THE FUND | RETIREE HEALTH & WELLNESS
SAN ANTONIO FIRE AND POLICE

Plan Document

January 1, 2025

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GENERAL INFORMATION

NAME OF PLAN:	The Fund Retiree Health & Wellness San Antonio Fire and Police
PLAN YEAR:	January 1 through December 31
PLAN SPONSOR:	The Fund Retiree Health & Wellness San Antonio Fire and Police 11603 W. Coker Loop, Suite 210 San Antonio, Texas 78216
PLAN ADMINISTRATOR:	Prefund Retiree Benefits Administrator The Fund Retiree Health & Wellness San Antonio Fire and Police 11603 W. Coker Loop, Suite 210 San Antonio, Texas 78216 (210) 494-6500
NAMED FIDUCIARY:	Prefund Retiree Benefits Administrator The Fund Retiree Health & Wellness San Antonio Fire and Police 11603 W. Coker Loop, Suite 210 San Antonio, Texas 78216 (210) 494-6500
AGENT FOR SERVICE OF LEGAL PROCESS:	Prefund Retiree Benefits Administrator The Fund Retiree Health & Wellness San Antonio Fire and Police 11603 W. Coker Loop, Suite 210 San Antonio, Texas 78216 (210) 494-6500
PLAN EFFECTIVE DATE:	The Effective Date of this Plan is January 1, 2008
TAX ID NUMBER:	74-2882962
REVISION DATE:	January 1, 2025

The purpose of the Plan is to provide retired Firefighters and Police Officers with a family health Plan, with coverage and benefits defined herein.

This Plan Document defines and provides for coverage and administration for the benefits contained herein. The coverage provisions applicable to a Covered Person shall collectively be referred to as the Plan, and the provisions of this document 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 by an Act of the Texas Legislature and are codified in Article 6243q, Vernon's Texas Civil Statutes. This Plan is open to Uniformed Prefund Retirees.

The benefits provided and defined in the Plan are self-funded by the Plan Sponsor at the time this document was drafted, but the Plan Sponsor is entitled to reinsure any portion of its obligations hereunder, and additionally may contract for any carrier acceptable to the Plan Sponsor.

PURSUANT TO STATE LAW, ANY BENEFITS UNDER THE PLAN ARE SUBJECT TO CHANGE AS MAY BE DETERMINED BY THE BOARD OF TRUSTEES OF THE FUND RETIREE HEALTH & WELLNESS SAN ANTONIO FIRE AND POLICE.

The Plan Sponsor may select a Claims Administrator from time to time or may elect to administer claims under the Plan as an internal function. The Plan Sponsor's Claim Administrator is not an insurer.

BY THIS AGREEMENT,
The Plan Document and Summary Plan Description of
The Fund Retiree Health & Wellness San Antonio Fire And Police
is hereby adopted January 1, 2025. This Plan Document amends and replaces any prior statement of the health care coverage contained in the Plan or any predecessor to the Plan.

Authorized Signature _____

Print Name _____

Title _____

Date _____

PLAN AND CLAIMS ADMINISTRATION

Administration and payment of claims under the Plan shall be carried out by the Plan Administrator. It shall be a principal duty of the Plan Administrator to see that the Plan is carried out as written. The Plan Administrator shall have full power to administer the Plan and all of its details, and to make all final determinations about coverage on behalf of the Plan Sponsor.

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.

Important! Important! Important!

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

Pre-certification is required for all inpatient admissions and surgery whether incurred inpatient, outpatient, or ambulatory surgical center.
See page 38 for list of items in physician's office that require precert

Members who are enrolled in both Medicare Part A and B are not subject to precertification requirements.

Please see Chapter 7, page 38 for more details on precertification.

CHAPTER 1 SUMMARY OF MEDICAL, PRESCRIPTION & ACCIDENT BENEFITS

1. Medical Benefits

FIRE AND POLICE RETIREE HEALTH CARE FUND, SAN ANTONIO GOVERNING STATUTE AS AMENDED OCTOBER 1, 2007

ARTICLE 5. RETIREMENT HEALTH BENEFITS

SECTION 5.01. RETIREMENT HEALTH BENEFITS.

Commencing January 1, 2013, on January 1 of each year the board shall increase the amount of the maximum deductible and out-of-pocket payments established under Subsections (f) and (g) of this section by a percentage equal to the then most recently published annual percentage increase in health care costs as set out in a published index selected by the actuary that reflects annual changes in health care costs. The annual percentage increase provided for by this subsection may not exceed eight percent.

Written notice of the annual deductible and out-of-pocket maximum per individual will be communicated prior to the applicable plan year.

Coinsurance ..... 80% in-network/ 60% out-of-network

Lifetime Maximum per individual ……..…… $3,000,000

All services rendered at the Fire & Police Retiree Health Care Fund Clinic will not be subject to the Plan's deductible or coinsurance.

2. Accident Benefit
(Covered medical expenses incurred within ninety (90) days of the Accidental Injury)

Benefit……...…100% up to $500; then
regular medical plan benefits apply

3. Prescription Benefits

Retail up to a 30 day supply (non-maintenance medications)
0% co-insurance Generic
20% Brands with no Alternative

Mail Order on Maintenance Medications
For drugs with the "maintenance" indication, members may fill each medication twice at the retail pharmacy and then fill at mail order for coverage. Beginning with the third fill of each medication, the

claim will reject and members will pay the full cost at retail or fill at mail order to obtain their fill. This member cost will not apply to the out of pocket maximum.

90-day supply **Mail order only**

0% co-insurance Generic
20% co-insurance Brand with no Alternative

Generic or Therapeutic Equivalent

Brands with a direct generic available: If a member or physician requests the brand product when a direct generic equivalent is available, the member will pay the difference between brand and generic cost. **The Plan will cover only the cost of the generic equivalent.** This member cost will not apply to the out of pocket maximum.

Brands with a therapeutic equivalent available: For those brand products targeted by the Pharmacy Benefit Manager (Alternative Therapy Program), the member will pay the cost difference between the brand medication and the generic alternative. **The Plan will cover only the cost of the generic alternative.** The member cost will not apply to the out of pocket maximum. Pharmacy Benefit Manager will help members move from target brands to generic alternative by contacting prescribers on the members' behalf to request and facilitate interchange with member approval.

PREFERRED PROVIDER NETWORK

The Fund Retiree Health & Wellness San Antonio Fire and Police participates in a Preferred Provider Network of hospitals, physicians and other providers that are contracted to furnish, at negotiated costs, medical care for the retirees 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 Preferred Provider Network's website. A Covered Person may choose any health care provider.

The Health Fund reserves the right to terminate or modify the Preferred Provider Network program, or any portion thereof, at any time. In the event the changes the PPO provider, the Health Fund will ensure that the retiree will not be substantially affected by a disruption of available in-network providers.

PPO Exceptions

This Plan includes a **PREFERRED PROVIDER ORGANIZATION (PPO)** with various medical providers. Enhanced benefits are available for most services rendered by a PPO provider. The Plan will also pay **in accordance with the PPO benefits** for covered expenses incurred:

1. for **related Non-PPO Ancillary Services** rendered in a PPO network hospital;

2. in the event of a **medical emergency**, including related Ancillary Services;

3. **outside** the eligible PPO network, while **traveling or residing more than** 50 **miles outside** the eligible PPO network;

CHAPTER 2 GENERAL PLAN COVERAGE FOR ELIGIBLE PARTICIPANTS

ELIGIBILITY REQUIREMENTS

Eligible Retiree

Any eligible Employee that retires under the rules of the Fire and Police Pension Fund will be eligible for the Fire and Police Retiree Health Care Fund 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.

