

# City of Gulfport

## HEALTH BENEFIT PLAN

### Summary Plan Document

*Plan Supervisor: Select Administrative Services, 14110 Airport Road, Ste. 100, Gulfport, MS 39503, (800) 847-6621*

#### IMPORTANT INFORMATION

This plan has been revised to comply with the provisions of the Patient Protection and Affordable Care Act (PPACA) including Reconciliation Act Impact. This plan is a non-grandfathered plan under PPACA.

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This is a Summary Plan Description of the Benefits available to you and your dependents (where family coverage is elected) under your enrollment. This Summary Plan Document contains valuable information. Please review and save for future reference.

**Plan Name:** City of Gulfport Self Funded Employee Benefits Plan

**Plan Type:**

**Original Effective Date of Plan:** June 1, 1993

**Employer Identification Number of Plan Sponsor (EIN):** 64-6000413

**Plan Number (used for Form 5500):** 501

**Plan Sponsor/Administrator:**

City of Gulfport

Gulfport, Mississippi 39501

**Named Fiduciary:**

City of Gulfport

Gulfport, Mississippi 39501

**Agent for Legal Process:** Plan Sponsor named above

**Plan Years:**

The fiscal records of this Plan are kept on the basis of the Plan Year.

**Funding Medium and Type of Plan Administration:**

Self-Funded. The Plan is administered on behalf of the Plan Administrator by Select Administrative Services (SAS).

**Plan Amendment and Termination:**

Plan Sponsor has the right to amend or terminate the Plan at any time. No consent of any participant or beneficiary is required to terminate, modify, amend, or change the Plan. Plan Sponsor does not promise the continuation of any benefits nor does it promise any specific level of benefits at or during retirement.

**Department of Labor Office:**

Department of Labor

61 Forsyth St., Suite 7B54

Atlanta, GA 30303

(404) 562-2156

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## I. OBTAINING HEALTH CARE SERVICES

This section has been prepared to help explain the coverage provided by your health plan. It explains how to obtain medical care, what health services are covered, and what portion of the health care cost you are required to pay. You should refer to this information whenever you need medical services. The SAS Customer Service Center can help you any time you have a problem or question. Call a representative at (800) 847-6621 if you:

- Have a benefit or coverage question
- Need to replace a lost or stolen ID Card
- Need to update your name, address, or phone number
- Have a complaint, problem, suggestion, or have any other questions about your health care coverage

### **Provider Network Directory**

Your provider network includes those providers participating with First Choice Mississippi. A provider directory is available on the SAS website at [www.selectadministrativeservices.com](http://www.selectadministrativeservices.com). You may select a participating or non-participating provider. Your plan will pay higher benefits and you will incur less out-of-pocket expense if you choose a participating provider. It is your responsibility to verify that the provider you choose participates prior to obtaining services.

### **Emergency Services**

When faced with an emergency illness or injury, contact the local emergency service or proceed to the nearest emergency care facility.

### **Pre-Authorization**

Pre-authorization is the review of a requested service for medical necessity. This process helps ensure that you are getting the most appropriate care available. The SAS Medical Management Department validates the medical necessity of services. **You are responsible for notifying the Medical Management Department before receiving the services listed below. Benefits will be reduced by 50% if you do not call Medical Management before receiving the services listed below.** The penalty applies to each hospitalization, surgical procedure, diagnostic procedure, or treatment plan. The Medical Management Department number is (228) 865-0514 or (800) 847-6621. You should contact the Medical Management Department of SAS for authorization within five (5) working days prior to receiving the services listed below. Authorization from SAS will be provided within two (2) working days of your initial request.

### **Services Requiring Pre-Authorization:**

All inpatient admissions

Inpatient Mental Disorder/Substance Abuse Treatment

All rental Durable Medical Equipment and any DME purchase of \$500

All prescription medications with a cost of \$1,000 or more per 30-day supply (i.e. Lupron, Rebetrone, growth hormone) must be preauthorized through Express Scripts, Inc.

In addition, certain prescription medications that may cause interactions with other drugs, require other lab testing, or cause other health concerns (i.e. Lamisil Tablets, Acutane) must be preauthorized through Express Scripts, Inc.

### **Pre-notification is required for the following services:**

Chemotherapy / Radiation Therapy

Maternity Care

### **Limitations and Exclusions**

Limitations and exclusions that apply to your benefits are listed in the General Limitations and Exclusions

Section of this Summary Plan Document. All benefits are subject to the stated limitations and exclusions.

### **Co-payments**

All services and benefits are subject to the stated co-payment/coinsurance amounts, limitations, exclusions, and provisions of this Summary Plan Document. This Summary Plan Document shows different co-payments/coinsurance for different covered services. Co-payments do not accrue toward any calendar year deductible or any calendar year maximum out-of-pocket. When a provider performs two or more covered services on the same day, you pay the higher co-payment only. You would pay more than one co-payment for services on the same day if more than one provider is involved, such as paying a facility co-payment and a physician co-payment to the doctor. Co-payments for prescription drugs do not accrue toward any calendar year deductible or any calendar year maximum out-of-pocket.

### **Coinsurance Amounts**

Your portion of the cost of health care services that is listed as a percentage of total charges is called coinsurance. This figure will be based on the contracted rate for participating providers. For out-of-network providers, this amount is subject to the Usual, Customary and Reasonable (UCR) limits set by the Plan. If you access out-of-network providers, you will be responsible for any amounts over the UCR reimbursement. The amount over UCR does not accrue toward any calendar year deductible or any calendar year maximum out-of-pocket.

### **Usual, Customary, and Reasonable (UCR)**

If you and/or your eligible dependents receive services by out-of-network providers, you may be responsible for additional costs. The plan reimburses out-of-network providers at Usual, Customary, and Reasonable (UCR) levels, which may be less than the amount charged by the out-of-network provider. Any amounts over UCR are the responsibility of the member and **DO NOT** count toward any calendar year deductible or any calendar year out-of-pocket maximum. The Plan will reimburse the provider up to UCR and this amount will be used to calculate coinsurance amounts. The member must pay deductibles, coinsurance, and any balance over the plan reimbursement. If you have any questions concerning this policy, please contact SAS prior to receiving your services.

### **Deductibles**

The In- Network benefit includes a calendar year deductible per individual, with a maximum of three (3) per family. The deductible is required to be paid prior to any benefits being reimbursed by the plan. The deductible is the first amount paid by the member, and does not count toward any calendar year out-of-pocket maximum. The deductibles listed must be met separately.

The Out-of-Network benefit includes a calendar year deductible of \$2,000 per individual, with a maximum of 3 per family (\$6,000). In-Network and Out-of-Network deductibles accumulate separately.

### **Maximum Out-of-Pocket**

When the total coinsurance applied to covered services received by an individual member reaches the per member maximum out-of-pocket, no coinsurance will be taken on additional covered services provided to that member in the same calendar year. When the total coinsurance applied to all covered services received by a family reaches the per family maximum out-of-pocket, no coinsurance will be taken on additional covered services provided to any member of that family in the same calendar year. Co-payments for pharmacy and prescription drugs do not count toward any maximum out-of-pocket.

There is no maximum coinsurance limit on out-of network services. Any amounts over the SAS negotiated fee schedule or penalties are considered the member's responsibility and **DO NOT** count toward any maximum out-of-pocket expense.

II. City of Gulfport Employee Benefit Plan: Schedule of Benefits

**HEALTH OPTION I**

<b>SERVICES: HEALTH OPTION I</b>	<b>In Network</b>	<b>Out of Network</b>
<b>PY Deductible</b> Per member/family	\$500 / \$1,500	\$2,000 / \$6,000
<b>PY Out-of-Pocket Maximum</b> Per member/family	\$1,500 / \$4,500	Unlimited
<b>Annual Plan Maximum</b>	\$1,000,000 per covered person	
<b><u>PHYSICIAN SERVICES</u></b> Physician Office Visits only Other services provided in the Physician office  Physician charges for radiology, pathology, hospital services or surgery	\$25 Copay 20% Coinsurance – Deductible does not apply  20% Coinsurance after PY Deductible	50% Coinsurance after PY Deductible
<b><u>EMERGENCY CARE SERVICES</u></b>  Emergency Room Facility Services Urgent Care Facility Services Land and air ambulance	\$125 Copay, then 20% Coinsurance after Deductible	
<b><u>FACILITY SERVICES</u></b> Inpatient Facility Services  Outpatient/Ambulatory Surgery/Diagnostic Services	20% Coinsurance after Deductible	50% Coinsurance after PY Deductible
<b><u>MATERNITY SERVICES</u></b>  Physician Services for Obstetrical Care  Inpatient Facility Charges for Delivery	20% Coinsurance after Deductible	50% Coinsurance after PY Deductible
<b><u>WELLNESS BENEFIT/ PREVENTATIVE CARE</u></b> Covered at 100% with no deductible and no co-pay	Age Appropriate Recommended Testing based on PPACA Guidelines	N/A within this tier
<b><u>KIDNEY DIALYSIS SERVICES</u></b> Dialysis services	20% Coinsurance after Deductible	50% Coinsurance after PY Deductible
<b><u>SKILLED NURSING FACILITY SERVICES</u></b>	20% Coinsurance after Deductible	50% Coinsurance after PY Deductible
<b><u>OSTOMY SUPPLIES</u></b>	20% Coinsurance after Deductible	50% Coinsurance after PY Deductible



II. City of Gulfport Employee Benefit Plan: Schedule of Benefits

**HEALTH OPTION II**

<b>SERVICES: HEALTH OPTION II</b>	<b>In Network</b>	<b>Out of Network</b>
<b>PY Deductible Per member/family</b>	\$1,000 / \$3,000	\$2,000 / \$6,000
<b>PY Out-of-Pocket Maximum Per member/family</b>	\$1,500 / \$4,500	Unlimited
<b>Lifetime Plan Maximum Included in and out of network</b>	\$1,000,000 per covered person	
<b><u>PHYSICIAN SERVICES</u></b> Physician Office Visits only Other services provided in the Physician office  Physician charges for radiology, pathology, hospital services or surgery	\$40 Copay 20% Coinsurance – Deductible does not apply  20% Coinsurance after PY Deductible	50% Coinsurance after PY Deductible
<b><u>EMERGENCY CARE SERVICES</u></b> Emergency Room Facility Services Urgent Care Facility Services Land and air ambulance	\$125 Copay, then 20% Coinsurance after Deductible	
<b><u>FACILITY SERVICES</u></b> Inpatient Facility Services  Outpatient/Ambulatory Surgery/Diagnostic Services	20% Coinsurance after Deductible	50% Coinsurance after PY Deductible
<b><u>MATERNITY SERVICES</u></b> Physician Services for Obstetrical Care  Inpatient Facility Charges for Delivery	20% Coinsurance after Deductible	50% Coinsurance after PY Deductible
<b><u>WELLNESS BENEFIT/ PREVENTATIVE CARE</u></b> Covered at 100% with no deductible and no co-pay	Age Appropriate Recommended Testing based on PPACA Guidelines	N/A within this tier
<b><u>KIDNEY DIALYSIS SERVICES</u></b> Dialysis services	20% Coinsurance after Deductible	50% Coinsurance after PY Ded.
<b><u>SKILLED NURSING FACILITY SERVICES</u></b>	20% Coinsurance after Deductible	50% Coinsurance after PY Ded.
<b><u>OSTOMY SUPPLIES</u></b>	20% Coinsurance after Deductible	50% Coinsurance after PY Ded.

