Summary Plan Description and Plan Document for the City of Gulfport Health and Welfare Benefit Plan

- Medical and Prescription Drug Benefits
- Dental Benefits
- Flexible Spending Accounts

Updated Effective: 01/01/2016

Introduction

City of Gulfport (the “Employer” or “Company”) is pleased to offer you this benefit plan. It is a valuable and important part of your overall compensation package.

This booklet describes your medical and prescription drug benefits, dental benefits, flexible spending accounts and serves as the Summary Plan Description (SPD) and Plan document for the City of Gulfport employee Health and Welfare Benefit Plan (“the Plan”). It sets forth the provisions of the Plan that provide for payment or reimbursement of Plan benefits.

We encourage you to read this booklet and become familiar with your benefits. You may also wish to share this information with your enrolled family members.

This SPD and Plan replace all previous booklets you may have in your files. Be sure to keep this booklet in a safe and convenient place for future reference.

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Introduction

Plan Overview

Your Eligibility

You are eligible for benefits if you are:

- A full-time active employee normally scheduled to work a minimum of 30 hours per week;
- On the regular payroll of the Company; and
- In a class of employees eligible for coverage.

The following individuals are not eligible for benefits: part-time employees, employees of a temporary or staffing firm, payroll agency, or leasing organization, contract employees, and other individuals who are not on the Company payroll, as determined by the Company, without regard to any court or agency decision determining common-law employment status.

Eligible Dependents

You may enroll your eligible dependents on your coverage. Your eligible dependents include:

- your legal spouse (as determined by Federal law);
- your child under age 26 regardless of financial dependency, residency with you, marital status, or student status;
- your unmarried child of any age who is principally supported by you and who is not capable of self-support due to a physical or mental disability that began while the child was covered by the Plan;
- your unmarried child of any age who is not capable of self-support due to a physical or mental disability that occurred before age 26, whose disability is continuous, and who is principally supported by you.

"Principally supported by you" means that the child is dependent on you for more than one-half of his or her support, as defined by Code Section 152 of the Internal Revenue Code.

For purposes of the Plan, your child includes:

- your biological child;
- your legally adopted child (including any child under age 18 placed in the home during a probationary period in anticipation of the adoption where there is a legal obligation for support);
- a step child as long as you are married to the child's natural parent;
- a child for whom you are the court-appointed legal guardian;
- an eligible child for whom you are required to provide coverage under the terms of a Qualified Medical Child Support Order (QMCSO) or a National Medical Support Notice (NMSN).

An eligible dependent does *not* include:

- a person enrolled as an employee under the Plan;

- any person who is in active military services;
- a former Spouse; or
- a person who is covered as a dependent of another employee covered under the Plan. If you and your spouse are both employed by the Company, each of you may elect your own coverage (based on your own eligibility for benefits) or one of you may be enrolled as a dependent on the other's coverage, but only one of you may cover your dependent children.

In addition, an eligible dependent who lives outside the U.S. cannot be covered as your dependent, unless the dependent has established his or her primary residence with you.

It is your responsibility to notify the Company if your dependent becomes ineligible for coverage.

Proof of Dependent Eligibility

The Company reserves the right to verify that your dependent is eligible or continues to be eligible for coverage under the Plan. If you are asked to verify a dependent's eligibility for coverage, you will receive a notice describing the documents that you need to submit. To ensure that coverage for an eligible dependent continues without interruption, you must submit the required proof within the designated time period. If you fail to do so, coverage for your dependent may be canceled retroactively.

When Coverage Begins

For You

Your health care coverage begins on the first day following 60 days of employment for All Full Time, non-elected employees and after you meet all eligibility requirements. Your health care coverage begins on the first day you are actively at work for Elected Officials and after you meet all eligibility requirements.

If you are rehired within 30 days of terminating employment, you will be automatically reinstated in coverage under the same coverage you previously had in effect as of the date you are rehired and will not have to satisfy any waiting period.

For Your Dependents

If you enroll your eligible dependents within 31 days of your initial eligibility, their coverage begins at the same time as yours.

Coverage for newly eligible dependents will begin on the date they become a dependent as long as you enroll them within 31 days of the date on which they became eligible. If you acquire a new dependent, such as through marriage, coverage will begin on the date they become an eligible dependent (such as of the date of marriage) as long as you enroll the dependent within 31 days of the date on which they became eligible. If you wait longer than 31 days, you may not be able to enroll them until the next annual open enrollment period.

A newborn child born while you are enrolled for medical coverage will not automatically be enrolled in the Plan. Coverage will be effective with the newborn's date of birth, provided the child is enrolled within 31 days of birth. A separate annual deductible and coinsurance will apply to charges incurred by the newborn child.

Your Cost for Coverage

Both the Company and you share in the cost of your health care benefits. Each year, the Company will evaluate all costs and may adjust the cost of coverage during the next annual enrollment. Your enrollment materials will show the coverage categories available to you.

You pay your portion of this cost through pre-tax payroll deductions taken from your pay each pay period. Your actual cost is determined by the coverage you select and the number of dependents you cover. You must elect coverage for yourself in order to cover your eligible dependents.

Wellness Benefit Premium

The Plan offers a wellness program to encourage and support your well-being and health. The wellness program may include a health assessment and intervention program, that includes a personal health risk questionnaire. Participation in the wellness program may result in financial incentives or rewards under the Plan.

If it is unreasonably difficult due to a medical condition for you to achieve the standards for any reward under the wellness program, or if it is medically inadvisable for you to attempt to achieve the standards for a reward, contact the Claims Administrator to determine an alternative method for you to qualify for the reward.

Enrolling for Coverage

New Hire Enrollment

As a newly eligible employee, you will receive enrollment information when you first become eligible for benefits. To enroll in medical and/or prescription drug and/or dental coverage, you will need to make your coverage elections by the deadline shown in your enrollment materials. When you enroll in the Plan, you authorize the Company to deduct any required premiums from your pay.

The elections you make will remain in effect until the next December 31, unless you have a qualifying change in status. After your initial enrollment, you will enroll during the designated annual open enrollment period. If you do not enroll for coverage when initially eligible, you will only be eligible for the default coverage designated by the Plan Administrator, as shown in your enrollment materials.

You will automatically receive identification (ID) cards for you and your eligible dependents when your enrollment is processed.

Late Entrant

Your enrollment will be considered timely if your completed enrollment form is received within 31 days after you become eligible for coverage. You will be considered a “late entrant” if:

- You elect coverage more than 31 days after you first become eligible
- You again elect coverage after cancelling

Unless the Special Enrollment Rights (see below) apply, if you are a late entrant, you will be required to wait until the next open enrollment period (but no longer than 12 months) to enroll in coverage.

Annual Open Enrollment

Each year during a designated open enrollment period, you will be given an opportunity to make your elections for the upcoming year. Your open enrollment materials will provide the options available to you and your share of the premium cost, as well as any default coverage you will be deemed to have elected if you do not make an election by the specified deadline. The elections you make will take effect on the following January 1 and stay in effect through December 31, unless you have a qualifying change in status.

Effect of Section 125 Tax Regulations on this Plan

This Plan is designed and administered in accordance with Section 125 regulations of the Internal Revenue Code. This enables you to pay your share of the cost for coverage on a pre-tax basis. Neither the Company nor any fiduciary under the Plan will in any way be liable for any taxes or other liability incurred by you by virtue of your participation in the Plan.

Because of this favorable tax-treatment, there are certain restrictions on when you can make changes to your elections. Generally, your elections stay in effect for the Plan Year and you can make changes only during each annual open enrollment. However, at any time throughout the year, you can make changes to your coverage within 31 days of the following:

- The date you have a qualifying change in status as described below;
- The date you meet the Special Enrollment Rights criteria described below.

Qualifying Change in Status

If you experience a change in certain family or employment circumstances that results in you or a covered dependent gaining or losing eligibility under a health plan, you can change your coverage to fit your new situation without waiting for the next annual open enrollment period.

As defined by the Internal Revenue Service (IRS), status changes applicable to health care coverage include:

- your marriage;
- the birth, adoption, or placement for adoption of a child;
- your death or the death of your spouse or other eligible dependent;
- your divorce, annulment, or legal separation;
- a change in a dependent child’s eligibility due to age or eligibility for other coverage;
- a change in employment status for you or your spouse that affects benefits (including termination or commencement of employment, strike or lockout, or commencement of or return from an unpaid leave of absence);
- a significant change in coverage or the cost of coverage;
- a reduction or loss of your or a dependent’s coverage under this or another plan;
- a court order, such as a QMCSO or NMSN, that mandates coverage for an eligible dependent child.

If you experience a change in certain family or employment circumstances, you can change your coverage. Changes must be consistent with status changes as described above. For example, if you get married, you may change your coverage level from you only to you and

your spouse. If you move, and your current coverage is no longer available in the new area, you may change your coverage option.

You should report a status change as soon as possible, but no later than 31 days, after the event occurs.

Special Enrollment Rights

If you decline enrollment for yourself or your dependents (including your spouse) because you have other health coverage, you may be able to enroll yourself and your dependents in this Plan, if you or your dependents lose eligibility for that other coverage (or if the employer stopped contributing towards your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

You or an affected eligible dependent may also enroll in coverage if eligibility for coverage is lost under Medicaid or the Children’s Health Insurance Program (CHIP), or if you become eligible for premium assistance under Medicaid or CHIP. You must enroll under this Plan within 60 days of the date you lose coverage or become eligible for premium assistance.