PLEASE NOTE:

- **Once coverage is in effect, no new spouse or Dependent may be added to the Plan.**
- **Termination of coverage for any Covered Spouse and/or Dependent is permanent and once terminated, any such individual(s) cannot be added back to the Plan.**

An Eligible Dependent is:

1. The eligible retiree's spouse, if elected at the time of initial coverage. A spouse that is legally separated under a court decree under the laws of Texas or another state shall not be an eligible Dependent,

2. All natural children including legally adopted, under legal guardianship of the covered retiree and who have not yet reached their twenty-third (23rd) birthday, provided the children have never been married and are Principally Dependent upon the eligible retiree, 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 retiree and the natural parent of the child, so long as (a) they permanently reside in the retiree's household, and (b) are Principally Dependent on the retiree.

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, stepparents or guardians are employed by the Plan.

Incapacitated Dependent

An eligible Dependent child who is physically or mentally incapable of self-support upon attaining the age of twenty three (23) 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 retiree, 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 retiree at least thirty-one (31) days prior to such child's attainment of age twenty three (23).

Any incapacitated dependent is required to apply for, purchase and maintain Medicare Benefits. A copy of the determination from the Social Security Office must be submitted to The Fund Retiree Health & Wellness San Antonio Fire and Police office.

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;

2. The date all coverage or certain benefits are terminated in a particular class by modification of the Plan

Termination of Coverage for Dependents

Coverage with respect to the Covered Person's Dependents shall terminate under the Plan 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.

Provision Applicable to All Retirees

Retirees and spouses shall be entitled to basic coverage under The Fund Retiree Health & Wellness San Antonio Fire and Police Plan from the date of retirement until the date of eligibility for Medicare. Upon reaching the age or 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 employee's retirement. If the retiree dies, then a previously Covered Spouse shall be eligible for continued coverage.

A surviving spouse who obtains coverage under this Plan shall be eligible for continued coverage until re-marriage or death.

Only previously covered Dependents elected on the retiree enrollment form for the Plan at the time of the employee's retirement are eligible for coverage.

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 retiree or Covered Spouse, 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 the Summary of Medical, Prescription, and Accident Benefits for retirees, not to exceed the benefits otherwise applicable under The Fund Retiree Health & Wellness San Antonio Fire and Police Plan Document.

The surviving spouse, upon the death of 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, 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 pension law of the Fire and Police Pension Fund, San Antonio;
2. A surviving spouse who is covered under another health plan shall be covered as a Dependent for purposes or coordination of benefits under this Plan;
3. A surviving spouse hereunder shall be eligible for continued coverage until re-marriage or death;
4. A surviving spouse hereunder has no right to elect any Dependent coverage.

CHAPTER 3 COBRA PROVISIONS

CONTINUATION COVERAGE

On April 7, 1986, a federal law was enacted requiring that most employers sponsoring group health Plans offer employees 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, in a summary fashion, of rights and obligations under the continuation coverage provisions of COBRA. The Employee 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 no 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.

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.

Any questions about COBRA should be directed to the
The Fund Retiree Health & Wellness San Antonio Fire and Police Office,
11603 W. Coker Loop, Suite 210, San Antonio, Texas 78216

CHAPTER 4 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.

"**ALLOWABLE EXPENSE**" means any necessary expenses incurred up to the Maximum Allowable Charge while eligible for benefits under the Plan; subject to limitations and exclusions

"**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.

"ANCILLARY SERVICES" are supplementary or auxiliary services rendered, e.g. laboratory services and x-rays.

"ANNUAL PRESCRIPTION CO-INSURANCE OUT-OF-POCKET" is the sum of in-network prescription co-insurance under the Plan Document. When the annual out of pocket is reached prescription covered expenses incurred during that Plan year will be paid at 100%. Coinsurance amounts paid for out-

of-network prescriptions do not apply to the out of pocket maximum under the group health care coverage. The amount a member pays for any non-covered drug will not be included in calculating the Annual Prescription Co-Insurance Out-of-Pocket maximum. The member is responsible for paying 100% of the cost for any non-covered drug and the contracted rates will not be available.

"**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 retirees and Dependents, the Calendar Year is the Effective Date of their coverage through December 31 of the same year.

"CITY" means City of San Antonio.

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

"**COINSURANCE/OUT OF POCKET**" 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 Covered Person's obligation, and is referred to as "Coinsurance." If the Plan provides for out of network payment of 60% of eligible medical expense, the remaining 40% is the Covered Person's obligation is referred to as "Coinsurance." If the Plan provides for an in-network prescription payment of 80%, the remaining 20% is the Covered Person's obligation and is referred to as "co-insurance."

Out of Pocket does not include:

- Charges beyond the Maximum Allowable Charge;
- Penalties resulting from non-compliance with pre-certification;
- Co-insurance for inpatient or outpatient mental & nervous benefits;
- Charges not covered under the Plan

"**COSMETIC PROCEDURES**" means any expenses incurred in connection with the care and treatment of, or operations which are performed for plastic, reconstructive, or cosmetic purposes or any other service or supply which are primarily used to improve, alter, or enhance appearance of a physical characteristic which is within the broad spectrum of normal but which may be considered displeasing or unattractive, except when required by an Injury.

"**COVERED PERSON**" means an eligible retiree 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.

"COVERED SPOUSE" means a person who is enrolled as a spouse at the time of the eligible employee's retirement

"**CUSTODIAL CARE**" means care or confinement designated principally for the assistance and maintenance of the Participant, in engaging in the activities of daily living, whether or not totally disabled. This care or confinement could be rendered at home or by persons without professional skills or training.

This care may relieve symptoms or pain but is not reasonably expected to improve the underlying medical condition. Custodial Care includes, but is not limited to, assistance in eating, dressing, bathing and using the toilet, preparation of special diets, supervision of medication which can normally be self-administered, assistance in walking or getting in and out of bed, and all domestic activities.

"**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.

"**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.

"DEPENDENT" means the eligible retiree's spouse if coverage is elected at the time of initial coverage and/or; the eligible retiree's natural children including legally adopted, under legal guardianship of the covered retiree and who have not yet reached their twenty-third (23rd) birthday, provided the children have never been married and are Principally Dependent upon the eligible retiree, as directed by court order, for support and maintenance and/or; stepchildren during the marriage between the eligible retiree and the natural parent of the child, so long as they permanently reside in the retiree's household and are Principally Dependent on the retiree

"**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. lancets and lancet devices;
c. insulin and insulin analogs;
d. injection aids; syringes;
e. prescriptive oral agents for controlling blood sugar levels; and
f. 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.

"EFFECTIVE DATE", when applied to an Employee that retires under the rules of the Fire and Police Pension Fund is the date the Employee is eligible for The Fund Retiree Health & Wellness San Antonio Fire and Police health program. The individual's Effective Date may or may not be the same as the individual's enrollment date.

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

"EMERGENCY SERVICES" Emergency Services are health care services provided in a Hospital emergency facility or comparable facility to evaluate and stabilize medical conditions, including a behavioral health condition, of a recent onset and severity including, but not limited to, severe pain that would lead a prudent layperson, possessing an average knowledge of medicine and health to believe that his or her condition, Illness, or Injury is of such a nature that failure to get immediate medical care could result in:

1. placing his or her health in serious jeopardy;
2. serious impairment to bodily functions;
3. serious dysfunction of any Body Organ or part;
4. serious disfigurement; or
5. in the case of a pregnant woman, serious jeopardy to the health of the fetus.