<b>HEALTH OPTION II</b>	<b>In Network</b>	<b>Out of Network</b>
<b>SERVICES</b>		
<b><u>DIABETIC SERVICES</u></b> Diabetic Foot Care  Diabetic Education (Diabetic supplies are covered under the pharmacy benefits)	20% Coinsurance after Deductible	50% Coinsurance after PY Deductible
<b><u>HOME HEALTH SERVICES</u></b> Home Health Services –  Hospice – Outpatient	20% Coinsurance after Deductible	50% Coinsurance after PY Deductible
<b><u>PROSTHETIC MEDICAL APPLIANCES</u></b>  Internal and external prosthetic appliances and applicable hardware	20% Coinsurance after Deductible	50% Coinsurance after PY Deductible
<b><u>DURABLE MEDICAL EQUIPMENT</u></b> Rental or purchase of medical equipment	20% Coinsurance after Deductible	50% Coinsurance after PY Deductible
<b><u>REHABILITATION SERVICES</u></b>  Short-term rehabilitative therapy services	20% Coinsurance after Deductible	50% Coinsurance after PY Deductible
<b><u>CARDIAC REHABILITATION SERVICES</u></b> Cardiac Rehabilitation	20% Coinsurance after Deductible	50% Coinsurance after PY Deductible
<b><u>MENTAL HEALTH &amp; CHEMICAL DEPENDENCY SERVICES</u></b>  <ul style="list-style-type: none"> <li>• Outpatient Care</li> <li>• Structured Sub-acute Care/Psychiatric Day Treatment/Partial Hospitalization</li> <li>• Residential Care for Children and Adolescents</li> <li>• Inpatient Care/Crisis Stabilization Unit</li> </ul>	20% Coinsurance after Deductible	50% Coinsurance after PY Deductible
<b><u>PRESCRIPTION BENEFIT</u></b>  Retail Pharmacy, 30 Day Supply Generic Brand name on formulary Brand name non-formulary  Mail Order, 90 Day Supply Generic Brand name on formulary Brand name non-formulary  Specialty Injectable Drugs, 30 Day Supply		\$10 Copay \$20 Copay \$35 Copay  \$25 Copay \$50 Copay \$85 Copay  \$100 Copay

II. City of Gulfport Employee Benefit Plan: Schedule of Benefits

**HEALTH OPTION III**

<b>SERVICES: HEALTH OPTION III</b>	<b>In Network</b>	<b>Out of Network</b>
<b>PY Deductible Per member/family</b>	\$2,000 / \$6,000	\$2,000 / \$6,000
<b>PY Out-of-Pocket Maximum Per member/family</b>	\$2,000 / \$6,000	Unlimited
<b>Lifetime Plan Maximum Included in and out of network</b>	\$1,000,000 per covered person	
<b><u>PHYSICIAN SERVICES</u></b> Physician Office Visits only Other services provided in the Physician office  Physician charges for radiology, pathology, hospital services or surgery	\$40 Copay 20% Coinsurance – Deductible does not apply  20% Coinsurance after PY Deductible	50% Coinsurance after PY Deductible
<b><u>EMERGENCY CARE SERVICES</u></b>  Emergency Room Facility Services Urgent Care Facility Services Land and air ambulance	\$125 Copay, then 20% Coinsurance after Deductible	
<b><u>FACILITY SERVICES</u></b> Inpatient Facility Services  Outpatient/Ambulatory Surgery/Diagnostic Services	20% Coinsurance after Deductible	50% Coinsurance after PY Deductible
<b><u>MATERNITY SERVICES</u></b> Physician Services for Obstetrical Care  Inpatient Facility Charges for Delivery	20% Coinsurance after Deductible	50% Coinsurance after PY Deductible
<b><u>WELLNESS BENEFIT/ PREVENTATIVE CARE</u></b> Covered at 100% with no deductible and no co-pay	Age Appropriate Recommended Testing based on PPACA Guidelines	N/A within this tier
<b><u>KIDNEY DIALYSIS SERVICES</u></b> Dialysis services	20% Coinsurance after Deductible	50% Coinsurance after PY Ded.
<b><u>SKILLED NURSING FACILITY SERVICES</u></b>	20% Coinsurance after Deductible	50% Coinsurance after PY Ded.
<b><u>OSTOMY SUPPLIES</u></b>	20% Coinsurance after Deductible	50% Coinsurance after PY Ded.

<b>HEALTH OPTION III</b>	<b>In Network</b>	<b>Out of Network</b>
<b>SERVICES</b>		
<b><u>DIABETIC SERVICES</u></b> Diabetic Foot Care  Diabetic Education (Diabetic supplies are covered under the pharmacy benefits)	20% Coinsurance after Deductible	50% Coinsurance after PY Deductible
<b><u>HOME HEALTH SERVICES</u></b> Home Health Services –  Hospice – Outpatient	20% Coinsurance after Deductible	50% Coinsurance after PY Deductible
<b><u>PROSTHETIC MEDICAL APPLIANCES</u></b>  Internal and external prosthetic appliances and applicable hardware	20% Coinsurance after Deductible	50% Coinsurance after PY Deductible
<b><u>DURABLE MEDICAL EQUIPMENT</u></b> Rental or purchase of medical equipment	20% Coinsurance after Deductible	50% Coinsurance after PY Deductible
<b><u>REHABILITATION SERVICES</u></b>  Short-term rehabilitative therapy services	20% Coinsurance after Deductible	50% Coinsurance after PY Deductible
<b><u>CARDIAC REHABILITATION SERVICES</u></b> Cardiac Rehabilitation	20% Coinsurance after Deductible	50% Coinsurance after PY Deductible
<b><u>MENTAL HEALTH &amp; CHEMICAL DEPENDENCY SERVICES</u></b>  <ul style="list-style-type: none"> <li>• Outpatient Care</li> <li>• Structured Sub-acute Care/Psychiatric Day Treatment/Partial Hospitalization</li> <li>• Residential Care for Children and Adolescents</li> <li>• Inpatient Care/Crisis Stabilization Unit</li> </ul>	20% Coinsurance after Deductible	50% Coinsurance after PY Deductible
<b><u>PRESCRIPTION BENEFIT</u></b>  Retail Pharmacy, 30 Day Supply Generic Brand name on formulary Brand name non-formulary  Mail Order, 90 Day Supply Generic Brand name on formulary Brand name non-formulary  Specialty Injectable Drugs, 30 Day Supply		<p>\$10 Copay <b>Generic Mandate</b> \$20 Copay \$35 Copay</p> <p>\$25 Copay <b>Generic Mandate</b> \$50 Copay \$85 Copay</p> <p>\$100 Copay</p>

### **III. MEDICAL PLAN LIMITATIONS & EXCLUSIONS**

The limitations and exclusions applying to your benefits are listed in this General Limitations and Exclusions Section.

#### **Limitations**

Coverage is limited to services provided in relation to a covered diagnosis or procedure.

Reconstructive surgery is limited to the reconstruction necessary to repair a dysfunction or disfigurement resulting from injury, tumor, or congenital anomaly.

Charges submitted by a hospital as part of an inpatient confinement are limited to services related to the condition for which the confinement was approved.

Coverage of services that are provided, paid for, or required by state or federal law is limited to those services for which benefits are available through Medicaid.

Benefits for covered prescription and non-prescription drugs, medications, and pharmaceuticals are limited to those covered items purchased and administered in a clinical setting by the provider. Formulas necessary for the treatment of phenylketonuria (PKU) or other heritable diseases are covered to the same extent as drugs available only on orders of a physician.

Coverage for orthotics is limited to those services or products used in the treatment of all medical conditions other than for the treatment of feet.

Transportation or travel by means of any private or commercial carrier is limited to covered ambulance services.

Ambulance Services benefits are limited to services provided in relation to covered emergency care services

Inpatient diagnostic testing is limited to services directly related to the condition for which the hospitalization is authorized.

Coverage for wigs, hairpieces or cranial prosthesis is limited to a calendar year maximum of \$750, following chemotherapy or radiation therapy only.

Skilled Nursing Facility Services benefits are limited to:

- Medical conditions subject to significant clinical improvement
- Maximum of 60 days per calendar year.
- Services provided instead of hospitalization, either in place of an admission or upon discharge from inpatient care
- Services determined medically necessary by the plan based on acuity of services and patient condition.

Family Planning services benefits are limited to include: testing, counseling, genetic counseling, Federal Drug Administration approved contraceptive injections, the fitting or dispensing of an IUD or diaphragm, removal of IUD or Norplant, and office surgery.

Medically necessary maternity education programs include:

- Prepared childbirth, Lamaze, teen pregnancy, cesarean section, and vaginal birth after cesarean
- Parenting, breast-feeding, and stress management during pregnancy

Infertility Services benefits are limited to diagnostic services to determine the cause of infertility.

Coverage of ostomy supplies is limited to: bags, stoma caps, skin cleanser, skin prep, paste, powder, dressings, syringes, sheaths, and gloves.

Medically necessary covered diabetic services include:

- Diabetic Foot Care- Trimming of nails
- Diabetic equipment - Blood glucose monitors, including monitors designed to be used by blind individuals, maximum one per plan year; insulin pumps; associated appurtenances; and insulin infusion devices; podiatric appliances for the prevention of complications associated with diabetes

Medically necessary diabetic education programs include:

- Diabetes care and self-management training

- Dietary counseling for diabetes management

Home Health Care Services benefits are limited to services provided for:

- Chemotherapy
- Radiation therapy
- Treatment of terminal illness
- Treatments determined by the plan to be medically necessary and appropriate to be rendered in a home setting

Physical, occupational, respiratory, audiology or speech therapy received in the home is provided under the rehabilitation services benefit.

Prosthetic Medical Appliances benefits are limited to appliances that serve a physical purpose. Repair or replacement of external prostheses is covered only when required by marked physical changes, growth, or malfunction of the device as determined by the plan.

The purchase of external breast prosthesis and any associated garment is limited to purchase of the initial prosthesis and bra following mastectomy without reconstruction.

Durable Medical Equipment benefits are limited to equipment able to withstand repeated use, that primarily and customarily serves a medical purpose, is not generally useful in the absence of illness or injury, and is appropriate for use in the home.

Replacement of Durable Medical Equipment is covered only when required by marked physical changes or growth.

Breast pumps must be determined to be medically necessary by the plan to be eligible for coverage.

Rehabilitation Services benefits must be medically necessary and appropriate and are limited to services that:

- Prevent dysfunction, restore functional ability, or facilitate maximal adaptation to impairment;
- Are for therapy provided by a physician or by a licensed or certified physical, occupational, respiratory, audiology, or speech therapist, and;
- Are provided according to a specific, written treatment plan that details the treatment, including frequency and duration, and provides for on-going reviews.

Cardiac Rehabilitation Services benefits, determined to be medically necessary, are limited to services provided immediately following a:

- Documented episode of unstable angina
- Coronary Artery Bypass Graft surgery
- Coronary Angioplasty procedure

and are limited to 36 sessions within 12 consecutive weeks.

Mental Health Services benefits for outpatient care services are limited to a combined, maximum benefit of 26 visits per plan year, and may include individual, family or group therapy, medication management, and home health visits.

Mental Health Services Benefits include the following definitions:

- Outpatient Care - Services for evaluation and treatment provided on a per-visit basis.
- Structured Sub-acute Care/Psychiatric Day Treatment/Partial Hospitalization - A program that does not require 24-hour-a-day supervision but requires the intensity of daily treatment.
- Inpatient Care/Crisis Stabilization Unit - Services that require 24-hour-a-day supervision and the intensive medical monitoring of an acute inpatient hospitalization.

Mental Health Services benefits for Inpatient Care/Crisis Stabilization Unit services and Residential Care for Children and Adolescents services are limited to a combined, maximum benefit of 30 days per calendar year. Benefits for Structured Sub-acute Care/Psychiatric Day Treatment/Partial Hospitalization services are limited to a combined, maximum benefit of 60 days per calendar year. For Structured Sub-acute Care/Psychiatric Day Treatment/Partial Hospitalization, each two days of treatment will be considered equal to one day of inpatient treatment in determining the combined, maximum benefit. Mental illness benefits are limited

as follows:

- All services must be provided in relation to a covered diagnosis or procedure.
- Serious Mental Illness will mean the following psychiatric conditions as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM):

Schizophrenia  
Paranoid and other psychotic disorders  
Bipolar disorders (mixed, manic, depressive, and hypomanic)  
Major depressive disorders (single episode or recurrent)  
Schizo-affective disorders (bipolar or depressive)  
Pervasive developmental disorders  
Obsessive-compulsive disorders  
Depression in childhood or adolescence

Treatment for chemical dependency must include a planned, structured, and organized program that promotes a chemical-free status. Alcohol and chemical dependency are limited to \$1,500 per person per plan year for each benefit. The program may include different facilities or modalities and is complete when the member:

- Is discharged on medical advise, or
- Has completed a series of these treatments without a lapse in treatment, or
- Fails to materially comply with the treatment program for a period of 30 days

Limited Dental Services benefits are limited to treatment:

- For the repair of accidental, non-occupational injury to sound, natural teeth
- Started within 30 days of the accident
- Completed within 180 days of the accident
- Maximum benefit of \$500 per calendar year

Coverage for treatment of temporomandibular joint (TMJ) disorder and craniomandibular disorder are limited to medically necessary diagnostic services and surgical treatment. All services are limited to a maximum \$5,000.00 lifetime benefit. Charges related to dental services or malocclusions are not covered.

Vision care provided only in cases of disease or injury to the eye.

Organ Transplant Services benefits are limited to medically necessary and pre-authorization:

- Bone marrow
- Cornea
- Heart
- Liver
- Kidney
- Lung
- Pancreas
- Any combination of these covered transplant

## **Exclusions**

The following services are specifically **excluded** from coverage under this Summary Plan Document.

1. Any service or treatment for which you would not legally be required to pay in the absence of coverage provided by this Summary Plan Document, except for Medicaid.
2. Care for conditions that state or local law requires treatment in a public facility.
3. Care for military service connected disabilities for which the member is legally entitled to services and for which facilities are reasonably available to the member.
4. Services rendered by an immediate relative of the member or by a person who resides in the member's home. An immediate relative is the spouse, child, parent, grandparent, or sibling of the member and includes in-law and stepfamily relationships formed through a current or previous marriage.