This “special enrollment right” exists even if you previously declined coverage under the Plan. You will need to provide documentation of the change. Contact the Plan Administrator to determine what information you will need to provide.

When Coverage Ends

If the employee's last day of employment is before the 10th of the month, coverage ends on the 15th; if the last day of employment is after the 10th of the month, coverage ends on the last day of the month, unless benefits are extended as described below.

Coverage for your covered dependents ends when your coverage ends or, if earlier, on the day your dependent is no longer eligible for coverage or becomes eligible for coverage under another employer’s plan. However, for a dependent child who reaches limiting age, coverage ends on the last day of the month your dependent reaches the limiting age.

Coverage will also end for you and your covered dependents as of the date the Company terminates this Plan or, if earlier, the date you request termination of coverage for you and your covered dependents. Coverage will also end as of the date you or a covered dependent has a claim denied due to exceeding a maximum benefit, if applicable, under the Plan.

If your coverage under the Plan ends for reasons other than the Company’s termination of all coverage under the Plan or you exceeding a Plan limit, you and/or your eligible dependents may be eligible to elect to continue coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) as described below.

Cancellation of Coverage

If you fail to pay any required premium for coverage under the Plan, coverage for you and your covered dependents will be canceled and no claims incurred after the effective date of cancellation will be paid.

Rescission of Coverage

Coverage under the Plan may be rescinded (canceled retroactively) if you or a covered dependent perform an act, practice, or omission that constitutes fraud, or you make an intentional misrepresentation of material fact as prohibited by the terms of the Plan. Coverage may also be rescinded for failure to pay required premiums or contributions as required by the Plan.

Coverage may be rescinded to your date of divorce if you fail to notify the Plan of your divorce and you continue to cover your ex-spouse under the Plan. Coverage will be canceled prospectively for errors in coverage or if no fraud or intentional misrepresentation was made by you or your covered dependent. You will receive 30 days advance written notice of any cancellation of coverage to be made on a prospective basis.

The Plan reserves the right to recover from you and/or your covered dependents any benefits paid as a result of the wrongful activity that are in excess of the premiums paid. In the event the Plan terminates or rescinds coverage for gross misconduct on your behalf, continuation coverage under COBRA may be denied to you and your covered dependents.

Coverage While Not at Work

In certain situations, health care coverage may continue for you and your dependents when you are not at work, so long as you continue to pay your share of the cost. If you continue to be paid while you are absent from work, any premium payments will continue to be deducted from your pay on a pre-tax basis. If you are not receiving your pay during an absence, you will need to make arrangements for payment of any required premiums. You should discuss with your supervisor what options are available for paying your share of costs while you are absent from work.

If You Take a Leave of Absence – FMLA

Employees may use accumulated sick leave concurrently with FML absence for payment of any required contribution; absent the use of sick leave, employee contributions are required as described in the City's FMLA policy.

If You Take a Leave of Absence – Non-FMLA

If you take an approved leave of absence (paid or unpaid), your coverage will continue through the end of the month in which your leave begins or as provided for and documented in the City of Gulfport’s personnel policy.

If You Take a Military Leave of Absence

If you are absent from work due to an approved military leave, health care coverage may continue for up to 24 months under both the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) and COBRA, which run concurrently, starting on the date your military service begins.

Your Medical Benefits

Your medical benefits are delivered through a network of participating doctors, hospitals, laboratories, home health care agencies, and other health care providers, who have agreed to provide services at a discounted cost.

The Plan does not require you to select a primary care physician to coordinate your care and you do not have to obtain a referral to see a specialist.

A network of providers gives you the flexibility to choose providers inside or outside the network each time you need care. In most cases, the Plan covers the same medical services whether you receive care in- or out-of-network. Refer to the Summary of Medical Benefits chart below for more information.

To select a PCP, or to obtain a listing of current providers (at no cost to you) or confirm whether a provider participates in the network, contact the claims administrator for the network shown on your ID card.

If you use in-network providers, the Plan pays a higher percentage of covered expenses (after you meet any applicable deductible). Generally, you will not be required to file a claim form when you receive in-network benefits but in some cases, the provider or claims administrator may require you to do so.

If you receive professional services for anesthesiology, radiology, emergency room physician services, or pathology which are provided by an out-of-network provider but rendered at in-network facility, those services will be paid at the in-network level of benefits.

If you use out-of-network providers, the Plan pays a lower percentage of covered expenses (after you meet any applicable deductible), up to the Select Administrative Services fee schedule amount or maximum plan allowance (see explanation below). You are responsible for charges in excess of this limit and this excess amount may not apply to your deductible or any out-of-pocket maximum. You may also pay a higher deductible and out-of-pocket maximum (if applicable) out-of-network, and you may be required to file claim forms. See the Summary of Medical Benefits chart below for additional information.

If you live in an area where no in-network provider is available within 60 miles of your residence, the Plan will apply and pay services at the in-network level of benefits.

However, if you travel into an area that offers an in-network provider, and you choose not to use the in-network provider, then all services will be covered at the out-of-network level of benefits as described above.

Your Deductible

A deductible is money you must pay for certain covered expenses before the Plan pays benefits. It is calculated on a calendar year basis.

Consult the Summary of Medical Benefits chart for more information. Your medical deductible does not include:

- co-payments
- amounts in excess of the maximum amount payable under the Plan
- any expenses not covered under the Plan.

Deductible Accumulation

Each individual must meet the individual deductible before benefits are payable unless the family deductible is satisfied by one or more individuals, which will then satisfy the family deductible.

Charges applied to the out-of-network deductible will not be used to satisfy the in-network deductible amount and vice-versa.

Your Co-payment

Once you meet the deductible, some services may require a co-payment – a fixed dollar amount you must pay before the Plan pays for that service. This amount applies regardless of whether the deductible has been satisfied. Any co-payments will be shown in the Summary of Medical Benefits Chart below.

Your Coinsurance

Once you meet your deductible, the Plan pays a portion, or percentage, of certain covered medical expenses, and you are responsible to pay a portion. The percentage you must pay is called your coinsurance. For most services, the Plan will pay a higher percentage of the cost when you receive care in-network, which means your percentage will be lower.

The amount or percentage you pay depends on the type of provider you see, where you receive services, and how you are billed for these services. The Summary of Medical Benefits chart below shows the coinsurance levels for common medical services in-network and out-of-network.

Coinsurance and Deductible Maximum

When your coinsurance and deductible amount for covered medical expenses reaches the coinsurance and deductible maximum limit, the Plan pays 100% of the coinsurance of covered medical expenses. It is calculated on a calendar year basis. Co-payments for both medical services and prescription drugs will continue to apply. See the Summary of Medical Benefits chart below for the annual coinsurance and deductible maximum amounts.

Out-of-Pocket Maximum

The out-of-pocket maximum limits the total portion of costs you must pay. It is calculated on a calendar year basis. When your deductible, co-payments, and coinsurance for medical and prescription drugs for covered medical expenses reach the out-of-pocket maximum, the Plan pays 100% of covered medical expenses. See the Summary of Medical Benefits chart below for the out-of-pocket maximum amounts.

Your out-of-pocket maximum does not include:

- amounts in excess of the maximum amount payable under the Plan
- any expenses not covered under the Plan.
- penalties for failure to pre-certify inpatient admissions and home health services.
- the weight loss surgery co-payment of $2,000.

Out-of-Pocket Accumulation

Each individual must meet the individual out-of-pocket maximum before benefits are payable unless the family out-of-pocket maximum is satisfied by one or more individuals, which will then satisfy the family deductible.

Charges applied to the out-of-network out-of-pocket maximum will not be used to satisfy the in-network out-of-pocket maximum and vice-versa.

Maximum Allowed Amount (SAS Fee Schedule Amount)

If you use out-of-network providers, covered medical expenses are subject to the SAS Fee Schedule amount, and you are responsible for paying any charges above this limit. The SAS Fee Schedule amount is based on the amount determined by the Plan for a covered service or supply. Determination is based on the:

- complexity of the service and level of specialty of the provider;
- range of services provided; and
- the geographic area where the provider is located and other geographic areas with similar medical cost experience.

Summary of Medical Benefits

Option I

	In-Network	Out-of-Network
Annual Deductible (applies to expenses below unless otherwise noted)	$500 / individual $1,500 / family	$2,000 / individual $6,000 / family
Annual Coinsurance and Deductible Maximum **Annual Out-of-Pocket Maximum** (includes covered expenses under the Plan)	$2,000 / individual $6,000 / family $6,600 / individual $13,200 / family	No Limit / individual No Limit / family No Limit / individual No Limit / family

	In-Network (after deductible, unless noted)	Out-of-Network (after deductible, unless noted)
Allergy Testing, Serum, and Treatment	Plan pays 80% Deductible does not apply	Plan pays 50%
Allergy Shots	Plan pays 80% Deductible does not apply	Plan pays 50%
Ambulance Service	Plan pays 80%	Plan pays 80%
Ambulatory Surgical Center	Plan pays 80%	Plan pays 50%