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

"EXPERIMENTAL OR INVESTIGATIONAL"
services or treatments that are not widely used or accepted by most practitioners or lack credible evidence to support positive short or long-term outcomes from those services or treatments and that are not the subject of, or in some manner related to, the conduct of an Approved Clinical Trial, as such term is defined herein; these services are not included under or as Medicare reimbursable procedures, and include services, supplies, care, procedures, treatments or courses of treatment which meet either of the following requirements:

1. Do not constitute accepted medical practice under the standards of the case and by the standards of a reasonable segment of the medical community or government oversight agencies at the time rendered.
2. Are rendered on a research basis as determined by the United States Food and Drug Administration and the AMA's Council on Medical Specialty Societies.

A drug, device, or medical treatment or procedure is Experimental if one of the following requirements is met:

1. If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;
2. If reliable evidence shows that the drug, device or medical treatment or procedure is the subject of ongoing Phase I, II, or III clinical trials or under study to determine all of the following:

    a. Maximum tolerated dose.
    b. Toxicity.
    c. Safety.
    d. Efficacy.
    e. Efficacy as compared with the standard means of treatment or Diagnosis.

3. If reliable evidence shows that the consensus among experts regarding the drug, device, or medical treatment or procedure is that further studies or clinical trials are necessary to determine all of the following:

    a. Maximum tolerated dose.
    b. Toxicity.
    c. Safety.

d. Efficacy.
e. Efficacy as compared with the standard means of treatment or Diagnosis.

Reliable evidence shall mean one or more of the following:

1. Only published reports and articles in the authoritative medical and scientific literature.
2. The written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, or medical treatment or procedure.
3. The written informed consent used by the treating facility or by another facility studying substantially the same drug, device, or medical treatment or procedure.

Notwithstanding the above, a prescription drug for a treatment that has been approved by the Food and Drug Administration (FDA) but is used as a non-approved treatment shall not be considered Experimental/Investigational for purposes of this Plan and shall be afforded coverage to the same extent as any other prescription drug, provided that the drug is recognized by one of the following as being Medically Necessary for the specific treatment for which it has been prescribed:

1. The American Medical Association Drug Evaluations.
2. The American Hospital Formulary Service Drug Information.
3. The United States Pharmacopeia Drug Information.
4. A clinical study or review article in a reviewed professional journal.

Subject to a medical opinion, if no other Food and Drug Administration (FDA) approved treatment is feasible and as a result the Participant faces a life or death medical condition, the Plan Administrator retains discretionary authority to cover the services or treatment.

The Plan Administrator retains maximum legal authority and discretion to determine what is Experimental.

"**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.

"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.

"**INCAPACITATED DEPENDENT**" means an eligible Dependent child who is physically or mentally incapable of self-support upon attaining the age of twenty-three years; must be solely dependent on the retiree; and must be incapacitated by a disability that arose while such Dependent was a covered Dependent while on the active or retired Plan.

"**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 herein.

"MAXIMUM ALLOWABLE CHARGE" shall mean the amount payable for a specific covered item under this Plan. The Maximum Allowable Charge will be a negotiated rate, if one exists.

If none of the above factors is applicable, the Maximum Allowable Charge will be determined by the Plan to be the Medicare reimbursement rates presently utilized by the Centers for Medicare and Medicaid Services ("CMS") either multiplied by165% of the Medicare approved amount for facility changes or 135% for all other services unless otherwise indicated as follows:

If no Medicare reimbursement rate is available for a given item of service or supply, Medicare reimbursement rates will be calculated based on one of the following:

- Visium Medicare Equivalency tables (prices established by CMS utilizing standard Medicare Payment methods and/or based upon supplemental Medicare or Medicaid pricing data for items Medicare doesn't cover based on data from CMS);
- Visium Approximation tool (prices established by CMS utilizing standard Medicare payment methods and/or based upon prevailing Medicare rates in the community for non-Medicare facilities for similar services and/or supplies provided by similarly skilled and trained providers of care); or
- Visium Care Crosswalk (prices established by CMS utilizing standard Medicare payment methods for items in alternate settings based on Medicare rates provided for similar services and/or supplies paid to similarly skilled and trained providers of care in traditional settings).

If and only if none of the factors above is applicable, the Plan Administrator will exercise its discretion to determine the Maximum Allowable Charge based on any of the following: Medicare cost data, amounts actually collected by Providers in the area for similar services, or average wholesale price (AWP) or manufacturer's retail pricing (MRP). These ancillary factors will take into account generally-accepted billing standards and practices.

When more than one treatment option is available, and one option is no more effective than another, the least costly option that is no less effective than any other option will be considered within the Maximum Allowable Charge. The Maximum Allowable Charge will be limited to an amount which, in the Plan Administrator's discretion, is charged for services or supplies that are not unreasonably caused by the treating Provider, including errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients. A finding of Provider negligence or malpractice is not required for services or fees to be considered ineligible pursuant to this provision.

"**MEDICALLY NECESSARY**", "Medical Necessity" and similar language refers to health care services ordered by a Physician exercising prudent clinical judgment provided to a Participant for the purposes of evaluation, Diagnosis or treatment of that Participant's Illness or Injury. Such services, to be considered Medically Necessary, must be clinically appropriate in terms of type, frequency, extent, site and duration for the Diagnosis or treatment of the Participant's Illness or Injury. The Medically Necessary setting and level of service is that setting and level of service which, considering the Participant's medical symptoms and conditions, cannot be provided in a less intensive medical setting. Such services, to be considered Medically Necessary must be no more costly than alternative interventions, including no intervention and are at least as likely to produce equivalent therapeutic or diagnostic results as to the Diagnosis or treatment of the Participant's Illness or Injury without adversely affecting the Participant's medical condition. The service must meet all of the following requirements:

1. Its purpose must be to restore health.
2. It must not be primarily custodial in nature.
3. It is ordered by a Physician for the Diagnosis or treatment of an Illness or Injury.
4. The Plan reserves the right to incorporate CMS guidelines in effect on the date of treatment as additional criteria for determination of Medical Necessity and/or a Covered Expense.

For Hospital stays, this means that acute care as an Inpatient is necessary due to the kind of services the Participant is receiving or the severity of the Participant's condition and that safe and adequate care cannot be received as an Outpatient or in a less intensified medical setting. The mere fact that the service is furnished, prescribed or approved by a Physician does not necessarily mean that it is "Medically Necessary." In addition, the fact that certain services are specifically excluded from coverage under this Plan because they are not "Medically Necessary" does not mean that all other services are "Medically Necessary".

To be Medically Necessary, all of the above criteria must be met. The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary based on recommendations of the Plan Administrator's own medical advisors, the findings of the American Medical Association or similar organization, or any other sources that the Plan Administrator deems appropriate.

Off-label Drug use is considered Medically Necessary when all of the following conditions are met:

1. The Drug is approved by the Food and Drug Administration (FDA).
2. The prescribed Drug use is supported by one of the following standard reference sources:
    a. Micromedex® DRUGDEX®.
    b. The American Hospital Formulary Service Drug Information.
    c. Medicare approved compendia.
    d. Scientific evidence is supported in well-designed clinical trials published in peer-reviewed medical journals, which demonstrate that the Drug is safe and effective for the specific condition.
3. The Drug is otherwise Medically Necessary to treat the specific condition, including life threatening conditions or chronic and seriously debilitating conditions.

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

- Group or blanket insurance;
- Group practice, group BlueCross, group BlueShield, individual practice offered on a group basis, or other group prepayment coverage;
- Labor management trusteed 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 (PhD), 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 Fund Retiree Health & Wellness San Antonio Fire and Police or any designee of The Fund Retiree Health & Wellness San Antonio Fire and Police.

"**PLAN DOCUMENT**" means this document and any addendum, which collectively provide and define coverage for particular retirees and Dependents.

"**PLAN SPONSOR**" means The Fund Retiree Health & Wellness San Antonio Fire and Police.

"**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
e. 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.