5. Any medical, surgical, or health care procedure or treatment held to be experimental or investigational at the time it is performed.
6. Services or products not for the specific treatment of illness or injury, including, but not limited to:
  - personal, convenience, or comfort items
  - personal kits provided on admission to a hospital
  - living accommodations or expenses, guest meals, or cots
  - television
  - telephone
  - finance charges
  - announcements
  - photographs
  - alternative methods of treatment including, such as
    - acupuncture
    - sleep therapy
    - megavitamin therapy
    - nutritionally based alcoholism therapy
    - holistic or homeopathic care, including drugs
    - ecological or environmental medicine
    - hypnotherapy or hypnotic anesthesia
    - transsexual surgery, including medical or psychological counseling or hormonal therapy, in preparation for or subsequent to any such surgery.
7. Routine care and treatment of the exterior surfaces of the feet. Excluded services include, but are not limited to:
  - removal or reduction of corns or calluses
  - splints
  - trimming of nails
  - treatment of flat feet
  - braces
  - corrective orthopedic shoes, orthotics, and arch supports
8. Treatment of obesity or complications of obesity treatment, regardless of associated medical or psychological condition including, but not limited to:
  - intestinal or stomach bypass surgery
  - gastric stapling
  - wiring of the jaw
  - insertion of gastric balloons
9. Services primarily to improve member's appearance, which will not result in significant functional improvement. Exclusions include, but are not limited to:
  - plastic surgery
  - surgical treatment of keloid formation
  - rhinoplasty
  - scar revision
  - abrasion of the skin
  - tattoo removal or camouflage
  - chemical applications or peels
  - electrolysis depilation
  - liposuction procedures
  - hair replacement or transplantation
  - revision or reformation of sagging skin on any part of the body described as

- relating to the eyelids, face, neck, abdomen, arms, legs, or buttocks
  - procedures performed in connection with the enlargement, reduction, implantation, or appearance of a part of the body described as relating to the breast, face, lips, jaw, chin, nose, ears, or genitals
- 10. Aids, appliances, or supplies that possess features not required by the patient's condition, are not primarily medical in nature, are self-help devices, are primarily for the patient's comfort or convenience, are for common household use, are research equipment, or are deemed experimental by the plan, including, but not limited to:
  - Dentures
  - contact lenses
  - motor-driven wheel chairs and beds
  - over-the-counter medications
  - home testing kits or supplies
  - foot orthotics and arch supports
  - diapers or incontinent supplies
  - elastic stockings, garter belts, or corsets
  - elevators
  - bed boards, bathtub lifts, over-bed tables, adjustable beds, telephone arms, sauna or whirlpool baths, chairs
  - exercise equipment or enrollment in health or athletic clubs
  - hypo-allergenic pillows or mattresses, or water beds
  - cervical collars, slings, or traction apparatus
  - air purifiers, air conditioners, or water purifiers
  - stethoscopes, sphygmomanometers, or other blood pressure units
  - Hearing Aids, batteries, and examinations for the fitting of hearing aids.
- 11. Drugs or substances not approved by the FDA, labeled "Caution - Limited by Federal Law to Investigational use," or considered experimental.
- 12. Formulas, dietary supplements, or special diets
- 13. Services primarily for rest, custodial, domiciliary, or convalescent care
- 14. Respite care; recreational or educational therapy
- 15. Reports, evaluations, or physical examinations not required for treatment of health conditions, or not directly related to medical treatment, except as covered under the wellness benefit. Examples include, but are not limited to services (including immunizations) for: compliance with a court order, employment, insurance, camp, adoption, school, travel, or government licenses.
- 16. Private room accommodations; private duty nursing in an inpatient facility
- 17. Any procedure performed for sex determination of the fetus. Examples include, but are not limited to: ultrasound, amniocentesis, or any assisted reproductive technology procedure.
- 18. Reversal of sterilization; subsequent re-sterilization
- 19. Insertion or supply of Norplant or any similar device
- 20. Infertility treatment; infertility medications
- 21. Surrogate parenting
- 22. Any costs associated with the collection, storage, purchase, or processing of sperm for use in any assisted reproductive technology procedure. Any assisted reproductive technology (ART) procedure that enhances a woman's ability to become pregnant. Examples of ART procedures include, but are not limited to: intra-uterine insemination, GIFT procedures, ZIFT procedures, and in-vitro fertilization.
- 23. Homemaker, chore, or similar services
- 24. Routine maintenance of any external device, appliance, equipment, or supply.
- 25. Repairs to Prosthetic Medical Appliances determined to be cosmetic by the plan.
- 26. Routine maintenance of any Durable Medical Equipment
- 27. Work hardening programs

28. Supervised exercise that is not EKG monitored
29. Biofeedback; marriage, career, or financial counseling; behavioral training and/or remedial education
30. Treatment of mental retardation or mental deficiency
31. Evaluation and treatment of learning and developmental disabilities, and minimal brain dysfunction.
32. Psychological testing or psychotherapy for the treatment of attention deficit disorders or related conditions.
33. Repair or replacement of any dental implant, pontic, bridge, or denture; routine orthodontia services
34. Appliances or splints for conditions involving the teeth, jaws, or tongue
35. Routine dental care, including, but not limited to:
  - fillings or other dental repair procedures
  - prescription drugs for dental treatment
  - treatment for diseases of the teeth or gums
  - extraction of teeth, including wisdom teeth
  - treatment for malocclusion or malposition of teeth or jaws (mandibular or maxillary hyper/hypoplasia)
  - Hospital care
  - x-rays
  - replacement of teeth, including fixed or removable prostheses
  - anesthesia or professional services related to or required for the sole purpose of providing dental care
  - inpatient or outpatient surgery required for any dental care
36. Radial keratotomy and other keratoplasties or keratotomies; LASIKS procedures.
37. Artificial Organ Transplants; cross-species whole organ transplants; organ donor transportation or lodging costs provided to any member for the donation of any organ or element of the body to a non-member recipient.
38. Services that are a result of conditions or complications for an excluded benefit.
39. Care and/or treatment of maternity services for a dependent child.
40. Care and/or treatment of a child born to a dependent child in the absence of legal custody of the employee and/or employee's legal spouse.

#### **IV. PRESCRIPTION DRUG BENEFITS**

Prescription Drug Benefits are available to eligible members. Prescription drug co-payments do not count toward any calendar year out-of-pocket maximum. Except for emergency care, benefits are available only if covered drugs are dispensed by a participating pharmacy.

##### **Retail Pharmacy**

The participating pharmacy will furnish up to a thirty (30) day supply of a covered drug for a co-payment of:

- The lesser of \$10.00 or the cost for each new prescription and/or refill for a generic drug listed on the drug formulary; or
- The lesser of \$20.00 or the cost for each new prescription and/or refill for a brand name drug listed on the drug formulary; or
- The lesser of \$35.00 or the cost for each new prescription and/or refill of a brand name drug not listed on the drug formulary.

Covered quantities include up to a thirty (30) day supply for each new covered prescription or refill. You must pay 100% for any amount of a covered prescription exceeding covered quantities, including lost or misplaced medications.

### **Limitations:**

- Up to eight (8) fluid ounces of a liquid medication, except for liquid potassium supplements
- Up to three (3) ounces net weight of ointment, cream, or gel, except vaginal medication which will be limited to one tube
- Up to two (2) standard packages of a nasal or oral inhaler
- One (1) vial containing up to 15 milliliters of any eye or ear medications
- One (1) thirty (30) day supply of oral contraceptives
- Seventy-five percent (75%) of a medication has to have been consumed, based on the dosage instructions of the physician, in order to be refilled.

### **Mail Order (for maintenance medication)**

The benefits for mail order prescription drugs are available for maintenance drugs and medicines that are dispensed according to a mail order prescription. Mail order prescriptions must be dispensed by a participating mail order pharmacy.

The participating mail order pharmacy will furnish up to a ninety (90) day supply of a covered drug for a co-payment of:

- The lesser of \$25.00 or the cost for each new prescription and/or refill for a generic drug listed on the drug formulary; or
- The lesser of \$50.00 or the cost for each new prescription and/or refill for a brand name drug listed on the drug formulary; or
- The lesser of \$85.00 or the cost for each new prescription and/or refill of brand name drug not listed on the drug formulary.

### **Prescription Drug Exclusions**

There is no benefit under your prescription drug plan for the following, however, there may be coverage for these services under your medical plan:

- Contraceptive devices
- Devices of any type, including but not limited to, artificial appliances, therapeutic or prosthetic devices, supports, or other non-medical products
- Medical supplies except those specifically listed as covered items
- Immunization agents, allergy and biological sera
- Prescription drugs intended for parenteral use, other than self-administered injectible medication, if pre-approved by SAS
- Prescription drugs produced from blood, blood plasma, and blood products, derivatives, Haemophile M, Factor VIII, and synthetic blood products
- Experimental or investigational drugs
- Fertility medications
- Appetite suppressants
- Drugs that by Federal and/or state law do not require a prescription (except for PKU and other heritable disease supplements) and over-the-counter (OTC) medications or their equivalents, even if written on a prescription
- Drugs consumed in an inpatient or other institutional setting
- Vitamins, nutritional, or dietary supplements, except when required by a prescription
- Drugs intended for use in a participating physician's office or clinical setting
- Prescription drugs for cosmetic conditions not covered, including but not limited to, Retin-A (for patients over the age of 25) and Minoxidil
- Smoking cessation patches, gum and other such aids
- Medications not used for an FDA-approved indication
- Anabolic steroids

- Drug infusion/metering devices
- Growth hormones
- Replacement of a previous prescription that was lost, spilled, stolen, or otherwise misplaced

## **Section 1 - GENERAL DEFINITIONS**

**ACUTE:** A condition with sudden or severe symptoms which makes it necessary to seek medical advice.

**ADMINISTRATOR:** The person or entity designated to act as plan administrator in governing plan documents.

**ADVERSE BENEFIT DETERMINATION:** A denial, reduction, or termination of, or failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a member's eligibility to participate in the plan.

**ALCOHOLISM:** The chronic and habitual use of alcoholic beverages by any person to the extent that such person has lost the power of self-control with respect to the use of such beverages.

**AMBULATORY SURGICAL CENTER:** An appropriately licensed institution or facility, either free-standing or as part of a hospital, with permanent facilities equipped and operated for the primary purpose of performing surgical procedures and to which a patient is admitted to and discharged from within a twenty-four (24) hour period.

**APPLICATION:** The form provided by the plan administrator that each eligible person is required to complete and submit to the administrator to enroll for coverage.

**BILLED CHARGE:** The amount a provider or pharmacy would charge the general public for services or prescription drugs.

**BRAND NAME DRUG:** A prescription that may or may not have a generic equivalent.

**CALENDAR YEAR:** January 1, 12:00 a. m. to December 31, 11:59 p. m.

**CHEMICAL DEPENDENCY:** The abuse of, or the psychological or physical dependence on, or addiction to a controlled substance.

**CHEMICAL DEPENDENT TREATMENT CENTER:** A facility that provides a program for the treatment of a chemical dependency according to a written treatment plan approved and monitored by a physician. The facility is also:

1. Affiliated with a hospital under contract with an established system for patient referral;
2. accredited as such a facility by the Joint Commission on Accreditation of Health Care Organizations as a chemical dependency treatment center; and
3. licensed as a chemical dependency treatment program.

**CHEMICAL DEPENDENCY TREATMENT CENTER SERIES:** Is a planned, structured and organized program to promote chemical free status. The series may include different facilities or modalities and is complete:

1. when the member is discharged on medical advice from inpatient detoxification, inpatient rehabilitation/treatment, partial hospitalization or intensive outpatient;
2. when the member completes a series of these levels of treatments without a lapse in treatment; or
3. when the member fails to materially comply with the treatment program for thirty (30) days

**CLAIM:** Written proof of loss due to injury or illness or any condition showing that services and/or supplies have been supplied to the eligible person under the plan.

**CONGENITAL ANOMALY:** A defective development or formation of a part of the body that is learned to have been present at birth.

**CONTRACT YEAR:** The twelve (12) month period beginning on the group effective date of this contract and each twelve (12) month period thereafter, unless otherwise terminated as hereinafter provided.

**CO-PAYMENT:** The payment to the attending participating provider or physician required from the member. The specific co-payment amounts that apply to the various covered services for the plan type selected are listed in the Summary Plan Document.

**COSMETIC SURGERY:** Surgery that is primarily for the purpose of improving appearance and does not, other than incidentally, correct or improve a functional impairment.

**COURSE OF TREATMENT:** That period of time represented by an inpatient hospital admission and related discharge during which time treatment has been received by a member or that period of time authorized by a participating provider and/or the administrator as necessary to complete a cycle of treatment and subsequently provide a medical release to the member.