	In-Network (after deductible, unless noted)	Out-of-Network (after deductible, unless noted)
Anesthetics, Oxygen, Transfusions	Plan pays 80%	Plan pays 50%
Chemotherapy	Plan pays 80%	Plan pays 50%
Chiropractic Care Limited to 50 visits per calendar year	Plan pays 50%	Plan pays 50%
Diagnostic X-rays and Lab Services (includes advanced radiological imaging)		
Performed in and billed by a physician's office (Deductible does not apply In-Network)	Plan pays 80%	Plan pays 50%
Performed in and billed by an outside lab/facility	Plan pays 80%	Plan pays 50%
Pre-admission Testing (performed prior to a hospital confinement)	Plan pays 80%	Plan pays 50%
Durable Medical Equipment	Plan pays 80%	Plan pays 50%
Hearing Aids and Hearing Exams Limited to a maximum benefit of $500 per ear every 2 calendar years	Plan pays 100% Deductible does not apply	Plan pays 100% Deductible does not apply
Emergency/Acute Care Hospital ER Room (copayment waived if admitted)	$125 Copayment, then Plan pays 80%	$125 Copayment, then Plan pays 80%
Hemodialysis	Plan pays 80%	Plan pays 50%
Home Health Care Limited to 100 visits per calendar year in combination with Private Duty Nursing Precertification required.	Plan pays 80%	Plan pays 50%
Hospice Care Lifetime maximum benefit of $10,000	Plan pays 80%	Plan pays 50%

	In-Network (after deductible, unless noted)	Out-of-Network (after deductible, unless noted)
Hospital Services – Inpatient Requires precertification – see also Pregnancy below.	Plan pays 80%	$750 Copayment, then Plan pays 50%
Hospital Services – Outpatient	Plan pays 80%	Plan pays 50%
Infertility Treatment (includes services for the diagnosis of infertility only)	Facility: Plan pays 80% Office Services: Plan pays 80%, deductible does not apply to services rendered in office	Plan pays 50%
Maternity Benefits – includes physician services for prenatal visits and routine pre- and post-partum care, childbirth and pregnancy-related conditions		
Physician Services	Plan pays 80%	Plan pays 50%
Inpatient hospital services or birthing center including labor and delivery (requires precertification for extended stay only)	Plan pays 80%	Plan pays 50%
Newborn Care – Inpatient	Plan pays 80%	Plan pays 50%
Medical Supplies (covered under Durable Medical Equipment above)	Plan pays 80%	Plan pays 50%
Mental Health and Substance Abuse Treatment		
Doctor's office visits or	Plan pays 100% after $25 co-payment	Plan pays 50%
Outpatient/Intermediate Care	Plan pays 80%	Plan pays 50%
Inpatient Care (requires precertification)	Plan pays 80%	$750 Copay, then Plan pays 50%
Organ Transplants – See description of coverage and limitations below Precertification required.	Plan pays 80%	Plan pays 50%
Private Duty Nursing Limited to 100 visits per plan year in combination with Home Health Care visits	Plan pays 80%	Plan pays 50%

	In-Network (after deductible, unless noted)	Out-of-Network (after deductible, unless noted)
***Primary Care Physician** - Office visit for injury or sickness (excludes preventive care, surgery and other medical services and supplies) (Deductible does not apply In-Network)	Plan pays 100% after $25 co-payment	Plan pays 50%
***Specialist Physician** – Office visit for injury or sickness (excludes preventive care, surgery and other medical services and supplies) (Deductible does not apply In-Network)	Plan pays 100% after $25 co-payment	Plan pays 50%
Prosthetics	Plan pays 80%	Plan pays 50%
Radiation Therapy	Plan pays 80%	Plan pays 50%
Reconstructive Surgery	Plan pays 80%	Plan pays 50%
Routine Preventive Care/Wellness Benefits		
Routine periodic and screening exams	Plan pays 100%	Plan pays 50%
Routine gynecological exam/Pap smear and mammogram	Plan pays 100%	Plan pays 50%
Well-baby/Well-child Care	Plan pays 100%	Plan pays 50%
Immunizations	Plan pays 100%	Plan pays 50%
Second Surgical Opinions – voluntary	Plan pays 100% after $25 Copayment	Plan pays 50%
Skilled Nursing Facility Limit of 90 days per plan year	Plan pays 80%	Plan pays 50%
Sterilization Procedures	Plan pays 80% Deductible waived if performed in Office setting	Plan pays 50%

	In-Network (after deductible, unless noted)	Out-of-Network (after deductible, unless noted)
Surgery		
Hospital Inpatient Precertification required.	Plan pays 80%	$750 Copayment, then Plan pays 50%
Outpatient Facility	Plan pays 80%	Plan pays 50%
Therapy Services		
Cardiac Rehabilitation Therapy Must be initiated within 12 weeks after other treatment for the medical condition ends. Occupational Therapy Physical Therapy Pulmonary/Respiratory Therapy Speech Therapy Excludes habilitative therapy treatment to help keep, learn or improve skills and functioning (versus rehabilitative therapy following an illness/injury)	Plan pays 80% Plan pays 80%	Plan pays 50% Plan pays 50%
Performed in and billed by Physician's office	Plan pays 80%	Plan pays 50%
Performed at outpatient facility or inpatient	Plan pays 80%	Plan pays 50%
Weight Loss Surgery Lifetime Maximum benefit of $20,000 including the $2,000 co-payment. Co-payment does not apply to the Combined Out-of-Pocket Maximum	$2,000 Copayment, then Plan pays 100%	$2,000 Copayment, then Plan pays 100%

** A Primary Care Physician or PCP may be a family practitioner, general practitioner, internist, gynecologist, or pediatrician. A Specialist may be a physician or other health care provider other than a PCP, for example, a cardiologist, allergist, gynecologist, chiropractor, or physical therapist. The final designation will depend on how the provider has chosen to contract with the network.*

Summary of Medical Benefits

Option II

	In-Network	Out-of-Network
Annual Deductible (applies to expenses below unless otherwise noted)	$1,000 / individual $3,000 / family	$2,000 / individual $6,000 / family
Annual Coinsurance and Deductible Maximum **Annual Out-of-Pocket Maximum** (includes covered expenses under the Plan)	$2,500 / individual $7,500 / family $6,600 / individual $13,200 / family	No Limit / individual No Limit / family No Limit/ individual No Limit / family

	In-Network (after deductible, unless noted)	Out-of-Network (after deductible, unless noted)
Allergy Testing, Serum, and Treatment	Plan pays 80% Deductible does not apply	Plan pays 50%
Allergy Shots	Plan pays 80% Deductible does not apply	Plan pays 50%
Ambulance Service	Plan pays 80%	Plan pays 80%
Ambulatory Surgical Center	Plan pays 80%	Plan pays 50%
Anesthetics, Oxygen, Transfusions	Plan pays 80%	Plan pays 50%
Chemotherapy	Plan pays 80%	Plan pays 50%
Chiropractic Care Limited to 50 visits per calendar year	Plan pays 50%	Plan pays 50%
Diagnostic X-rays and Lab Services (includes advanced radiological imaging)		
Performed in and billed by a physician's office (Deductible does not apply In-Network)	Plan pays 80%	Plan pays 50%
Performed in and billed by an outside lab/facility	Plan pays 80%	Plan pays 50%

	In-Network (after deductible, unless noted)	Out-of-Network (after deductible, unless noted)
Pre-admission Testing (performed prior to a hospital confinement)	Plan pays 80%	Plan pays 50%
Durable Medical Equipment	Plan pays 80%	Plan pays 50%
Emergency/Acute Care Hospital ER Room (copayment waived if admitted)	$125 Copay, then Plan pays 80%	$125 Copay, then Plan pays 80%
Hearing Aids and Hearing Exams Limited to a maximum benefit of $500 per ear every 2 calendar years	Plan pays 100% Deductible does not apply	Plan pays 100% Deductible does not apply
Hemodialysis	Plan pays 80%	Plan pays 50%
Home Health Care Limited to 100 visits per calendar year in combination with Private Duty Nursing Precertification required.	Plan pays 80%	Plan pays 50%
Hospice Care Lifetime maximum benefit of $10,000	Plan pays 80%	Plan pays 50%
Hospital Services – Inpatient Requires precertification – see also Pregnancy below.	Plan pays 80%	$750 Copayment, then Plan pays 50%
Hospital Services – Outpatient	Plan pays 80%	Plan pays 50%
Infertility Treatment (includes services for the diagnosis of infertility only)	Facility: Plan pays 80% Office Services: Plan pays 80%, deductible does not apply to services rendered in office	Plan pays 50%
Maternity Benefits – includes physician services for prenatal visits and routine pre- and post-partum care, childbirth and pregnancy-related conditions		
Physician Services	Plan pays 80%	Plan pays 50%
Inpatient hospital services or birthing center including labor and delivery (requires precertification for extended stay only)	Plan pays 80%	Plan pays 50%

	In-Network (after deductible, unless noted)	Out-of-Network (after deductible, unless noted)
Newborn Care – Inpatient	Plan pays 80%	Plan pays 50%
Medical Supplies (covered under Durable Medical Equipment above)	Plan pays 80%	Plan pays 50%
Mental Health and Substance Abuse Treatment		
Doctor's office visits	Plan pays 100% after $40 co-payment	Plan pays 50%
Outpatient/Intermediate Care	Plan pays 80%	Plan pays 50%
Inpatient Care (requires precertification)	Plan pays 80%	$750 Copayment, then Plan pays 50%
Organ Transplants – See description of coverage and limitations below Precertification required.	Plan pays 80%	Plan pays 50%
Private Duty Nursing Limited to 100 visits per plan year in combination with Home Health Care visits	Plan pays 80%	Plan pays 50%
***Primary Care Physician** - Office visit for injury or sickness (excludes preventive care, surgery and other medical services and supplies) (Deductible does not apply In-Network)	Plan pays 100% after $40 co-payment	Plan pays 50%
***Specialist Physician** – Office visit for injury or sickness (excludes preventive care, surgery and other medical services and supplies) (Deductible does not apply In-Network)	Plan pays 100% after $40 co-payment	Plan pays 50%
Prosthetics	Plan pays 80%	Plan pays 50%
Radiation Therapy	Plan pays 80%	Plan pays 50%
Reconstructive Surgery	Plan pays 80%	Plan pays 50%
Routine Preventive Care/Wellness Benefits		

