

PLAN DOCUMENT AND  
SUMMARY PLAN DESCRIPTION  
FOR

CITY OF GULFPORT  
SELF-FUNDED HEALTH AND DENTAL  
INSURANCE PLAN

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## INTRODUCTION

This document is a description of City of Gulfport Self-Funded Employee Benefits Plan (the Plan). No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain catastrophic health expenses.

Coverage under the Plan will take effect for an eligible Employee and designated Dependents when the Employee and such Dependents satisfy the Waiting Period and all the eligibility requirements of the Plan.

The Employer fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason.

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, maximums, co-payments, exclusions, limitations, definitions, and eligibility.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated, even if the expenses were incurred as a result of an accident, injury or disease that occurred, began, or existed while coverage was in force. An expense for a service or supply is incurred on the date the service or supply is furnished.

If the Plan is terminated, the right of Covered Persons are limited to covered charges incurred before termination.

This document summarizes the Plan rights and benefits for covered Employees and their Dependents and is divided into the following parts:

**Eligibility, Funding, Effective Date and Termination.** Explains eligibility for coverage under the Plan, funding of the Plan and when the coverage takes effect and terminates.

**Schedule of Benefits.** Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services.

**Benefit Descriptions.** Explains when the benefit applies and the types of charges covered.

**Cost Management Services.** Explains the methods used to curb unnecessary and excessive charges.

***This part should be read carefully since each Participant is required to take action to assure that the maximum payment levels under the Plan are paid.***

**Defined Terms.** Defines those Plan terms that have a specific meaning.

**Plan Exclusions.** Shows what charges are **not** covered.

**Claim Provisions.** Explains the rules for filing claims and the claim appeal process.

**Coordination of Benefits.** Shows the Plan payment order when a person is covered under more than one plan.

**Third Party Recovery Provision.** Explains the Plan's rights to recover payment of charges when a Covered Person has a claim against another person because of injuries sustained.

**COBRA Continuation Options.** Explains when a person's coverage under the Plan ceases and the continuation options which are available.

## **ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS**

### **ELIGIBILITY**

#### **Eligible Classes of Employees.**

All Active and Retired Employees of the Employer.

**Eligibility Requirements for Employee Coverage.** A person is eligible for Employee coverage from the first day that he or she:

- (1) is a Full-Time, Active Employee of the Employer. An Employee is considered to be Full-Time if he or she normally works at least 40 hours per week and is on the regular payroll of the Employer for that work.
- (2) is a Retired Employee of the Employer.
- (3) is in a class eligible for coverage.
- (4) completes the employment Waiting Period of 90 consecutive days as an Active Employee. A "Waiting Period" is the time between the first day of employment and the first day of coverage under the Plan. The Waiting Period is counted in the Pre-Existing Conditions exclusion time.

#### **Eligible Classes of Dependents.**

A Dependent is any one of the following persons:

- (1) A covered Employee's Spouse and unmarried children from birth to the limiting age of 19 years. The Dependent children must be primarily dependent upon the covered Employee for support and maintenance. However, a Dependent child will continue to be covered after age 19, provided the child is a full-time student, primarily dependent upon the covered Employee for support and maintenance, is unmarried and under the limiting age of 24. When the child reaches either limiting age, coverage will end on the child's birthday.
- (2) A covered Employee's Spouse and unmarried children, who were eligible to join the Plan but are not Plan Participants because they could not give evidence of good health to the Plan when such evidence was required, but are otherwise still eligible through dependency status as defined by this Plan.
- (3) Any child of a Plan Participant who is an alternate recipient under a qualified medical child support order shall be considered as having a right to Dependent coverage under this Plan with no Pre-existing Conditions provision applied.
- (4) A covered Dependent child who is Totally Disabled, incapable of self-sustaining employment by reason of mental retardation or physical handicap, primarily dependent upon the covered Employee for support and maintenance, unmarried and covered under the Plan when reaching the limiting age. The Plan Administrator may require, at reasonable intervals during the two years following the Dependent's reaching the limiting age, subsequent proof of the child's Total Disability and dependency.

After such two-year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

### Definitions

The term "Spouse" shall mean the person recognized as the covered Employee's husband or wife under the laws of the state where the covered Employee lives. The Plan Administrator may require documentation proving a legal marital relationship.

The term "children" shall include natural child, adopted child or child placed with a covered Employee in anticipation of adoption, stepchild and any other child related to the Employee by blood or marriage, if the Employee is the Legal Guardian of this child, and provided such child resides in the Employee's household in a normal parent child relationship and is dependent upon the employee for the majority (50% or over) of his or her support and maintenance

The phrase "child placed with a covered Employee in anticipation of adoption" refers to a child whom the Employee intends to adopt, whether or not the adoption has become final, who has not attained the age of eighteen (18) as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

The phrase "primarily dependent upon" shall mean dependent upon the covered Employee for support and maintenance as defined by the Internal Revenue Code and the covered Employee must declare the child as an income tax deduction. The Plan Administrator may require documentation proving dependency, including birth certificates, tax records or initiation of legal proceedings severing parental rights

### Excluded as Dependents:

- Other individuals living in the covered Employee's home, but who are not eligible as defined.
- The divorced former Spouse of the Employee.
- Any person who is on active duty in any military service of any country.
- Any person who is covered under the Plan as an Employee.

If a person covered under this Plan changes status from Employee to Dependent or Dependent to Employee, and the person is covered continuously under this Plan before, during and after the change of status, credit will be given for deductibles and all amounts applied to maximums.

If both husband and wife are Employees, their children will be covered as Dependents of the husband or wife, but not of both.

**Eligibility Requirements for Dependent Coverage.** A family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for Dependent coverage.

At any time, the Plan may require proof that a Spouse or a child qualifies or continues to qualify as a Dependent as defined by this Plan.

## **FUNDING**

### **Cost of the Plan.**

City of Gulfport pays 95% of the cost of Employee coverage under the Plan. The Employee pays 5%.

City of Gulfport also shares the cost of Dependent coverage under this Plan with the covered Employees. The City of Gulfport pays 55% of the cost of Dependent coverage and the Employee pays 45%.

The enrollment application for coverage will include a payroll deduction authorization. This authorization must be filled out, signed and returned with the enrollment application.

The level of any Employee contributions is set by the Plan Administrator. The Plan Administrator reserves the right to change the level of Employee contributions.

## **PRE-EXISTING CONDITIONS**

**NOTE:** The length of the Pre-Existing Conditions Limitation may be reduced or eliminated if an eligible person has Creditable Coverage from another health plan.

An eligible person may request a certificate of Creditable Coverage from his or her prior plan and the Employer will assist any eligible person in obtaining a certificate of Creditable Coverage from a prior plan.

If, after Creditable Coverage has been taken into account, there will still be a Pre-Existing Conditions Limitation imposed on an individual, that individual will be so notified.

Covered charges incurred under Medical Benefits for Pre-Existing Conditions are not payable unless incurred 12 consecutive months or 18 months if a Late Enrollee after the person's Effective Date. This time may be offset if the person has Creditable Coverage from his or her previous plan.

A Pre-Existing Condition is a condition for which medical advice, diagnosis, care or treatment was recommended or received within six months of the person's Effective Date under this Plan. Genetic Information is not a condition. Treatment includes receiving services and supplies, consultations, diagnostic tests or prescribed medicines. In order to be taken into account, the medical advice, diagnosis, care or treatment must have been recommended by, or received from, a Physician.

The Pre-Existing Condition does not apply to pregnancy, to a newborn child who is covered under this Plan within 31 days of birth, or to a child who is adopted or placed for adoption before attaining the age of 18 and who, as of the last day of the 31 – day period beginning on the date of the adoption or placement for adoption, is covered under this Plan. A Pre-Existing Condition exclusion may apply to coverage before the date of the adoption or placement for adoption.

The prohibition on Pre-Existing Condition exclusion for newborn, adopted, or pre-adopted children does not apply to an individual after the end of the first 63 – day period during all of which the individual was not covered under any Creditable Coverage.

## ENROLLMENT

**Enrollment Requirements.** An Employee must enroll for coverage by filling out and signing an enrollment application. The covered Employee is required to enroll for Dependent coverage including coverage for newborn children.

### TIMELY ENROLLMENT

- (1) Timely Enrollment – The enrollment will be “timely” if the completed form is received by the Plan Administrator no later than 31 days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period.
- (2) Employees and their Dependents who are not in this Plan because they could not present evidence of good health to the Plan before the Health Insurance Portability and Accountability Act (HIPAA) was effective, but are otherwise eligible for coverage under the terms of this Plan, will be treated by this Plan as Timely Enrollees during the first 31 days after this Plan is subject to HIPAA.

If two Employees (husband and wife) are covered under the Plan and the Employee who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other covered Employee with no waiting period as long as coverage has been continuous.

- (3) Late Enrollment – An enrollment is “late” if it is not made on a “timely basis” or during a Special Enrollment Period. Late Enrollees and their Dependents who are not eligible to join the Plan during a special Enrollment Period may join only during open enrollment.

If an individual loses eligibility for coverage as a result of terminating employment or a general suspension of coverage under the Plan, then upon becoming eligible again due to resumption of employment or due to resumption of Plan coverage, only the most recent period of eligibility will be considered for purposes of determining whether the individual is a Late Enrollee.

The time between the date a Late Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period. Coverage begins on January 1<sup>st</sup>.

### SPECIAL ENROLLMENT PERIODS

The enrollment date for anyone who enrolls under a Special Enrollment Period is the first date of coverage. Thus, the time between the date a special enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period.

- (1) **Individuals losing other coverage.** An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if each of the following conditions is met:
  - (a) The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.
  - (b) If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.
  - (c) The coverage of the Employee or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of

loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment or reduction in the number of hours of employment) or employer contributions towards the coverage were terminated.

- (d) The Employee or Dependent requests enrollment in this Plan not later than 31 days after the date of exhaustion of COBRA coverage or the termination of coverage or employer contributions, described above.
- (e) If the Employee or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim), that individual does not have a Special Enrollment right.

(2) **Dependant beneficiaries.** If:

- (a) The Employee is a participant under this Plan (or has met the waiting Period applicable to becoming a participant under this Plan and is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and
- (b) A person becomes a Dependent of the Employee through marriage, birth, adoption or placement for adoption,

then the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan as a covered Dependent of the covered Employee. In the case of the birth or adoption of a child, the Spouse of the covered Employee may be enrolled as a Dependent of the covered Employee if the Spouse is otherwise eligible for coverage.

The coverage of the Dependent enrolled in the Special Enrollment Period will be effective:

- (a) in the case of marriage, the first day of the first month beginning after the date of the completed request for enrollment is received;
- (b) in the case of a Dependent's birth, as of the date of birth; or
- (c) in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

**Enrollment Requirements for Newborn Children.**

A newborn child of a covered Employee is automatically eligible for coverage in this Plan. Charges for covered nursery care and covered routine physician care will be applied toward the Plan of the newborn child. If the newborn child is required to be enrolled and is not enrolled in this Plan on a timely basis, as defined in the section "Timely Enrollments" following this section, there will be no payment from the Plan and the covered parent will be responsible for all costs.

For coverage of sickness or injury, including medically necessary care and treatment of congenital defects, birth abnormalities or complications resulting from prematurely, if the newborn child is required to be enrolled, he or she must be enrolled as a Dependent under this Plan within 31 days of the child's birth in order for non-routine coverage to take effect from the birth.

## EFFECTIVE DATE

**Effective Date of Employee Coverage.** An employee will be covered under this Plan as of the first day of the calendar month following the date that the Employee satisfies all of the following:

- (1) The Eligibility Requirement
- (2) The Active Employee Requirement
- (3) The Enrollment Requirements of the Plan

### **Active Employee Requirement.**

An Employee must be an Active Employee (as defined by this Plan) for this coverage to take effect.

**Effective Date of Dependent Coverage.** A Dependent's coverage will take effect on the day that the Eligibility Requirements are met; the Employee is covered under the Plan; and all Enrollment Requirements are met.

## TERMINATION OF COVERAGE

When coverage under this Plan stops, Plan Participants will receive a certificate that will show the period of coverage under this Plan. Please contact the Plan Administrator for further details.

**When Employee Coverage terminates.** Employee coverage will terminate on the earliest of the following dates (except in certain circumstances, a covered Employee may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled COBRA Continuation Option):

- (1) The date the Plan is terminated.
- (2) The day the covered Employee ceases to be in one of the Eligible Classes. This includes death or termination of Active Employment of the covered Employee. (See the COBRA Continuation Option.)

### **Continuation During Periods of Employer-Certified Disability, Leave of Absence or Layoff.**

A person may remain eligible for a limited time if Active, full-time work ceases due to disability, leave of absence or layoff. This continuance will end as follows:

**For disability leave under Worker's Compensation:** coverage will continue as long as an employee is unable to go to work and is entitled to Workmen's Compensation disability. The city of Gulfport will continue paying the City's portion of the cost of the employee's coverage under this Plan. The employee must pay the cost for dependent coverage (if applicable).

**For Leave of Absence:** coverage will continue for a period of not longer than six (6) months that next follows the month in which the person last worked as an Active Employee.