**COVERED SERVICES:** Those medically necessary services that are listed in the Summary Plan Document when provided or authorized by the member's physician or the administrator, or in the case of mental health services, Mental Health Management Services.

**CRISIS STABILIZATION UNIT:** A 24-hour, licensed residential program that is usually short-term in nature. It provides intensive supervision and highly structured activities to persons who are experiencing a moderate to severe psychiatric crisis.

**CUSTODIAL CARE:** Services and supplies furnished to the member to train or help in activities of daily living, such as bathing, feeding, dressing, walking, and taking oral medicine. Custodial care also means services and supplies, such as dressing changes and catheter care, which can safely and adequately be supplied by persons other than licensed health care professionals. Custodial care also means care that ambulatory patients customarily provide for themselves, such as ostomy care, measuring and recording urine and blood sugar levels, and administering insulin. The administrator will decide if a service or treatment is custodial care.

**DENTIST:** A person licensed to practice dentistry by the state in which s/he provides services.

**DEPENDENT:** A member of your family who meets the eligibility requirement of Section 2 of this Summary Plan Document, who is listed by you on the enrollment application, and for whom the required premium has been paid.

**DOMICILIARY CARE:** The care provided for persons not able to live independently because they are disabled or infirm. Refer to the definition of custodial care defined above.

**DRUG FORMULARY:** A pre-approved listing of drugs that are safe, efficient, and cost effective.

**DURABLE MEDICAL EQUIPMENT:** Equipment that is:

1. Medically necessary;
2. Made for and mainly used in the treatment of an injury or illness;
3. Not primarily and customarily used for a non-medical purpose;
4. Made to withstand prolonged use and suited for use in the home; and
5. Not for altering air quality or temperature or for exercise or training (including but not limited to, air conditioners, humidifiers, dehumidifiers, purifiers, exercise bicycles, whirlpool baths, sun lamps, heat lamps or heating pads).

**EDUCATIONAL:** The primary purpose of the service or supply is to provide the member with any of the following:

1. training in activities of daily living;
2. Instructions in scholastic skills such as reading and writing;
3. preparation for an occupation; or
4. treatment for learning disabilities.

Training in activities of daily living does not include training directly related to treatment of an illness or injury that resulted in a loss of a previously demonstrated ability to perform those activities.

**EFFECTIVE DATE:** The date coverage begins for eligible persons and dependents.

**ELIGIBLE PERSON:** An individual as defined in Section 2 of this Summary Plan Document.

**EMERGENCY CARE:** Bona fide emergency services provided after the sudden onset of a severe medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in:

1. placing the patient's health in serious jeopardy;
2. serious impairment to bodily function; or
3. serious dysfunction of any bodily organ or part.

**EMPLOYER:** Same as "Group"

**EXCLUSIONS:** The specific conditions or services that the plan does not cover.

**EXPERIMENTAL OR INVESTIGATIVE:** Means that the administrator determines that one or more of the following is true:

1. The service or supply is under study or in a clinical trial to evaluate its toxicity, safety, or efficacy for a particular diagnosis or set of indications. Clinical trials include, but are not limited to, phase

- I, II, and III clinical trials.
2. The prevailing opinion within the appropriate specialty of the United States medical profession is that the service or supply needs further evaluation for the particular diagnosis or set of indications before it is used outside clinical trials or other research settings.  
The administrator will determine if this item (2) is true based on:
    - a. Published reports in authoritative medical literature; and
    - b. Regulations, reports, publications and evaluations issued by government agencies such as the Agency for Health Care and Research, the National Institutes of Health, and the FDA.
  3. In the case of a drug, a device or other supply that is subject to FDA approval:
    - a. It does not have FDA approval; or
    - b. It has FDA approval only under its Treatment Investigation New Drug regulation or a similar regulation;
    - c. It has FDA approval, but it is being used for an indication or at a dosage that is not accepted off-label use. Unlabeled uses of FDA-approved drugs are not considered experimental or investigational if they are determined to be:
      - (1) included in one or more of the following medical compendia: the American Medical Association Drug Evaluations, the American Hospital Formulary Service Drug Information, and the United States Pharmacopoeia Drug Information and other authoritative compendia as identified from time to time by the Secretary of Health and Human Services, or
      - (2) can be established based on supportive clinical evidence in peer-reviewed medical publications.
  4. The provider's institutional review board acknowledges that the use of the service or supply is experimental or investigational and subject to that board's approval.
  5. Research protocols indicate that the service or supply is experimental or investigational. This item 4 applies for protocols used by the member's provider as well as for protocols used by other providers studying substantially the same service or supply.

**FACILITY:** A health care or residential treatment center licensed by the state in which it operates to provide medical inpatient, residential, day treatment, partial hospitalization or outpatient care. Facility also means a treatment center for the diagnosis and/or treatment of chemical dependency or mental illness.

**FAMILY:** means employee and the employee's dependents who are covered under the plan.

**FDA:** The Food and Drug Administration, an agency of the United States government.

**GENERIC DRUG:** A pharmaceutical and therapeutic equivalent to a brand name drug.

**GROUP:** City of Gulfport

**EFFECTIVE DATE:** The date when coverage begins.

**HEALTH CARE PLAN:** Any plan whereby the group undertakes to provide, arrange for, pay for, or reimburse any part of the cost of any health care services; provided, however, a part of such plan consists of arranging for or the provision of health care services, as distinguished from indemnification against the cost of such service, on a prepaid basis through insurance or otherwise.

**HEALTH CARE SERVICES:** Any services, including the furnishing to any individual of pharmaceutical services, medical, chiropractic, mental health, or dental care, or hospitalization or incident to the furnishing of such services, care, or hospitalization, as well as the furnishing to any person of any and all other services for the purpose of preventing, alleviating, curing or healing human illness or injury or a single health care service plan.

**HEALTH STATUS RELATED FACTORS:** Means health status; medical condition, including both physical and mental illness; claims experience; receipt of health care; medical history; genetic information; evidence of insurability, including conditions arising out acts of family violence; and disability.

**HERITABLE DISEASE:** An inherited disease that could result in mental or physical handicap or death.

**HOME HEALTH AGENCY:** An agency or organization that is duly licensed in the state which it provides services to provide skilled nursing services and other therapeutic services in the home.

**HOSPICE:** An institution or facility that provides a coordinated plan of inpatient and outpatient home care for a terminally ill patient and his family. It operates as a unit or program that only admits terminally

ill patients, and is separate from any other facility. However, it may be affiliated with a hospital or Home Health Care Agency. A terminally ill patient is one who does not have a reasonable prospect for cure and who has a life expectancy of six months or less. The attending physician must certify that the member is a terminally ill patient.

**HOSPITAL:** A licensed public or private institution, licensed as a hospital, by the state in which it provides services.

**HOSPITAL CONFINEMENT:** Registered and confined as a resident bed patient in a hospital on the recommendation of a physician.

**ILLNESS:** A sickness, disease, bodily disorder or infirmity that are first manifested after the effective date of coverage and while the coverage is in force.

**INITIAL ENROLLMENT PERIOD:** A period of time established by the group and the administrator during which eligible persons and/or their eligible dependents first become eligible to enroll as members and it starts on the date of the member's first initial date of enrollment eligibility. The initial enrollment period must be at least 31 days and shall consist of an entire calendar month, beginning on the first day of the month and ending on the last day of the month. If the month is February, the period shall last through March 2nd.

**INJURY:** Injury means accidental bodily injury sustained by a covered member that is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while coverage is in force.

**INPATIENT SERVICES:** means therapeutic services which are available twenty-four (24) hours a day in a hospital or other treatment facility licensed by the state in which it provides services.

**KIDNEY DIALYSIS CENTER:** Any facility licensed by the state in which it provides services, approved by Medicare, and contracted with the administrator to provide outpatient services and/or instruction to members in home kidney dialysis treatments.

**LATE ENROLLEE:** Means any employee or dependent eligible for enrollment who requests enrollment in the health benefit plan after the expiration of the initial enrollment period established under the terms of the first plan for which that employee or dependent was eligible through the employer after the expiration of an open enrollment period.

An employee or dependent is not a Late Enrollee if:

1. the individual:
  - was covered under another health benefit plan or self-funded employer health benefit plan at the time the individual was eligible to enroll;
  - declines in writing, at the time of the initial eligibility, stating that coverage under another health benefit plan or self-funded employer health benefit plan was the reason for declining enrollment;
  - has lost coverage under another health benefit plan or self-funded employer health benefit plan as a result of the termination of employment; the reduction of the number of hours of employment, the termination of the other plans coverage; the termination of contributions toward the premium made by the employer; or the death of a spouse, or divorce; and
  - requests enrollment not later than the 31st day after the date on which coverage under the other health benefit plan or self-funded employer health benefit plan terminates; a court has ordered coverage to be provided for a spouse under a covered employee's plan and request for enrollment is made not later than the 31st day after the date on which the court order is issued;
2. the individual is employed by an employer who offers multiple health benefit plans and the individual elects a different health benefit plan during an open enrollment period; or
3. a court has ordered coverage to be provided for a child under a covered employee's plan and the request for enrollment is made not later than the 31st day after the date on which the employer receives the court order.

**LIFE-THREATENING:** A disease or condition for which the likelihood of death is probable unless the course of the disease or condition is interrupted.

**MATERNITY:** Ante/postpartum care, childbirth, including complications associated with pregnancy.

**MEDICAL DIRECTOR:** The physician, licensed in Mississippi, designated by the administrator and/or

such other physicians as the medical director. This physician is responsible for supervising the delivery of medical services to members and for monitoring the quality of medical care rendered to members.

**MEDICALLY NECESSARY:** Means the covered services prescribed to diagnose or treat an injury or illness that are known to be safe and effective in accordance with the accepted standards of medical practice in the medical community in the area where services are rendered. Such services must be:

1. not provided primarily for the convenience of the member, the member's physician, or the facility providing the service;
2. consistent with professionally recognized standards of care with respect to quality, frequency and duration;
3. not primarily educational, experimental or investigative; and
4. consistent with the member's symptoms, diagnosis or treatment.

**MEDICARE:** Parts A and B of Title XVIII of the Social Security Act and any amendments or regulations to that act.

**MEMBER:** Any person covered under this contract.

**MENTAL ILLNESS:** means any psychiatric disease identified in the current edition of The International Classification of Diseases or The American Psychiatric Association Diagnostic and Statistical Manual.

**NON-FORMULARY DRUG:** A prescription drug not listed on the plan's formulary.

**OPEN ENROLLMENT PERIOD:** A period of time, provided annually, after the initial enrollment period, during which eligible persons and/or their eligible dependents may enroll in the plan. The annual open enrollment period must be at least 31 days and shall consist of an entire calendar month, beginning on the first day of the month and ending on the last day of the month. If the month is February, the period shall last through March 2nd.

**ORGAN TRANSPLANT:** The harvesting of solid and/or non-solid organs, glands or tissues (including bone marrow, bone marrow stem cells, pancreas, and cornea) from one individual and reintroducing that organ, tissue, or gland into that same or another individual.

**OUT-OF-POCKET MAXIMUM:** The out-of-pocket maximum is the total amount the member must pay each calendar year before the plan pays covered benefits at 100% of eligible charges. All out-of-pocket maximum amounts are listed in the Summary Plan Document. Out-of-pocket maximums do not include co-payment amounts, charges for services not covered by this Summary Plan Document, or amounts over UCR.

**OUTPATIENT TREATMENT FACILITY:** means (1) a clinic or other similar location which is certified by the state in which it provides services as a qualified provider of outpatient services for the treatment of mental illness, or (2) the office of a health service provider.

**OUTPATIENT SERVICES:** means therapeutic services which are provided to a patient according to an individualized treatment plan which does not require the patient's full-time confinement to a hospital or other treatment facility licensed by the state in which it provides services. The term outpatient service refers to services that may be provided in a hospital, an outpatient treatment facility, or other appropriate setting.

**PARTIAL HOSPITALIZATION:** means inpatient treatment, other than full twenty-four (24) hour programs in a treatment facility licensed by the state in which it provides services; the term includes day, night and weekend treatment programs.

**PARTICIPATING PHYSICIAN:** Any licensed physician who, at the time of providing covered services, has contracted with the plan to provide to members the services as described in this Summary Plan Document.

**PARTICIPATING PROVIDER:** Duly licensed physicians, osteopaths, hospitals, skilled nursing facilities, home health agencies, alcohol and drug abuse facilities, and any other licensed health professionals, facilities, or providers who, at the time of providing for covered health services, have contracted with the plan to provide to members the services as described in this Summary Plan Document.

**PHYSICIAN:** An individual licensed to practice medicine in the state which s/he provides services.

**PLAN SPONSOR:** The employer that maintains the plan.

**PLAN SUPERVISOR:** Means Select Administrative Services. The plan supervisor provides services to the administrator under an administrative services agreement. The plan supervisor is not the

administrator or the plan sponsor.

