stand-alone CT Scan – precertification **not** required) | 80% (after Deductible)<br><br>Diagnostic mammogram (including 3D) for Covered Persons with personal or family history of breast cancer:<br>100% (Deductible waived), up to one (1) test per Person, per Calendar Year with no cost sharing; subsequent diagnostic mammograms are subject to cost sharing shown above | 50% Allowed Amount (after Deductible) |
| **Family Planning**<br>(Including but not limited to consultations and diagnostic tests) | | |
| **For Women** (See also Prescription Drug Benefit and Preventive Care Section) | 100% (Deductible waived) | Not Covered |
| **For Men** | 100% (Deductible waived) | Not Covered |
| **Hearing Aids**<br><br>Up to one (1)* set per Person, every 5 years | Device:<br>80% (after Deductible)<br><br>Repairs:<br>100% (after Deductible), up to a maximum of $1,000 every 5 years | Device:<br>50% Allowed Amount (after Deductible)<br><br>Repairs:<br>100% (after Deductible), up to a maximum of $1,000 every 5 years |
| **Voluntary Sterilization** | | |
| **For Women** | 100% (Deductible waived) | Not Covered |
| **For Men** | 100% (Deductible waived) | Not Covered |

***These maximums are combined In-Network and Out-of-Network maximums.**

- **DISEASE MANAGEMENT AND PREVENTION PROGRAMS:**

  **Weigh to GO!** is replaced with **Weight Management Program**

  Any reference to **GoStrong Diabetes Benefit Program** is **replaced** with **Comprehensive Diabetes Management Program**

**SECTION V. MEDICAL BENEFITS:**

- **C. Disease Management and Prevention Programs, subparagraphs (1), (2) and (3)** are hereby **deleted** and **replaced** in their entirety with the following:

**C. Disease Management and Prevention Programs**

Disease-based intervention programs administered by a City approved program. Participation is voluntary. The Plan covers the cost of the program listed in the Schedule of Benefits.

These programs include:

**(1) Weight Management**

These programs include education and counseling to assist with the achievement of long-term weight control. Levels 2, 3, and the Weight Management Maintenance Program are covered under the Plan. Removal of excess skin due to weight loss will be covered for members who participate in and are compliant in the Weight Management Program. Weight Management can assist members with losing weight, provide education on how to improve health through proper nutrition and exercise, and assist in meeting individual personal health, fitness and weight loss goals. This program is covered under The Plan as long as requirements continue to be met by the participant. Participant requirements are evaluated on a quarterly basis. If a participant fails to meet program requirements for any quarter, the Plan will not cover the cost of the program for four quarters following the failure to meet Plan requirements. The program will communicate with the treating physician during the member's active participation. Lab work must be completed and processed at St. Joseph's/Candler labs. A copy of lab results will be sent to the member's physician. To enroll in the program, contact St. Joseph's/Candler Wellness Center, 5353 Reynolds Street Phone: 912-819-8800 to schedule an Orientation visit.

**(2) Diabetes Education Services**

Educational services are offered to individuals with diabetes who are newly diagnosed, those who have had a change in their diabetic condition, juvenile onset and gestational diabetes. The education series will cover up to 4 hours of individual instruction through an ADA certified provider. The education will include a diabetes overview, and education regarding nutrition, exercise and activity, instruction regarding medications, monitoring and use of results, prevention, detection and treatment of serious complications. When participants require more long-term monitoring, the Comprehensive Diabetes Management program is recommended. Contact St Joseph's/ Candler Center for Disease Management, 836 East 65th St, Bldg. #4, Phone: 912-819-6146

**(3) Comprehensive Diabetes Management Program (CDMP)**

The Comprehensive Diabetes Management Program (CDMP) is designed to teach individuals with diabetes to self-manage the disease. In order to maintain optimal control of this condition, individuals must be directly involved in the day-to-day management of the disease. This diabetes engagement program assists individuals with diabetes to attain the knowledge and skills to make informed choices, to facilitate independent behavior changes and, ultimately, to reduce the risk of complications. The program is designed for all patients with differing risk levels of diabetes. Program components include quarterly visits with a nurse care manager, individualized education and support, free membership to Candler Wellness Center, nutrition therapy, glucose monitoring equipment and testing supplies, comprehensive lab work, and more To enroll in CDMP, contact St Joseph's/ Candler Center for Disease Prevention & Management, 836 East 65th St, Bldg. #4, Phone: 912-819-6146.

- **D. Covered Services, (10) Other Services and Supplies:**

  **(c) Bariatric surgery** is hereby **deleted** and **replaced** in its entirety with the following:

  Bariatric surgery may be covered under the plan and only for those who have met the guidelines of the American Bariatric Association. Wellstar MCG Health in Augusta, GA is the designated in-network facility for bariatric surgery. Wellstar MCG Health's surgical protocols may include additional requirements that are not listed here.