**For Layoff:** coverage will continue for a period of not longer than thirty-one (31) days that follows the date of the person last worked as an Active Employee.

While continued, coverage will be that which was in force on the last day worked as an Active Employee. However, if benefits reduce for others in the class, they will also reduce for the continued person.

**Continuation During Family and Medical Leave.** Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor.

During any leave taken under the Family and Medical Leave Act, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated..

If the Employee voluntarily terminates employment for reasons within their control at or before the end of their leave, the Employee may be required to reimburse the Employer for contributions made by the Employer on behalf of the Employee and on behalf of the Employee's Dependents during the leave. The Employer has the right to withhold these reimbursements from any funds the Employer might owe the Employee following their voluntary termination (wages, overtime, commissions, salary, bonuses, accrued vacation pay or sick leave pay or benefits payable under this Plan or any other employee benefit plan under which the Employee is entitled to payment). The Employer also has the right to recover any required Employee contributions the Employer has made on behalf of the Employee or the Employee's Dependents during the leave to ensure continuity of coverage. If an Employee decides to take FMLA absence, the Employee should contact the Plan Administrator for further information and election forms.

**Rehiring a Terminated Employee.** A terminated Employee who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements, with the exception of an Employee returning to work directly from City of Gulfport COBRA coverage. This Employee does not have to satisfy the employment Waiting Period or Pre-Existing Conditions provision.

**Employees on Military Leave.** Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act under the following circumstances. These rights apply only to Employees and their Dependents covered under the Plan before leaving for military service.

- (1) The maximum period of coverage of a person under such an election shall be the lesser of:
  - (a) The 18 month period beginning on the date on which the person's absence begins; or
  - (b) The day after the date on which the person was required to apply for or return to a position or employment and fails to do so.
- (2) A person who elects to continue health plan coverage may be required to pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.
- (3) An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an

exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

Plan exclusions and Waiting Periods may be imposed for any Sickness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, military service.

**When Dependent Coverage Terminates.** A Dependent's coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Dependent may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled COBRA Continuation Option):

- (1) The date the Plan or Dependent coverage under the Plan is terminated.
- (2) The date that the Employee's coverage under the Plan terminates for any reason including death. (See the COBRA Continuation Option.)
- (3) The date a covered Spouse loses coverage due to loss of dependency status. (See the COBRA Continuation Option.)
- (4) On the first date that a Dependent child ceases to be a Dependent as defined by the Plan. (See the COBRA Continuation Option.)
- (5) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

## **OPEN ENROLLMENT**

During the annual open enrollment period, covered Employees and their covered Dependents will be able to change some of their benefit decisions based on which benefits and coverages are right for them. Employees and their Dependents who are Late Enrollees will be able to enroll in the Plan. The Open Enrollment period will be the calendar month of November.

Benefit choices made during the open enrollment period will become effective January 1<sup>st</sup> and remain in effect until the next January 1<sup>st</sup> unless there is a change in family status during the year (birth, death, marriage, divorce, adoption) or loss of coverage due to loss of a Spouse's employment. To the extent previously satisfied, Coverage Waiting Periods and Pre-Existing Conditions Limits will be considered satisfied when changing from one plan to another plan.

Benefit choices made during the open enrollment period for Late Enrollees will become effective January 1<sup>st</sup>. A Plan Participant who fails to make an election during open enrollment will automatically retain his or her present coverages.

## SCHEDULE OF BENEFITS

### Active Employee and Their Eligible Dependents

#### MEDICAL BENEFITS

All benefits described in this Schedule are subject to the exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator's determination that: care and treatment is Medically Necessary; that charges are Usual and Reasonable; that services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

MRI's, Out Patient Surgery, Home Health Services, and Hospitalization and Facility treatments of a Non-Emergency nature must be pre-certified within 5 days before services are rendered or reimbursement from the Plan may be reduced up to 50%. The attending Physician does not have to obtain precertification from the plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a Caesarian delivery. (Please see the Cost Management section in this booklet for details).

The Plan is a plan which contains a Network Provider Organization.

This Plan has entered into an agreement with certain Hospitals, Physicians and other health care providers, which are called Network Providers. Because these Network Providers have agreed to charge reduced fees to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees.

Therefore, when a Covered Person uses a Network Provider, that Covered Person will receive a higher payment from the Plan than when a Non-network Provider is used. It is the Covered Person's choice as to which Provider to use.

Covered Services obtained from a Non-network Provider will be covered at the Network benefit level under the following circumstances in the event treatment is for an accident or emergency medical condition as determined by the Claims Administrator,.

Additional information about this option, as well as a list of Network Providers will be given to covered Employees and updated as needed.

#### **Deductibles/Co-payments payable by Plan Participants**

Deductibles/Co-payments are dollar amounts that the Covered Person must pay before the Plan pays.

A deductible is an amount of money that is paid once a Calendar Year per Covered Person. Typically, there is one deductible amount per Plan and it must be paid before any money is paid by the Plan for any covered services. Each January 1<sup>st</sup>, a new deductible amount is required. The benefit period is one calendar year commencing each January 1 through December 31. Any Covered Services incurred during the calendar months of October, November and December which were applied toward the Deductible Amount for that benefit period, but did not satisfy the Deductible Amount, may be applied to the Deductible Amount for the next succeeding calendar year. Deductibles do not accrue toward the 100% maximum out-of-pocket payment.

A co-payment is a smaller amount of money that is paid each time a particular service is used. Typically, there may be co-payments on some services and other services will not have any co-payments. Co-payments do not accrue toward the 100% maximum out-of-pocket payment.

<b>Services</b>	<b>Network Providers</b>	<b>Non-network Providers</b>
<b>Maximum Lifetime Benefit</b>	\$ 1,000,000	\$ 1,000,000
<b>Co-Insurance</b>	<b>80/20</b>	<b>50/50</b>
<b>Out-of-pocket Maximum</b>		
▪ Per Covered Person	\$ 1,500	\$ 10,000
▪ Per Family Unit	3 individuals	3 individuals
<b>Deductible</b>		
▪ Per Covered Person	\$ 500	\$1,500
▪ Per Family Unit	3 individuals	3 individuals
<b>Physician Services</b>		
▪ Office Visits - Includes up to \$200 of Physicians Office Lab Tests, X-rays, Therapeutic Injections (must be performed in office). Separate charges of Pathology labs and Radiology labs are subject to the CY deductible and out-of-pocket.	\$ 25 Copay	50% after deductible
▪ Spinal Manipulation /Chiropractic (50 visits Max)	50% after deductible	50% after deductible
▪ Second and Third Surgical Opinion	100% , No deductibles	100% , No deductibles
<b>Inpatient Facility Services</b>		
▪ Per Hospital Confinement	\$ 100 additional deductible	\$ 750 additional deductible
▪ Room and Board	80% after deductibles	50% after deductibles
▪ Intensive Care Unit	80% after deductibles	50% after deductibles
<b>Outpatient Facility Services</b>		
▪ Ambulatory/OP Surgery	80% after deductible	50% after deductible
▪ MRI/CT Scan, Ultrasound	80% after deductible	50% after deductible
▪ Diagnostic: Lab, X-ray, Mammogram	80% after deductible	50% after deductible
<b>Emergency Services</b>		
▪ Emergency Room Facility	\$ 75 additional deductible	\$ 75 additional deductible
▪ Emergency Room Physician	80% after deductibles	50% after deductibles
▪ Urgent Care Centers	\$ 25 Copay	50% after deductible
▪ Ambulance Air/Land	80% after deductible to nearest facility only	50% after deductible to nearest facility only
<b>Other Outpatient Medical Services</b>		
▪ Durable Medical Equipment Rental/Purchase	80% after deductible	50% after deductible
▪ Prosthetic Medical Appliances	80% after deductible	50% after deductible
▪ Rehab Services Physical and Occupational, etc.	80% after deductible	50% after deductible

<b>Services</b>	<b>Network Providers</b>	<b>Non-network Providers</b>
<b>Specialized Treatment</b>		
<ul style="list-style-type: none"> <li>▪ <b>Skilled Nursing Facility</b></li> </ul>	80% after deductible semi private room rate ordered within 14 days following a 3 -day hospital stay 90 day max stay	50% after deductible semi private room rate ordered within 14 days following a 3 -day hospital stay 90 day max stay
<ul style="list-style-type: none"> <li>* <b>Registered Dietician</b></li> </ul>	80% after deductible (one time only with doctor referral and not for obesity treatment)	50% after deductible (one time only with doctor referral and not for obesity treatment)
<ul style="list-style-type: none"> <li>▪ <b>Birthing Center</b></li> </ul>	80% after deductible	50% after deductible
<ul style="list-style-type: none"> <li>▪ <b>Hospice Care</b></li> </ul>	80% after deductible \$ 10,000 Lifetime Max	50% after deductible \$ 10,000 Lifetime Max
<ul style="list-style-type: none"> <li>▪ <b>Rehabilitation Facility Acute Care Only</b></li> </ul>	80% after deductible	50% after deductible
<ul style="list-style-type: none"> <li>▪ <b>Home Health Care</b></li> </ul>	80% after deductible 100 visits Max	50% after deductible 100 visits Max
<ul style="list-style-type: none"> <li>▪ <b>Private Duty Nursing (Outpatient Only)</b></li> </ul>	80% after deductible \$ 5,000 Year Max	50% after deductible \$ 5,000 Year Max
<ul style="list-style-type: none"> <li>▪ <b>Cardiac Rehabilitation initiated within 12 weeks after other treatment</b></li> </ul>	80% after deductible	50% after deductible
<b>Mental/Nervous and Substance Abuse Treatment</b>		
<ul style="list-style-type: none"> <li>▪ <b>Inpatient (10 days CY Max / 30 days Lifetime Max)</b></li> </ul>	80% after deductible	50% after deductible
<ul style="list-style-type: none"> <li>▪ <b>Outpatient (50 visits per CY)</b></li> </ul>	80% after deductible	50% after deductible
<ul style="list-style-type: none"> <li>▪ <b>Not Covered (May be covered under EAP Plan)</b> <ul style="list-style-type: none"> <li>▪ <b>Marital Counseling</b></li> <li>▪ <b>Family Counseling</b></li> <li>▪ <b>Sex Counseling</b></li> <li>▪ <b>Hypnosis</b></li> </ul> </li> </ul>		
<b>Preventive Care</b>		
<ul style="list-style-type: none"> <li>▪ <b>Routine Well Adult/ Well Child Care</b> NOTE: \$200 year maximum includes all routine, preventive, screening, OB/GYN and Physician examinations and Immunizations</li> </ul>	100% after Copay \$ 200 CY Max	N/A
<ul style="list-style-type: none"> <li>▪ <b>Routine Well Newborn Care</b></li> </ul>	80% after deductible	50% after deductible
<ul style="list-style-type: none"> <li>▪ <b>Hearing Test - ( Only 1 visit per year)</b></li> </ul>	\$ 25 Copay/Plan pays remaining at 100%	N/A
<ul style="list-style-type: none"> <li>▪ <b>Vision Services - Eye Exam (Only 1 visit per year)</b></li> </ul>	\$ 25 Copay/Plan pays remaining at 100%	N/A
<ul style="list-style-type: none"> <li>▪ <b>Immunizations (under age 19)</b></li> </ul>	100%	N/A

<b>Services</b>	<b>Network Providers</b>	<b>Non-network Providers</b>
<b>Transplant</b>		
<ul style="list-style-type: none"> <li>▪ <b>Recipient</b></li> </ul>	100% after deductible	50% after deductible overall max of \$ 100,000
<ul style="list-style-type: none"> <li>▪ <b>Donor (to the extent that they are not covered elsewhere)</b></li> </ul>	100% after deductible overall max of \$10,000 or 12 months after donor discharged from hospital, whichever comes first.	50% after deductible overall max of \$10,000 or 12 months after donor discharged from hospital, whichever comes first.
<b>Maternity Care</b>		
<ul style="list-style-type: none"> <li>▪ <b>Physicians Service for OB</b></li> </ul>	80% after deductible	50% after deductible
<ul style="list-style-type: none"> <li>▪ <b>Inpatient Admission (pre-certification is not required for length of stay that is less than 48 hours for vaginal delivery and less than 96 hours for Caesarian delivery)</b></li> </ul>	80% after deductible	50% after deductible
<ul style="list-style-type: none"> <li>▪ Charges billed with the Pregnancy diagnosis are not eligible for the office co-pay. All charges related to the Pregnancy will be subject to the deductible and co-insurance provisions of the Plan.</li> </ul>	<b>Dependent Daughters are NOT COVERED</b>	<b>Dependent Daughters are NOT COVERED</b>
<b>Prescription Drug Benefits</b>		
<b>Retail</b>		
<ul style="list-style-type: none"> <li>▪ <b>Generic Brands</b></li> </ul>	\$10.00	
<ul style="list-style-type: none"> <li>▪ <b>Brands with generics</b></li> </ul>	\$20.00	
<ul style="list-style-type: none"> <li>▪ <b>Brands without generics</b></li> </ul>	\$35.00	
<b>Mail-Order/Retail (90-day Maintenance Drugs Only Expected to be on for 1 year or more.)</b>		
<ul style="list-style-type: none"> <li>▪ <b>Generic Brands</b></li> </ul>	\$10.00	
<ul style="list-style-type: none"> <li>▪ <b>Brands with generics</b></li> </ul>	\$20.00	
<ul style="list-style-type: none"> <li>▪ <b>Brands without generics</b></li> </ul>	\$35.00	
<b>Covered Prescription Benefits</b>		
<ul style="list-style-type: none"> <li>▪ Legend Drugs</li> <li>▪ Compound Prescriptions</li> <li>▪ Insulin and Insulin Syringes</li> <li>▪ Diabetic Supplies (test strips)</li> <li>▪ Prenatal Vitamins</li> <li>▪ Vitamins with Fluoride</li> </ul>	<b>Exclusions</b>	
	<ul style="list-style-type: none"> <li>▪ Over the counter drugs</li> <li>▪ Non-Insulin syringes</li> <li>▪ Biological Serums</li> <li>▪ Gleevec</li> <li>▪ Diet Control Drugs</li> <li>▪ Medical Devices/Supplies</li> <li>▪ Fertility Drugs</li> <li>▪ Erectile Dysfunction / Organic Impotence Drugs</li> <li>▪ Diagnostic Agents</li> <li>▪ Contraceptive Devices</li> <li>▪</li> </ul>	<ul style="list-style-type: none"> <li>▪ Hair Growth Stimulants</li> <li>▪ Smoking Cessation Drugs</li> <li>▪ Retin A (over age 26)</li> <li>▪ Growth Hormones</li> <li>▪ Other Vitamins</li> <li>▪ Non Drug items</li> <li>▪ Experimental Drugs</li> <li>▪ Refills obtained more than one year after original date or prior to 75% of the completion of the projected use</li> </ul>