**PRESCRIPTION:** The authorization for a prescription drug issued by a provider who is licensed to prescribe in the ordinary course of his/her professional practice. Out-of-network physicians can authorize prescriptions.

**PRESCRIPTION DRUG:** (1) is medically necessary for your condition; (2) legally requires a prescription; and (3) is obtained from a participating pharmacy.

**PRIMARY CARE PHYSICIAN (PCP):** Primary Care Physician (PCP) specialties include: Family Practice, Internal Medicine, General Practice, and Pediatrics.

**PROVIDER:** A licensed physician, osteopath, hospital, facility, physician's assistant, nurse practitioner, podiatrist, chiropractor, optometrist, dentist, audiologist, speech and language pathologist, master social worker, dietician, professional counselor, psychologist, chemical dependency counselor, and psychological associate. Provider also means other licensed medical practitioners or who are furnishing or providing any covered health services under a license, certificate, or other legal authorization issued or granted under the laws of the state in which they provide services.

**PSYCHIATRIC DAY TREATMENT FACILITY:** see Partial Hospitalization.

**RESIDENTIAL TREATMENT CENTER FOR CHILDREN AND ADOLESCENTS:** A child-care institution that provides residential care and treatment for emotionally disturbed children and adolescents. The treatment center is licensed by the state in which it provides services. It is accredited as a Residential Treatment Center by the Council on Accreditation, the Joint Commission on Accreditation of Health Care Organizations, or the American Association of Psychiatric Services for Children.

**SCHEDULE OF BENEFITS:** The schedule made a part of this Summary Plan Document that sets forth the benefits and services that are available to members.

**SEMI-PRIVATE:** The charge made by a hospital for a room containing two (2) or more beds.

**SHORT TERM:** A course of treatment lasting sixty (60) days or less.

**SICKNESS:** Physical illness or disease, which does not include mental illness.

**SKILLED NURSING FACILITY or EXTENDED CARE FACILITY:** An institution or facility which:

1. is accredited under one program of the Joint Commission on Accreditation of Health Care Organizations as a Skilled Nursing Facility or is recognized by Medicare as an Extended Care Facility;
2. furnishes room and board and 24 hour a day skilled nursing care by, or under the supervision of a registered nurse (RN); and
3. is not a clinic, a rest facility, a home for the aged, a place for drug addicts, or alcoholics, or a place for custodial care.

**SOUND NATURAL TEETH:** Sound natural teeth are teeth that are free of active or chronic clinical decay, have at least 50% bony support, are functional in the arch, and have not been excessively weakened by multiple dental procedures.

**SPECIALIST PHYSICIAN:** Any physician, other than a Primary Care Physician (PCP) who has contracted with the plan to provide specialist care to members. Specialist services can be obtained without referral from a PCP.

**SUBSCRIBER:** An eligible person who has satisfied the eligibility and participation requirements specified in this Summary Plan Document.

**SUMMARY PLAN DOCUMENT:** This document.

**TREATMENT PLAN:** A treatment plan with specific attainable goals and objectives appropriate to the patient and the program.

**USUAL, CUSTOMARY, AND REASONABLE CHARGES:** The Usual, Customary and Reasonable Charge made by an out-of-network provider who renders or furnishes covered services, treatments or supplies; provided the charge is not in excess of the general level of charges made by others who render or furnish the same or similar services, treatments or supplies to persons:

1. who reside in the same geographical area; and
2. whose illness or injury is comparable in nature and severity.

**UTILIZATION REVIEW AGENT:** Means an entity that is certified to perform Utilization Review Program functions by the state in which they provide services.

**UTILIZATION REVIEW PROGRAM:** Means the screening criteria and utilization review

procedures of the plan or its designated utilization review agent.

**YOU AND YOUR:** The eligible employee and/or his/her eligible dependents.

**WAITING PERIOD:** A period of time established by the employer that must pass before an individual who is a potential member in a health benefit plan is eligible to be covered for benefits.

**WE, US or OUR:** City of Gulfport or the Administrator.

## **Section 2 - ELIGIBILITY, EFFECTIVE DATE AND ENROLLMENT**

**2.1 ELIGIBLE PERSONS.** All Full-Time Employees of the Employer and falls under one of the following Classes:

Class A –Includes individuals attaining the positions of Mayor, Councilmember, or Director and completing the employment waiting period. The waiting period under the Plan for Class A Employees is completed on the date of Full-Time Employment.

Class B – Includes all other full-time employees not specifically stated as Class A who completes the employment waiting period. A “waiting period” is that time between the first day of employment and the first day of coverage under the Plan. The waiting period under the Plan is completed on the first day of the month coinciding with three consecutive months of Full-Time employment.

**2.2 ELIGIBLE DEPENDENTS.** To be eligible to enroll as a dependent, the dependent must be the subscriber’s:

1. legal spouse and/or;
2. unmarried child:
  - a. a child who is under 19 years of age;
  - b. a child who is a full-time student under 25 years of age and primarily dependent on the subscriber for financial support. While the student is enrolled in a school outside the service area, he/she may be eligible for in-network benefits. Coverage shall be provided for an entire academic term during which the child begins as a full-time student and remains enrolled, regardless of whether the number of hours of instruction for which the child is enrolled is reduced to a level that changes the child’s academic status to less than that of a full-time student. Coverage shall be continuous until the 10th day of instruction of the subsequent academic term on which date we may terminate coverage of the child if the child does not return to full-time status before that date;
  - c. a child who is medically certified as disabled and dependent upon the parent. Coverage will not terminate for a child who reaches the limiting age of 25, subject to Paragraph 2.1(2)b above, if the child is: (1) incapable of self-sustaining employment by reason of mental retardation or physical handicap, and (2) chiefly dependent upon the employee, insured party, or member for support and maintenance. The parent may be required to furnish proof of such incapacity and dependency within thirty-one (31) days before the child’s attainment of the limiting age and subsequently, as required, but not more frequently than annually after the two-year period following the child’s attainment of the limiting age;
  - d. Any other child included as an eligible dependent under an employer’s benefit plan.
3. Children designated by a court of a competent jurisdiction under the terms of a Qualified Medical Child Support Order (QMCSO). Such coverage will be automatic upon receipt of a copy of the QMCSO and the required premium.
4. Court Ordered Coverage for a Spouse: If a court has ordered the subscriber to provide coverage for a spouse, coverage will be automatic for the first thirty-one (31) days following the date on which the court order is issued. To continue coverage beyond thirty-one (31) days, the subscriber must notify the employer in writing and pay the required premium within that thirty-one (31) day period. The employer must then notify the plan in writing within forty (40) days of the date the court ordered the subscriber to provide coverage for the spouse or minor child and pay the appropriate premium. If the subscriber notifies the employer after the thirty-one (31) day period,

the dependent's coverage will become effective according to the provisions for late enrollees.

**2.3 ADOPTED CHILDREN.** If a subscriber adopts a child while covered under this plan, the child is covered from the time the subscriber is a party in or to a legal action to adopt the child or 31 days after the date adoption is final. Coverage of an adopted child terminates unless notification of the adoption and any required premiums are received not later than thirty-one (31) days of the date the insured becomes party in a suit in which adoption of the child is sought; or the 31st day after the date of the adoption.

**2.4 GRANDCHILDREN.** Any children of the subscriber's or the spouse's children are eligible for coverage if the children are the subscriber's court order dependents.

**2.5 NEWBORN CHILDREN.** Any newborn children of a covered subscriber are eligible for coverage as any other dependent. Congenital anomalies are covered as any other illness or injury. The newborn coverage will be initiated following the completion of an enrollment form. The employer must then notify the plan in writing within thirty-one (31) days of the date of birth and pay the appropriate premium to the plan.

## **2.6 EFFECTIVE DATE FOR ELIGIBLE PERSONS AND THEIR DEPENDENTS .**

**2.6.1 INITIAL ENROLLMENT PERIOD.** An eligible person and the eligible person's eligible dependents are entitled to coverage if the employee applies during the initial enrollment period that is the period of time established by the group and the administrator. Initial enrollment begins when the eligible person and/or his eligible dependents first become eligible to enroll and ends 31 days from the date of eligibility. The eligible person must submit a properly completed application to the group and list themselves and their eligible dependents on the enrollment application.

**2.6.2 ANNUAL OPEN ENROLLMENT PERIOD.** An annual open enrollment period is a period of time established by the group and the administrator during which the eligible person may apply for coverage under the plan, after the initial enrollment period, for themselves and their eligible dependents. The eligible person must submit a properly completed application to the group and list themselves and their eligible dependents on the enrollment application. If the employee satisfies the eligibility requirements and the applicable premiums are paid, the eligible person and eligible dependents are covered on the first day the eligible person became eligible for coverage. The annual open enrollment period is October 1 – October 31.

**2.6.3 SPECIAL ENROLLMENT.** Other than the initial and annual open enrollment periods, an eligible person may apply for enrollment during a special enrollment period based on the following:

1. Coverage was waived by an eligible person during the initial or annual open enrollment period because he or she was covered under another group health plan at the time. The eligible person must request enrollment within thirty-one (31) days of losing the other coverage. Documentation must be provided with the enrollment form substantiating the loss of coverage.
2. An eligible person has a change in family composition due to marriage, birth of a child, adoption of a child, or because an eligible person becomes party in a suit for the adoption of a child. The eligible person must request enrollment within thirty-one (31) days of the event.
3. An individual becomes a dependent due to marriage, birth of a child, adoption of a child or because an eligible person becomes party in a suit for the adoption of a child. The eligible person must request enrollment within thirty-one (31) days of the event.

**2.6.4 LATE ENROLLMENT.** Other than the initial and annual open enrollment periods, a late enrollee may apply for coverage for themselves and/or their eligible dependents more than

thirty-one (31) days after they become eligible. The employee must submit a properly completed application to the group. We may exclude from coverage a late enrollee until the next annual open enrollment period. The administrator will approve the employee's application for coverage if the eligible person satisfies the eligibility requirements and the applicable premium is paid.

**2.7 CONTRIBUTION.** You must pay part of the premium of the insurance unless the group has agreed to pay the full premium.

**2.8 NOTIFICATION OF INELIGIBILITY.** A condition of participation in the plan is the subscriber's responsibility to notify the administrator in writing of any changes in status that affect the subscriber or the ability of the subscriber's dependents to meet the eligibility criteria as set forth in this Section.

### **Section 3 - CONTINUATION OF COVERAGE UNDER COBRA**

On April 7, 1986, Public Law 99272, Title X was enacted requiring that most employers sponsoring group health plans offer employees and their eligible dependents the opportunity for a temporary extension of health care coverage, called "continuation coverage" at group rates in certain instances where coverage under the plan would otherwise end. This summary is intended to inform you of your rights and obligations under the continuation coverage provisions of the law. (Both you and your spouse should take the time to read this notice carefully.) If you are an employee of your employer covered by your employer group health plan, you have a right to choose this continuation coverage if you lose your group health coverage because of a reduction in your hours of employment or the termination of your employment, for reasons other than gross misconduct on your part.

If you are the *spouse* of an employee covered by your employer group health plan, you have the right to choose continuation coverage for yourself if you lose group health coverage under your employer group health plan for any of the following reasons:

- (1) The death of your spouse;
- (2) Termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment with your employer;
- (3) Divorce or legal separation from your spouse; or
- (4) Your spouse becomes entitled to Medicare.

In the case of a dependent child of an employee covered by your employer group health plan, he or she has the right to continuation coverage if group health coverage under your employer group health plan is lost for any of the following reasons:

- (1) The death of the employee;
- (2) Termination of the employee's employment (for reasons other than gross misconduct) or reduction in the employee's hours of employment with your employer;
- (3) The employee's divorce or legal separation;
- (4) The employee becomes entitled to Medicare; or
- (5) The dependent child ceases to be a "dependent child" under your employer group health plan.

Under the law, the employee or an eligible dependent has the responsibility to inform the Plan Administrator of a divorce, legal separation, or a child losing dependent status under your employer group health plan within sixty (60) days of the date of the event or the date in which coverage would end under the Plan because of the event, whichever is later. Your employer has the responsibility to notify the Plan Administrator of the employee's death, termination, or reduction in hours of employment or Medicare

entitlement.

Similar rights may apply to certain retirees, spouses, and dependent children if your employer commences a bankruptcy proceeding and these individuals lose coverage.

When the Plan Administrator is notified that one of these events has occurred, the Plan Administrator will, in turn, notify you that you have the right to choose continuation coverage. Under the law, you have at least sixty (60) days from the date you would lose coverage as a result of one of the events described above to inform the Plan Administrator that you want continuation coverage.

If you do not choose continuation coverage within sixty (60) days of the qualifying event date, your group health insurance coverage will end. Not choosing continuation coverage will cause a break in your continued coverage, and any such break of more than sixty-three (63) days could cause loss of coverage portability.