"**PRE-CERTIFICATION**" means before a Covered Person receives care from a Covered Provider on a non-emergency inpatient basis or receives other medical services, the utilization review administrator will, in conjunction with the attending physician, certify the care as appropriate for Plan reimbursement. A non-emergency stay is a service received by a Covered Provider and
can be scheduled in advance.

"**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

"**RECIPIENT**" means a Covered Person who undergoes a surgical operation to receive a Body Organ transplant.

"RECOVER" or "RECOVERY" means all monies paid to the Covered Person by way of judgment, settlement, or otherwise to compensate for all losses caused by the Injury or Sickness, whether or not said losses reflect medical or dental charges covered by the Plan. "Recoveries" further includes, but is not limited to, recoveries for medical or dental expenses, attorneys' fees, costs and expenses, pain and

suffering, loss of consortium, wrongful death, lost wages and any other recovery of any form of damages or compensation whatsoever.

"**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 not a place for Custodial Care.
b. Is under the resident supervision of a Physician or registered nurse (R.N.);
c. Provides continuous skilled nursing care for 24 hours of every day;
d. Requires that the health care of every patient be under the supervision of a Physician;
e. Provides that a Physician be available at all times to furnish necessary medical care in emergencies;
f. Maintains clinical records for each patient;
g. Has an effective utilization review Plan;
h. Has a transfer agreement with at least one (1) Hospital;
i. 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;

"SUBROGATION" means the Plan's right to pursue and place a lien upon the Covered Person's claims for medical or dental charges against the other person.

“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.

"THIRD PARTY" means any Third Party including another person or a business entity.

"TRANSPLANT SURGERY" means the transfer of Body Organ(s) from a Donor to a Recipient.

CHAPTER 5 COVERED MEDICAL EXPENSES

Covered Medical Expenses shall be the portion, set forth in the, Summary of Medical, Prescription, and Accident Benefits of the Maximum Allowable Charges for the following services, supplies, and treatment when Medically Necessary and when ordered by a licensed Physician or Surgeon. Medical expenses exceeding the Maximum Allowable Charge expenses covered by this Plan will be the obligation of the Covered Person.

Ambulance services Medically Necessary professional involving the assessment and administration of care by medically trained personnel and the transportation of patients within an appropriate, safe and monitored environment.

Forms of transportation that are generally available to the public (e.g., vans, buses taxis, airplanes) are not covered under the ambulance benefit.

Covered ambulance services must fall within the rules and regulations of the governing body of the applicable county or municipality.

Anesthetic and its administration

Attention Deficit Disorder expenses.

Child Immunizations. Any immunizations recommended by the Center for Disease Control, for covered Dependents from birth through the date the child is six (6) years of age. The plan will only cover state mandated immunizations for dependent children after age six.

Chiropractic Services. Spinal manipulation/chiropractic services by a licensed M.D., D.O. or D.C. Provider must submit treatment plan, including explanation of medical necessity, and treatment plan must be approved. The initial chiropractic visit will be covered only after the Plan reviews and approves the treatment plan.

Diabetes. Coverage shall be provided to each Covered Person as defined herein for:

a. Diabetes Equipment;
b. Diabetes Supplies; and
c. Diabetes self-management training programs as defined herein.

- training provided to a Covered Person 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;
- 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
- 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.

Diagnostic radiology, radiation therapy and laboratory examinations

Hospice Care. Covered only when the attending Physician has diagnosed the Covered Person's condition as being terminal, determined that the person is not expected to live more than six months and placed the person under a Hospice Care Plan.

Covered Charges for Hospice Care Services and Supplies are payable as described in the Schedule of Benefits.

Bereavement counseling services by a licensed social worker or a licensed pastoral counselor for the patient's immediate family (Covered Spouse and/or other covered Dependents). Bereavement services must be furnished within six months after the patient's death. Charges for bereavement counseling are subject to the limits as described in the Schedule of Benefits.

Hospital or Rehabilitation Facility daily room charges.

Hospital Services and supplies

Maternity. Expenses incurred for maternity care and services shall be covered on the same basis as for any other illness incurred by the eligible retiree or the Covered Spouse only.

Under Federal law, group health Plans generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. The 48-hour period (or 96-hour period if applicable) begins at the time a delivery occurs in the Hospital (or in the case of multiple births, at the time of the last delivery) or, if the delivery occurs outside the Hospital, at the time a mother is admitted. However, Federal law generally does not prohibit the mother's attending provider, after consulting with the mother, from discharging the mother earlier than 48 hours (or 96 hours if applicable) following the delivery.

If a decision is made to discharge a mother 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.

Mastectomy. For reconstruction of the breast on which a Medically Necessary mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; prostheses and treatment of physical complications for all stages of the mastectomy, including lymphedemas.

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 retirees and covered 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, and orthotic devices that are medically necessary to restore or maintain the ability to complete activities of daily living or essential job-related activities and that are not solely for comfort or convenience, including all services and supplies medically necessary for the effective use, repair, or replacement of a prosthetic or orthotic device.

   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;

   Prosthetic and orthotic devices covered under this section shall be limited to those devices and supplies in the medicare fee schedule for durable medical equipment, prosthetics, orthotics and supplies, but replacements of devices shall occur no more frequently than every five (5) years. Special circumstances approved by the board may permit replacement after three (3) years, except when required due to growth or development of a dependent child.
f. 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;
g. Medical supplies such as ostomy supplies, casts, splints, trusses and braces;
h. Orthopedic shoes when prescribed by a physician.

Mental Health Services. Mental and nervous conditions are limited to a COMBINED $30,000 Lifetime Maximum for both inpatient and outpatient care. A Mental and nervous condition is a psychological or behavioral pattern that occurs in an individual and is thought to cause distress or disability that is not expected as part of normal development or culture. Categories of diagnoses may include dissociative disorders, mood disorders, anxiety disorders, psychotic disorders, personality disorders, ambulatory disorders and other categories.

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 serious mental illnesses is limited to 45 days of inpatient treatment per calendar year and 60 visits for outpatient treatment per calendar year, which includes group and individual therapy

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.

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 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.

Occupational Therapy. Therapy must be provided by a licensed occupational therapist, ordered by a Physician, and result from an injury or sickness and improve a body function. Covered Charges do not include recreational programs, maintenance therapy or supplies used in occupational therapy.

Organ Transplants. Benefits are limited to patients not eligible for Medicare.

Institutes of Excellence™ (IOE) Network
IOE network is a special network of hospitals that specialize in organ and bone marrow/stem cell transplants. An Institute of Excellence is a participating facility that has been specifically contracted by Aetna for your transplant type. The maximum charge made by the IOE for such services and supplies will be the amount agreed to between Aetna and the IOE.

Transplant Expenses
Once it has been determined that you or one of your dependents may require an organ transplant, you, or your physician should call the precertification department to discuss coordination of your transplant care. Aetna will coordinate all transplant services. In addition, you must follow any precertification requirements. Organ means solid organ; stem cell; bone marrow; and tissue.

Benefits may vary if an Institute of Excellence™ (IOE) facility or non-IOE is used. In addition, some expenses listed below are payable only within the IOE network. The IOE facility must be specifically approved and designated by Aetna to perform the procedure you require.

A transplant will be covered as preferred care only if performed in a facility that has been designated as an IOE facility for the type of transplant in question. Any treatment or service related to transplants, which is provided by a facility not specified as an IOE network facility, even if the facility is considered as a preferred facility for other types of services, will be covered at the non-preferred level. Please read each section carefully.