**Dental Benefits (non Orthodontia)**

- 100% of first \$150 in charges  
Then \$50 CY deductible
- 80% for the next \$375 in charges
- 50 % for the charges above \$375 (subject to annual maximum of \$1,500)

**Orthodontia Benefits**

- \$50 CY deductible
- \$1,500 lifetime maximum
- Benefits limited to dependent children up to age 19, to age 24 if full-time student

**MEDICAL BENEFITS**

Medical Benefits apply when covered charges are incurred by a Covered Person for care of an Injury or Sickness and while the person is covered for these benefits under the Plan.

**DEDUCTIBLE**

**Deductible Amount.** This is an amount of covered charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year a Covered Person must meet the deductible shown in the Schedule of Benefits.

This amount will not accrue toward the 100% maximum out-of-pocket payment.

**Family Unit Limit.** When three members of a Family Unit have satisfied their Calendar Year deductibles, the deductibles of all members of that Family Unit will be considered satisfied for that year.

**Deductible For A Common Accident.** This provision applies when two or more Covered Persons in a Family Unit are injured in the same accident. These persons need not meet separate deductibles for treatment of injuries incurred in this accident; instead, only one deductible for the Calendar Year in which the accident occurred will be required for them as a unit.

**BENEFIT PAYMENT**

Each Calendar Year, benefits will be paid for the covered charges of a Covered Person that are in excess of the deductible and any co-payments. Payment will be made at the rate shown under Percentage Payable in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount or any listed limit of the Plan.

**OUT-OF-POCKET LIMIT**

Covered Charges are payable at the percentages shown each Calendar Year until the out-of-pocket limit shown in the Schedule of Benefits is reached. Then, Covered Charges incurred by a Covered Person will be payable at 100% (except for the charges excluded) for the rest of the Calendar Year.

When a Family Unit reaches the out-of-pocket limit, Covered Charges for that Family Unit will be payable at 100% (except for the charges excluded) for the rest of the Calendar Year.

**MAXIMUM BENEFIT AMOUNT**

The Maximum Benefit Amount is shown in the Schedule of Benefits. It is the total amount of benefits that will be paid under the Plan for all covered charges incurred by a Covered Person.

**COVERED CHARGES**

Covered charges are the Usual and Reasonable Charges that are incurred for the following items of service and supply. These charges are subject to the benefit limits, exclusions and other provisions of the Plan. A charge is incurred on the date that the service or supply is performed or furnished.

- (1) **Hospital Care.** The medical services and supplies furnished by a Hospital or Ambulatory Surgical Center or Birthing Center. Covered charges for room and board will be payable as shown in the Schedule of Benefits. After 23 observation hours, a confinement will be considered an inpatient confinement.

Room charges made by a Hospital having only private rooms will be allowed at 90% of the average private room rate.

Charges for an Intensive Care Unit stay are Payable as described in the Schedule of Benefits.

- (2) **Coverage of Pregnancy.** The Usual and Reasonable Charges for the care and treatment of Pregnancy are covered the same as any other Sickness for a covered Employee or covered Spouse.

Group health plans 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 the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

**There is no coverage of Pregnancy for a Dependent Child.**

- (3) **Skilled Nursing Facility Care.** The room and board and nursing care furnished by a Skilled Nursing Facility will be payable if and when:
  - (a) the patient is confined as a bed patient in the facility;
  - (b) the confinement starts within 14 days of a Hospital confinement of at least three days;
  - (c) the attending Physician certifies that the confinement is needed for further care of the condition that caused the Hospital confinement; and
  - (d) the attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility.

Covered charges for a Covered Person's care in these facilities is limited to the covered daily charge limit shown in the Schedule of Benefits.

- (4) **Physician Care.** The professional services of a Physician for surgical or medical services.
  - (a) Charges for multiple surgical procedures will be covered expense subject to the following provisions:

- (i) If bilateral or multiple surgical procedures are performed by one (1) surgeon, benefits will be determined based of the Usual and Reasonable Charge that is allowed for the primary procedures; 50% of the Usual and Reasonable Charge will be allowed for each additional procedure performed through the same incision. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered “incidental” and no benefits will be provided for such procedures;
  - (ii) If multiple unrelated surgical procedures are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the Usual and Reasonable Charge for each surgeon’s primary procedure. If two (2) or more surgeons performs a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed the usual and Reasonable percentage allowed for that procedure; and
  - (iii) If an assistant surgeon is required, the assistant surgeon’s covered charge will not exceed 25% of the surgeon’s Usual and Reasonable allowance.
- (5) **Dependent Child Learning Impairment Care.** The following terms apply to this provision:
  - (a) **Benefit Period:** A period of six (6) consecutive months beginning on the date a covered Dependent child first incurs a treatment charge which is not attributable to a prior benefit period. (A charge shall be deemed to be incurred as of the date of treatment giving rise to the charge or as the date of purchase of the service covered by the charge. When a charge is made for total treatments or services rendered across a specific period of time, a pro rated portion of such charge shall be deemed to be incurred on a daily basis throughout such period).
  - (b) **Educational Therapy:** The application of therapeutic training exercises and multi-sensory teaching techniques to an individual with a learning impairment when the application of such exercises and techniques is principally intended to reduce the degree of impairment rather than to impart specific subject matter knowledge.
  - (c) **Remedial Clinic:** A legally constituted institution (not owned or operated by national government) used principally as a facility for remedial education or training through education therapy with:
    - 1. 24 hour supervision by a Physician or registered graduate nurse (R.N).
    - 2. The services of a Physician available at all times and
    - 3. A staff comprised of a legally qualified psychiatrist or a psychologist and such physical and educational therapists as may be necessary to formulate and implement Treatment Plans.
  - (d) **Treatment Plan:** A program of habilitative or rehabilitative treatment formulated and implemented by a remedial clinic, which is intended both (1) to cure or to improve any condition, whether functional or organic which causes or contributes to a learning impairment and (2) to overcome, improve or compensate for the learning impairment.

If on the recommendation of a Physician, a Dependent child incurs treatment charges as defined below in connection with a Treatment Plan, the Administrator shall pay to the covered Employee with respect to such Dependent child the benefit specified below, subject to the following provisions and other provisions of the Plan.

No benefits will be payable under the other provisions of the Plan with respect to charges incurred in connection with a Treatment Plan.

- (a) **Amount of Benefit:** The benefit shall be paid as outlined in the Schedule of Benefits for any other illness or accident.
1. For inpatient treatment, the out-of-pocket provisions as outlined in the Schedule of Benefits will apply, however, there will be a \$50,000 Lifetime maximum benefit for these learning impairment benefits and a \$10,000 Calendar Year maximum for these benefits.
  2. Outpatient treatment for a learning impairment, the benefit shall be payable on the basis of 50% of the treatment charges with a maximum per Calendar Year of \$10,000 and a maximum for a Lifetime of \$50,000.
- (b) **Treatment Charges:** Treatment charges include any of the following charges when made to or on behalf of a Dependent child by a remedial clinic in connection with a treatment plan for such Dependent child.
1. Charges for an initial series of physical, neurological, mental, associative memory, lateral dominance and similar standard tests administered by a remedial clinic to determine the nature and extent of a learning impairment and to formulate a treatment plan therefore.
  2. Charges for room and board furnished by a remedial clinic on its own immediate premises for a Dependent child who is treated on a resident basis.
  3. Charges for educational therapy.
  4. Charges for periodic administration of standard achievement tests to evaluate the Dependent child's progress under the treatment plan.
- (c) **Exclusions and limitations:** The benefit provided in this Dependent Child Learning Impairment Benefit provision shall not be payable with respect to:
1. Charges in excess of customary and reasonable or which are not incurred on the recommendation of a Physician, or which the covered Employee or covered Dependent child is not legally required to pay.
  2. Charges for tutoring in specific subjects.

3. Charges for the purchase or rental of books, tools, equipment, implements, eyeglasses, contact lenses, hearing aids or supplies of any kind.
  4. Charges for or in connection with travel or participation in sports, hobbies, encampments and other activities which are principally recreational regardless of whether or not such travel and activities are considered part of a treatment plan.
- (6) **Employee Assistance Program** – A program with contracted facilities to provide care for Employees and their Covered Dependents related to emotional distress, marital, financial complications or other health related problems.
- (7) **Private Duty Nursing Care.** The private duty nursing care by a licensed nurse (R.N., L.P.N. or L.V.N.). Covered charges for this service will be included to this extent:
- (a) **Inpatient Nursing Care.** Charges are covered only when care is Medically Necessary or not Custodial in nature and the Hospital's Intensive Care Unit is filled or the Hospital has no Intensive Care Unit.
  - (b) **Outpatient Nursing Care.** Charges are covered only when care is Medically Necessary and not Custodial in nature. The only charges covered for Outpatient nursing care are those shown below, under Home Health Care Services and Supplies. Outpatient private duty nursing care on a 24-hour shift basis is not covered.
- (8) **Home Health Care Services and Supplies.** Charges for home health care services and supplies are covered only for care and treatment of an Injury or Sickness when Hospital or Skilled Nursing Facility confinement would otherwise be required. The diagnosis, care and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan.
- Benefit payment for nursing, home health aide and therapy services is subject to the Home Health Care limit shown in the Schedule of Benefits.
- A home health care visit will be considered a periodic visit by either a nurse or therapist, as the case may be, or four hours of home health aide services.
- (9) **Hospice Care Services and Supplies.** Charges for hospice care services and supplies are covered only when the attending Physician has diagnosed the Covered Person's condition as being terminal, determined that the person is not expected to live more than six months and placed the person under a Hospice Care Plan.
- Covered charges for Hospice Care Services and Supplies are payable as described in the Schedule of Benefits.
- Bereavement counseling services by a licensed social worker or a licensed pastoral counselor for the patient's immediate family (covered Spouse and/or covered Dependent Children). Bereavement services must be furnished within six months after the patient's death.
- (10) **Other Medical Services and Supplies.** These services and supplies not otherwise included in the items above are covered as follows.

- (a) Local Medically Necessary professional land or air ambulance service. A charge for this item will be a Covered Charge only if the service is to the nearest Hospital or Skilled Nursing Facility where necessary treatment can be provided unless the Plan Administrator finds a longer trip was Medically Necessary.
- (b) Anesthetic; oxygen; blood; and blood derivatives that are not donated or replaced; intravenous injections and solutions. Administration of these items is included.
- (c) Cardiac rehabilitation as deemed Medically Necessary provided services are rendered (a) under supervision of a Physician; (b) in connection with a myocardial infraction, coronary occlusions or coronary bypass surgery; (c) initiated within 12 weeks after other treatment for the medical condition ends; and (d) in a Medical Care Facility as defined by this Plan.
- (d) Radiation or chemotherapy and treatment with radioactive substances. The materials and services of technicians are included.
- (e) Initial contact lenses or glasses required following cataract surgery.
- (f) Rental of durable medical or surgical equipment if deemed Medically Necessary. These items may be bought rather than rented, with the cost not to exceed the fair market value of the equipment at the time of purchase, but only if agreed to in advance by the Plan Administrator.
- (g) Medically Necessary services for care and treatment of jaw joint conditions, including Temporomandibular Joint syndrome.
- (h) Laboratory studies.
- (i) Treatment of Mental Disorders. Covered charges for care, supplies and treatment of Mental Disorders will be limited as follows:  
  
All treatment is subject to the benefit payment maximums shown in the Schedule of Benefits.  
  
