

**City of Gulfport
Summary of Medical Benefits
Retiree Employee Benefit Plan**

| SERVICES: RETIREE PLAN | In Network | Out of Network |
|--|--|---|
| Annual Deductible (applies to expenses below unless otherwise noted) | \$500 / individual \$1,000/ family | \$1,000/ individual \$2,000/ family |
| Annual Coinsurance and Deductible Out-of-Pocket Maximum | \$2,500/ individual \$5,000/ family | No Limit/ individual No Limit/family |
| Annual Combined Coinsurance, Deductible, and Co-payment Out-of-Pocket Maximum (includes both medical and prescription drug benefits covered under the Plan) | \$6,600/ individual \$13,200/ family | No Limit/ individual No Limit/family |
| Maximum Plan Year Benefit | Unlimited | |
| Lifetime Plan Maximum | Unlimited | |
| <u>PHYSICIAN SERVICES</u> Physician Office Visits, Other services provided in the Physician office, Physician charges for radiology, pathology, hospital services or surgery | 20% Coinsurance after Deductible | 40% Coinsurance after Deductible |
| <u>WELLNESS BENEFIT/ PREVENTATIVE CARE</u> Age Appropriate Recommended Testing based on ACA Guidelines | Paid at 100% with no deductible and no copay | 40% Coinsurance after Deductible |
| <u>MENTAL HEALTH & CHEMICAL DEPENDENCY SERVICES</u> <ul style="list-style-type: none"> • Outpatient Care –includes office visits and outpatient facility services. • Inpatient Care –requires preauthorization | 20% Coinsurance after Deductible | 40% Coinsurance after Deductible |
| <u>EMERGENCY CARE SERVICES</u> Emergency Room Facility Services Urgent Care Facility Services Land and air ambulance | 20% Coinsurance after Deductible | 20% Coinsurance after Deductible |
| <u>FACILITY SERVICES</u> Inpatient Facility Services- requires preauthorization Outpatient/Ambulatory Surgery/Diagnostic Services | 20% Coinsurance after Deductible | 40% Coinsurance after Deductible |
| <u>SKILLED NURSING FACILITY SERVICES</u> Requires preauthorization. Limited to a maximum benefit of 60 days per calendar year. | 20% Coinsurance after Deductible | 40% Coinsurance after Deductible |
| <u>WEIGHT LOSS SURGERY</u> Lifetime Maximum benefit of \$20,000 including the \$2,000 co-payment. Co-payment does not apply to the Combined Out-of-Pocket Maximum | \$2,000 Copayment, then Plan pays 100% | \$2,000 Copayment, then Plan pays 100% |
| <u>DURABLE MEDICAL EQUIPMENT</u> Rental or purchase of medical equipment and medical supplies. | 20% Coinsurance after Deductible | 40% Coinsurance after Deductible |
| <u>HEARING AIDS AND HEARING EXAMS</u> Limited to a maximum benefit of \$500 per ear every 2 calendar years. | Plan pays 100% Deductible does not apply | Plan pays 100% Deductible does not apply |

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| RETIREE PLAN SERVICES | In Network | Out of Network |
|---|--|---|
| <u>CHIROPRACTIC SERVICE</u> Limited to a maximum of 50 visits per year. | 20% Coinsurance after Deductible | 40% Coinsurance after Deductible |
| <u>REHABILITATION SERVICES</u> Short-term rehabilitative therapy services including physical therapy, occupational therapy and speech therapy. | 20% Coinsurance after Deductible | 40% Coinsurance after Deductible |
| <u>CARDIAC REHABILITATION SERVICES</u> Limited to 36 sessions within 12 consecutive weeks. | 20% Coinsurance after Deductible | 40% Coinsurance after Deductible |
| <u>HOME HEALTH SERVICES</u> Home Health Services – requires preauthorization. Services are limited to a maximum benefit of 100 visits. Hospice – Outpatient | 20% Coinsurance after Deductible | 40% Coinsurance after Deductible |
| <u>PROSTHETIC MEDICAL APPLIANCES</u> Internal and external prosthetic appliances and applicable hardware | 20% Coinsurance after Deductible | 40% Coinsurance after Deductible |
| <u>OSTOMY SUPPLIES</u> | 20% Coinsurance after Deductible | 40% Coinsurance after Deductible |
| <u>MATERNITY SERVICES</u> Physician Services for Obstetrical Care Inpatient Facility Charges for Delivery Requires preauthorization for extended stay only | 20% Coinsurance after Deductible | 40% Coinsurance after Deductible |
| <u>DIABETIC SERVICES</u> Diabetic Foot Care Diabetic Education (Diabetic supplies are covered under the pharmacy and DME benefits) | 20% Coinsurance after Deductible | 40% Coinsurance after Deductible |
| <u>KIDNEY DIALYSIS SERVICES</u> Dialysis services | 20% Coinsurance after Deductible | 40% Coinsurance after Deductible |
| <u>PRESCRIPTION BENEFIT</u> Some drugs may require pre-authorization or they may not be covered. Contact the Pharmacy Benefit Manager at the number on your ID card for more information. | In-Network Retail and Mail Pharmacies | Enhanced Pharmacy Program Pharmacies |
| Retail Pharmacy, 30 Day Supply Generic Brand name on formulary Brand name non-formulary | \$10 Copay \$20 Copay \$35 Copay | \$ 8 Copay \$ 5 Copay \$15 Copay |
| Mail Order, 90 Day Supply Generic Brand name on formulary Brand name non-formulary | \$25 Copay \$50 Copay \$85 Copay | \$16 Copay \$15 Copay \$35 Copay |
| Specialty Drugs, 30 Day Supply | \$100 Copay | \$75 Copay |