Covered Transplant Expenses. Covered transplant expenses include the following:

- Charges for activating the donor search process with national registries.
- Compatibility testing of prospective organ donors who are immediate family members. For the purpose of this coverage, an "immediate" family member is defined as a first-degree biological relative. These are your; biological parent, sibling or child.
- Inpatient and outpatient expenses directly related to a transplant**.**
- Charges made by a **physician** or transplant team.
- Charges made by a **hospital,** outpatient facility or **physician** for the medical and surgical expenses of a live donor, but only to the extent not covered by another plan or program.
- Related supplies and services provided by the IOE facility during the transplant process. These services and supplies may be excluded: physical, speech and occupational therapy; bio-medicals and immunosuppressants; home health care expenses and home infusion services.

Covered transplant expenses are typically incurred during the four phases of transplant care described below. Expenses incurred for one transplant during these four phases of care will be considered one Transplant Occurrence.

A Transplant Occurrence is considered to begin at the point of evaluation for a transplant and end either: (1) 180 days from the date of the transplant; or (2) upon the date you are discharged from the hospital or outpatient facility for the admission or visit(s) related to the transplant, whichever is later.

The four phases of one Transplant Occurrence and a summary of covered transplant expenses during each phase are:

1. Pre-transplant Evaluation/Screening: Includes all transplant-related professional and technical components required for assessment, evaluation and acceptance into a transplant facility's transplant program.
2. Pre-transplant/Candidacy Screening: Includes HLA typing/compatibility testing of prospective organ donors (related and/or non-related).
3. Transplant Event: Includes inpatient and outpatient services for all covered transplant-related health services and supplies provided to you and a donor during the one or more surgical procedures or medical therapies for a transplant; prescription drugs provided during your inpatient stay or outpatient visit(s), including bio-medical and immunosuppressant drugs; physical, speech or occupational therapy provided during your inpatient stay or outpatient visit(s); cadaveric and live donor organ procurement.
4. Follow-up Care: Covered services varies among IOE contracts, most often excludes: home health care services; home infusion services; and immunosuppressants.

For the purposes of this section, the following will be considered to be one Transplant Occurrence:

- Heart
- Lung
- Heart/ Lung
- Simultaneous Pancreas Kidney (SPK)
- Pancreas
- Kidney
- Liver
- Intestine
- Bone Marrow/Stem Cell transplant
- Multiple organs replaced during one transplant surgery
- Tandem transplants (Stem Cell)
- Sequential transplants
- Re-transplant of same organ type within 180 days of the first transplant
- Any other single organ transplant, unless otherwise excluded under the Plan

The following will be considered to be more than one Transplant Occurrence:

- Autologous Blood/Bone Marrow transplant followed by Allogeneic Blood/Bone Marrow transplant (when not part of a tandem transplant)
- Allogeneic Blood/Bone Marrow transplant followed by an Autologous Blood/Bone Marrow transplant (when not part of a tandem transplant)
- Pancreas transplant following a kidney transplant
- A transplant necessitated by an additional organ failure during the original transplant surgery/process.
- More than one transplant when not performed as part of a planned tandem or sequential transplant (e.g., a liver transplant with subsequent heart transplant).

Exclusions/Limitations. The transplant coverage does not include charges for:

- Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient Transplant Occurrence.

- Services and supplies furnished to a donor when recipient is not a covered person.
- Home infusion therapy after the Transplant Occurrence.
- Harvesting or storage of organs, without the expectation of immediate transplantation for an existing illness.
- Harvesting and/or storage of bone marrow, tissue or stem cells without the expectation of transplantation within 12 months for an existing illness.
    - Cornea (Corneal Graft with Amniotic Membrane) or Cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise authorized.

Other Covered Provider, not related by blood or marriage, treatment and services.

Physical Therapy. Physical therapy by a licensed physical therapist. The therapy must be in accord with a Physician's exact orders as to type, frequency and duration and for conditions which are subject to significant improvement through short-term therapy.

Physician or Surgeon Treatment.

Preventive Services:

a. The first Pap smear per Calendar Year (doctor's procedure charge, lab expenses and office visit) for female Covered Person will be covered at 100%. The Calendar Year deductible and out of pocket will be waived for in network providers, regardless of the claim's routine or diagnostic coding. If services are rendered out of network, the benefit will be subject to the out of network Calendar Year deductible and out of pocket.
   (Any pap smear submitted thereafter would be subject to the Calendar Year deductible and out of pocket).
b. The first mammogram per Calendar Year for female Covered Person age thirty-five (35) and over will be considered at 100%. The Calendar Year deductible and out of pocket will be waived for in network providers, regardless of the claim's routine or diagnostic coding. If services are rendered out of network, the benefit will be subject to the out of network Calendar Year deductible and out of pocket.
   (Any mammogram submitted thereafter would be subject to the Calendar Year deductible and out of pocket.)
c. One (1) routine physical examination per Calendar Year for an eligible retiree and Covered Spouse is covered.
   The Plan will cover 100% the cost of the exam by a licensed Physician
   to a maximum benefit of $400 per Calendar Year per retiree and $400 per Calendar Year per Covered Spouse for **IN NETWORK PROVIDERS.**
   (Out of network providers, subject to the out of network deductible and Coinsurance.)
d. A physical examination for the detection of prostate cancer and prostate specific Antigen test used for the detection of prostate cancer will be covered at 100% for an in network provider 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.
   (Out of network providers, subject to the out of network deductible and Coinsurance.)

f. A physical examination (as described below) for the detection of colorectal cancer will be covered at 100% for in network providers for the retiree and spouse.

The ACS recommends that people at average risk* of colorectal cancer **start regular screening at age 45**. This can be done either with a sensitive test that looks for signs of cancer in a person's stool (a stool-based test), or with an exam that looks at the colon and rectum (a visual exam). These options are listed below.
People who are in good health and with a life expectancy of more than 10 years should continue regular colorectal cancer screening through the **age of 75**.
For people **ages 76 through 85**, the decision to be screened should be based on a person's preferences, life expectancy, overall health, and prior screening history.
People **over 85** should no longer get colorectal cancer screening.
*For screening, people are considered to be at average risk if they **do not** have:

- A personal history of colorectal cancer or certain types of polyps
- A family history of colorectal cancer
- A personal history of inflammatory bowel disease (ulcerative colitis or Crohn's disease)
- A confirmed or suspected hereditary colorectal cancer syndrome, such as familial adenomatous polyposis (FAP) or Lynch syndrome (hereditary non-polyposis colon cancer or HNPCC)
- A personal history of getting radiation to the abdomen (belly) or pelvic area to treat a prior cancer

Test options for colorectal cancer screening
Several test options are available for colorectal cancer screening:

Stool-based tests

- Highly sensitive fecal immunochemical test (FIT) every year
- Highly sensitive guaiac-based fecal occult blood test (gFOBT) every year
- Multi-targeted stool DNA test (mt-sDNA) every 3 years

Visual (structural) exams of the colon and rectum

- Colonoscopy every 10 years
- CT colonography (virtual colonoscopy) every 5 years
- Flexible sigmoidoscopy (FSIG) every 5 years

f. The vaccination for influenza (flu shot) will be covered at 100% for eligible retiree and Covered Spouse; **the Calendar Year Deductible and out of pocket will be waived for in network providers IF given in conjunction with the annual physical examination. If services are rendered out of network, the benefit will be subject to the out of network Calendar Year Deductible and out of pocket**.
(The covered expense of the flu shot will apply to the $400 Calendar Year maximum for the physical exam.)

Renal Dialysis Services (Outpatient). This Section describes the Plan's Dialysis Benefit Preservation Program (the "Dialysis Program"). The Dialysis Program shall be the exclusive means for determining the amount of Plan benefits to be provided to Plan members and for managing cases and claims involving dialysis services and supplies, regardless of the condition causing the need for dialysis.

The member's first 40 renal dialysis visits, cumulative and not subject to annual reset, are subject to the Maximum Allowable Charge and paid at 60% Out-of-Network, subject to plan deductible. Additional visits are paid at 150% of the national Medicare allowable amount, adjusted for the geographic wage index.