Physician's visits are limited to one treatment per day.  
  
Psychiatrists (M.D.), psychologists (Ph. D.) may bill the Plan directly. Other licensed mental health practitioners must be under the direction of and must bill the Plan through these professionals.
- (j) Injury to or care of mouth, teeth, and gums. Charges for injury to or care of the mouth, teeth, gums and alveolar processes will be covered charges under Medical Benefits only if that care is for the following oral surgical procedures.  
  
Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.  
  
Repair due to Injury to sound natural teeth. This repair must be made within 6 months from the date of an accident.  
  
Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.

Incision of sensory sinuses, salivary glands or ducts

Removal of impacted teeth

Reduction of dislocations and excision of temporomandibular joints (TMJs).

No charge will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.

- (k) Occupational therapy by a licensed occupational therapist. Therapy must be ordered by a Physician, result from an Injury or Sickness and improve a body function. Covered expenses do not include recreational programs, maintenance therapy or supplies used in occupational therapy.

**(l) Coverage for organ and/or tissue transplants.**

**Pre-Authorization Requirement for Organ Transplants.\***

Expenses incurred in connection with any organ or tissue transplant listed in this provision will be covered subject to referral to and pre-authorization by the Plan Administrator's authorized medical review specialist. (Kidney and cornea transplants are not subject to this provision, but will be considered on the same basis as any other medical expense coverage under this Plan.) *Transplant coverage is offered under this Plan through a preferred provider network of specialized professionals and facilities. Coverage is also provided for Transplant services obtained outside of the preferred network, at a reduced benefit level.*

As soon as reasonably possible, but in no event more than ten (10) days after a Covered Person's attending physician has indicated that the Covered Person is a potential candidate for a transplant, the Covered Person or his physician should contact the Plan Administrator for *referral to the network's medical review specialist for evaluation and pre-authorization*. A comprehensive treatment plan must be developed for this Plan's medical review, and must include such information as the diagnosis, the nature of the transplant, the setting of the procedure (i.e., name and address of the Hospital), any secondary medical complications, a five year prognosis, two (2) qualified opinions confirming the need for the procedure, as well as a description and the estimated cost of the proposed treatment. (One or both confirming second opinions may be waived by the Plan's medical review specialist.) Additional attending physician's statements may also be required. *The Covered Person may provide a comprehensive treatment plan independent of the preferred provider network, but this will be subject to medical appropriateness review and may result in non-network benefit coverage.*

All potential transplant cases will be assessed for their appropriateness for Large Case Management.

\*Failure to pre-authorize a transplant procedure and/or utilize an In-Network facility will result in the application of a \$5,000 deductible to all

covered expenses incurred as a result of the transplant. This deductible is in addition to any other plan deductible and co-payment requirements which would normally be applicable to the transplant procedure.

### **Organ Transplant Network**

*As a result of the pre-authorization review, the Covered Person, will be asked to consider obtaining transplant services at a participating transplant center. The term "participating transplant center" means "a licensed healthcare facility which has entered into a participation agreement with fee arrangements as established with the Claims Administrator to provide health services to the Plan's Sponsor". The transplant network's goal is to perform necessary transplants in the most appropriate setting for the procedure with consideration of and enhancement of the quality of patient care.*

*There is no obligation for the patient to use network services. However, benefits for the transplant and its related expenses will vary depending on whether services are provided in or out of the transplant network. If a transplant is performed out of network, but the Covered Person has received approval from the Plan's medical review specialist for out of network services, then network benefits will apply to the transplant and its related expenses. If services are provided out of network without approval from the medical review specialist, then out of network benefits will apply.*

### **Transplant Benefit Period**

Covered transplant expenses will accumulate during a Transplant Benefit Period, and will be charged toward the transplant benefit period maximums, if any, shown in the Transplant Schedule of Benefits. The term "Transplant Benefit Period" means the period which begins on the date of the initial evaluation and ends on the date which is twelve consecutive months following the date of the transplant. (If the transplant is a bone marrow transplant, the date the marrow is reinfused is considered the date of the transplant.)

### **Covered Transplant Expenses**

The term "covered expenses" with respect to transplant includes the reasonable and customary expenses for services and supplies which are covered under this Plan (or which are specifically identified as covered only under this provision) and which are medically necessary and appropriate to the Transplant:

1. Charges incurred in the evaluation, screening, and candidacy determination process.
2. Charges incurred for organ transplantation.
3. Charges for organ procurement, including donor expenses not covered under the donor's plan of benefits.
  - (i) coverage for organ procurement from a non-living donor will be provided for costs involved in removing, preserving and transporting the organ

- (ii) coverage for organ procurement from a living donor will be provided for the costs involved in screening the potential donor, transporting the donor to and from the site of the transplant, as well as for medical expenses associated with removal of the donated organ and the medical services provided to the donor in the interim and for follow up care.
  - (iii) if the transplant procedure is a bone marrow transplant, coverage will be provided for the cost involved in the removal of the patient's bone marrow (autologous) or donated marrow (allogenic). Coverage will also be provided for search charges to identify an unrelated match, treatment and storage costs of the marrow, up to the time of reinfusion. (The harvesting of the marrow need not be performed within the transplant benefit period).
- 4. Charges incurred for follow up care, including immuno-suppressant therapy.
  - 5. Charges for transportation to and from the site of the covered organ transplant procedure for the recipient and one other individual, or in the event that the recipient or the donor is a minor, two (2) other individual. All reasonable and necessary lodging and meal expenses incurred during the transplant benefit period will be covered up to a maximum of \$5,000 per transplant benefit period.

#### **Re-Transplantation.**

Re-transplantation will not be covered.

#### **Accumulation of Expenses**

Expenses incurred during any one transplant period for the recipient and for the donor will accumulate towards the recipient's benefit and will be included in the Plan's overall per person maximum lifetime benefit.

#### **Donor Expenses**

Medical expenses of the donor will be covered under this provision to the extent that they are not covered elsewhere under this Plan or any other benefit plan covering the donor. In addition, medical expense benefits for a donor who is not a participant under this Plan are limited to a maximum of \$10,000 per transplant benefit period when the transplant services are provided out of network. This does not include the donor's transportation and lodging expenses.

#### **Pre-Existing Condition Limitation.**

Transplant charges will be subject to this Plan's pre-existing conditions limitations.

- (m) The initial purchase and fitting of orthotic appliances such as braces, splints or other appliances which are required for support for an injured

or deformed part of the body as a result of a disabling congenital condition or an Injury or Sickness, with the exception of dental braces or corrective shoes.

- (n) **Physical therapy** by a licensed physical therapist. The therapy must be in accord with a Physician's exact orders as to type, frequency and duration and to improve a body function.
- (o) Prescription Drugs (as defined).
- (p) **Routine Preventive Care.** Covered charges under Medical Benefits are payable for routine Preventive Care as described in the Schedule of Benefits.

**Charges for Routine Well Adult Care.** Routine well adult care is care by a Physician that is not for an Injury or Sickness.

**Charges for Routine Well Child Care.** Routine well child care is routine care by a Physician that is not for an Injury or Sickness.

- (q) The initial purchase and fitting of prosthetic devices which replace body parts.
- (r) **Reconstructive Surgery.** Correction of abnormal congenital conditions and reconstructive mammoplasties will be considered covered charges.
- (s) **Speech therapy** by a licensed speech therapist. Therapy must be ordered by a Physician and follow either: (i) surgery for correction of a congenial condition of the oral cavity, throat or nasal complex (other than a frenectomy) of a person; (ii) and Injury; or (iii) a Sickness that is other than a learning or Mental Disorder.
- (t) **Spinal Manipulation/Chiropractic services** by a licensed M.D., D.O. or D.C.
- (u) Sterilization procedures.
- (v) Surgical dressings, splints, casts and other devices used in the reduction of fractures and dislocations.
- (w) Coverage of **Well Newborn Nursery/Physician Care.**

**Charges for Routine Nursery Care.** Routine well newborn nursery care is room, board and other normal care for which a Hospital makes a charge.

This coverage is only provided if a parent is a Covered Person who was covered under the Plan at the time of the birth and the newborn child is an eligible Dependent and is neither injured nor ill.

The benefit is limited to Usual and Reasonable Charges for nursery care for the newborn child while Hospital confined as a result of the child's birth.

Charges for covered routine nursery care will be applied toward the Plan of the newborn child.

Group health plans generally may not, under Federal Law, restrict benefits for any hospital length 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 the issuer for prescribing a length of stay not in excess of 8 hours (or 96 hours).

**Charges for Routine Physician Care.** The benefit is limited to the Usual and Reasonable Charges made by a Physician for the newborn child while Hospital confined as a result of the child's birth.

Charges for covered routine Physician care will be applied toward the Plan of the newborn child.

- (x) Diagnostic X-rays.

## COST MANAGEMENT SERVICES

### Cost Management Services Phone Number

Please refer to name and telephone number shown on your identification card.

The patient or family member must call this number to receive certification of certain Cost Management Services. This call must be made at least five days in advance of services being rendered or within two business days after an emergency.

**Any reduced reimbursement due to failure to follow cost management procedures will not accrue toward the 100% maximum out-of-pocket payment.**

### UTILIZATION REVIEW

Utilization review is a program designed to help insure that all Covered Persons receive necessary and appropriate health care while avoiding unnecessary expenses.

The program consists of:

- (a) Pre-certification of the Medical Necessity for the following non-emergency services before Medical and/or Surgical services are provided:
- (b) Retrospective review of the Medical Necessity of the listed services provided on an emergency basis;
- (c) Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending Physician; and
- (d) Certification of services and planning for discharge from a Medical Care Facility or cessation of medical treatment.

The purpose of the program is to determine what is payable by the Plan. This program is not designed to be the practice of medicine or to be a substitute for the medical judgement of the attending Physician or other health care provider.

If a particular course of treatment or medical service is not certified, it means that the Plan will not consider that course of treatment as appropriate for the maximum reimbursement under the Plan.

In order to maximize Plan reimbursements, please read the following provisions carefully.

### Here's how the program works.

**Pre-certification.** Before a Covered Person enters a Medical Care Facility on a non-emergency basis, the utilization review administrator will, in conjunction with the attending Physician, certify the care as appropriate for Plan reimbursement. A non-emergency stay in a Medical Care Facility is one that can be scheduled in advance. Pre-certification is encouraged but not required in the case of an admission in connection with childbirth.

The utilization review program is set in motion by a telephone call from the Covered Person. Contact the utilization review administrator at the telephone number shown on your identification card **at least five days before** services are scheduled to be rendered with the following information:

- The name of the patient and relationship to the covered Employee
- The name, Social Security number and address of the covered Employee
- The name of the Employer
- The name and telephone number of the attending Physician
- The name of the Medical Care Facility, proposed date of admission, and proposed length of stay
- The diagnosis and/or type of surgery

If there is an **emergency admission** to the Medical Care Facility, the patient, patient's family member, Medical Care Facility or attending Physician must contact the name and telephone number shown on your identification card **within two business days** of the first business day after the admission.

The utilization review administrator will determine the number of days of Medical Care Facility confinement authorized for payment. **Failure to follow this procedure may reduce reimbursement received from the Plan.** Penalty for failure to follow Pre-certification guidelines will not be applied to any Hospital admission in connection with childbirth.

***If the Covered Person does not receive authorization as explained in this section, allowable expenses will be reduced to 50 % of the covered charges.***

**Concurrent review, discharge planning.** Concurrent review of a course of treatment and discharge planning from a Medical Care Facility are parts of the utilization review program. The utilization review administrator will monitor the Covered Person's Medical Care Facility stay or use of other medical services and coordinate with the attending Physician, Medical Care Facilities and Covered Person either the scheduled release or an extension of the Medical Care Facility stay or extension or cessation of the use of other medical services.

If the attending Physician feels that it is Medically Necessary for a Covered Person to receive additional services or to stay in the Medical Care Facility for a greater length of time than has been pre-certified, the attending Physician must request the additional services or days. Also, if a Physician believe that it is Medically Necessary for a Covered Person who is hospitalized in connection with childbirth to stay in the Medical Care Facility for a greater length of time than 48 hours following a normal vaginal delivery or 96 hours following a cesarean section, the Physician should request the additional days.

## **SECOND AND/OR THIRD OPINION PROGRAM**

Certain surgical procedures are performed either inappropriately or unnecessarily. In some cases, surgery is only one of several treatment options. In other cases, surgery will not help the condition.

In order to prevent unnecessary or potentially harmful surgical treatments, the second and/or third opinion program fulfills the dual purpose of protecting the health of the Plan's Covered Persons and protecting the financial integrity of the Plan.

Benefits will be provided for a second (and third, if necessary) opinion consultation to determine the Medical Necessity of an elective surgical procedure. An elective surgical procedure is one that can be scheduled in advance; that is, it is not an emergency or of a life-threatening nature.