  Bariatric Surgery requires pre-certification through the Care Coordinators by Quantum Health.
  The patient or their physician should contact ***Care Coordinators by Quantum Health*** at 1-866-360-7926.

  One bariatric surgical procedure will be approved per covered member during their coverage by The Plan. Removal of excess skin will also be covered.

  **Clinical requirements for bariatric surgery under the Plan:**

  - Treatment indicated by any ONE of the following:
    - Patient has a BMI exceeding 40 $kg/m^2$.
    - Patient's BMI is greater than 35 $kg/m^2$ and two or more clinically serious conditions exist (e.g., obesity hypoventilation, sleep apnea, diabetes, hypertension (high blood pressure), cardiomyopathy, musculoskeletal dysfunction, joint replacement, GERD, hypertriglyceridemia or hypercholesteremia, back pain, urinary incontinence, renal failure, arthritis.)
    - Documentation in the medical record of unsuccessful sustained weight loss

  - Surgical intervention indicated because patient has met all the following criterion:
    - Must have obtained full growth and be over the age of 18 years.
    - Patient is well-informed and motivated
    - Completion of psychological evaluation
    - Completion of pre-operative labs and other testing, as deemed necessary
    - Behavior modification program supervised by a qualified professional;
    - Participation in a physician-supervised nutrition and exercise program for six (6) months prior to surgery.
      - The St Joseph's/Candler Weight Management program is covered by the plan and meets the requirements for members seeking bariatric surgery. (See "Weight Management" under "Disease Management and Prevention Programs" in this section for more program details.)
      - Wellstar MCG Health in Augusta, GA offers a physician-supervised nutrition and exercise pre-operative program that is covered by the plan and meets the requirements for members seeking bariatric surgery. The Wellstar MCG pre-operative program is designed specifically for bariatric surgical candidates. It consists of 6 monthly face-to-face dietitian visits in Augusta to educate the patient on behavior and nutrition changes specific to their bariatric surgery. The visits are goal driven with monthly tracking of food intake to assure surgery candidates are meeting their specific goals. Members can call the Care Coordinators at Quantum Health for program details.
    - Documentation of patient commitment to continue with six (6) months of post-surgical nutrition and exercise program, upon release by a physician.
    - Documentation of attending physician commitment to post-operative plan of care to include the schedule of follow up visits

  **Contraindications to bariatric surgery:**

  Requests for bariatric surgery will be denied if any one or more of the following conditions are present:

  - Untreated major depression or psychosis
  - Suicidal ideation
  - Active eating disorders
  - Current drug or alcohol abuse
  - Noncompliance with pre-surgical nutrition program and/or inability to comply with nutritional requirements including life-long vitamin replacement

**(r)** The Covered Service related to **hearing aids** is hereby **deleted** and **replaced** in its entirety with the following:

Hearing aids

**SECTION XV. CLAIMS AND APPEALS PROCEDURES AND STATEMENT OF RIGHTS:**

- **C. When and How to File a Claim, (2)** is hereby **deleted** and **replaced** in its entirety with the following:

  How a claim may be filed depends on the type of claim:

  **(2)** *Non-Urgent Care and Pre-Service Claims...*
  - Electronically
  - Hand delivery
  - Facsimile (FAX): 877-498-3681
  - US Mail:
    Health Care Coordinators
    Quantum Health - Appeals Department
    5240 Blazer Parkway
    Dublin, OH 43017
    (866) 360-7926

- **F. Internal Appeals and External Review of Denied Claims, (3) How and Where to Submit Appeals** is hereby **deleted** and **replaced** in its entirety with the following:

  **(3)** *How and Where to Submit Appeals*

  Urgent Care Claim, Non-Urgent Care Claim and Post-Service Claim appeals or requests for external review may be submitted to the PAE or the Prescription Benefit Manager using one of the following methods:

| **Medical Appeals** | |
|---|---|
| Quantum Health Care Coordinators<br>Appeals Department<br>5240 Blazer Pkwy<br>Dublin, OH 43017<br>Phone #: (866) 360-7926 | **Method:**<br>▪ Telephone<br>▪ U.S. Mail<br>▪ Hand delivery<br>▪ Facsimile (FAX): (877) 498-3681 |
| **Prescription Inquiries/Prior Authorization/Appeals** | |
| Covered Persons should contact the Prescription Benefit Manager directly at the telephone number listed on his/her ID card for directions on submitting appeals. | |

**Accepted by:**
**The City of Savannah - TCN**

Jeffery Grant — Human Resources Director

**Authorized Signature** | **Title**

Jeffery Grant — 08/09/2024

**Print Name** | **Date**

Version 1.1; 06/28/2024