Medicare Part B Reimbursement:
If you or your covered dependent has End-Stage Renal Disease ("ESRD"), the Plan's medical programs primary status applies during the first 30 months of dialysis, or the first 30 months of treatment in connection with a transplant. Thereafter, Medicare generally becomes the primary payer of benefits.

The Medicare Secondary Payer statute requires the Plan to identify members in the Plan, including eligible dependents, who are eligible for Medicare, including those eligible based on ESRD. To ensure the correct coordination of claims payments, members are required to provide the Plan the basis for their eligibility to Medicare (age, ESRD, or disability) and the effective date of Medicare Part A and Part B.

During the period where the Plan has primary status, Medicare Part B monthly premiums for covered members and their dependents that have become entitled, including dually entitled, to Medicare based on ESRD, will be covered by the Plan. Reimbursement for monies withheld by Medicare from Social Security, Railroad Retirement, or Office of Personnel Management payments will be made at the end of each calendar quarter.

Skilled Nursing Facility Charges. Must be medically necessary. All charges in excess of 100 days of care, per event, must be submitted to the Board for approval prior to the expiration of the initial 100 day treatment period. If the initial 100 day treatment period is covered by Medicare in whole or part, the Board must review and approve the treatment Plan in excess of the benefit provided by Medicare, including any extension of the initial 100 day treatment Plan. Coverage for additional confinement days is subject to medical review and Board approval.

Sleep Studies are covered at home or facility based on medically necessity.

Speech Therapy. Services of a licensed speech therapist are covered when therapy is rendered in accordance with Physician's specific instructions as to type and duration when speech was present before the illness and/or injury, and for a child born under the Plan with a developmental disorder or birth defects. Therapy must follow either: (i) surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy) of a person; (ii) an injury; or (iii) a sickness that is other than a learning or Mental Disorder.

Sterilization. Voluntary sterilization is covered.

Substance Abuse & Dependence Treatment. Substance abuse & dependence treatments are limited to a COMBINED $30,000 Lifetime Maximum for both inpatient and outpatient care, inclusive of detoxification services. Substance abuse & dependence is defined as: A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period: (1) Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions or expulsions from school; neglect of children or household); (2) Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use); (3) Recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct; (4) Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights).

Surgery in mouth or oral cavity 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. dental treatment for fractured or dislocated 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.

Telehealth. Services covered by the Plan, that are provided by an eligible practitioner by telephone or video communication. Covered services are limited to those provided by a Preferred Provider Network Physician for established patients.

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.

CHAPTER 6 EXCLUSIONS

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

Abortions are not covered unless the attending Physician certifies that the mother's life would be endangered if the fetus were carried to term.

Acupuncture or hypnosis including if used in lieu of anesthesia.

Administrative Costs. Preparing medical reports or itemized bills.

Alternative Medicine. Holistic or homeopathic treatment, naturopathic services, and thermography including drugs.

B12 Injections

Convalescent or Custodial Care. Care in a health resort, rest home, nursing home, residential treatment center, or any institution primarily providing convalescent, or Custodial Care.

Cochlear Implants

Cosmetic Procedures that are incurred in connection with the care and/or treatment of Surgical Procedures which are performed for plastic, reconstructive or cosmetic purposes or any other service or supply which are primarily used to improve, alter or enhance appearance, whether or not for psychological or emotional reasons, except to the extent where it is needed for: (a) repair or alleviation of damage resulting from an Accident; (b) because of infection or Illness; (c) because of congenital disease, developmental condition or anomaly of a covered Dependent Child which has resulted in a functional defect. A treatment will be considered cosmetic for either of the following reasons: (a) its primary purpose is to beautify or (b) there is no documentation of a clinically significant impairment, meaning decrease in function or change in physiology due to injury, illness or congenital abnormality. The term “cosmetic services” includes those services which are described in IRS Code Section 213(d)(9).

Counseling. Marital, family, vocational and other counseling services, except for nutritional counseling for diabetics.

Custodial Care.

Exercise equipment or exercise programs.

Experimental and Investigational services are not covered by the Plan

Eye exercises, visual training (orthoptics), eyeglasses, contact lenses and exams for determining visual acuity

Family planning, infertility treatment and services including but not limited to: artificial insemination and personal therapy for infertility.

Gender-Affirming Care. Gender-Affirming Care. The Plan excludes the following gender-affirming services:

- Psychotherapy.
- Pre- and post-surgical hormone therapy.
- Gender-affirming surgery/ies.

Gene Therapy

Genetic Testing, including BRCA testing.

Hearing Aids or examinations for determining level of hearing.

Hospice Care. Coverage does not include the following charges:

a. nutritional services, including special meals 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.

Military Service. Diseases contracted or injuries sustained as a result of service in any branch of the armed forces.

No Legal Obligation to Pay. Which the Covered Person has no legal obligation to pay, or for which no charge would be made if the Covered Person had no health coverage.

Not Medically Necessary for the diagnosis and treatment of an illness or injury or which exceed the Maximum Allowable Charges.

Nutritional Supplements, including prescription and over the counter vitamins.

Obesity. Surgery and/or treatment of obesity, morbid obesity, dietary control, or for weight reduction, whether medically necessary or not.

Organ Transplant. 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:

    - Approval by the U.S. Food and Drug Administration, the American Medical Association or the appropriate Medical Specialty Society;
    - Medical and scientific literature;
    - Scientifically demonstrated health benefits;

- Safety and effectiveness compared to alternatives; and
- 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

Orthognathic. Medical, dental or surgical treatment including associated diagnostic procedures of orthognathic conditions.

Orthotics (arch supports, etc.) and other supportive devices for feet that are not prescribed by a Physician.

Personal Convenience Items. Air conditioners, filters, humidifiers, dehumidifiers, and purifiers.

Physical or Psychological Therapy in an in or outpatient setting where art, play, music, drama, reading, nutrition, massage, education, home economics or recreational activities is the method of treatment.

Pregnancy of a Dependent Child.

Providers Not Participating in Medicare. There will be no coverage for services received from providers not participating in Medicare.

Related By Blood or Marriage Any treatment or service rendered by a Covered Provider related by blood or marriage.

Reversal or Attempted Reversal of Sterilization.

Routine or Preventative Immunizations. Services and supplies for routine or preventative immunizations or vaccinations except for child immunizations.

Routine Physical Examination services, unless covered as noted within Chapter 6, Covered Expenses.

Self-Inflicted Injury. Intentionally self-inflicted injury, whether sane or insane.

Sexual Dysfunction. 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.

Smoking Cessation seminars, services, devices or medications.

Special Education, counseling or care for learning deficiencies or behavioral problems whether or not associated with a manifest mental disorder or other disturbance.

Taxes. Sales tax, transportation, tariffs, immigration fees for international travel, or federal excise taxes.

Timely Filing. Claims filed more than one (1) year from the month the covered service or supply was provided. NOTE: The claim-filing deadline is defined as one year from the month in which the services were rendered. The claim-filing deadline will include the submission of any supporting or additional information requested for completion of claim processing.

EXAMPLE: Date of service is January 3, 2009. The claim filing deadline for this claim is January 31, 2010.
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Travel or accommodations, whether or not recommended by a Physician.

Treatment in mouth or oral cavity to include 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. However, that this exclusion shall not be applicable to services and supplies rendered to a child which are necessary for treatment or correction of a congenital defect.

Vision Care. Expenses for the following:

1. For eye refractions, eyeglasses, contact lenses, or the vision examination for prescribing or fitting eyeglasses or contact lenses (except for aphakic patients, and soft lenses or sclera shells intended for use in the treatment of Illness or Injury).
2. For refractive procedures or other plastic surgeries to correct vision in lieu of eyeglasses.
3. Vision therapy (orthoptics) and supplies.
4. Orthokeratology lenses for reshaping the cornea of the eye to improve vision.