**A SECOND SURGICAL OPINION IS RECOMMENDED** for the following list of Surgical Procedures, when performed on a non-emergency basis:

- (a) Mastectomy, Mammoplasty
- (b) Repair of Foot Disorders
- (c) Laminectomy
- (d) Revision of Nasal Structure
- (e) Coronary Artery By-Pass Surgery
- (f) Cholecystectomy (gall bladder surgery)
- (g) Herniorrhaphy (hernia repairs)
- (h) Tonsillectomy and/or Adenoidectomy
- (i) Hemorrhoidectomy (removal of hemorrhoids)
- (j) Prostatectomy (removal of prostate)
- (k) Hysterectomy (removal and/or repairs of uterus, tubes or ovaries)
- (l) Dilation & Curettage (D&C) of Uterus
- (m) Removal of Cataract
- (n) Varicose Vein Stripping or Ligation
- (o) Carpal Tunnel Disorder
- (p) Total Knee Replacement
- (q) Total Hip Replacement

#### **PREADMISSION TESTING SERVICE**

The Medical Benefits percentage payable will be 100% for diagnostic lab tests and x-ray exams when:

- (1) performed on an outpatient basis within seven days before a Hospital confinement;
- (2) related to the condition which causes the confinement; and
- (3) performed in place of tests while Hospital confined.

Covered charges for this testing will be payable at 100% even if tests show the condition requires medical treatment prior to Hospital confinement or the Hospital confinement is not required. The deductible will also be waived for these tests.

#### **CASE MANAGEMENT**

When a catastrophic condition, such as a spinal cord injury, cancer, AIDS or a premature birth occurs, a person may require long-term, perhaps lifetime care. After the person's condition is diagnosed, he or she might need extensive services or might be able to be moved into another type of care setting—even to his or her home.

Case Management is a program whereby a case manager monitors these patients and explores, discusses and recommends coordinated and/or alternate types of appropriate Medically Necessary care. The case manager consults with the patient, the family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient. This plan of care may include some or all of the following:

- personal support to the patient;
- contacting the family to offer assistance and support;
- monitoring Hospital or Skilled Nursing Facility;
- determining alternative care options; and
- assisting in obtaining any necessary equipment and services.

Case Management occurs when this alternate benefit will be beneficial to both the patient and the Plan.

The case manager will coordinate and implement the Case Management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The Plan Administrator, attending Physician, patient and patient's family must all agree to the alternate treatment plan.

Once agreement has been reached, the Plan Administrator will direct the Plan to reimburse for Medically Necessary expenses as stated in the treatment plan, even if these expenses normally would not be paid by the Plan.

***Note: Case Management is a voluntary service. There are no reductions of benefits or penalties of the patient and family choose not to participate.***

**Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommend for any other patient, even one with the same diagnosis.**

#### **SPECIAL CASE CONSIDERATION**

You or your covered Dependents may qualify for the Individual Case Management program, at the discretion of the Third Party Claims Administrator and the Plan Administrator, based on various criteria including diagnosis, severity, length of illness, and proposed or rendered treatment. The program seeks to identify candidates for Individual Case Management as early as possible and work with patients, their Physicians and families, and other community resources to determine treatment alternative and available benefits.

When the Third Party Administrator determines that extra-contractual benefits should be provided to cover specific services not otherwise covered under the Plan in order to achieve the most efficient and effective use of medical resources, alternative benefits will be recommended. Alternative benefits will be implemented only when agreed to in writing by you, (or your representative), your Physician and the Third Party Administrator.

Individual case management and alternative benefits are determined solely at the discretion of the Third Party Administrator and the Plan Administrator and do not in any way amend, alter, augment or rescind any provisions of this Plan.

Except as otherwise provided in the written alternative benefits agreement, all terms and conditions of the Plan; including, but not limited to, the Lifetime maximum and all other limitations and exclusions, will remain in effect.

## DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized.

**Active Employee** is an Employee who is on the regular payroll of the Employer and who is scheduled to perform the duties of his or her job with the Employer on a full-time basis.

**Ambulatory Surgical Center** is a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (RNs) and does not provide for overnight stays.

**Baseline** shall mean the initial test results to which the results in future years will be compared in order to detect abnormalities.

**Birthing Center** means any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre or post-delivery confinement.

**Calendar Year** means January 1<sup>st</sup> through December 31<sup>st</sup> of the same year.

**COBRA** means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

**Cosmetic Dentistry** means dentally unnecessary procedures.

**Cosmetic Surgery** means medically unnecessary surgical procedures, usually, but not limited to, plastic surgery directed toward preserving beauty or correcting scars, burns, or disfigurements.

**Covered Person** is an Employee, Retiree or Dependant who is covered under this Plan.

**Creditable Coverage** includes most health coverage, such as coverage under a group health plan (including COBRA continuation coverage), HMO membership, an individual health insurance policy, Medicaid or Medicare.

Creditable Coverage does not include coverage consisting solely of dental or vision benefits.

**Custodial Care** is care (including room and board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication which could normally be self-administered.

**Dentist** is a person who is properly trained and licensed to practice dentistry and who is practicing within the scope of such license.

**Durable Medical Equipment** means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an illness or injury and (d) is appropriate for use in the home.

**Employee** means a person who is an Active, regular Employee of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship.

**Employee Assistance Program** means a program with contracted facilities to provide care for Employees and their covered Dependents related to emotional distress, marital, financial complications or other health related problems.

**Employer** is City of Gulfport

**Enrollment Date** is the first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period.

**ERISA** is the Employee Retirement Income Security Act of 1974, as amended.

**Experimental and/or Investigational** means services, supplies, care and treatment which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical and dental community or government oversight agencies at the time services were rendered.

The Plan Administrator must make an independent evaluation of the experimental/non-experimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Plan Administrator will be final and binding on the Plan. The Plan Administrator will be guided by the following principles:

- (1) if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
- (1) if the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or
- (2) if Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or Investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or
- (3) if Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use.

**Family Unit** is the covered Employee or Retiree and the family members who are covered as Dependents under the Plan.

**Generic Drug** means a Prescription Drug which has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a Generic Drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the

professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

**Genetic Information** means information about genes, gene products and inherited characteristics that may derive from an individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes.

**Home Health Care Agency** is an organization that meets all of these tests: its main function is to provide Home Health Care Services and Supplies; it is federally certified as a Home Health Care Agency; and it is licensed by the state in which it is located, if licensing is required.

**Home Health Care Plan** must meet these tests: it must be a formal written plan made by the patient's attending Physician which is reviewed at least every 30 days; it must state the diagnosis; it must certify that the Home Health Care is in place of Hospital confinement; and it must specify the type and extent of Home Health Care required for the treatment of the patient.

**Home Health Care Services and Supplies** include; part-time or intermittent nursing care by or under the supervision of a registered nurse (RN); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and speech therapy; medical supplies; and laboratory services by or on behalf of the Hospital.

**Hospice Agency** is an organization where its main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located, if licensing is required.

**Hospice Care Plan** is a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

**Hospice Care Services and Supplies** are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, home care, and family counseling during the bereavement period.

**Hospice Unit** is a facility or separate Hospital Unit, that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

**Hospital** is an institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets these tests: it is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations; it is approved by Medicare as a Hospital; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians; it continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of registered nurses (RNs); and it is operated continuously with organized facilities for operative surgery on the premises.

The definition of "Hospital" shall be expanded to include the following:

- A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.
- A facility operating primarily for the treatment of Substance Abuse if it meets these tests: maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; has a Physician in regular attendance; continuously provides 24-hour-a-day nursing service by a registered nurse (RN); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse.

**Illness** means a bodily disorder, disease, physical sickness or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage or Complications of Pregnancy.

**Injury** means an accidental physical Injury to the body caused by unexpected external means.

**Intensive Care Unit** is defined as a separate, clearly designated service area which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has: facilities for special nursing care not available in regular rooms and wards of the Hospital; special life saving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (RN) in continuous and constant attendance 24 hours a day.

**Legal Guardian** means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

**Lifetime** is a word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean while covered under this Plan. Under no circumstances does Lifetime mean during the lifetime of the Covered Person.

**Medical Care Facility** means a Hospital, a facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

**Medical Emergency** means a sudden onset of a condition with acute symptoms requiring immediate medical care and includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

**Medically Necessary** care and treatment is recommended or approved by a Physician or Dentist; is consistent with the patient's condition or accepted standards of good medical and dental practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of medical and dental services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary.

The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

**Medicare** is the Health Insurance For The Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

**Mental Disorder** means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

**Morbid Obesity** is a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight in the most recent Metropolitan Life Insurance Co. tables (or similar actuarial table) for a person of the same height, age and mobility as the Covered Person.

**No-Fault Auto Insurance** is the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

**Outpatient Care** is treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Ambulatory Surgical Center, or the patient's home.

**Pharmacy** means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

**Physician** means a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Dental Surgery (DDS), Doctor of Podiatry (DPM), Doctor of Chiropractic (DC), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Profession Physical Therapist, Midwife, Occupational Therapist, Optometrist (OD), Physiotherapist, Psychiatrist, Psychologist (PhD), Speech Language Pathologist and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

**Plan** means City of Gulfport Self-Funded Employee Benefits Plan, which is a benefits plan for certain employees of City of Gulfport and is described in this document.

**Plan Participant** is any Employee, Retiree or Dependent who is covered under this Plan.

**Plan Year** is the 12-month period beginning on either the effective date of the Plan or on the day following the end of the first Plan Year which is a short Plan Year.

**Pre-Existing Condition** is a condition for which medical advice, diagnosis, care or treatment was recommended or received within twelve months (18 months if a Late Enrollee) of the person's Effective Date under this Plan. Genetic Information is not a condition. Treatment includes receiving services and supplies, consultations, diagnostic tests or prescribed medicines.

The Pre-Existing Condition does not apply to pregnancy, to a newborn child who is covered under this Plan within 31 days of birth, or to a child who is adopted or placed for adoption before attaining age 18 and who, as of the last day of the 31-day period beginning on the date of the adoption or placement for adoption, is covered under this Plan. A Pre-Existing Condition exclusion may apply to coverage before the date of the adoption or placement for adoption.

The prohibition on Pre-Existing Condition exclusion for newborn, adopted, or pre-adopted children does not apply to an individual after the end of the first 63-day period during all of which the individual was not covered under any creditable coverage.

**Pregnancy** is childbirth and conditions associated with Pregnancy, including complications.

**Prescription Drug** means any of the following; a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend; "Caution; federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of a Sickness or Injury.

**Retiree** means a former Employee with over twenty-five (25) years of services and over the age of sixty (60).

**Retired Employee** is a former Active Employee of the Employer who was retired while employed by the Employer under the formal written plan of the Employer and elects to contribute to the Plan the contribution required from the Retired Employee.

**Sickness** is an Illness, disease or Pregnancy, (with the exception of pregnancy or its complications for a dependent daughter.)

**Skilled Nursing Facility** is a facility that fully meets all of these tests:

- (1) It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered nurse (RN) or by a licensed practical nurse (LPN) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.
- (2) Its services are provided for compensation and under the full-time supervision of a Physician.
- (3) It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.
- (4) It maintains a complete medical record on each patient.
- (4) It has an effective utilization review plan.
- (5) It is not, other than incidentally, a place for rest, the age, drug addicts, alcoholics, mental retardates, Custodial or educational care or care of Mental Disorders.
- (7) It is approved and licensed by Medicare.

This term also applies to charges incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation hospital or any other similar nomenclature.

**Speech Therapy** is charges by a licensed speech therapist. The therapy must be to restore speech loss or correct impairment due to:

- (1) A birth defect where therapy follows corrective surgery; or
- (2) An Injury; or
- (3) An Illness other than a mental or learning disorder.

**Spinal Manipulation/Chiropractic Care** means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

**Substance Abuse** is the condition caused by regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs that results in a chronic disorder affecting physical health and/or personal or social functioning. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

**Temporomandibular Joint (TMJ)** syndrome is the treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint. Care and treatment shall include, but are not limited to orthodontics, crowns, inlays, physical therapy and any appliance that is attached to or rests on the teeth.

**Total Disability (Totally Disabled)** means: In the case of a Dependent Child, the complete inability as a result of Injury or Sickness to perform the normal activities of a person of like age and sex in good health.

**Usual and Reasonable Charge** is a charge which is not higher than the usual charge made by the provider of the care or supply and does not exceed the usual charge made by most providers of like service in the same area. This test will consider the nature and severity of the condition being treated. It will also consider medical complications or unusual circumstances that require more time, skill or experience.

The Plan will reimburse based on the actual charge billed if it is less than the Usual and Reasonable Charge.

The Plan Administrator has the discretionary authority to decide whether a charge is Usual and Reasonable.