If you choose continuation coverage, your employer is required to give you coverage, which, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated employees or eligible dependents. The law requires that you be afforded the opportunity to maintain continuation coverage for 36 months unless you lost group health coverage because of a termination of employment or reduction in hours, whereas, the required continuation coverage period is 18 months. These 18 months may be extended for affected individuals to 36 months from termination of employment if other events, such as a death, divorce, legal separation, or Medicare entitlement, occur during that 18 month period. Also, if you or your spouse gives birth to or adopts a child while on continuation coverage, you will be allowed to change your coverage status to include the child.

Under no circumstances will continuation coverage last beyond 36 months from the date of the original event that caused a qualified beneficiary to be eligible to elect coverage. The 18 months may be extended to 29 months if an individual is determined by the Social Security Administration to be disabled, for Social Security disability purposes, as of the termination or reduction in hours of employment, or within sixty (60) days thereafter. To benefit from this extension, a qualified beneficiary must notify the Plan Administrator of that determination within sixty (60) days and before the end of the original 18 month period. The affected individual must also notify the Plan Administrator within thirty (30) days of any final determination that the individual is no longer disabled.

Individuals entitled to COBRA continuation coverage are called qualified beneficiaries. Individuals who may be qualified beneficiaries are the spouse, dependent children of a covered employee, and in certain circumstances, the covered employee. Under current law, in order to be a qualified beneficiary, an individual must generally be covered under a group health plan on the day before the event that caused a loss of coverage, such as termination of employment, or a divorce from, or death of, the covered employee. HIPAA expands this requirement so that a child born to the covered employee, or who is placed for adoption with the covered employee, during the period of COBRA continuation coverage, is also a qualified beneficiary.

The law also provides that continuation coverage may be cut short for any of the following reasons:

- (1) Your employer no longer provides group health coverage to any of its employees;
- (2) The premium for continuation coverage is not paid on time;
- (3) The qualified beneficiary becomes covered under another group health plan after electing to participate in a continuation coverage plan;
- (4) The qualified beneficiary becomes entitled to Medicare after electing to participate in a continuation of coverage plan;
- (5) The qualified beneficiary extends coverage for up to 29 months due to disability and there has been a final determination that the individual is no longer disabled.

Under the COBRA rules, there are situations in which a group health plan may stop making COBRA continuation coverage available earlier than usually permitted. One situation is when the qualified beneficiary obtains coverage under a plan that limits or excludes coverage for any preexisting condition of the qualified beneficiary. The plan providing the COBRA continuation coverage cannot stop making the COBRA continuation coverage available merely because of the coverage under the other group health plan. HIPAA limits the circumstances under which plans can apply exclusions for preexisting conditions. HIPAA makes a coordination change to the COBRA rules, so that if a group health plan limits or excludes benefits for preexisting conditions, those limits or exclusions would not apply to, or would be satisfied by, an individual receiving COBRA continuation coverage. HIPAA rules limiting the applicability of exclusions for preexisting condition became effective in plan years beginning on or after July 1, 1997.

You are not required to show that you are insurable to choose continuation coverage. However, continuation coverage under COBRA is provided subject to your eligibility for coverage. The group health Plan Administrator reserves the right to terminate your COBRA coverage retroactively if you are determined to be ineligible.

The law does not require your employer to pay any of the premiums for your continuation coverage, therefore you are required to pay the full premium. There is a 30 day grace period for payment of the regularly scheduled premium.

**3.8 MILITARY SERVICE.** These provisions summarize continuation of coverage under this Plan for employees absent from work due to military service. The Plan intends to provide benefits as mandated by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), and any amendments thereof.

As an employee you have a right to choose this continuation of coverage if you are absent from work due to service in one of the uniformed services of the United States. "Service" means: active duty, active duty for training, initial active duty for training, inactive duty training, full time National Guard duty and absence from work to determine the employee's fitness for any of the designated types of duty.

Employees who are dishonorably discharged from the military are not eligible.

Under the law, the employee must give the employer written or verbal advance notice of the military leave, if it is practical to do so. A designated, authorized officer of the branch of the military in which the employee will be serving may also provide such notice directly to the employer.

If you choose continuation of coverage, the employer is required to offer you coverage identical to that provided under the Plan prior to your military leave. Like COBRA coverage, such coverage may be continued for up to eighteen months during a period of military service. The cumulative length of the employee's absences cannot exceed five years.

If you feel you might have continuation rights under USERRA, please contact your Plan Administrator as soon as possible.

**3.9 CONTINUATION DURING FAMILY AND MEDICAL LEAVE.** The Family and Medical Leave Act of 1993 (FMLA) requires employers to provide up to 12 weeks of unpaid, job-protected leave during any 12 month period to eligible employees for certain family and medical reasons. These Plan provisions are intended to comply with the law and any pertinent regulations, and interpretation is governed by them. Please see the Plan Administrator for details of the FMLA policy adopted by the employer when you need to take FMLA leave.

## **Section 4 - CLAIM PROCEDURES**

The plan supervisor is responsible for evaluating all benefit claims under the plan. Reasonable claim procedures will be used in determining your claim. The plan supervisor has the right to secure independent medical advice and to require such other evidence as it deems necessary in order to decide your claim.

If the plan supervisor denies your claim, in whole or in part, you will receive a written notice setting forth the reason(s) for denial. If your claim is denied, you may appeal the decision and request a review of the denied claim. Your appeal will be reviewed in accordance with reasonable claims procedures. If you don't appeal on time, you will lose your right to file suit in a state or federal court, as you will not have exhausted your internal administrative appeal rights.

The Claim Procedures referenced above are furnished as a separate document that accompanies this Summary Plan Document. The claim procedures describe how benefit claims and appeals are made and decided under your health benefit plan. They also outline the specific timeframes for filing and deciding all claims and appeals. Consult this document for details regarding the benefits provided under your health benefit plan.

## **Section 5 - COORDINATION OF BENEFITS (COB)**

**5.1 APPLICABILITY.** The Coordination of Benefits (COB) provision applies under this plan when the member has health care coverage under more than one plan. Plan and This Plan are defined below. This plan provision will only apply for the duration of the employee's employment. If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of this plan are determined before or after those of another plan. The benefits of this plan:

1. will not be reduced when this plan determines its benefits before another plan; but
2. may be reduced when another plan determines its benefits first.

### **5.2 DEFINITIONS:**

1. **PLAN** is any of these that provide benefits or services for, or because of, medical or dental care or treatment:

- a. Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
- b. Coverage under a government plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended).

Each contract or other arrangement for coverage under 1 or 2 is a separate plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

2. **THIS PLAN** is the part of the plan that provides benefits for health care expenses.
3. **PRIMARY PLAN/SECONDARY PLAN:** The order of benefit determination rules state whether this plan is a primary plan or secondary plan covering the person.
  - When this plan is a primary plan, its benefits are determined before those of the other plan and without consideration of the other plan's benefits.
  - When this plan is a secondary plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits.
  - When there are more than two plans covering the person, this plan may be a primary plan as to one or more other plans, and may be a secondary plan as to a different plan or plans.
4. **ALLOWABLE EXPENSE** means a medically necessary, usual, reasonable, and customary item of expense for health care; when the item of expense is covered at least in part by one or more plans covering the member for whom claim is made. When the plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense

and a benefit paid. An expense or service that is not covered by any of the plans is not an allowable expense. The following are not allowable expenses:

- a. The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an allowable expense under the above definition unless the patient's stay in a private room is medically necessary either in terms of generally accepted medical practice, or as specifically defined in the plan.
  - b. If a person is covered by two or more plans that compute their benefit payments on the basis of usual and customary fees, any amount in excess of the highest of the usual and customary fees for a specific benefit is not an allowable expense.
  - c. If a person is covered by two or more plans that provide benefits and services on the basis of negotiated fees, an amount in excess of the highest negotiated fee is not an allowable expense.
  - d. If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary fees and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangements shall be the allowable expense for all plans.
  - e. When benefits are reduced under a primary plan because a member does not comply with the plan provisions, the amount of such reduction will not be considered an allowable expense. Examples of such provisions are those related to second surgical opinions or precertification of admissions or services.
5. **CLAIM DETERMINATION PERIOD** means a calendar year. However, it does not include any part of a year during which a member has no coverage under this plan, or any part of a year before the date this COB provision or a similar provision takes effect.

### **5.3 ORDER OF BENEFIT DETERMINATION RULES.**

1. **General:** When there is a basis for a claim under this plan and another plan, this plan is a secondary plan that has its benefits determined after those of the other plan, unless;
  - a. the other plan has rules coordinating its benefits with those of this plan; and
  - b. both those rules and this plan's rules require that this plan's benefits be determined before those of the other plan.
2. **Rules:** This plan determines its order of benefits using the first of the following rules that applies:
  - a. Non-Dependent/Dependent - The benefits of the plan that cover the member as an employee are determined before those of the plan that covers the member as a dependent. Except that, if the member is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is:
    - secondary to the plan covering the member as a dependent; and
    - primary to the plan covering the member as other than a dependent (e.g. a retired employee);then the benefits of the plan covering the member as a dependent are determined before those of the plan covering that member as other than a dependent.
  - b. Dependent Child/Parents Not Separated or Divorced - Except as stated in Paragraph 3 below, when this plan and another plan cover the same child as a dependent of different persons, called parents:
    - The benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but
    - If both parents have the same birthday, the benefits of the plan that covered one parent longer are determined before those of the plan that covered the other parent for a shorter period of time.

However, if the other plan does not have the rule described in 2a. immediately above, but instead has a rule based on gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

- c. Dependent Child/Separated or Divorced - If two or more plans cover a member as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
- first, the plan of the parent with custody of the child; then
  - the plan of the spouse of the parent with custody; and
  - finally, the plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The plan of the other parent will be the secondary plan. This paragraph does not apply with respect to any claim determination period or plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.

- d. Joint Custody - If the specific terms of a court decree state that the parents will share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child will follow the order of benefit determination rules outlined in Paragraph 2.
- e. Active/Inactive Employee - The benefits of a plan which covers a member as an employee who is neither laid off nor retired are determined before those of a plan which covers the member as a laid off or retired employee. The same would hold true if a member is a dependent of a person covered as a retiree and an employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this Rule 5 is ignored.
- f. Continuation Coverage - If a member whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following will be the order of benefit determination:
- first, the benefits of a plan covering the member as an employee, (or as the member's dependent);
  - second, the benefits under the continuation coverage.
- If the other plan does not have the rule described above, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
- g. Longer/Shorter Length of Coverage - If none of the above rules determine the order of benefits, the benefits of the plan that covered an employee longer are determined before those of the plan that covered the member for the shorter term.

#### **5.4 EFFECT ON THE BENEFITS OF THIS PLAN:**

1. **When This Section Applies:** This section applies when this plan is the secondary plan in accordance with the order of benefits determination outlined above. In that event, the benefits of this plan may be reduced under this section.
2. **Reduction in This Plan's Benefits:** The benefits of this plan will be reduced when the sum of:
  - a. the benefits that would be payable for the allowable expense under this plan in the absence of this COB provision; and
  - b. the benefits that would be payable for the allowable expense under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made; exceeds those allowable expenses in a claim determination period. In that case, the benefits of this plan will be reduced so that they and the benefits payable under the other plans do not total more than those allowable expenses.

When the benefits of this plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this plan.

**5.5 RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION.** Certain facts are needed to apply these COB rules. The administrator has the right to decide which facts are needed. The administrator may get needed facts from or give them to any other organization or person. The administrator need not tell, or get the consent of, any person to do this. Each person claiming benefits

under this plan must give the administrator any facts needed to pay the claim.

**5.6 FACILITY OF PAYMENT.** A payment made under another plan may include an amount that should have been paid under this plan. If it does, the administrator may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this plan. The 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.

**5.7 RIGHT TO RECOVERY.** If the amount of the payments made by the plan is more than the plan should have paid under this COB provision, the plan may recover the excess from one or more of:

1. the persons the plan has paid or for whom the plan has paid;
2. insurance companies; or
3. other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

**5.8 DISCLOSURE.** Each member agrees to disclose to the plan at the time of enrollment, at the time of receipt of services and benefits, and from time to time as requested by the administrator, the existence of other health coverage, the identity of the carrier, and the group through which such coverage is provided.

**5.9 TEFRA (Tax Equity and Fiscal Responsibility Act) Options for Employers with 20 or More Employees.**

Actively working, covered employees and their covered spouses who are eligible for Medicare will be permitted to choose one of the following options, if the employee is 65 or older and eligible for Medicare:

1. Option one: The services of this Summary Plan Document will be provided **before** the services of Medicare.
2. Option two: The subscriber and his/her dependents will **not** be covered by this Summary Plan Document and will **only** be covered by Medicare.

