

**CITY OF GULFPORT HEALTH BENEFIT PLAN
SUMMARY OF BENEFITS FOR OPTION 3**

OPTION 3	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS**
Calendar Year (CY) Deductible	\$2000 Member / 3 Individuals per Family	\$2000 Member / 3 Individuals per Family
CY Maximum Out-of-Pocket (MOOP) Includes CY Deductible	\$4000 Member/ 3 Individuals per Family	Unlimited
CY Maximum Coinsurance (excludes CY Deductible)	\$2000 Member/3 per Family	
Lifetime Plan Maximum – applies to all covered services	\$1,000,000 Member	
<u>PHYSICIAN and ALLIED HEALTH PROFESSIONAL SERVICES</u> <u>Office Services</u> Office Visits Other Office Services such as lab and x-rays <u>Other Services</u> Physician services for radiology, pathology, hospital or ambulatory surgery, emergency room, inpatient care, obstetrical care, and other physician services.	\$40 co-pay 20% coinsurance (deductible waived) 20% coinsurance after CY deductible	50% coinsurance after CY deductible
<u>EMERGENCY CARE SERVICES</u> Emergency Room Facility Services Ambulance (land or air) Urgent Care Centers Other services in the Urgent Care setting	\$75 co-pay, then 20% coinsurance after CY deductible 20% coinsurance after CY deductible \$35 co-pay 20% coinsurance (deductible waived)	\$75 co-pay, then 50% coinsurance after CY deductible 50% coinsurance after CY deductible 50% coinsurance after CY deductible
<u>FACILITY SERVICES</u> Inpatient Facility Services Outpatient Facility services, including ambulatory surgery, MRI/CT Scans, Ultrasound, Lab, X-Ray and other outpatient facility services. Inpatient Rehabilitation Services - Acute Care Only	20% coinsurance after CY deductible 20% coinsurance after CY deductible 20% coinsurance after CY deductible	\$750 co-pay, then 50% coinsurance after CY deductible 50% coinsurance after CY deductible 50% coinsurance after CY deductible
<u>PREVENTATIVE HEALTH/ WELLNESS SERVICES</u> Routine Well Adult/ Well Child Care Limited to \$800 per member per calendar year; includes routine, preventative screening, OB/GYN, physician exam, immunizations over the age of 19, and 1 hearing test per year. Immunizations under age 19; These immunizations are separate from the Preventative/Wellness limitation of \$800 per year.	Covered at 100% Up to \$800 with no copay Covered at 100%	Not covered at the OON Level Not covered at the OON Level
<u>PHYSICAL MEDICINE</u> Rehabilitative therapy services: Physical and Occupational	20% coinsurance after CY deductible	50% coinsurance after CY deductible
<u>CHIROPRACTIC SERVICES</u> Spinal Manipulation and other services provided by a licensed Doctor of Chiropractic. (DC) Limited to a maximum of 50 visits per year.	50% coinsurance after CY deductible	50% coinsurance after CY deductible

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<u>SPEECH THERAPY</u> Rehabilitative therapy services: Speech	20% coinsurance after CY Deductible	50% coinsurance after CY deductible
<u>MATERNITY SERVICES</u> Physician Services for OB care, including office visits and other office services. All services related to pregnancy will be subject to the deductible and coinsurance. Maternity services for dependent daughters are not covered by the plan. Facility Services for Inpatient Admission or Birthing Center Services	20% coinsurance after CY deductible	50% coinsurance after CY deductible
<u>MENTAL/NERVOUS AND SUBSTANCE ABUSE SERVICES</u> Physician Office Visits Other services rendered in the mental health provider’s office Mental Health Provider Services in other settings such as inpatient, outpatient facilities, etc. <u>Facility Services</u> Inpatient Care Outpatient Hospital Visits	\$40 co-pay 20% coinsurance (deductible waived) 20% coinsurance after CY deductible 20% coinsurance after CY deductible 20% coinsurance after CY deductible	50% coinsurance after CY deductible 50% coinsurance after CY deductible 50% coinsurance after CY deductible \$750 co-pay, then 50% coinsurance after CY deductible 50% coinsurance after CY deductible
<u>DURABLE MEDICAL EQUIPMENT (DME) ORTHOTIC DEVICES and PROSTHETIC APPLIANCES</u> Rental or purchase of durable medical equipment, prosthetic appliances, and orthotic devices.	20% coinsurance after CY Deductible	50% coinsurance after CY deductible
<u>HOME HEALTH</u> Services are limited to a maximum benefit of 100 visits.	20% coinsurance after CY deductible	50% coinsurance after CY deductible
<u>HOSPICE SERVICES</u> Services are limited to a Lifetime Maximum benefit of \$10,000.	20% coinsurance after CY deductible	50% coinsurance after CY deductible
<u>SKILLED NURSING FACILITY</u> Limited to a 90 day maximum stay.	20% coinsurance after CY deductible	50% coinsurance after CY deductible
<u>CARDIAC REHABILITATION SERVICES</u> Initiated within 12 consecutive weeks after other treatment	20% coinsurance after CY deductible	50% coinsurance after CY deductible
<u>OTHER MEDICAL SERVICES</u> Registered Dietician Limited to 1 visit per lifetime with physician referral; excludes referral for obesity. Private Duty Nursing Limited to outpatient services only, with a maximum benefit of \$5,000 per year.	20% coinsurance after CY deductible	50% coinsurance after CY deductible

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Prescription Drug Benefits	
<u>Generic Drug Mandate</u> Generic drugs are preferred. The member pays the difference between the cost of the brand drug and the generic drug, plus the brand copay when a member or a physician requests the brand drug.	
<u>Retail Pharmacy - limited to a 30 day supply</u>	
Generic	\$10 Co-pay
Brand Name Formulary	\$20 Co-pay
Brand Name Non-Formulary	\$35 Co-pay
<u>Mail Order for Maintenance Drugs - limited to a 90 day supply</u>	
Generic	\$25 Co-pay
Brand Name Formulary	\$50 Co-pay
Brand Name Non-Formulary	\$85 Co-pay
<u>Specialty Injectable Drugs - limited to a 30 day supply</u>	
	\$100 Co-pay

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