## PLAN EXCLUSIONS

**Note: All exclusions related to Prescription Drugs are shown in the Prescription Drug Plan.**

**Note: All exclusions related to Dental are shown in the Dental Plan.**

**For all Medical Benefits shown in the Schedule of Benefits, a charge for the following is NOT COVERED:**

- (1) **Abortion.** Services, supplies, care or treatment in connection with an abortion unless the life of the mother is endangered by the continued Pregnancy or the Pregnancy is the result of rape or incest.
- (2) **Acupuncture.** Services, supplies, care or treatment in connection with acupuncture or acupressure.
- (3) **Appointments.** Broken appointments the Participant fails to keep or completion of claim forms.
- (4) **Complications of non-covered treatments.** Care, services or treatment required as a result of complications from a treatment not covered under the Plan.
- (5) **Cosmetic Services.** Care and treatment, services and supplies provided for cosmetic purposes, except for correction of defects incurred by the Covered Person through traumatic injuries or diseases requiring surgery or to correct a congenital defect which has resulted in a functional defect.
- (6) **Custodial Care.** Services or supplies provided mainly as a rest cure, maintenance or Custodial Care.
- (7) **Educational or vocational testing.** Services for educational or vocational testing or training, this does not include services provided under Dependent Child Learning Impairment Care described elsewhere in this book.
- (8) **Excess charges.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Usual and Reasonable Charge.
- (9) **Exercise programs.** Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupation or physical therapy covered by this Plan.
- (10) **Experimental or not Medically Necessary.** Care and treatment that is either Experimental/Investigational or not Medically Necessary.
- (11) **Eye care.** Radial keratotomy or other eye surgery to correct near-sightedness. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting except as part of the Routine Well Adult/Well Child Provision and subject to that provision's annual maximum benefit. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages.
- (12) **Foot Care.** The following care, treatment or supplies for the feet: orthopedic shoes; orthopedic prescription devices to be attached to or placed in shoes; treatment for callus, corn or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease); any manipulative procedure for weak or fallen

- arches, flat or pronated foot, or foot strain, or bunions; (except for open cutting operations).
- (13) **Government coverage.** Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law.
- (14) **Hair loss.** Care and treatment for hair loss including wigs, hair transplants or a drug that promises hair growth, whether or not prescribed by a Physician.
- (15) **Hearing aids and exams.** Charges for services or supplies in connection with hearing aids or exams for their fitting. This exclusion shall not apply to the initial purchase of a hearing aid if the loss of hearing is a result of a surgical procedure.
- (16) **Hospital employees.** Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.
- (17) **Illegal acts.** Charges for services received as a result of Injury or Sickness caused by or contributed to by engaging in an illegal act or occupation; by committing or attempting to commit any crime, criminal act, assault or other felonious behavior; or by participating in a riot or public disturbance.
- (18) **Incarcerated.** For treatment of illness or injury which occurred while under arrest or confined in a penal institution.
- (19) **Impotence.** Care, treatment, services, supplies or medication in connection with treatment for impotence.
- (20) **Infertility.** Care and treatment for infertility, artificial insemination or in vitro fertilization.
- (21) **Marital Counseling.** Charges for marital counseling, except for services provided under Employee Assistance Program provision of this Plan.
- (22) **No charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.
- (23) **Non-emergency Hospital admissions.** Care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.
- (24) **Non-emergency Use of Emergency Room.** Any charges occurring because of the abuse (as defined by the Plan Administrator) of a Hospital emergency room for treatment of an Injury or Illness not generally regarded as an emergency procedure will not be considered as an eligible charge under this Plan.
- (25) **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay.
- (26) **No Physician recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.

- (27) **Not specified as covered.** Services, treatments and supplies which are not specified as covered under this Plan.
- (28) **Obesity.** Care and treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another Sickness.
- (29) **Occupational.** Care and treatment of an Injury or Sickness that is occupational – that is, arises from work for wage or profit including self-employment.
- (30) **Outside the United States.** Services rendered in a Hospital in a country outside of the fifty United States will be paid only when coverage is not otherwise available as a part of a national health care program of the country involved and claims can be stated in U.S. dollars.
- (31) **Personal comfort items.** Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattress, blood pressure instruments, scales, elastic bandages or stocking, nonprescription drugs and medicines, and first-aid supplies and non-hospital adjustable beds.
- (32) **Plan design excludes.** Charges excluded by the Plan design as mentioned in this document.
- (33) **Pregnancy of daughter.** Care and treatment of Pregnancy and Complications of Pregnancy for a dependent daughter only.
- (34) **Relative giving services.** Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.
- (35) **Replacement braces.** Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional.
- (36) **Routine care.** Charges for routine or periodic examinations, screening examinations, evaluation procedures, preventative medical care, or treatment or services not directly related to the diagnosis or treatment of a specific Injury, Sickness or pregnancy-related condition which is known or reasonably suspected, unless such care is specifically covered in the Schedule of Benefits.
- (37) **Self-Inflicted.** Any loss due to an intentionally self-inflicted Injury, while sane or insane.
- (38) **Services before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was Covered under this Plan or after coverage ceased under this Plan.
- (39) **Services not rendered.** No charges will be paid for services which are not rendered.
- (40) **Sex Changes.** Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment.

- (41) **Sleep disorders.** Care and treatment for sleep disorders unless deemed Medically Necessary.
- (42) **Smoking cessation.** Care and treatment for smoking cessation programs, including smoking deterrent patches.
- (43) **Speech therapy.** Services for speech therapy:
  - (a) To correct pre-speech deficiencies or delayed speech development;
  - (b) To improve speech skills that have not fully developed;
  - (c) To overcome learning difficulties;
  - (d) Special education, including lessons in sign language, to instruct a family member whose ability to speak has been lost or impaired, to function without that ability.

This exclusion does not apply when therapy is to restore speech loss or correct speech impairment due to:

  - (a) A birth defect where therapy follows corrective surgery; or
  - (b) An Injury; or
  - (d) An Illness other than a mental or learning disorder.
- (44) **Substance abuse.** Care and treatment of Substance Abuse.
- (45) **Surgical sterilization reversal.** Care and treatment for reversal of surgical sterilization.
- (46) **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges as defined as a covered expense.
- (47) **War.** Any loss that is due to a declared or undeclared act of war.

## **EMPLOYEE ASSISTANCE PROGRAM**

At times, Employees and/or their Dependents may incur personal problems that affect their work performance, daily living activities and their health. These problems may be related to emotional distress, marital, financial complications or other health related problems that are too difficult to overcome without assistance.

The City of Gulfport is pleased to have an Employee Assistance Program available for our Employees and their eligible Dependents who are covered under the Medical Plan. The goal of this program is to assist these individual in obtaining the care that will aid and support them in dealing with those particular problems. The City of Gulfport has engaged a group of physicians, clinics and hospital that will provide these services for a contracted fee.

The program provides for an assessment and a limited number of visits at no cost to the Employee or the covered Dependent. If additional outpatient care is required following a small co-payment from the patient, the Plan will cover the contracted expenses up to maximum of 52 visits per Calendar Year. In some instances, the patient may encounter problems related to a completely different diagnosis in the same Calendar Year. When this occurs, the program again provides for an assessment and limited number of visits at no cost to the patient. However, the visits for each separate diagnosis combine toward the maximum of 52 visits per Calendar Year.

In situations where inpatient care is required, the Plan will provide benefits under the Mental Disorder Provisions stated elsewhere in this booklet.

**RETIREES**

Employees with a minimum of twenty-five (25) or more years of service at any age or a minimum of four (4) years of service at or over the age of sixty (60) (PERS) or in the MUNI retirement system are eligible to continue their coverage under this Plan as Retirees with certain limitations. A Retiree’s eligible Dependents are those persons who were covered as Dependents at the time the Active Employee became a Retiree. Dependents acquired after an Employee has retired are not eligible to enroll under this Plan.

All benefits terminate for the Retiree or Covered Dependent upon the Retiree/Dependent becoming eligible for Medicare.

Upon retirement, benefits under this Plan are reduced to a Lifetime maximum of \$500,000. If any member has exceeded \$500,000 while covered as an Active Employee or Dependent of an Active Employee, the member is considered to have exceeded the Retiree plan maximum and is no longer eligible for coverage under the Retiree provision. However, that individual would be eligible to continue coverage under the COBRA provision of the Plan.

Benefits available under the Plan for Retirees and their Covered Dependent are shown in the following Schedule of Benefits:

**Schedule of Benefits – Retirees and Their Eligible Dependents**

	<b>PPO</b>	<b>Non-PPO</b>
<b>Calendar Year Deductible</b>	\$500 per person (limit 2 per family)	\$1,000 per person (limit 2 per family)
<b>First \$10,000 annually of covered expenses after deductible met</b>	80%	N/A
<b>Excess over \$10,000 annually of covered expenses after deductible met</b>	100%	N/A
<b>First \$20,000 annually of covered expenses after deductible met</b>	N/A	60%
<b>Excess over \$20,000 annually of covered expenses after deductible met</b>	N/A	100%

MAXIMUM PLAN YEAR BENEFIT  
(PPO & NON-PPO INTEGRATED) \$50,000

LIFETIME MAXIMUM \$500,000

**ALL BENEFITS TERMINATE FOR THE RETIREE UPON THE EMPLOYEE/DEPENDENT BECOMING ENTITLED FOR MEDICARE.**

## **PRESCRIPTION DRUG BENEFITS**

### **PHARMACY DRUG CHARGE**

Participating pharmacies have contracted with the Plan to charge Covered Person reduced fees for covered Prescription Drugs purchased through their drug card.

### **CO-PAYMENT**

The co-payment is applied to each covered pharmacy drug charge and is shown in the Schedule of Benefits. The co-payment amount is not a covered charge under the Medical Plan. Any one prescription is limited to the greater of a 30-day supply or a 100-unit dose.

If a drug is purchased from a non-participating pharmacy, or a participating pharmacy when the Covered Person's ID card is not used, the amount payable in excess of the co-payment will be the ingredient cost and dispensing fee.

### **MAIL ORDER DRUG BENEFIT OPTION**

The mail order drug benefit option is available for maintenance medication (those that are taken expected to be taken for more than one year, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.). Because of volume buying, the mail order pharmacy is able to offer Covered Person significant savings on their prescriptions.

### **CO-PAYMENT**

The co-payment is applied to each covered mail order prescription charge and is shown in the Schedule of Benefits. It is not a covered charge under the Medical Plan. Any one prescription is limited to the greater of a 90-day supply or a 300-unit dose.

### **COVERED PRESCRIPTION DRUGS**

- (1) All drugs, including oral contraceptives, prescribed by a Physician, that require a prescription either by federal or state law, except injectables (other than insulin) or any other drugs not covered under this Plan.
- (3) All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity.
- (4) Insulin when prescribed by a Physician.

### **LIMITS TO THIS BENEFIT**

This benefit applies only when a Covered Person incurs a covered Prescription Drug charge. The covered drug charge for any one prescription will be limited to:

- (1) Refills only up to the number of times specified by a Physician.
- (2) Refills up to one year from the date of order by a Physician.

**EXPENSES NOT COVERED**

This benefit will NOT cover a charge for any of the following:

- (1) **Administration.** Any charge for the administration of a covered Prescription Drug.
- (2) **Consumed on premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.
- (3) **Devices.** Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device.
- (4) **Experimental.** Experimental drugs and medicines, even though a charge is made to the covered Person.
- (5) **FDA.** Any drug not approved by the Food and Drug Administration.
- (6) **Immunization.** Immunization agents or biological sera.
- (7) **Impotence.** A charge for impotence medication.
- (8) **Infertility.** A charge for infertility medication.
- (9) **Injectables.** A charge for hypodermic syringes and/or needles, injectables or any prescription directing administration by injection (other than insulin).
- (10) **Investigational.** A drug or medicine labeled: "Caution – limited by federal law to investigational use."
- (11) **Medical exclusions.** A charge excluded under Medical Plan Exclusions.
- (12) **No prescription.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin.
- (13) **Smoking cessation.** A charge for Prescription Drugs for smoking cessation (i.e., nicotine gum).
- (14) **Smoking deterrent patches.** A charge for smoking deterrent patches.

## HOW TO SUBMIT A CLAIM

When a Covered Person has a claim to submit for payment that person must:

- (1) Obtain a claim form from the Personnel Office or the Plan Administrator.
- (2) Complete the Employee portion of the form. **ALL QUESTIONS MUST BE ANSWERED.**
- (3) For Plan reimbursements, attach bills for services rendered. **ALL BILLS MUST SHOW:**
  - Name of Plan
  - Employee's name
  - Name of patient
  - Name, address, telephone number of the provider of care
  - Diagnosis
  - Type of services rendered, with diagnosis and/or procedure codes
  - Date of services
  - Charges
- (4) Send the above to the Claims Administrator at this address:

BENCHMARK ADMINISTRATORS, LLC  
PO BOX 16767  
JACKSON, MS 39236-6767  
(601) 366-0596 OR (800) 445-2075

## WHEN CLAIMS SHOULD BE FILED

Claims should be filed with the Claims Administrator within 90 days of the date charges for the service were incurred. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date may be declined or reduced unless:

- (a) it's not reasonably possible to submit the claim in that time; and
- (b) the claim is submitted within one year from the date incurred. This one-year period will not apply when the person is not legally capable of submitting the claim.