The employer will provide the subscriber with a choice of one of these options at least one month before the subscriber turns 65. These options will be offered to all new employees, age 65 or older, when the employee is hired. If option one is chosen, the subscriber's rights under this Summary Plan Document will be subject to the same requirements as an employee or dependent who is under age 65. There are two categories of people who are eligible for Medicare. The calculation and payment of benefits differ for each category.

1. Category one (1) includes those people who are:
  - a. Actively working, covered employees age 65 or older who choose option one;
  - b. covered spouses (age 65 or older) of actively working, covered employees (65 or older) who choose option one;
  - c. covered spouses (age 65 or older) of actively working, covered employees (under age 65);
  - d. Actively working, covered employees (of employers with 100 or more employees) and their covered dependents who are entitled to Medicare because of a disability other than End Stage Renal Disease (ESRD); or
  - e. covered individuals entitled to Medicare solely because of ESRD during at most twelve (12) months after the individual has been determined eligible for ESRD benefits.
2. Category two (2) includes those people who are:
  - a. retired employees or their spouses;
  - b. covered employees (of employers with less than 100 employees) and their covered dependents who are entitled to Medicare because of a disability other than ESRD; or
  - c. covered individuals entitled to Medicare solely because of ESRD for more than twelve (12) months after the individual has been decided to be eligible for ESRD benefits.

**5.10 CALCULATION AND PROVISION OF SERVICE.** For members in category one, services are first provided by this Summary Plan Document without regard to any benefits provided by Medicare. Medicare will then figure its benefits.

For members in category two, this Summary Plan Document provides the services. The group will then have the right to recover the full amount of all Medicare benefits the member is entitled to receive. This will take place whether or not the member is enrolled in Medicare. The member should authorize payment of Medicare benefits directly to the group, or else he/she is responsible to the group for the value of the services received. The member is also responsible to the group for the value of all the group services reimbursable by Medicare if the member is not enrolled for all benefits he/she is entitled to receive.

## **Section 6 - SUBROGATION**

### **6.1 PAYMENT CALCULATION**

- A. The Plan may elect, but is not required, to conditionally advance payment or extend credit of medical benefits in those situations where an injury, sickness, disease or disability is caused in whole or in part by, or results from, the acts or omissions of a third party, or from the acts or omissions of an Employee and/or Dependent (“Covered Person”) where other insurance (such as auto or homeowners) is available. As a condition of providing benefits in such situations, the Plan and its agents shall have the right to recoup all benefits paid:
1. by subrogation directly from the responsible party (whether an unrelated third party or another Covered Person) or its insurer, without regard to whether the Covered Person is pursuing a claim against that responsible party;
  2. by reimbursement from the Covered Person, when the Covered Person has recovered compensation for such injury from any source described in Section 7.1 D, or
  3. by recovering from the appropriate responsible party, be it money or other property, by virtue of a constructive trust, in order to create an equitable basis for recovery.

By accepting benefits under the Plan, the Covered Person recognizes this property right or equitable interest of the Plan in any cause of action the Covered Person may have or the proceeds thereof.

- B. The Covered Person, his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees, by acceptance of the Plan’s payment of Eligible Expenses, to maintain 100% of the Plan’s payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust and without dissipation except for reimbursement to the Plan or its assignee.
- C. The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys’ fees and costs, or application of the common fund doctrine, make whole doctrine, Rimes doctrine, or any other similar legal theory, or other deductions, without regard to whether the Covered Person is fully compensated by his/her net recovery from all the sources, and without regard to allocation or designation of the recovery. The obligation exists whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. The Plan explicitly has the first priority right of recovery and/or a first lien to the extent of benefits provided by the Plan, even where a participant or beneficiary is not made whole. Said right and/or lien may be filed with any person or organization responsible, or potentially responsible, to the Covered Person for indemnification, the Covered Person’s attorney, or the Court. If the Covered Person’s net recovery is less than the benefits paid, then the Plan is entitled to be paid all of the net recovery achieved. The Covered Person agrees to pay all of his or her own legal fees incurred in litigation against such third parties, and to hold the Plan harmless against any claims made against the Plan by the attorneys retained by the Covered Person.
- D. The Plan’s rights of subrogation and/or reimbursement shall have priority against and shall

constitute a first priority right of recovery and/or a first lien against any and all payments, settlements, judgments or awards made by or received from:

1. responsible party, its insurer, or any other source on behalf of that party;
  2. first party insurance through medical payment coverage or personal injury protection;
  3. the Covered Person's uninsured or underinsured motorist coverage;
  4. any prior contract of insurance from any insurance company or guarantor of a third party;
  5. worker's compensation or other liability insurance company; or
  6. any other source, including but not limited to crime victim restitution funds, any dental, disability or other benefit payments, and no-fault or school insurance coverage.
- E. The Plan may in its own name or in the name of the Covered Person or their personal representative commence a proceeding or pursue a claim against such other third person for the recovery of all damages in the full extent of the value of any such benefits or services furnished or payments advanced or credit extended by the Plan.

If the Covered Person fails to make a claim against or pursue damages against:

1. the responsible party, its insurer, or any other source on behalf of that party;
2. any first party insurance through dental payment coverage or personal injury protection;
3. the Covered Person's uninsured or underinsured motorist coverage;
4. any policy, contract of insurance from any insurance company or guarantor of a third party;
5. worker's compensation or other liability insurance company; or
6. any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and no-fault or school insurance coverage;

then the Plan or its assignee shall be subrogated to the Covered Person's rights. The Covered Person or his or her guardian or the estate of a Covered Person, assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any sources listed above.

- F. These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Covered Person.

**6.2 EXCESS INSURANCE:** If at the time of injury, sickness, disease or disability there is available, or potentially available based on information known or provided to the Plan, to the Covered Person any other insurance, or other form of indemnification, including but not limited to judgment at law or settlements, the benefits under this Plan shall apply only as excess insurance over such other sources of indemnification. The Plan's benefits shall be excess to:

1. the responsible party, its insurer, or any other source on behalf of that party;
2. any first party insurance through medical payment coverage or personal injury protection;
3. the Covered Person's uninsured or underinsured motorist coverage;
4. any policy, contract of insurance from any insurance company or guarantor of a third party;
5. worker's compensation or other liability insurance company; or
6. any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and no fault or school insurance coverage.

### **6.3 OBLIGATIONS**

A. It is the Covered Person's obligation to:

1. to cooperate with the Plan or its agents in defining, verifying and protecting its rights of subrogation and reimbursement;
2. to provide the Plan with pertinent information regarding the injury or sickness, including various forms of documentation, accident reports, settlement reports and any other requested additional information;
3. to take such action, furnish such information and assistance, and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
4. to do nothing to prejudice the Plan's rights of subrogation and reimbursement;
5. to promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and
6. to not settle, without the prior consent of the Plan, any claim that the Covered Person may

- have against any legally responsible party or insurance carrier.
- B. Failure to comply with any of these requirements by the Covered Person, his or her attorney, or guardian may, at the Plan's discretion, result in a forfeiture of payment by the Plan of dental benefits and any funds or payments due under this Plan may be withheld to satisfy the Covered Person's obligation. Failure to comply shall render the Covered Person responsible for the attorneys' fees and costs incurred by the Plan in protecting its rights.

#### **6.4 MINOR STATUS**

- A. In the event the Covered Person is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian, as the case may be, shall take and cooperate in any and all action requested by the Plan to seek and obtain any requisite court approval in order to bind the minor and his or her estate insofar as the subrogation and reimbursement provisions are concerned.
- B. If the minor's parents or court-appointed guardian fail or refuse to take such action, the Plan shall have no obligation to advance payment or extend credit of dental benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

**6.5 LANGUAGE INTERPRETATION:** The Plan Administrator has full discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation/reimbursement rights.

**6.6 SEVERABILITY:** In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable sickness, injury, disease or disability.

### **Section 7 - INDEPENDENT AGENTS**

**7.1 LIMITATION ON LIABILITY.** The administrator does not guarantee that any participating provider will honor or properly perform contracts. The administrator, upon request, will use its best efforts to obtain needed services for a member from another physician if a member encounters performance difficulty with a participating provider. The administrator will not be liable to a member for an act of omission or commission by a participating provider.

### **Section 8 - HEALTH CARE SERVICES**

**8.1 BENEFITS AND SERVICES.** The plan agrees to arrange for the provision of benefits and services in accordance with the procedures and subject to the limitations and exclusions specified in this Summary Plan Document.

All hospital admissions must be authorized by the plan, and the member's condition or required services must be such that treatment can be rendered only in a hospital setting. The plan and the requesting physician may decide to provide medically necessary services on an outpatient basis or in an outpatient surgery unit. The use of alternative levels of care, such as outpatient hospital or home care, will be encouraged where possible based on member condition or treatment.

All charges related to services and supplies incurred prior to the member's effective date, or after the member's termination date of coverage under this Summary Plan Document will not be covered.

**8.2 IDENTIFICATION CARD.** All members covered under this Summary Plan Document will receive a plan identification card. All members must present this card at the time they receive healthcare services from a participating provider. The cardholder must be an eligible member under this Summary Plan Document. Any person receiving services or other benefits to which he/she is not entitled will be solely responsible for the full payment of any charges associated with the services received. If any member permits the use of the member's identification card by any other person, the card may be confiscated and the plan has the right to terminate the member's and their dependents coverage under this Summary Plan Document. The administrator may terminate the member's entitlement to benefits with not less than fifteen (15) days written notice.

**8.3 EMERGENCARE SERVICES.** When faced with an emergency illness or injury, it is suggested you contact the local emergency service or proceed to the nearest emergency care facility. The plan will pay for emergency care wherever it is provided.

The plan will pay for medical screening examinations or other evaluation provided to you in the emergency department necessary to determine whether an emergency medical condition exists. The plan will also pay for necessary emergency care services provided to you and services originating in a hospital emergency department for the stabilization of an emergency medical condition.

If the illness or injury is not an emergency, contact your physician before seeking treatment. Your physician will direct you to the most appropriate place of service.

If you are admitted directly to an inpatient facility from the emergency department of the same facility, all emergency care charges will be subject to the appropriate inpatient co-payment/coinsurance.

**Notifying The Plan Upon Emergency Care Admission.** You or someone you designate, should notify the plan within seventy-two (72) hours of any emergency care admission, or as soon as possible. Please provide the following information:

- date of service,
- name of the facility where you are being treated,
- your diagnosis, with accident details if accident related, and
- whether your physician directed you to this facility.

## **Section 9 - EXCLUSIONS ON SERVICE RESPONSIBILITIES**

The rights of members and obligations of participating providers under this Summary Plan Document are subject to the exclusions as specified below.

**9.1 MAJOR DISASTER OR EPIDEMIC.** In the event of any major disaster or epidemic that would severely limit the availability of participating providers to provide healthcare services on a timely basis, participating providers will, in good faith, use their best efforts to render the benefits and services covered insofar as practical according to their best judgment and within the limitation of such facilities and personnel as are then available. If the plan and the participating provider will, in good faith, have used their best efforts to provide or make arrangements for the benefits and services, they will have no further liability or obligation for delay or failure to provide such benefits and services due to a shortage of available facilities or personnel resulting from such disaster or epidemic.

**9.2 CIRCUMSTANCES BEYOND CONTROL.** In the event that, due to circumstances not reasonably within the control of the plan or participating providers, such as the complete or partial

destruction of facilities because of war, riot, civil insurrection, or the disability of a significant number of participating providers, the rendering of benefits and services covered hereunder is delayed or rendered impractical, neither the plan nor any participating provider will have any liability or obligation on account of such delay or such failure to provide such benefits and services, if they will, in good faith, have used their best efforts to provide or make arrangements for the benefits and services covered insofar as practical according to their best judgment and within the limitations of such facilities and personnel as are then available.

**9.3 FRAUDULENTLY OBTAINED BENEFITS.** In the event a member fraudulently obtains healthcare services as a result of the improper or unauthorized use of a plan identification card, such member agrees and is solely responsible for the payment of all charges for services so obtained and for the payment of all reasonable costs of collection thereof, including court costs, collection fees and attorney fees.

## **Section 10 - GENERAL PROVISIONS**

**10.1 INCONTESTABILITY.** After two (2) years from the date of issue of this policy, no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability commencing after the expiration of such two-year period.

**10.2 RELEASE AND CONFIDENTIALITY OF MEDICAL RECORDS.** The member must authorize the release of all medical information requested by the plan. The plan agrees to maintain and preserve the confidentiality of all medical information. The plan may supply medical information to its Utilization Review Agent, a peer review committee or governmental agency, as permitted by law.

The plan can deny the claim if the member refuses to authorize a release of medical information requested by the plan.

**10.3 CLERICAL ERROR.** Subject to the provisions of this Summary Plan Document, clerical errors in record keeping:

1. will not deny coverage that otherwise would have been issued;
2. will not continue coverage that otherwise would have ended; and
3. may require a change in premium.