	In-Network (after deductible, unless noted)	Out-of-Network (after deductible, unless noted)
Routine periodic and screening exams	Plan pays 100%	Plan pays 50%
Routine gynecological exam/Pap smear and mammogram	Plan pays 100%	Plan pays 50%
Well-baby/Well-child Care	Plan pays 100%	Plan pays 50%
Immunizations	Plan pays 100%	Plan pays 50%
Second Surgical Opinions – voluntary	Plan pays 100% after $40 Copayment	Plan pays 50%
Skilled Nursing Facility Limit of 90 days per plan year	Plan pays 80%	Plan pays 50%
Sterilization Procedures	Plan pays 80% Deductible waived if performed in Office setting	Plan pays 50%
Surgery		
Hospital Inpatient Precertification required.	Plan pays 80%	$750 Copayment, then Plan pays 50%
Outpatient Facility	Plan pays 80%	Plan pays 50%
Therapy Services		
Cardiac Rehabilitation Therapy Must be initiated within 12 weeks after other treatment for the medical condition ends. Occupational Therapy Physical Therapy Pulmonary/Respiratory Therapy Speech Therapy Excludes habilitative therapy treatment to help keep, learn or improve skills and functioning (versus rehabilitative therapy following an illness/injury)	Plan pays 80%	Plan pays 50%

	In-Network (after deductible, unless noted)	Out-of-Network (after deductible, unless noted)
Performed in and billed by Physician's office	Plan pays 80%	Plan pays 50%
Performed at outpatient facility or inpatient **Weight Loss Surgery** Lifetime Maximum benefit of $20,000 including the $2,000 co-payment. Co-payment does not apply to the Combined Out-of-Pocket Maximum	Plan pays 80% $2,000 Copayment, then Plan pays 100%	Plan pays 50% $2,000 Copayment, then Plan pays 100%

** A Primary Care Physician or PCP may be a family practitioner, general practitioner, internist, gynecologist, or pediatrician. A Specialist may be a physician or other health care provider other than a PCP, for example, a cardiologist, allergist, gynecologist, chiropractor, or physical therapist. The final designation will depend on how the provider has chosen to contract with the network.*

Summary of Medical Benefits

Option III

	In-Network	Out-of-Network
Annual Deductible (applies to expenses below unless otherwise noted)	$2,000 / individual $6,000 / family	$6,000 / individual $18,000 / family
Annual Coinsurance and Deductible Maximum **Annual Out-of-Pocket Maximum** (includes covered expenses under the Plan)	$4,000 / individual $12,000 / family $6,600 / individual $13,200 / family	No Limit / individual No Limit / family No Limit / individual No Limit / family

	In-Network (after deductible, unless noted)	Out-of-Network (after deductible, unless noted)
Allergy Testing, Serum, and Treatment	Plan pays 80% Deductible does not apply	Plan pays 50%
Allergy Shots	Plan pays 80% Deductible does not apply	Plan pays 50%
Ambulance Service	Plan pays 80%	Plan pays 80%

	In-Network (after deductible, unless noted)	Out-of-Network (after deductible, unless noted)
Ambulatory Surgical Center	Plan pays 80%	Plan pays 50%
Anesthetics, Oxygen, Transfusions	Plan pays 80%	Plan pays 50%
Chemotherapy	Plan pays 80%	Plan pays 50%
Chiropractic Care Limited to 50 visits per calendar year	Plan pays 50%	Plan pays 50%
Diagnostic X-rays and Lab Services (includes advanced radiological imaging)		
Performed in and billed by a physician's office (Deductible does not apply In-Network)	Plan pays 80%	Plan pays 50%
Performed in and billed by an outside lab/facility	Plan pays 80%	Plan pays 50%
Pre-admission Testing (performed prior to a hospital confinement)	Plan pays 80%	Plan pays 50%
Durable Medical Equipment	Plan pays 80%	Plan pays 50%
Emergency/Acute Care Hospital ER Room (copayment waived if admitted)	$125 Copayment, then Plan pays 80%	$125 Copayment, then Plan pays 80%
Hearing Aids and Hearing Exams Limited to a maximum benefit of $500 per ear every 2 calendar years	Plan pays 100% Deductible does not apply	Plan pays 100% Deductible does not apply
Hemodialysis	Plan pays 80%	Plan pays 50%
Home Health Care Limited to 100 visits per calendar year in combination with Private Duty Nursing Precertification required.	Plan pays 80%	Plan pays 50%
Hospice Care Lifetime maximum benefit of $10,000	Plan pays 80%	Plan pays 50%

	In-Network (after deductible, unless noted)	Out-of-Network (after deductible, unless noted)
Hospital Services – Inpatient Requires precertification – see also Pregnancy below.	Plan pays 80%	$750 Copayment, then Plan pays 50%
Hospital Services – Outpatient	Plan pays 80%	Plan pays 50%
Infertility Treatment (includes services for the diagnosis of infertility only)	Facility: Plan pays 80% Office Services: Plan pays 80%, deductible does not apply to services rendered in office	Plan pays 50%
Maternity Benefits – includes physician services for prenatal visits and routine pre- and post-partum care, childbirth and pregnancy-related conditions		
Physician Services	Plan pays 80%	Plan pays 50%
Inpatient hospital services or birthing center including labor and delivery (requires precertification for extended stay only)	Plan pays 80%	Plan pays 50%
Newborn Care – Inpatient	Plan pays 80%	Plan pays 50%
Medical Supplies (covered under Durable Medical Equipment above)	Plan pays 80%	Plan pays 50%
Mental Health and Substance Abuse Treatment		
Doctor's office visits	Plan pays 100% after $40 co-payment	Plan pays 50%
Outpatient/Intermediate Care	Plan pays 80%	Plan pays 50%
Inpatient Care (requires precertification)	Plan pays 80%	$750 Copay, then Plan pays 50%
Organ Transplants – See description of coverage and limitations below Precertification required.	Plan pays 80%	Plan pays 50%
Private Duty Nursing Limited to 100 visits per plan year in combination with Home Health Care visits	Plan pays 80%	Plan pays 50%

	In-Network (after deductible, unless noted)	Out-of-Network (after deductible, unless noted)
***Primary Care Physician** - Office visit for injury or sickness (excludes preventive care, surgery and other medical services and supplies) (Deductible does not apply In-Network)	Plan pays 100% after $40 Copayment	Plan pays 50%
***Specialist Physician** – Office visit for injury or sickness (excludes preventive care, surgery and other medical services and supplies) (Deductible does not apply In-Network)	Plan pays 100% after $40 Copayment	Plan pays 50%
Prosthetics	Plan pays 80%	Plan pays 50%
Radiation Therapy	Plan pays 80%	Plan pays 50%
Reconstructive Surgery	Plan pays 80%	Plan pays 50%
Routine Preventive Care/Wellness Benefits		
Routine periodic and screening exams	Plan pays 100%	Plan pays 50%
Routine gynecological exam/Pap smear and mammogram	Plan pays 100%	Plan pays 50%
Well-baby/Well-child Care	Plan pays 100%	Plan pays 50%
Immunizations	Plan pays 100%	Plan pays 50%
Second Surgical Opinions – voluntary	Plan pays 100% after $40 Copayment	Plan pays 50%
Skilled Nursing Facility Limit of 90 days per plan year	Plan pays 80%	Plan pays 50%
Sterilization Procedures	Plan pays 80% Deductible waived if performed in Office setting	Plan pays 50%

	In-Network (after deductible, unless noted)	Out-of-Network (after deductible, unless noted)
Surgery		
Hospital Inpatient Precertification required.	Plan pays 80%	$750 Copayment, then Plan pays 50%
Outpatient Facility	Plan pays 80%	Plan pays 50%
Therapy Services		
Cardiac Rehabilitation Therapy Must be initiated within weeks after other treatment for the medical condition ends. Occupational Therapy Physical Therapy Pulmonary/Respiratory Therapy Speech Therapy Excludes habilitative therapy treatment to help keep, learn or improve skills and functioning (versus rehabilitative therapy following an illness/injury)	Plan pays 80%	Plan pays 50%
Performed in and billed by Physician's office	Plan pays 80%	Plan pays 50%
Performed at outpatient facility or inpatient **Weight Loss Surgery** Lifetime Maximum benefit of $20,000 including the $2,000 co-payment. Co-payment does not apply to the Combined Out-of-Pocket Maximum	Plan pays 80% $2,000 Copayment, then Plan pays 100%	Plan pays 50% $2,000 Copayment, then Plan pays 100%

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Eligible Expenses

Eligible expenses are for services and supplies that are approved by a physician or other approved provider and must be medically necessary for the care and treatment of a covered sickness, accidental injury, pregnancy or other covered health care condition. Services received from an out-of-network provider are subject to the Reasonable and Customary limit (see above).