Vocational therapy.

Workers' Compensation or Occupational Medical Policy. 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.

CHAPTER 7 PRE-CERTIFICATION

Pre-certification requirements are applicable to all Covered Persons, including those who have other insurance.

a. Elective Services: For Elective Services, Certification should be performed at least five (5) working days before the scheduled service. Pre-certification requirements are applicable to all Covered Persons, including those who have other insurance.

Note: Examples of other insurance are Aetna, BlueCross BlueShield, etc.

b. Emergency Services (defined in Ch. 4, P 19): For Emergency Services, Certification should be performed within seven (7) working days for all Covered Persons who do not have any other primary insurance coverage. 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. For covered Persons with additional insurance, notification should be certified following the emergency.

In either case, Medical Necessity (defined in in Ch. 4, P 22) will need to be determined or the claim may be denied.

Members who are enrolled in both Medicare Part A and Part B are not subject to precertification.

The following services must be pre-certified or the Plan's reimbursement may be reduced or the service may be denied due to lack of medical necessity.

Note: This may not be a complete list of services that require certification.

Hospitalizations
Inpatient and Outpatient Surgery
Inpatient Substance Abuse/Mental Disorder Treatments
Skilled Nursing Facility Stays
Home Health Care
Hospice Care
Home Infusion
Infusion Therapy
CAA's
Sleep Studies
Maternity Care after 48/96 Hours
ER Hospitalization
Cardiac Catheterizations
Rehabilitation Services
Pain Management Therapy
Office Injections

Note: Precert is not required for a routine colonoscopy.

Effective October 30, 2023, CAT Scans, MRIs, PET Scans and office surgeries in a dermatology office do not require precertification.

If the benefit is reduced because pre-certification authorization is not obtained, the maximum benefit paid will be fifty percent (50%) of the Maximum Allowable Charge. 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 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.

For all Pre-certification:

The patient or a family member must call The Fund Retiree Health & Wellness San Antonio Fire and Police office.

All providers must call the Claims Administrator.

CHAPTER 8 PRESCRIPTION DRUG COVERAGE

Obtaining Covered Prescriptions In-Network

With this program you can obtain prescriptions from two different sources.

Retail Pharmacy - Up to a 30-day Supply

The retail network of pharmacies is available for prescriptions you need right away or for a short time only (such as antibiotics). You can obtain up to a 30-day supply of medication from thousands of participating retail network pharmacies nationwide. To locate the nearest participating retail network pharmacy; call Member Services at 866-652-4237.

Mail Service Pharmacy

Prescriptions for maintenance medications or chronic long-term health conditions can be ordered through Pharmacy Benefit Manager Mail order pharmacy. Ordering through the mail is both a safe and easy way to receive prescriptions and save money.

To order, simply obtain a new prescription from your doctor for a 90-day supply. Then complete a Pharmacy Benefit Manager mail registration and order form and send it with your original prescription and appropriate co-insurance payment to the address indicated on the form.

Maximum Out-of-Pocket Benefit

Out-of-pocket maximum

FIRE AND POLICE RETIREE HEALTH CARE FUND, SAN ANTONIO GOVERNING STATUTE AS AMENDED OCTOBER 1, 2007

ARTICLE 5. RETIREMENT HEALTH BENEFITS

SECTION 5.01. RETIREMENT HEALTH BENEFITS.

Commencing January 1, 2013, on January 1 of each year the board shall increase the amount of the maximum deductible and out-of-pocket payments established under Subsections (f) and (g) of this section by a percentage equal to the then most recently published annual percentage increase in health care costs as set out in a published index selected by the actuary that reflects annual changes in health care costs. The annual percentage increase provided for by this subsection may not exceed eight percent.

Written notice of the annual deductible and out-of-pocket maximum per individual will be communicated prior to the applicable plan year.

Retail up to a 30 day supply (non-maintenance medications)

0% co-insurance Generic
20% Brands with no Alternative

Mail Order on Maintenance Medications

For drugs with the "maintenance" indication, members may fill each medication twice at the retail pharmacy and then must fill at mail order for coverage. Beginning with the third fill of each medication, the claim will reject and members must pay the full cost at retail or fill at mail order to obtain their fill. This member cost will not apply to the out of pocket maximum.

90-day supply Mail order only
0% co-insurance Generic
20% co-insurance Brand with no Alternative

Generic or Therapeutic Equivalent

Brands with a direct generic available: If a member or physician requests the brand product when a direct generic equivalent is available, the member will pay the difference between brand and generic cost. The Plan will cover only the cost of the generic equivalent. This member cost will not apply to the out of pocket maximum.

Brands with a therapeutic equivalent available: For those brand products targeted by the Pharmacy Benefit Manager SMPL (Save More Prescription List) Program, member will pay the cost difference between the Brand medication and the Generic alternative. The Plan will cover only the cost of the generic alternative. The member cost will not apply to the out of pocket maximum. Pharmacy Benefit Manager will help members move from target brands to generic alternative by contacting prescribers on the members' behalf to request and facilitate interchange with member approval.

Covered Items

The following items are covered under the prescription program, unless specifically listed in the "Exclusions and Limitations" section below.

- Federal legend drugs (drugs that federal law prohibits dispensing without a prescription)
- Compound prescriptions containing at least one legend ingredient
- Insulin and diabetic supplies such as disposable needles and syringes, blood test strips, and lancets and any other items mandated under Texas Insurance Code
- Topical acne agents through age 23
- ADHD drugs through age 19 (over age 19 prior authorization required)
- Oral contraceptives for retiree or eligible spouse only
- Only prescriptions which are prescribed for the condition for which they are labeled

Exclusions (See Chapter 6)

- Drugs used for cosmetic purposes, including but not limited to certain anti-fungal, hair loss treatments and those used for pigmenting/depigmenting and reducing wrinkles
- Diabetic alcohol swabs

- Fluoride supplements
- Nutritional/Dietary Supplements
- Over-the-counter medications and other over the counter items
- Vitamins
- Miscellaneous medical supplies
- Anti-obesity drugs
- Smoking cessation medications
- Experimental or Investigational drugs or for drugs labeled "Caution – limited by federal law to Investigational use"
- Immunization agents, allergens, serums, blood or blood plasma
- Therapeutic devices or appliances, support garments or other non-medical appliances, except those listed as covered drugs
- Coverage for prescription drug products for an amount which exceeds the supply limit (days supply or quantity limit)
- Prescription drug products for any condition, injury, sickness or mental illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws
- Drugs purchased during time of no coverage
- Drugs for any treatment or condition which is listed under expenses not covered in the medical Plan
- Charges to administer or inject any drug
- Prescription drugs that are not Medically Necessary
- Charges for delivering any drugs, except through the mail order benefit. Express or overnight delivery is at the member's expense.
- Experimental or Investigational medications
- Prescription drugs purchased from an institutional pharmacy for use while the member is an in-patient in that institution regardless of the level-of-care
- Reimbursement for prescription drugs purchased outside of your prescription drug benefit
- Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a Hospital, extended care facility, or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals.
- Off labeled drugs
- Penlac

Prior Authorizations

Certain prescriptions require "clinical prior authorization" or approval from your Plan before they will be covered. The pharmacy benefit manager administers the clinical prior authorization process on behalf of The Fund Retiree Health & Wellness San Antonio Fire and Police.

A Clinical Prior Authorization (CPA) can be initiated by you or your Physician by calling the pharmacy benefits manager. To initiate a clinical prior authorization, the caller should have available the name of the medication, Physician's name, telephone number (and fax number, if available), member's ID number, and the Rx group number (37FP).