The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

A request for Plan benefits will be considered a claim for Plan benefits, and it will be subject to a full and fair review. If a claim is wholly or partially denied, the Claims Administrator will furnish the Plan Participant with a written notice of this denial. This written notice will be provided within 90 days after receipt of the claim. The written notice will contain the following information:

- (a) the specific reason or reasons for the denial;
- (b) specific reference to those Plan provisions on which the denial is based;
- (c) a description of any additional information or material necessary to correct the claim and an explanation of why such material or information is necessary; and

- (d) appropriate information as to the steps to be taken if a Plan Participant wishes to submit the claim for review.

A Plan Participant will be notified within 90 days of receipt of the claim as to the acceptance or denial of a claim and if not notified within 90 days, the claim shall be deemed denied.

If special circumstances require an extension of time for processing the claim, the Claims Administrator shall send written notice of the extension to the Plan Participant. The extension notice will indicate the special circumstances requiring the extension of time and the date by which the Plan expects to render the final decision on the claim. In no event will the extension exceed a period of 90 days from the end of the initial 90-day period.

## **CLAIMS REVIEW AND APPEALS PROCEDURE**

If a Plan Participant (Employee or Covered Dependent) disagrees with any denial of a claim for Plan benefits or with any other decision concerning eligibility for coverage or benefits under the Plan, the Plan Participant may ask the Claims Administrator to review its initial claims determination, and, if still dissatisfied following this initial review, the Plan Participant may appeal the initial claims determination to the Plan Administrator, in accordance with the following procedures (PLEASE NOTE: time deadlines for seeking review or appeal):

### **Review of Initial Determination**

If a Plan Participant disagrees with any payment, non-payment, denial or initial determination regarding a claim for Plan benefits, the Plan Participants is entitled to further review of the initial determination, in accordance with the following procedures:

- (1) The Plan Participant must send a written request to the Claims Administrator, asking for further review of the initial determination, and
- (2) The written request must explain why and how the Plan Participant disagrees with the initial determination, including whether the Plan Participant disagrees with the determination in whole or in part; and
- (3) The written request must include the name and social security number of the Plan Participant, the name of the patient for whom Plan benefits are being claimed, the Group Identification Number, if any, and identification of the specific claims or services in dispute; and
- (4) The written request should include any information or documentation the Plan Participant believes should be considered upon review; and
- (5) The written request must be made no later than 60 days following the date of notification of the initial claims determination. (For purposes of this provision, a written request is deemed "made" when it is received in the offices of the Claims Administrator and the "date of notification" is the date the Participant receives written notification of the initial claims determination or the claim payment date, whichever occurs first.)

Written request for review should be directed to:

BenMark Administrators, LLC. (Claims Administrator)  
P.O. Box 16767  
Jackson, Mississippi 39205

The Claims Administrator, upon receipt of a timely written request, will conduct a review to consider whether the initial claims determination was correctly made in accordance with the provisions of the Plan, or whether an error occurred and can be corrected. The Claims Administrator will provide a written response to the Plan Participant (with a copy to the Plan Administrator) as soon as administratively feasible, but no later than 30 days after the written request for review is made. The Claims Administrator's written response will include the specific reasons for the initial claims determination, written in a manner calculated to be understood by the Participant and will include specific references to the pertinent Plan provision on which the decision is based. If the Claims Administrator does not complete a review and provide a written response within 30 days for any reason, the Plan Participant may consider the initial determination to be unaltered, and may then file an appeal with the Plan Administrator, as outlined below.

### **Appeals Procedure**

Following receipt of the Claims Administrator's written response to a request for review (or following 30 days without a written response from the Claims Administrator), if the Plan Participant continues to disagree with the initial claims determination, the Plan Participant may appeal the initial claims determination to the Plan Administrator, in accordance with the following procedures:

- (1) The Plan Participant must send a written appeal request to the Plan Administrator, appealing the initial determination; and
- (2) The written appeal request must explain why and how the Plan Participant disagrees with the initial determination and the explanation of the Claims Administrator upon its review, including whether the Plan Participant disagrees with the initial determination and review in whole or in part; and
- (3) The written appeal request should include any additional information or documentation the Plan Participant believes should be considered upon review; and
- (4) The written appeal request must be made no later than ten days following the date of notification by the Claims Administrator of the outcome of its review, or, in the case of no written response from the Claims Administrator after 30 days, the written appeal request must be made within 40 days following the submission of the written request for review to the Claims Administrator. (For purpose of this provision, a written appeal request is deemed "made" when it is received in the offices of the Plan Administrator.)

Written appeals requests should be directed to:

City of Gulfport, Plan Administrator  
P.O. Box 1780  
Gulfport, Mississippi 39502  
(228) 868-5770

The Plan Administrator, upon receipt of a timely written appeal request, will conduct a review to determine whether the initial claims determination and review was correct in accordance with the Plan, or whether, in the exercise of the Plan Administrator's discretion, the initial claims

determination should be reversed or modified, or the Plan should be construed so as to provide benefits.

The Plan Administrator will provide a written final determination to the Plan Participant, setting forth the Plan Administrator's decision. The written final determination will include the specific reasons for the decision, written in a manner calculated to be understood by the Participant and will include specific references to the pertinent Plan provisions on which the decision is based. The Plan Administrator's written final determination will be provided to the Plan Participant within 60 days from the date the Plan Participant's request for review was made to the Claims Administrator, except that in extenuating circumstance, the Plan Administrator may notify the Plan Participant that a longer time will be required to complete the appeal. If a long time is required to complete the appeal, the Plan Administrator will notify the Plan Participant of such extension within the 60-day period following the submission of the request for review to the Claims Administrator. The Plan Administrator will then complete the appeal and provide a written final determination to the Plan Participant no later than 120 days from the date the Plan Participant made the request for review to the Claims Administrator. (In any case when delay is caused by act or omission of the Plan Participant, the 120-day period for issuing a written final determination shall be extended accordingly, if additional time is required for the Plan Administrator to complete the appeal.)

#### **Special Notice – Exhaustion and Timeliness Required**

A Plan Participant is required to exhaust these administrative procedures before filing any lawsuit for Plan benefits, or to challenge any Plan administrative determination. (This means a Plan Participant must file the written request for review with the Claims Administrator, and follow up with a written appeal request to the Plan Administrator, if the Plan Participant intends to challenge any denial or administrative determination of Plan benefits, and wishes to take the matter to court). The Plan Administrator may, in its discretion, refuse to consider any appeal because not timely filed, or for failure to follow these procedures for a request for review or appeal, including but not limited to the failure to make a written request for review to the claims determination or claim payment date. Accordingly, any Plan Participant intending to dispute or challenge any initial claims determination or administrative decision concerning Plan benefits must take care to follow these procedures, and to file all written requests on a timely basis as outlined above.

#### **Plan Administrator Has Discretion and Final Authority**

Although the Claims Administrator may receive written requests for reviews, as outlined above, and may reconsider an initial claims determination, discretionary authority and final authority with regard to all Plan claims, issues, denials, administrative decision, claims determinations or Plan construction or interpretation is and shall remain with the Plan Administrator. The Claims Administrator is not a fiduciary of the Plan, and does not underwrite or insure any of the benefits nor otherwise provide any funding for the Plan. The named fiduciary of the plan is the Plan Administrator, or such other person or entity as the Plan Administrator shall designate elsewhere in the Plan document. The Plan Administrator shall have total and complete discretion to interpret the Plan Administrator's determinations shall be final, conclusive and binding on all parties.

## COORDINATION OF BENEFITS

**Coordination of the benefit plans.** Coordination of benefits sets out rules for the order of payment of Covered Charges when two or more plans – including Medicare – are paying. When a Covered Person is covered by this Plan and another plan, or the Covered Person's Spouse is covered by this Plan and by another plan or the couple's Covered children are covered under two or more plans, the plans will coordinate benefits when a claim is received.

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total allowable expenses.

**Benefit Plan.** This provision will coordinate the medical and dental benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans:

- (1) Group or group-type plans, including franchise or blanket benefit plans.
- (2) Blue Cross and Blue Shield group plans.
- (3) Group practice and other group prepayment plans.
- (4) Federal government plans or programs. This includes Medicare.
- (5) Other plans required or provided by law. This does not include Medicaid or any benefit plan like Medicaid, that by its terms, does not allow coordination.
- (5) No Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

**Allowable Charge.** For a charge to be allowable it must be a Usual and Reasonable Charge and at least part of it must be covered under this Plan.

In the case of HMO (Health Maintenance Organization) plans: This Plan will not consider any charges in excess of what an HMO provider has agreed to accept as payment in full. Also, when an HMO is primary and the Covered Person does not use an HMO provider, this Plan will not consider as an allowable charge any charge that would have been covered by the HMO had the Covered Person used the services of an HMO provider.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the allowable charge.

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

**Benefit Plan Payment Order.** When two or more plans provide benefits for the same allowable charge, benefit payment will follow these rules.

- (1) Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.
- (2) Plans with a coordination provision will pay their benefits up to the Allowable Charge:

- (a) The benefits of the plan which covers the person directly (that is, as an employee, member or subscriber) ("Plan A") are determined before those of the plan which covers the person as a dependent ("Plan B").

**Special Rule.** If: (1) the person covered directly is a Medicare beneficiary, and (2) Medicare is secondary to Plan B, and (3) Medicare is primary to Plan A (for example, if the person is retired), THEN Plan B will pay before Plan A.

- (b) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or Retired Employee. The benefits of a benefit plan which covers a person as a Dependent of an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a Dependent of a laid off or Retired Employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.
- (c) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired or a Dependent of an Employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.
- (d) When a child is covered as a Dependent and the parents are not separated or divorced, these rules will apply:
- (i) The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;
  - (ii) If both parents have the same birthday, the benefits of the benefit plan which has covered the patient for the longer time are determined before those of the benefit plan which covers the other parent.
- (e) When a child's parents are divorced or legally separated, these rules will apply:
- (i) This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.
  - (ii) This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a Dependent will be considered next. The benefit plan of the parent without custody will be considered last.
  - (iii) This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent.
  - (iv) If the specific terms of the court decree state that the parents shall 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 shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are not separated or divorced.

- (f) If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the plan will never pay more than 50% of allowable charges when paying a secondary.
- (3) Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts.
- (4) If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

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

**Right to Receive or Release Necessary Information.** To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Covered Person will give this Plan the information it asks for about other plans and their payment of allowable charges.

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

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

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

## THIRD PARTY RECOVERY PROVISION

### RIGHT OF SUBROGATION AND REFUND

**Conditional Benefit Payment.** If a Covered Person has medical or dental expenses as a result of an injury or accident, a third party may be liable for those expenses. In such case, the Plan may advance the Covered Person amounts to cover their benefits on a conditional basis. In order to receive such payments, the Covered Person is required to sign an agreement that acknowledges the conditional payments and the Plan has a right of subrogation to those benefits.”

**When this provision applies.** The Plan is entitled to recover the cost of any conditional benefits it has provided a Covered Person out of the proceeds of any judgement or settlement that the Covered Person receives from any policy or contract from any insurance company or carrier and /or any third-party, plan or fund. The Plan may recover any amounts owed to it before any amounts (including attorney’s fees incurred by the Covered Person) are deducted from the policy, proceeds, judgement or settlement. The Plan will be subrogated to all claims, demands, actions and rights or recovery against any entity, including but not limited to third parties and insurance companies, to the fullest extent of the Plan’s right of recovery.

Covered Persons must notify the Plan Administrator, in writing, of whatever benefits are paid under this Plan that may be subject to subrogation by the Plan. The Covered Person must also keep the Plan Administrator informed in advance of any settlement proposals advanced or agreed to by the third party or the third party’s insurer.

The Covered Person may incur medical or dental charges due to injuries which may be caused by the act or omission of a third party or a third party may be responsible for payment. In such circumstances, the Covered Person may have a claim against that third party, or insurer, for payment of the medical or dental charges. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any rights the Covered Person may have to recover payments from any third party or insurer. This subrogation right allows the Plan to pursue any claim which the Covered Person has against any third party or insurer, whether or not the Covered Person chooses to pursue that claim. The Plan may make a claim directly against the third party or insurer, but in any event, the Plan has a lien on any amount recovered by the Covered Person whether or not designated as payment for medical expenses. This lien shall remain in effect until the Plan is repaid in full.

The Covered Person:

- (1) automatically assigns to the Plan his or her rights against any third party or insurer when this provision applies; and
- (2) must repay to the Plan the benefits paid on his or her behalf out of the recovery made from the third party or insurer.

**Amount subject to subrogation or refund.** The Covered Person agrees to recognize the Plan’s right to subrogation and reimbursements. These rights provide the Plan with a priority over any funds paid by a third party to a Covered Person relative to the Injury or Sickness, including a priority over any claim for non-medical or dental charges, attorney fees, or other costs and expenses.

Notwithstanding its priority to funds, the Plan’s subrogation and refund rights, as well as the rights assigned to it, are limited to the extent to which the Plan has made, or will make, payments for medical or dental charges as well as any costs and fees associated with the enforcement of its rights under the Plan.

When a right of recovery exists, the Covered Person will execute and deliver all required instruments and papers as well as doing whatever else is needed to secure the Plan's right of subrogation as a condition to having the Plan make payments. In addition, the Covered Person will do nothing to prejudice the right of the Plan to subrogate.