**10.4 DISCLOSURE.** Each member agrees to release to the plan the presence of another plan's coverage, the identity of the carrier, and the group providing the coverage. The plan will request this information at the time of enrollment, the time of receipt of benefits and services, and other appropriate times.

**10.5 RECORDS AND INFORMATION.** The plan will conduct a review program for the healthcare services it provides. The plan may examine the records of each member for the purposes of this review. Information from medical records, physicians, or hospitals concerning patient-provider relations will be kept confidential. This information will not be released unnecessarily without the member's consent.

The plan will have the right to release or obtain information from any organization it deems necessary. This information exchange may take place without further notice to the member and to the extent allowed by law. Identifiable personal information will not be released by the plan without the written consent of the member. Any member claiming benefits will furnish the information necessary to carry out this Summary Plan Document.

**10.6 ASSIGNMENT.** Members' benefits under this Summary Plan Document are specific to the member and are not assignable or otherwise transferable. However, the administrator may assign this Summary Plan Document to its successor in interest or an affiliate.

## **Section 11 - RECONSTRUCTIVE SURGERY FOLLOWING MASTECTOMY**

In compliance with the Women's Health and Cancer Rights Act of 1998 (WHCRA) when a member receives benefits for a mastectomy and decides to have breast reconstruction, based on consultation between the attending physician and the patient, the following benefits will be subject to the same coinsurance and deductibles which apply to other plan benefits:

- reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prosthesis and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

## **Section 12 - NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT (NMHPA)**

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

## **Section 13 - NOTICE OF PRIVACY PRACTICES**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

This Notice of Privacy Practices describes how protected health information may be used or disclosed by your Group Health Plan ("the Plan") to carry out payment, health care operations, and for other purposes that are permitted or required by law. This Notice also sets out the Plans' legal obligations under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") concerning your protected health information, and describes your right to access and control your protected health information.

Protected health information (or "PHI") is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health plan, your employer (only when functioning on behalf of the group health plan), or a health care clearinghouse that relates to: (i) your past, present, or future physical or mental health or condition; (ii) the provision of health care to you; or (iii) the past, present, or future payment for the provision of health care to you. Not all of your medical information is protected by HIPAA.

This Notice of Privacy Practices has been drafted to be consistent with a set of regulations promulgated under HIPAA called "HIPAA Privacy Rule."

### **EFFECTIVE DATE**

This Notice of Privacy Practices is effective as of April 14, 2004.

## THE PLANS' RESPONSIBILITIES

The Plans maintain the privacy of your PHI as required by HIPAA and the HIPAA Privacy Rule. The Plans are obligated to provide you with a copy of this Notice of the Plans' legal duties and of their privacy practices with respect to PHI, and they must abide by the terms of this Notice.

### Primary Uses and Disclosures of Protected Health Information

The following is a description of how the Plans are most likely to use and/or disclose your PHI and to whom they are most likely to disclose it. The Plans may share PHI and must abide by the terms of this Notice.

- **Payment and Health Care Operations**

The Plans have a right to use and disclose your PHI without an authorization from you for all activities that are included within the definitions of "payment" and "health care operations" as set out in 45 C.F.R. § 164.501 (this provision is a part of the HIPAA Privacy Rule). The Plans have provided examples below of types of events that qualify as payment or health care operations. However, if you would like to see a more exhaustive list, refer to 45 C.F.R. §164.501.

- » *Payment*

Your PHI will be used or disclosed to pay claims for services provided to you and to obtain stop-loss reimbursements or to otherwise fulfill the Plans' responsibilities for coverage and providing benefits. For example, your PHI may be disclosed when a provider requests information regarding your eligibility for coverage under the Plans, or the Plans may use your information to determine if a treatment that you received was medically necessary.

- » *Health Plan Operations*

The Plans will use or disclose your PHI to support the provision and payment for health care services. These functions include, but are not limited to: quality assessment and improvement, reviewing provider performance, licensing, stop-loss underwriting, business planning, and business development. For example, the Plans may use or disclose your PHI: (i) to provide coordination of benefits; (ii) to respond to a customer services inquiry from you; or (iii) in connection with fraud and abuse detection and compliance programs.

- **Business Associates**

The Plans contract with individuals and entities (Business Associates) to perform various functions on behalf of the Plans or to provide certain types of services. To perform these functions or to provide the service, the Business Associates may receive, create, maintain, use, or disclose PHI, but only after the Business Associates agree in writing to contract terms designed to appropriately safeguard your information. For example, the Plans may disclose your PHI to a Business Associate to administer claims or to provide services support, utilization management, subrogation, or pharmacy benefit management. Examples of the Plans' business associates would be the Third Party Administrator, Select Administrative Services, which will be handling many of the functions in connection with the operation of the Group Health Plan; the retail pharmacy; and the mail order pharmacy.

- **Other Covered Entities**

The Plans may use or disclose your PHI to assist health care providers in connection with their treatment or payment activities, or to assist other covered entities in connection with payment activities and certain health care operations. For example, the Plans may disclose your PHI to a health care provider when needed by the provider to render treatment to you, and they may disclose PHI to another covered entity to conduct health care operations in the areas of quality assurance and improvement activities, or accreditation, certification, licensing, or credentialing. This also means that the Plans may disclose or

share your PHI with other insurance carriers in order to coordinate benefits, if you or your family members have coverage through another carrier.

- **Plan Sponsor**

The Plans may disclose your PHI to your employer, the plan sponsor of the Plans for purposes of plan administration, including all types of health plan operations, or pursuant to an authorization request signed by you.

### **Additional Protections**

To the extent that state law provides greater privacy protection for your PHI, state law will continue to apply to the use and disclosure of such information. For example, records related to treatment for alcoholism or mental illness may require the express authorization of the subject of the records prior to disclosure.

### **Other Possible Uses and Disclosures of PHI**

The following is a description of other possible ways in which the Plans may (and are permitted to) use and/or disclose your PHI.

- **Required by Law**

The Plans may use or disclose your PHI to the extent that federal law requires the use or disclosure. For example, the Plans may disclose your PHI when required by national security laws or public health disclosure laws.

- **Public Health Activities**

The Plans may use or disclose your PHI for public health activities that are permitted or required by law. For example, the Plans may use or disclose information for the purpose of preventing or controlling disease, injury, or disability, or the Plans may disclose such information to a public health authority authorized to receive reports of child abuse or neglect. The Plans also may disclose PHI, if directed by a public health authority, to a foreign government agency that is collaborating with the public health authority.

- **Health Oversight Activities**

The Plans may disclose your PHI to a health oversight agency for activities authorized by law, such as: audits; investigations; inspections; licensure or disciplinary actions; or civil, administrative, or criminal proceedings or actions. Oversight agencies seeking this information include government agencies that oversee: (i) the health care system; (ii) government benefit programs; (iii) other government regulatory programs; and (iv) compliance with civil rights laws.

- **Legal Proceedings**

The Plans may disclose your PHI: (1) in the course of any judicial or administrative proceeding; (2) in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized); (3) in response to a subpoena, a discovery request, or other lawful process, and (4) to appropriate law enforcement in the performance of their duties once the relevant Plan has met all administrative requirements of the HIPAA Privacy Rule. For example, the Plans may disclose your PHI in response to a subpoena for such information, but only after the Plans first meet certain conditions required by the HIPAA Privacy Rule.

- **To Prevent a Serious Threat to Health or Safety**

Consistent with applicable federal and state laws, the Plans may disclose your PHI if the relevant Plan determines that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health

or safety of a person or the public. The Plans also may disclose PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.

- **To Coroners, Medical Examiners, and Funeral Directors**

The Plans may provide your PHI to a coroner, medical examiner, or funeral director for purposes of identifying a deceased person, determining the cause of death, or otherwise aiding in the performance of their lawful duties.

- **Organ and Tissue Donation**

The Plans may disclose PHI to organizations that handle organ, eye, or tissue donation and transplantation.

- **Research**

The Plans may disclose your PHI to researchers, subject to limitations.

- **Military Activity and National Security, Protective Services**

Under certain conditions, the Plans may disclose your PHI if you are, or were, Armed Forces personnel for activities deemed necessary by appropriate military command authorities. If you are a member of foreign military services, they may disclose, in certain circumstances, your information to authorized federal officials for conduction of national security and intelligence activities, and for the protection of the President, and other authorized persons, or heads of state.

- **Workers' Compensation**

The Plans may disclose your PHI to comply with workers' compensation laws and other similar programs that provide benefits for work-related injuries or illnesses.

- **Others Involved in Your Health Care**

Using their best judgment, the Plans may make your PHI known to a family member, other relative, close personal friend, or other personal representative that you identify. Such a use will be based on how involved the person is in your care, or payment that relates to your care. The Plans may release information to parents or guardians, if allowed by law.

The Plans may also disclose your information to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location.

If you are not present or able to agree to these disclosures of PHI, then, using their best judgment, the Plans may determine whether the disclosure is in your best interest.

- **Disclosures to the Secretary of the U.S. Department of Health and Human Services**

The Plans are required to disclose your PHI to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining the Plans' compliance with the HIPAA Privacy Rule.

- **Disclosures to You**

The Plans are required to disclose to you most of your PHI in a "designated record set" when you request access to this information. Generally, a "designated record set" contains medical and billing records, as well as other records that are used to make decisions about your health care benefits. The Plans also are required to provide, upon your request, an accounting of most disclosures of your PHI that are for reasons other than payment and health care operations and are not disclosed through a signed authorization.

The Plans will disclose your PHI to an individual who has been designated by you as your personal representative and who has qualified for such designation in accordance with relevant state law. However, before the Plans will disclose PHI to such a person, you must submit a written notice of his/her

designation, along with the documentation, that supports his/her qualifications (such as power of attorney).

*Even if you designate a personal representative*, the HIPAA Privacy Rule permits us to elect not to treat the person as your personal representative if the Plans have a reasonable belief that: (i) you have been, or may be, subjected to domestic violence, abuse, or neglect by such person; (ii) treating such a person as your personal representative could endanger you; or (iii) the Plans determine, in the exercise of their best judgment, that it is not in your best interest to treat the person as your personal representative.

#### **Authorizations:**

The Plans will not use or disclose your medical information for any other purpose without your written authorization except as described in this Notice or otherwise permitted or required by law. Once given, you may revoke your authorization in writing at any time except to the extent that the Plans has taken an action in reliance on the use or disclosure as indicated in the authorization. To request a Revocation of Authorization form, you may contact the Plan at:

### **YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION**

You have the following rights with respect to your PHI.

- **Right to Request a Restriction**

You have the right to restrict certain uses and disclosures of your PHI for purposes of payment or health plan operations or for purposes of providing information to others involved in your healthcare decisions or payment for those decisions. The Plans are not required to agree with your request. However, if they do agree, the Plans will honor your request until you are notified to the contrary.

- **Right to Request Confidential Communications**

You have the right to request in writing to receive communications from the Plans in a confidential manner or in an alternative location or manner. The Plans will accommodate all reasonable requests.

- **Right to Inspect and Copy**

Generally, you may inspect and copy your medical information. You must make this request in writing. This right is subject to certain specific exceptions, and you may be charged a reasonable fee for any copies of your medical information.

- **Right to Amend**

You may ask us to amend your medical information. Your request may be denied for certain specific reasons. If your request is denied, you will be provided with a written explanation for the denial and information regarding further rights you may have at that point.

- **Right of an Accounting of Disclosures**

You have a right to receive an accounting of the disclosures of your medical information Made by the Plan since the lesser of (1) the period between your request and April 14, 2003, and (2) the last six years, except for disclosures for treatment, payment, or health plan operations, disclosures which you authorized, and certain other specific disclosure types. The right to receive this information is subject to certain exceptions, restrictions, and limitations.

- **Right to Paper Copy of This Notice**

You have the right to receive a paper copy of this Notice of Privacy Practices upon request. You may request additional copies of this Notice by contacting the Privacy Officer.

All requests required to be made in writing must be directed to the HIPAA Privacy Officer at the address described below.

You have the right to complain to us and/or to the United States Department of Health and Human Services if you believe that the Plans have violated your privacy rights. If you choose to file a complaint, you will not be retaliated against in any way. You may file a complaint in writing with the HIPAA Privacy Officer at the address below. Neither the Plan nor the City of Gulfport will retaliate against you in any way for filing a complaint with the Plans or the Department of Health and Human Services.

If you would like further information regarding your rights or regarding the uses and disclosures of your medical information, please contact:

***City of Gulfport***  
**Attn: Human Resource Director**  
**HIPAA Privacy Officer**  
**Gulfport, MS 39501**

**Revision of Notice of Privacy Practices**

The Plans reserve the right to change the terms of this Notice, making any revision applicable to all the PHI either of the Plans maintain. If the terms of this Notice are revised, a revised Notice will be posted at the City of Gulfport, and paper copies of the revised Notice of Privacy Practices will be available upon request. In the event of a material revision of the Plans' privacy practices, you will be provided a revised Notice.