The following are common conditions and services for which expenses are typically paid:

- **Ambulance** – includes medically necessary professional ambulance services. 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. Includes charges for local ground or air transportation by a professional ambulance service. Emergency ambulance services will be paid at the in-network provider level of benefits.
- **Ambulatory Surgical Center** – includes services and supplies provided by an Ambulatory Surgical Center in connection with a covered outpatient surgery. A Center is a licensed facility used mainly for performing outpatient surgery and does not provide for overnight stays.
- **Amniocentesis** – see Pregnancy
- **Anesthesia** – includes anesthetics and the services of a licensed physician or certified nurse anesthetist (C.R.N.A.)
- **Birthing Center** – includes services and supplies provided by a licensed Birthing Center in connection with a covered pregnancy.
- **Blood** – includes blood and blood derivatives (if not replaced by or on behalf of the patient), including blood processing and administration services. Also includes processing, storage, and administration charges for autologous blood (patient's own blood) when a covered person is scheduled for surgery that can be expected to require blood.
- **Cardiac Rehabilitation** – see Therapy, Short-Term
- **Chemical Dependency** – see Substance Abuse
- **Chemotherapy** – includes medically necessary and appropriate drugs and services of a physician or medical provider; also includes initial purchase of a wig following chemotherapy (Lifetime Maximum Benefit of $200).
- **Chiropractic Care** – includes musculoskeletal manipulation by a licensed physician (M.D. or D.O.) or chiropractor (D.C.) to correct vertebral and/or joint related disorders, such as incomplete dislocation, misalignment, sprain or strain.
- **Circumcision**
- **Counseling** – includes counseling services by a licensed or approved provider only for diabetes wellness benefits including nutritional education, and as required under the provisions of PPACA.

- **Dental Services** - Limited to treatment for the repair of accidental, non-occupational injury to sound, natural teeth;
- **Diagnostic Lab and X-Ray, Outpatient** – includes laboratory, X-ray, EKGs, and other non-surgical services performed to diagnose medical disorders by physicians throughout the United States; also includes advanced scanning and imaging work (e.g., CT scans, MRIs) and other similar advanced tests;
- **Durable Medical Equipment** –includes coverage for the rental (or purchase, if rental would be more costly) of durable medical equipment (including wheelchairs) required for therapeutic purposes, as prescribed by a covered provider and determined by the Plan to be medically necessary.

  Excludes replacement braces unless there is sufficient change in the patient's condition to make the original device no longer functional
- **Emergency Room Visits** – includes medical treatment for an emergency. An emergency is an accident or the sudden and unexpected onset of an acute condition, illness, or severe symptoms that require immediate medical care. Examples include fractures, lacerations, motor vehicle accidents, hemorrhage, shock, poisoning, or other conditions associated with deterioration of vital life functions.

  Colds, sore throats, flu, and infections are examples of nonemergencies, although they may require urgent treatment.

  The Plan determines which conditions and symptoms are medical emergencies using the "prudent layperson" definition of emergency. A prudent layperson is someone who possesses an average knowledge of health and medicine and, therefore, is able to determine that the absence of immediate medical attention may result in a serious medical condition for an ill or injured person. For example, if someone goes to the emergency room with chest pains and the situation turns out to be indigestion, a prudent layperson would agree that seeking emergency care was appropriate.
- **Hearing Aids and hearing exams** – includes related services, supplies, and fitting exams. Services are covered up to a maximum benefit of $500.00 per ear per member every 2 calendar years.
- **Hemodialysis Services** – includes the services of a person to assist the patient with home dialysis, when provided by a hospital, freestanding dialysis center or other approved covered provider.
- **Home Health Care/Nursing** – includes home visits by a staff member of a home health care or private duty nursing agency (including a person under contract or arrangement with the agency), or a licensed therapist, during which any of the following services are provided:
  - Part-time or temporary nursing care performed by an R.N. or a licensed practical nurse (L.P.N.)
  - Part-time or temporary care by a home health aide
  - Physical, occupational, speech, or respiratory therapy
  - Oxygen service

- Short-term care for mental illness when recovery or improvement is deemed likely

To be covered, home health care must be provided according to a home health care program set up in writing by a doctor. The doctor must state that the patient is, for all practical purposes, confined at home and the medical condition requires home health care.

To be covered, the home health care agency must:

- meet standards set by Medicare;
- be approved by the Plan; and
- be approved by your area's health care planning agency (if applicable).

Contact the Plan for approval before arranging home health care services.

- **Hospice Care** – includes hospice services furnished to a terminally ill person after the date the person enters the hospice care program. Also includes bereavement counseling services incurred before the patient's death for the patient and for covered members of the immediate family within 6 months of the patient's death.

  To be covered, the hospice care program must:

  - meet standards set by the National Hospice Organization;
  - be approved by the Plan;
  - be Medicare approved; and
  - be directed by a doctor.

  If the program is required to be state licensed, certified, or registered, it also must meet that requirement. Contact the Plan for approval before arranging hospice care services.

- **Hospital Services** – include hospital charges for the following:

  - Room and board - For a semiprivate room, charges are covered at the most common rate; for a private room in a hospital with semiprivate rooms, charges are covered only up to the hospital's most common semiprivate room rate. However, if it is medically necessary to stay in a private room, the full charge will be a covered medical expense. For a private room in a private-room-only hospital, the full cost of the private room will be considered a covered medical expense.
  - services required for medical or surgical care, whether as an outpatient or inpatient, and other related services;
  - services of nursing staff and other hospital staff providing care;
  - emergency room services; and
  - medically necessary services.

  An inpatient hospital stay for the diagnosis of a sickness or injury will be covered only if the stay is mandatory or is required for the safety of the patient or the success of a medical treatment or test. Also includes services that can be done on an outpatient basis, or services performed inpatient when a concurrent medical hazard exists that prevents the patient from being treated on an outpatient basis.

- **Infertility Diagnosis and Treatment** – includes services for the diagnosis of infertility (only).
- **Medical Supplies** – includes supplies such as casts, splints, dressings, catheters, colostomy bags, oxygen and syringes and needles for the treatment of allergies or diabetes.
- **Medicines** – includes medicines dispensed and administered during an inpatient stay. See Prescription Drug Benefits for outpatient prescription drug coverage information.
- **Mental Health** – coverage for mental health treatments are treated the same as benefits provided for other medical conditions in accordance with the Mental Health Parity and Addiction Equity Act of 2008.
- **Midwife** – includes services of a certified or registered nurse midwife when provided in conjunction with a covered pregnancy.
- **Newborn Care** – includes services and supplies for a covered newborn who is sick or injured, including infant formula when needed for the treatment of inborn errors of metabolism while the infant is hospital-confined. Also includes hospital nursery services and routine newborn care provided during the birth confinement or on an outpatient basis for non-hospital births.

  Services for a newborn child are covered only if the child is enrolled in coverage within 31 days of birth. Charges for a dependent child's newborn are not covered under the Plan. See "Pregnancy" below for additional information.
- **Obesity** - includes charges for surgery for morbid obesity if it is determined by SAS Medical Management that the treatment is medically necessary. Lifetime Maximum benefit of $20,000 per member. Charges over $20,000 are not covered by the plan. Charges for services at a weight reduction clinic, health spa, health fitness facility, or similar facility are excluded. Weight loss surgery copayment of $2,000 per member applies. Copayment does not apply to the Out-of-Pocket Maximum Limit.
- **Occupational Therapy** – see Therapy, Short-Term
- **Organ and Tissue Transplants** – If you or a covered dependent faces a potential transplant, contact the Plan as soon as possible to determine the benefits available to you.

  Benefits include charges incurred for the care and treatment related to an approved transplant.

  If the donor is covered by the Plan and the recipient is not, the Plan will cover charges of the donor for evaluating the organ/tissue and removing the organ/tissue from the donor. Donor transfer benefits are subject to a maximum paid benefit of $10,000. No transportation charges will be covered.

  If the Plan participant is the donor, the Plan will pay 100% of hospital and surgical costs for the removal of the donated organ, provided these costs are not covered under any other benefit plan.

  If the transplant recipient is covered by the Plan, benefits will be provided only when the hospital and physician customarily charge a recipient for such care and services.

No benefits will be payable for services for which a participant would not be legally obligated to pay if there were no coverage under the Plan. Benefits also include charges for organ procurement other than from a live donor (i.e., harvesting, storing, and transporting an organ to the transplant site.)

If the transplant recipient is covered by the Plan and the donor is not, expenses for the surgical removal will be considered expenses of the recipient and the Plan will pay hospital and surgical fees for the donor, unless the donor's coverage pays for such expenses.

Travel, lodging, and related expenses for the patient and one family member are covered only if the transplant is performed at an approved facility. These expenses will be reimbursed up to a maximum of $5,000 per transplant.

- **Orthotics** – includes orthopedic braces, casts, splints, trusses and other orthotics prescribed by a physician that are required for support of an injured or deformed part of the body as a result of a congenital condition or an accidental injury and medically necessary foot orthotics. Excludes foot orthotics.
- **Podiatry** – includes treatment for bunions (when an open cutting operation is performed); non-routine treatment of corns or calluses; toenails when at least part of the nail root is removed; or any required medically necessary surgical procedure on the foot. Excludes coverage for routine foot care or treatment of unstable or flat feet.
- **Pregnancy** – includes prenatal visits and routine pre- and post-partum care, routine ultrasounds, hospital stays, or birthing center, and obstetric services provided by a doctor or certified nurse-midwife (working under the direction of a doctor) for pregnancy, childbirth, or related complications for you and your covered spouse only.

  Maternity benefits may be provided even if the pregnancy began before covered under the Plan, as long as coverage is in effect when the pregnancy ends. If expenses are incurred after coverage ends, no benefits will be paid.