After the initial call is placed, the Clinical Services Representative obtains information and verifies that The Fund Retiree Health & Wellness San Antonio Fire and Police participates in a CPA program for the particular drug category. The Clinical Services Representative generates a drug specific form and faxes it to the prescribing Physician. Once the fax form is received back into the Clinical Call Center, a pharmacist reviews the information and approves or denies the request based on established protocols. Determinations may take up to 72 hours from Pharmacy Benefit Manager's receipt of the completed form, not including weekends and holidays.

If the prior authorization request is APPROVED, the Pharmacy Benefit Manager Clinical Service Representative contacts the person who initiated the request and enters an override into the Pharmacy Benefit Manager processing system for a limited period of time. The pharmacy will then process your prescription.

If the prior authorization request is DENIED, the Pharmacy Benefit Manager Clinical Call Center pharmacist contacts the person who initiated the request.

The categories/medications that require prior authorization include, but are not limited to:

- Attention Deficit Hyperactivity Disorder (ADHD)
- Narcolepsy
- Anabolic steroids (all forms)
- Anti-Fungals (i.e., Lamisil, Sporanox)
- Botulinum Toxins (Botox)
- Contraceptives (for Dependents)
- Crinone 8%
- Asthma (Xolair)
- Endometriosis (Lupron)
- Growth Hormone Deficiency (Genotropin, Nutropin)
- Osteoarthritis (Synvisc)
- Osteoporosis (Forteo)

- Parkinson's Disease (Apokyn)
- Precocious Puberty (Lupron-Ped)
- Prostate Cancer (Lupron, Viadur)
- Oral Impotency

The criteria for the Clinical Prior Authorization programs are based on nationally recognized guidelines; FDA approved indications and accepted standards of practice.

To confirm whether you need clinical prior authorization and/or to request a CPA, call Member Services at 866-652-4237.

Please have the information listed below when initiating your request for a clinical prior authorization:

- Name of your Medication
- Physician's Name
- Physician's Phone Number
- Physician's Fax Number, if available
- Member ID number (from your card)

Age, Quantity and Specialty Medication Limitations

Some medications are subject to age and quantity limits. Your prescription will be denied at time of purchase if it exceeds these limitations. Limitations are based on criteria developed with guidelines from various national medical agencies and in conjunction with Pharmacy Benefit Manager clinical review process.

Age Limitations

Certain medications having an age limitation include but are not limited to, the following health conditions:

- Attention Deficit Hyperactivity Disorder (ADHD)

Quantity Limitations

Certain medications having quantity limitations include but are not limited to, the following health conditions and medications:

- Impotency (8 per 30 days)
- Insomnia
- Migraine
- Butorphanol
- Oral Antiemetics
- Diflucan 150mg

CHAPTER 9 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.

Covered persons who have primary medical insurance with another health plan will receive secondary medical benefits under the Plan at the in-network level.

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); BlueCross/BlueShield;

3. Any labor-management trusteed 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, including Medicare.

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 trusteed 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 pan 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.

5. When medical payments are available under vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan deductibles. This Plan shall always be considered the secondary carrier regardless of the individual's election under PIP (personal injury protection) coverage with the auto carrier.

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.

a. 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.
b. 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.

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 a 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 Medically Necessary, Maximum Allowable Charge 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.

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.

Coordination with Medicare

Once the Covered Person is eligible for Medicare, the Covered Person is required to apply for, purchase and maintain Medicare benefits. When Medicare is to be the primary payer, the Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under any of these parts. The Plan Administrator may approve any alternate health care coverage provided by the eligible spouse of a retired or decease member, 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 the Summary of Medical, Prescription, and Accident Benefits for retirees, not to exceed the benefits otherwise applicable under The Fund Retiree Health & Wellness San Antonio Fire and Police Plan Document.

Claims Determination Period

Benefits will be coordinated on a Calendar Year basis. This is called the claims determination period.

Right to Receive or Release Necessary Information

To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Covered Person will give this Plan the information it asks for about other Plans and their payment of Allowable Charges.

Facility of Payment

This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

Right of Recovery

This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Covered Person. That repayment will count as a valid payment under the other benefit plan.

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

Exception to Medicaid

The Plan shall not take into consideration the fact that an individual is eligible for or is provided medical assistance through Medicaid when enrolling an individual in the Plan or making a determination about the payments for benefits received by a Covered Person under the Plan.

CHAPTER 10 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.

3. Rights of Plan Administrator. The Plan Administrator has a right to request reports on and approve of all settlements. As of the date of this document, the Plan Administrator utilizes NexClaim for subrogation services.

CHAPTER 11 GENERAL PROVISIONS

1. Proof of Loss

Written proof of loss and all supporting information 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. NOTE: The claim-filing deadline is defined as one year from the month in which the services were rendered. The claim-filing deadline will include the submission of any supporting or additional information requested for completion of claim processing.

2. Legal Actions

No action at law or in equity shall be brought to recover on the Plan unless the retiree has exhausted administrative remedies provided in the review and appeal process in Chapter 14.

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 as 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. Entire Contract

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

6. 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

7. 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.

8. 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.

9. Workers' Compensation

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

10. Statements

a. 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. 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.

11. Identification Cards

Identification card(s) will be issued, which indicate coverage by The Fund Retiree Health & Wellness San Antonio Fire and Police. Upon request, the Claims Administrator or The Fund Retiree Health & Wellness San Antonio Fire and Police 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.

12. 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 Plan finds that such an attempt has been made with respect to any payment due or to become due to any Covered Person, the Plan in its sole discretion may terminate the interest of such Covered Person or former Covered Person in such payment. And in such case the Plan 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 Plan 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 Plan, benefit payments may be assigned to health care providers.

CHAPTER 12 CLAIM FILING & CLAIM PAYMENT

1. Claim Filing

Only one (1) detailed claim form must be completed per person per year, even for different claims and/or diagnoses.

a. The original claim form shall be mailed to The Fund Retiree Health & Wellness San Antonio Fire and Police Benefits Office at 11603 W. Coker Loop, Suite 210, San Antonio, Texas 78216

b. The complete itemized bill shall include 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.

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. NOTE: The claim-filing deadline is defined as one year from the month in which the services were rendered. The claim-filing deadline will include the submission of any supporting or additional information requested for completion of claim processing.

All benefits under the Plan are payable to the retiree 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 retiree 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 retiree.

Benefits for medical expenses covered under the Plan may be assigned by a Covered Person 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 Person and the assignee has been received before the proof of loss is submitted.

3. 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 Person 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

CHAPTER 13 REVIEW & APPEAL PROCESS

APPEALS PROCESS FOR DISPUTED CLAIMS

The appeals process for disputed claims shall include the following:

1. Within 90 days of the denial of the claim, you may request, in writing to the Claims Administrator, that the Plan conduct a review of the processed claim. The appeal must be in writing and sent by mail (certified is recommended. Once the written appeal is received, the Claims Administrator has 60 days to respond. They will review the processed claim and inform you whether or not an error was made and any errors will be corrected. All requests for a review of denied benefits should include a copy of the initial denial letter and any other pertinent information.

2. If you wish to request a variance from the Plan specifications or to appeal after the Claims Administrator's determination, then you may send a second appeal within 45 days of the first appeal denial, to the Claims Administrator. The appeal must be in writing and sent by mail (certified is recommended). When the written request is received, the claim will be reviewed by the Claims Administrator and this review will be approved by the Plan Administrator. The results of this review will be furnished in writing to you within 90 days in most cases, but in no case more than 150 days. The decision of the Plan Administrator will be final and binding upon all parties.

   Any such appeal should be addressed in writing as follows:

   WebTPA
   PO Box 1808
   Grapevine, TX 76099