**Defined terms:** "Recovery" means monies paid to the Covered Person by way of judgement, settlement, or otherwise to compensate for all losses caused by the Injuries or Sickness whether or not said losses reflect medical or dental charges covered by the Plan.

"Subrogation" means the Plan's right to pursue the Covered Person's claims for medical or dental charges against the other person.

"Refund" means repayment to the Plan for medical or dental benefits that it has paid toward care and treatment of the Injury or Sickness.

**Recovery from another plan under which the Covered Person is covered.** This right of refund also applies when a Covered Person recovers under an uninsured or under insured motorist plan, homeowner's plan, renter's plan, medical malpractice plan or any liability plan.

## COBRA CONTINUATION OPTIONS

Federal law gives certain persons the right to continue their health care benefits beyond the date that they might otherwise terminate. The entire cost (plus the administration fee allowed by law) must be paid by the continuing person. Coverage will end if the covered individual fails to make timely payment of contributions of premiums (within a maximum of 45 days during initial premium/contribution and 30 days thereafter). This law is referred to as "COBRA", which stands for the Consolidated Omnibus Budget Reconciliation Act of 1985.

Complete instructions on COBRA will be provided by the Plan Participants who become qualified beneficiaries under COBRA.

### BENEFITS AFFECTED BY COBRA

There are two categories of benefits that may be continued under COBRA.

- (1) "Core benefits" are Medical Benefits. Any COBRA continuance option must include the offering of core benefits for which the person was covered just prior to the COBRA "qualifying event" (an event which qualifies a person for continued coverage under COBRA). A child born to or placed for adoption with the covered Employee during the period of COBRA coverage must also be offered these core benefits.
- (2) "Non-core benefits" include Dental Benefits, Vision Care Benefits and Flexible Spending Accounts under Section 125 (Cafeteria-type) plans.
- (3) If the "qualified beneficiary" (a person eligible for COBRA continuance) was covered by these core and non-core benefits prior to termination, the individual may, but is not required to, continue them under COBRA. Which benefits, if any, are to be continued will be indicated by the qualified beneficiary at the time of COBRA enrollment.

Life insurance, accidental death and dismemberment benefits and weekly income or long term disability benefits (if a part of the Employer's plan) are not considered for continuance under COBRA.

**Maximum Time Periods.** Continuation will be available for a qualified beneficiary up to the maximum time period shown in item (1), (2) or (3) below. Combined qualifying events will not continue a beneficiary's coverage for more than 36 months beyond the date of the original qualifying event.

- (1) Up to 18 months for an Employee and his covered Dependent(s) when coverage terminates due to reduction of hours worked, or termination of employment for reasons other than gross misconduct.

Note: A qualified beneficiary who is disabled may have COBRA coverage extended (and an extra fee charged) for himself and the other qualified beneficiaries in his or her family from 18 months to 29 months provided that:

- (a) the individual is determined as being disabled for Social Security purposes on the date of the qualifying event or within the first 60 days of COBRA coverage; and
- (b) the individual notifies the Plan Administrator within 60 days of the Social Security Administration's determination of disability and within the original 18-month COBRA period which applies to the person.

- (2) Up to 36 months for:
  - (a) a covered child who ceases to be an eligible Dependent;
  - (b) a covered Dependent of a deceased Employee;
  - (c) a former covered Spouse whose coverage ceases due to divorce or legal separation; or
  - (d) a covered Dependent when the Employee's coverage ceases due to entitlement for Medicare.
- (3) There is a special continuation period for Retired Employees and their Dependents when the Employer declares bankruptcy under Title 11 of the United States Code and the Retired Employees and their Dependents lose substantial coverage within one year before or after the date that the bankruptcy proceedings commenced. Coverage will be continued for each person until the date of that person's death. However, the surviving Spouse or children of a deceased Retired Employee, may continue coverage for up to a maximum of 36 months following the Retired Employee's death. For this item 3, coverage does not terminate when the person becomes eligible for Medicare.

Continued coverage may also cease before the end of the maximum period on the earliest of:

- (1) The date that the Employer ceases to provide a group health and dental plan to any Employee; or
- (2) The date that the qualified beneficiary first becomes, after the date of election, (a) covered under any other group health and dental plan (as an Employee or otherwise), or (b) entitled to benefits under Medicare (except as stated in item 3 above). However, a qualified beneficiary who becomes covered under a group health and dental plan which has a Pre-Existing conditions limit, must be allowed to continue COBRA coverage for the length of a Pre-Existing condition or to the COBRA maximum time period, if less. COBRA coverage may be terminated if the qualified beneficiary becomes covered under a group health plan with a Pre-Existing conditions limit, if the Pre-Existing conditions limit does not apply to (or is satisfied by) the qualified beneficiary by reasons of the group health plan portability, access and renewability requirements of the Health Insurance Portability and Accountability Act, ERISA or the Public Health Services Act.
- (3) The date the cost of continued coverage is not paid by the due date.
- (4) For an individual who has extended COBRA coverage of 29 months due to disability, COBRA coverage will end in the month that begins more than 30 days after a final determination has been made by the Social Security Administration that the individual is no longer disabled.

**Notice Requirements.** When coverage terminates due to an Employee's death, termination or eligibility for Medicare, the Employer has 30 days in which to notify the Claims Administrator of the qualifying event.

When coverage terminates due to divorce, legal separation or change of Dependent status, the qualified beneficiary has 60 days from the qualifying event or from the date coverage terminates in which to notify the Plan Administrator that the qualifying event has occurred.

Complete instructions on how to elect continuation will be provided by the Claims Administrator within 14 days of receiving notice of the qualifying event. Covered Persons then have 60 days in which to elect continuation. The 60 day period is measured from the later of the date coverage

terminates or the date notice of the right to continue is sent. If continuation is not elected in that 60-day period, then the right to elect continuation ceases.

## **RESPONSIBILITIES FOR PLAN ADMINISTRATION**

**PLAN ADMINISTRATOR.** City of Gulfport Self-Funded Employee Benefits Plan is the benefit plan of City of Gulfport, the Plan Administrator, also called the Plan Sponsor. It is to be administered by the Plan Administrator in accordance with the provisions of ERISA. An individual may be appointed by City of Gulfport to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator resigns, dies or is otherwise removed from the position, City of Gulfport shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

Service of legal process may be made upon the Plan Administrator.

### **DUTIES OF THE PLAN ADMINISTRATOR**

- (1) To administer the Plan in accordance with its terms.
- (2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omission.
- (3) To decide disputes which may arise relative to a Plan Participant's rights.
- (4) To prescribe procedures for filing a claim for benefits and to review claim denials.
- (5) To keep and maintain the Plan documents and all other records pertaining to the Plan.
- (6) To appoint a Claims Administrator to pay claims.
- (7) To perform all necessary reporting as required by ERISA.
- (8) To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Sec. 609.
- (9) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

**PLAN ADMINISTRATOR COMPENSATION.** The Plan Administrator serves without compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

**FIDUCIARY.** A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.

**FIDUCIARY DUTIES.** A Fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the Employees and their Dependents(s), and defraying reasonable expenses of administering the Plan. These are duties which must be carried out:

- (1) with care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matter, would use in a similar situation;
- (2) by diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and
- (3) in accordance with the Plan documents to the extent that they agree with ERISA.

**THE NAMED FIDUCIARY.** A “named fiduciary” is the one named in the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

- (1) the named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures; or
- (2) the named fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA.

**CLAIMS ADMINISTRATOR IS NOT A FIDUCIARY.** A Claims Administrator is **not** a fiduciary under the Plan by virtue of paying claims in accordance with the Plan’s rules as established by the Plan Administrator.

## **FUNDING THE PLAN AND PAYMENT OF BENEFITS**

The cost of the Plan is funded as follows:

**For Employee Coverage:** Funding is derived solely from the funds of the Employer and contributions made by the covered Employees.

**For Dependent Coverage:** Funding is derived from the funds of the Employer and contributions made by the covered Employees.

The level of any Employee contributions will be set by the Plan Administrator. These Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee or withheld from the Employee’s pay through payroll deduction.

Benefits are paid directly from the Plan through the Claims Administrator.

## **PLAN IS NOT AN EMPLOYMENT CONTRACT**

The Plan is not to be construed as a contract for or of employment.

## **CLERICAL ERROR**

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan

Participant, if it is requested, the amount of overpayment will be deducted from future benefits payable.

## **AMENDING AND TERMINATING THE PLAN**

If the Plan is terminated, the rights of the Plan Participants are limited to expenses incurred before termination.

The Employer has the right to amend the Plan in any and all respects at any time without prior notice to any Participant or Dependent. Any amendment must be in writing and executed by an authorized officer of the Employer. Such amendment will be effective without any action required by any subsidiaries of the Employer who have adopted the Plan by corporate resolution. The Plan Administrator will notify all Covered Persons of any substantive amendment no later than two hundred ten (210) days after the close of the Plan year in which the amendment is adopted. Covered Persons will be notified of any amendment (including a termination) which results in a material reduction in covered services or benefits no later than sixty (60) days after such amendment.

If the Schedule of Benefits is amended, benefits under the revised Schedule of Benefits will apply to all covered medical expenses and dental expenses incurred on and after the effective date of the revision. However, if a Participant is admitted to a Hospital as a bed patient prior to the effective date of the revision, benefits will only be payable for that Hospital stay under the Schedule of Benefits in effect at the time of admission.

The Plan may be terminated with respect to any and all Participants and Dependents at any time without prior notice. Such termination must be in writing and signed by an authorized officer of the Employer. The Plan Administrator will notify all Participants and Dependents if the Plan is terminated within the same time period required for the notification of a plan amendment. The Plan will automatically terminate if the Employer is legally dissolved, makes any general assignment for the benefit of its creditors, files for liquidation under the Bankruptcy Code, merges or consolidates with any other entity and is not the surviving entity, sells or transfers substantially all of its assets, or goes out of business. However, the Employer's successor may agree to assume the liability and continue the Plan.

## **CERTAIN EMPLOYEE RIGHTS UNDER ERISA**

Plan Participants in this Plan are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA specifies that all Plan Participants shall be entitled to:

Examine, without charge, at the Plan Administrator's office, all Plan documents and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.

Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

In addition to creating rights for Plan Participants, ERISA imposes obligations upon the individuals who are responsible for the operation of the Plan. The individuals who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Plan Participants and their beneficiaries. No one, including the Employer or any other person, may fire a Plan Participant or otherwise discriminate against a Plan Participant in any way to prevent the Plan Participant from obtaining benefits under the Plan or from exercising his or her rights under ERISA.

If a Plan Participant's claim for a benefit is denied, in whole or in part, the Plan Participant must receive a written explanation of the reason for the denial. The Plan Participant has the right to have the Plan review and reconsider the claim. Under ERISA there are steps that the Plan Participant can take to enforce the above rights. For instance, if the Plan Participant requests materials from the Plan and does not receive them within 30 days, that person may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and to pay the Plan Participant up to \$110 a day until he or she receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If the Plan Participant has a claim for benefits which is denied or ignored, in whole or in part, that participant may file suit in state or federal court.

If it should happen that the Plan fiduciaries misuse the Plan's money, or if a Plan Participant is discriminated against for asserting his or her rights, he or she may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Plan Participant is successful, the court may order the person sued to pay these costs and fees, for example, if it finds the claim or suit to be frivolous.

If the Plan Participant has any questions about the Plan, he or she should contact the Plan Administrator. If the Plan Participant has any questions about this statement or his or her rights under ERISA or the Health Insurance Portability and Accountability Act (HIPAA), that Plan Participant should contact either the nearest area office of the Pension and Welfare Benefits Administration, U.S. Department of Labor listed in the telephone directory or the Division of Technical Assistance and Inquires, Pension and Welfare Benefits Administration, at 200 Constitution Avenue, NW, Washington, DC 20210.

## **GENERAL PLAN INFORMATION**

### **TYPE OF ADMINISTRATION**

The Plan is a self-funded health plan and the administration is provided through a third party Claims Administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees. The Plan is not insured.

### **PLAN NAME**

City of Gulfport Self Funded Employee Benefits Plan

**PLAN NUMBER:** 501

**TAX ID NUMBER:** 64-6000413

**PLAN EFFECTIVE DATE:** June 1, 1993

**LATEST PLAN REVISION DATE:** June 1, 2002

**PLAN YEAR ENDS:** May 31<sup>st</sup>

### **EMPLOYER INFORMATION**

City of Gulfport  
P.O. Box 1780  
Gulfport, Mississippi 39502  
(228) 868-5770

### **PLAN ADMINISTRATOR**

City of Gulfport  
P.O. Box 1780  
Gulfport, Mississippi 39502  
(228) 868-5770

### **NAMED FIDUCIARY**

City of Gulfport  
P.O. Box 1780  
Gulfport, Mississippi 39502

### **AGENCY FOR SERVICE OF LEGAL PROCESS**

City of Gulfport  
P.O. Box 1780  
Gulfport, Mississippi 39502

### **CLAIMS ADMINISTRATOR**

BenMark Administrators, LLC  
P.O. Box 1780  
Jackson, Mississippi 39205  
(601) 366-0596 or (800) 445-2075