  Benefits for any hospital length of stay for the mother and newborn child may not be restricted to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a Cesarean section in accordance with the Newborns' and Mothers' Health Protection Act. A provider automatically will receive authorization from the Plan for prescribing a length of stay that does not exceed these time frames. The mother and newborn's attending physicians, only after consulting with the mother, may discharge the mother and newborn earlier than 48 or 96 hours.
- **Private Duty Nursing** – provided for services rendered in inpatient setting only when care is medically necessary and the hospital's intensive care unit is filled or the hospital has no intensive care unit. Provided in an outpatient setting only in conjunction with approved home health care (see above).
- **Prosthetics** – includes the initial purchase of artificial limbs, eyes or other prosthetic appliances required to replace natural limbs, eyes or other body parts which have been lost due to an accidental injury, sickness or surgery. Also includes replacement of a prosthetic device due to a change in the patient's physical condition that makes the original device no longer functional.

To comply with the Women's Health and Cancer Rights Act, coverage includes post-mastectomy breast prostheses.

- **Radiation Therapy** – includes radium and radioactive isotope therapy.
- **Reconstructive Surgery** – includes reconstructive surgery after a mastectomy, including reconstructive surgery of the breast on which the mastectomy was performed as well as reconstructive surgery of the other breast to produce a symmetrical appearance is also covered in accordance with the Women's Health and Cancer Rights Act of 1998. Coverage includes prostheses and treatment of physical complications in all stages of the mastectomy, including lymphedemas.

  Coverage also includes charges for reconstructive surgery or therapy to repair or correct a severe physical deformity or disfigurement which is accompanied by functional deficit; also includes surgery required to repair a congenital absence or agenesis (lack of formation or development) of a body part prior to age 18.
- **Respiratory/Pulmonary Therapy** – see Therapy, Short-Term
- **Routine Preventive Care/Wellness Benefits** – covers routine preventive care that includes, but is not limited to:
  - those services and procedures recommended to comply with the Patient Protection and Affordable Care Act;
  - well baby/well child care provided for children through age 18; and
  - immunizations administered in a doctor's office or health care facility except immunizations for the sole purpose of travel outside the U.S.
  - Include Vitamin D assays and diagnostic mammography following a routine screening mammography, if required.

  Recommended services and procedures can be found under the Prevention & Wellness tab at www.healthcare.gov.
- **Skilled Nursing/Sub-Acute Facility** – includes room and board and non-custodial nursing care provided under the treatment plan of a physician if the patient is confined as a patient in the facility. The confinement must begin within 14 days of a hospital stay when the physician certifies that further care is needed.
- **Sleep Disorders** – includes services, supplies, medications, and testing related to the diagnosis and treatment of sleep disorders, such as insomnia, narcolepsy, sleep apnea, and parasomnias. Excludes sleep therapy treatments designed to modify behaviors or sleep habits.
- **Smoking Cessation** – includes expenses for smoking cessation program
- **Speech Therapy** – see Therapy, Short-Term
- **Sterilization** – includes voluntary sterilization procedures for employee and covered spouse only. Excludes reverse sterilization procedures.
- **Substance Abuse** – includes inpatient, partial hospitalization, and outpatient treatment of substance abuse, as well as intensive outpatient programs if approved by the Plan. For Plan purposes, "substance abuse" is physical and/or emotional dependence on drugs, narcotics, alcohol or other addictive substances to a

debilitating degree. It does not include tobacco dependence or dependence on ordinary drinks containing caffeine.

- **Surgery** – includes surgeries performed in a doctor's office, outpatient facility or hospital. However, payments for multiple surgical procedures or surgeries involving more than one surgeon or assistant will be paid based on the primary procedure and the number of procedures and individuals involved. Payments for assistant surgeons may be limited as well. Any procedure not integral to the primary procedure or unrelated to the diagnosis will not be covered.
- **Therapy, Short-Term** – includes the following rehabilitation therapy services provided on an outpatient basis:
    - Cardiac Rehabilitation Therapy – includes services provided under the supervision of a physician in an approved facility in connection with a myocardial infarction, coronary occlusion, or coronary bypass surgery, in order to restore physiological and psychological well-being to an individual with heart disease. Must be initiated within 12 weeks after other treatment for the medical condition ends.
    - Physical Therapy – Includes services by a licensed therapist or physician for improvement of bodily function and provided in accordance with physician's order as to type, frequency and duration.
    - Occupational Therapy - includes services and supplies when provided by a certified occupational therapist under the direction of a physician that are needed to improve and maintain a patient's ability to function;
    - Pulmonary/Respiratory Therapy – includes services of a licensed respiratory or inhalation therapist, when prescribed by a physician as to type and duration for function improvement of chronic respiratory impairment;
    - Speech Therapy – Includes services of a licensed speech therapist when prescribed by a physician following surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy), injury, or sickness (other than a learning or mental disorder);

  Maintenance care is not covered under any category above.
- **TMJ / Jaw Joint Treatment** - includes medically necessary treatment of jaw joint problems such as temporomandibular joint syndrome and cranio-mandibular disorders or other conditions of the joint linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to that joint. Appliances for treatment of temporomandibular disorders and related orthodontic treatments are not covered.

For More Information

If you have a question about a covered service, or for more information about a specific procedure or service described above, contact the claims administrator at the number listed on the back of your ID card.

Expenses Not Covered

The following expenses, among others, are not covered under the Plan:

Alternative Treatments

- music therapy;
- massage therapy;
- charges for pain disorder services or treatment including, but not limited to biofeedback, aversion therapy, self-help programs, services rendered by a masseur/masseuse, health club membership fees, or any similar type program designed for pain disorders such as ultrasound-guided extracorporal shock wave therapy;
- acupuncture or acupressure treatments unless administered by a licensed physician;

Comfort/Convenience Items and Services

- custodial care/assistance with activities of daily living, whether in a residential care facility, skilled nursing facility, or at home, including help in walking, bathing, preparing meals and special diets, and supervising use of medication;
- personal convenience items or equipment including, but not limited to, radio/television rentals, air conditioners, humidifiers, air purification or heating units, exercise equipment, elastic bandages or stockings, non-hospital adjustable beds, orthopedic mattresses, blood pressure instruments, scales, and first aid supplies and other non-prescription drugs or medicines;

Dental/Oral

- Routine dental care, including, but not limited to:
  - Fillings or other dental repair procedures
  - Prescription drugs for dental treatment
  - Treatment for diseases of the teeth or gums
  - Treatment for malocclusion or malposition of teeth or jaws (mandibular or maxillary hyper/hypoplasia
  - Hospital care
  - X-rays
  - Replacement of teeth, including fixed or removable prostheses

Podiatry/Foot Care

- diagnosis, routine care, and treatment for the feet including orthopedic shoes, orthopedic prescription devices, arch supports, treatment of weak, strained, flat, unstable or unbalanced feet, subluxations of the foot, metatarsalgia, non-surgical care of bunions (except open cutting operations as may be covered under eligible expenses) and treatment of corns, calluses, or toenails (unless medically necessary for an underlying disease);
- Charges for examinations or fittings for routine care and treatment;
- Orthotics;

Medical Supplies/Appliances

- replacement braces unless there is sufficient change in the patient's condition to make the original device no longer functional;
- mechanical or artificial organ transplants or implants (except Intraocular Lens Implants);

Counseling

- services of dieticians and/or nutritionists and nutrition programs, except as specifically provided for elsewhere in this plan and as provided for under PPACA;
- counseling services, including services provided for marital, family,
- educational or vocational testing;
- ancillary services for learning disabilities or developmental delays;

Physical Appearance

- Other than for approved weight loss surgery, all other services, supplies, or treatment primarily for weight reduction or treatment of obesity, including but not limited to hormones, medications, exercise programs or use of exercise equipment, special diets or supplements, appetite suppressants, weight loss programs, and hospital confinements for weight reduction programs;
- services for cosmetic reasons, except for covered reconstructive surgery;
- expenses related to the care and treatment of hair loss (excluding wigs after chemotherapy if indicated under eligible expenses above);

Reproduction/Sexual

- abortion unless
    - the life of the mother is endangered by the continued pregnancy
    - a live birth is not possible or
    - the pregnancy was the result of rape or incest.

  However, expenses incurred to treat complications arising after the performance of an abortion are covered;
- services, supplies, or treatment for transsexualism, gender dysphoria, or sexual assignment or change, including medications, implants, hormone therapy, surgery, or medical or psychiatric treatment;
- treatment of benign gynecomastia;
- dependent pregnancies;
- sterilization reversals;
- contraceptives except as may be provided under the Prescription Drug benefit and in compliance with requirements of PPACA;
- fertility treatments such as in-vitro fertilization, GIFT, fertility assistance, and other artificial insemination or impregnation procedures;

- fertility treatments (except as provided under Eligible expenses above);
- diagnosis, care, or treatment of sexual dysfunction or impotence, including expenses for supplies or services for the restoration or enhancement of sexual activity not related to organic disease (except as may be covered under the Prescription Drug benefit);
- genetic testing;

Services Provided by Another Plan

- services and supplies covered by laws or regulations of any government agency, unless specifically covered under the Plan;
- services for any condition, illness, or injury, or complication thereof arising out of or in the course of employment, when the participant or covered dependent is furnished care or services covered hereunder, or could or might have been furnished such care and services if pursued or sought, according to the provisions of any Worker's Compensation or occupational disease law, or any other law or regulation of the United States, or of a state, territory or subdivision thereof, or under any policy of Worker's Compensation or occupational disease insurance, or according to any recognized legal remedy available to the participant or covered dependent;

Travel-Related Expenses

- travel and accommodation expenses unless provided above under the Plan for a particular service;
- expenses for care or treatment outside of the United States if travel was for the sole purpose of obtaining medical services;

Hospital/Hospice Services

- any hospital stay that is not for the diagnosis or treatment of a sickness or injury;
- non-emergency hospital admissions on a Friday or Saturday unless surgery is performed within 24 hours of admission;
- complications resulting from non-covered services (other than abortion);

Home Services/Nursing

- home management and compensatory training, meal preparation, safety procedures, and adaptive equipment instructions used to support activities of daily living;
- respite care;

Vision

- routine eye exams, eyeglasses, contact lenses, or related services, except the initial eyeglasses or contact lenses after a cataract operation or the special contacts necessary to treat keratoconus; this exclusion does not apply to aphakic patients and soft lenses or sclera shells for use as corneal bandages;
- expenses for radial keratotomy or any other surgery to correct nearsightedness or refractive errors;

Non-Compliance

- all charges in connection with treatments or medications where the patient either is in non-compliance with or is discharged from a hospital or skilled nursing facility against medical advice;

Behavioral Exclusions

- services to treat injuries sustained or a sickness contracted while the participant or covered dependent committed or attempted to commit a felony or misdemeanor, or was engaged in an illegal occupation or activity, assault, or felonious behavior or activity; this exclusion does not apply to an injury or sickness contracted as the result of domestic violence or a medical (both physical or mental) condition;
- services or expenses to treat an intentionally self-inflicted injury while sane or insane; this exclusion does not apply if the injury resulted from an act of domestic violence or a medical (both physical or mental) condition;
- services, supplies, care, or treatment for an injury or sickness that results from engaging in a hazardous hobby or activity. A hobby or activity is hazardous if it is characterized by a constant threat of danger or risk of bodily harm such as (but not limited to) skydiving, auto or powerboat racing, hang gliding, rock climbing, or bungee or base jumping;
- services, supplies, care or treatment resulting from a participant's or covered dependent's illegal use of alcohol. The arresting officer's determination of inebriation will be sufficient for this exclusion. Expenses will be covered for injured participants other than the person using controlled substances and expenses will be covered for substance abuse treatment as provided by the Plan (does not apply if the injury resulted from an act of domestic violence or a medical (physical and mental health) condition);
- services, supplies, care or treatment resulting from a participant's voluntary taking or being under the influence of any controlled substance, drug, hallucinogen, or narcotic not administered on the advice of a physician. Expenses will be covered for injured participants other than the person using controlled substances and expenses will be covered for substance abuse treatment as provided by the Plan (does not apply if the injury resulted from an act of domestic violence or a medical (physical and mental health) condition;
- services to treat injuries sustained or a sickness contracted while the participant or covered dependent committed or attempted to commit a serious illegal act which includes any act or series of acts that, if prosecuted as a criminal offense, a sentence to a term of imprisonment in excess of one year could be imposed. It is not necessary that criminal charges be filed, or if filed, that a conviction results, or that a sentence for a term in excess of one year be imposed for this exclusion to apply. Proof beyond a reasonable doubt is not required (does not apply if the injury resulted from an act of domestic violence or a medical (physical or mental health) condition);

- charges for failure to keep a scheduled visit, telephone consultations between patient and doctor, or completion of claim forms;
- services, supplies, care, or treatment for an injury or sickness which occurred as the result of or was caused by engaging in an illegal act or occupation; by committing or attempting to commit a crime, criminal act, assault or other felonious behavior; or by participating in a riot or public disturbance (does apply if the injury resulted from an act of domestic violence or a medical (physical or mental health) condition);

- sleep disorders (except as may be provided under eligible expenses);

All Other

- expenses resulting from complications of a treatment not covered by the Plan (other than abortion);
- services rendered by an unlicensed provider;
- services or supplies for sickness, defect, disease, or injury due to war or a warlike action in time of peace;
- services or supplies that are experimental or investigational;
- services or supplies that are not medically necessary for diagnosing or treating your condition, as determined by the Plan;
- any charges in excess of the maximum amount payable under the Plan for a particular service or supply (see “Maximum Allowed Amount” above);
- autopsies;
- services or supplies received before the patient is covered by the Plan;
- services or supplies for which the patient does not have to pay, or for which no charges would be made if this coverage did not exist;
- services not recommended and approved by a physician or treatment, services, or supplies when the participant is not under the regular care of a physician that is appropriate care for the injury or sickness; and
- services performed by a person who ordinarily resides in the participant’s home or who is related to the participant and/or his covered dependents as a spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.

Precertification

You and your covered dependents are required to obtain precertification for inpatient hospitalization and home health care as shown in the Summary of Medical Benefits above. In some cases, the in-network provider may obtain the precertification for you; however, to ensure that you receive the maximum benefit, you should verify that the request was submitted to the Plan.

A 50% penalty may be applied to the eligible amount for failure to pre-certify a service. To receive the maximum benefit and avoid any penalty for failure to precertify, you must call the number listed on the back of your ID card to precertify an admission or treatment:

- at least 1 week prior to any scheduled or non-emergency hospital admission or treatment;
- within 48 hours of an emergency or unscheduled admission. Your case will be reviewed by the Plan to determine how many days of treatment are medically necessary.

Precertification - Pregnancy and Childbirth

Precertification will not be required for an inpatient admission for pregnancy delivery that does not exceed 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery. If/when the pregnancy confinement for the mother or newborn is expected to exceed these limits, precertification for such extended confinement is required.

Penalty for Noncompliance with Precertification

If precertification requirements are not met, any covered expenses incurred may not be covered. In addition, if it is determined subsequently that all or part of the hospital stay was not medically necessary, all or part of the hospital confinement expenses will be denied and benefits will not be paid beyond the number of days considered medically necessary.

The precertification coordinator will work with your physician to determine the appropriate length of stay for your condition. If an extension is required for your hospital confinement, you (or a family member or your attending physician) must obtain approval for the extension before the original approved stay expires. If an extension is approved, you, your attending physician, and the hospital will receive written notification of the approval. If the criteria for an extended stay are not met, your stay will be denied and you may file an appeal of the denial through the Plan’s appeal process.

Case Management

Through the case management program, you receive appropriate health care services for serious or catastrophic medical conditions. The Plan Administrator may arrange for review and/or case management from a professional who is qualified to perform such services. The Plan Administrator has the right to alter or waive the normal provisions of the Plan when it is reasonable to expect a cost-effective result without sacrificing the quality of patient care. The case management program may provide benefits or alternative care not otherwise routinely available through the Plan under special circumstances.

While many diagnoses may require special attention, the Plan may use case management for conditions such as, but not limited to:

- Acquired Immune Deficiency Syndrome (AIDS);
- burns;
- coma;
- inpatient confinement expected to exceed 14 days;

- multiple sclerosis/Amyotrophic Lateral Sclerosis (Lou Gehrig's disease);
- neonatal birth;
- organ transplant;
- progressive neurological debilitative disease;
- certain psychiatric conditions;
- quadriplegic/paraplegic conditions;
- stroke; and
- multiple traumas from a vehicular accident.

Benefits provided under the program are subject to all other Plan provisions. Alternative treatments will be determined on the merits of each individual case and will not be considered as setting any precedent or creating any future liability with respect to any participant. Case management will be involved for in-network services that meet the established criteria.

Your Prescription Drug Benefits

How the Plan Works

If you elect medical coverage under the Plan, you are automatically enrolled in the Prescription Drug program. Your Plan helps pay the cost of covered prescription drugs that are medically necessary for treatment of a sickness or injury. Covered drugs must be:

- prescribed by a licensed physician or dentist and dispensed by a registered pharmacist; and
- approved by the United States Food and Drug Administration (FDA) for general use in treating the illness or injury for which they are prescribed.

Managed Pharmacy Network

Prescription drug benefits are provided through a managed pharmacy network.

You may purchase covered prescription drugs through the network in one of two ways:

- at a network retail pharmacy; or
- through the mail-service program for maintenance medications or any prescription not needed immediately.

A list of participating pharmacies can be found at www.magellanrx.com.

Coverage Categories and Your Co-payment

There are four tiers in the prescription drug Plan; each has a different co-payment that applies depending on where you have your prescription filled. The chart below shows your co-payment amounts, co-payment maximum out-of-pocket amounts, and any deductible. If your Plan has a deductible, you must satisfy the deductible before the Plan pays benefits.

Prescription Drug Tiers

Level 1 – Generic Drug: Using generic drugs when available, instead of costlier brand-name drugs, can save you money. Pharmacies will dispense generic equivalent drugs, which are therapeutically equivalent to their brand-name drug in safety and effectiveness, when taken as prescribed unless your physician orders a specific brand name drug. The co-payment for generic drugs is $10 per prescription for up to a 30-day supply. For generic drugs purchased through the mail service program, the co-payment is $25 per prescription for up to a 90-day supply.

Level 2 – Preferred or Formulary Brand Name Drugs: This category includes brand-name drugs for which there are no or limited generic drug alternatives. Most brand-name drugs used to treat asthma or diabetes are included in this category. If a generic drug is available, it will automatically be dispensed unless your physician orders a brand name drug or you request it. Your co-payment for formulary (brand-name) drugs at a network retail pharmacy is $20 per prescription for up to a 30-day supply. For formulary drugs purchased through the mail service program, the co-payment is $50 per prescription for up to a 90-day supply.

Level 3 – Non-Preferred or Non-Formulary Brand Name Drugs: This category includes brand-name drugs for which no generic equivalent drugs and/or appropriate generic drug

alternatives are available. Your co-payment for non-formulary drugs at a network retail pharmacy is $35 per prescription for up to a 30-day supply. For non-formulary drugs purchased through the mail service program, the co-payment is $85 per prescription for up to a 90-day supply.

Plan Option 3 has an ancillary charge if a brand name prescription is chosen when a generic drug exists, regardless if the brand is requested by the member or the physician. Members covered under Option 3, must pay the difference between the cost of the generic drug and the brand drug in addition to the brand co-payment.

Level 4 -- Specialty Medications: Certain drugs are considered "specialty medications" and may only be purchased through a network pharmacy, except as required in an emergency. The following are the therapeutic classifications of specialty medications under the Plan:

- Blood Modifiers
- Growth Hormones
- Hemophelia
- IGIV
- Interferon
- Oral Oncologics
- Pulmonary Hypertension
- Other (as determined by the Plan)

For information on ordering specialty medications, including dispensing limitations, contact the prescription drug benefit claims manager. Your co-payment for specialty drugs is $100 for up to a 30-day supply.

Using a Network Retail Pharmacy

The retail pharmacy network includes most chain and many local pharmacies. Present your medical ID card to the network pharmacy when you purchase covered prescription drugs. There are no claim forms to complete.

If You Use an Out-of-Network Retail Pharmacy

Coverage for prescriptions purchased at out of network pharmacies are not covered under this plan.

Mail-Service Program

The mail-service program is a cost-effective and convenient way to purchase up to a 90-day supply of covered medication through the mail. The mail-service program is used for maintenance prescription drugs, such as blood pressure medication, taken on a regular or long-term basis. It also can be used for any medication that is not needed immediately.

To fill a prescription through the mail-service program, you must complete an order form and include your co-payment (using a credit card, check, or money order). With your first order, you also must include the original prescription order written by your doctor and a completed patient profile form.

Your filled prescription will be mailed directly to your home. Your order will include a preprinted envelope and a notice with instructions on how to request a refill prescription; you will not need a new prescription from your doctor if the prescription is still valid. Refills can

also be conveniently refilled by phone or by using Pharmacy Manager's Web site www.magellanrx.com.

Your Prescription Drug Coverage

	Enhanced Pharmacy	**Enhanced Pharmacy** (up to a 90-day supply)	**In-Network Retail Pharmacy** (up to a 30-day supply)	**Mail-Service Program** (up to a 90-day supply)
	Copayment	**Copayment**	**Copayment**	**Copayment**
Generic	$8	$16	$10	$25
Preferred Brand Name (Formulary)	$5	$15	$20	$50
Non-Preferred Brand Name (Non-Formulary)	$15	$35	$35	$85
Specialty Injectable Drugs	$75	n/a	$100	n/a

Prior Authorization and Limits

Certain prescriptions may require prior authorization by the Pharmacy Benefit Manager. This process allows the Plan to verify that the drug is a part of a specific treatment plan and is medically necessary. Your physician will need to contact the Pharmacy Benefit Manager with written documentation of the reason for prescribing the medication and the length of time it should be covered. If you discover that a prescription requires prior authorization while you are at a retail pharmacy, you or the pharmacist will need to contact your doctor, who must then contact the Pharmacy Benefit Manager.

If your prescription is authorized by the Pharmacy Benefit Manager, you will be able to fill your prescription at any participating pharmacy or through the mail service program. If authorization is not received, you will be required to pay the full cost of the prescription.

Certain drugs may also be limited by drug-specific quantity limitations per month, benefit period, or lifetime as specified by the Plan and based on medical necessity. Other drugs may be covered under your medical benefits and will be subject to your deductible and coinsurance. If your prescription is affected by these limits, you or your pharmacist should contact the Pharmacy Benefit Manager.

Covered Prescription Drugs and Supplies

The following prescription drugs and supplies, among others, are covered under the Plan:

- AZT, Retrovir, and other drugs used for the purpose of treating HIV/AIDS, unless considered experimental or investigational;

- Alcohol swabs, when needed for injectable medicines;
- Hypodermic and insulin syringes and needles for administering injectable drugs if prescribed by a doctor and purchased with the drug as part of the same order;
- Diabetic supplies (such as Chemstrips);
- Insulin, disposable insulin pens, insulin cartridges, and pen needles (non-disposable insulin pens are considered medical supplies and are covered under medical benefits);
- Adapalene (Differin);
- Prescription prenatal vitamins;
- Drugs to treat narcolepsy including Provigil;
- Attention Deficit Disorder (ADD) drugs (e.g., Adderall, Dexedrine, Ritalin);
- Oral contraceptives, injectable contraceptives, and contraceptive devices (e.g., IUDs and diaphragms);
- All dosage forms of smoking-cessation aids, whether prescription type (such as Wellbutrin), or physician-prescribed over-the-counter type (such as nicotine patches and nicotine gum); this benefit is allowed for one treatment of up to 90 days in a lifetime.

Expenses Not Covered

The following drugs and supplies, among others, are not covered under the Plan:

- Any prescription refilled in excess of the number specified by the doctor, or any refill dispensed more than one year after the doctor's original order;
- Drugs or supplies covered under Workers' Compensation or occupational disease law or any similar law;
- Drugs labeled "Caution—limited by Federal law to investigational use," or experimental drugs, even though a charge is made to the individual;
- Drugs and medicines that may not be prescribed within the scope of the doctor's license;
- Medication administered in a doctor's office or health care facility;
- Prescriptions filled in hospital out-of-network pharmacies at time of discharge;
- Therapeutic devices or appliances, support garments, and other non-medicinal substances, regardless of intended use;
- Impotency drugs;
- Pigmenting and depigmenting agents;
- Drugs used to treat or cure baldness or hair loss (e.g., Minoxidil);
- Drugs for weight loss;
- Immunization agents or biological sera;
- Injectable Supplies (other than for Insulin);
- Anti-Wrinkling Agents (e.g., Renova);

- Drugs used for treatments that are cosmetic-related;
- Over-the-counter drugs and products unless specifically listed as covered expenses in the plan;
- Vitamins and dietary supplements that require a prescription;
- Fertility drugs;
- Compound drugs with a cost greater than $200 per claim.

Some drugs may require pre-authorization. If the necessary pre-authorization is not obtained, the drug may not be covered.

For More Information

If you have a question about a covered prescription or supply, or for more information about a specific drug or service described above, contact the claims administrator at the number listed on the back of your ID card.

Medicare Part D Creditable Coverage

If you are Medicare-eligible, you should be aware that Medicare offers prescription drug coverage (known as Medicare Part D). You are not required to choose this coverage. The Plan will continue to provide your prescription drug coverage if you become eligible for Medicare. If you enroll in coverage under this Plan and under Medicare Part D, you will be paying more for additional insurance that you may not need as Medicare Part D will not supplement your coverage under this Plan. There is no coordination between the plans.

Prescription drug coverage under this Plan is, on average, at least as good as Medicare prescription drug coverage; therefore, there is no advantage to signing up for Medicare Part D coverage. The government refers to this as “creditable coverage”. Since the Plan’s coverage is considered to be creditable, you will not be subject to penalties or restrictions if you later choose to enroll in a Medicare prescription drug plan.

Your Dental Benefits

The Plan provides dental benefits that cover services you receive from a licensed dentist. The Summary of Dental Benefits chart below shows the covered services under the Plan.

A dental charge is incurred on the date the service or supply is performed or furnished. However, there are times when one overall charge may be made for all or part of a treatment. In this case, the total charge will be apportioned to each separate visit or treatment. The pro-rata charge will be considered incurred as each visit or treatment is completed.

Annual Deductible

A deductible is the amount you must pay for certain covered expenses before the Plan pays benefits. The annual deductible is $50 per person; $150 per family. The dental deductible is separate from any other deductible that may apply under the Plan.

Coinsurance

Once you meet your deductible, the Plan pays a portion, or percentage, of certain covered dental expenses, and you are responsible to pay a portion. The percentage you must pay is called your coinsurance. Your coinsurance is determined by the type of service you receive as shown in the chart below.

Maximum Benefit

The maximum annual benefit is $1,000 per person per calendar year for Option I. Option I does not contain an orthodontia benefit.

Option II has a annual benefit of $2,000 per person per calendar year. There is a separate individual maximum benefit of $2,000 per lifetime for orthodontia treatment.

Covered Services

In order to be covered, all dental services must be:

- Medically necessary. In order to be deemed medically necessary, a service must conform with generally accepted standards of dental practice. Sometimes there is more than one acceptable form of treatment. The Plan covers the treatment that produces good, professional dental results and costs the least. If you want a more costly treatment, you must pay the difference in cost.
- Provided by a qualified and licensed dentist, physician, denturist, or dental hygienist under supervision of a dentist or physician practicing within the scope of his or her license.
- Reasonable and customary for a covered service or supply. The maximum amount payable by the Plan will be based on the amount determined by the Plan to be the prevailing charge for a covered service or supply. The prevailing charge is based on the complexity of the service and the fee typically charged for a given service by providers with similar training or experience in a given geographical area.

The Plan pays benefits up to the maximum approved amount based on the prevailing charge for a covered service or supply. If your provider charges more than this amount, you are responsible for paying any excess charges above this limit.

A service or supply is not automatically covered simply because it is recommended or prescribed by a dentist. Should you have any questions about whether a service is covered, contact the claims administrator shown on your ID card.

Orthodontic Benefits

All services must be performed by a licensed dentist. Orthodontia benefits are available only to covered dependents up to age 19. All orthodontia expenses must be reasonable and necessary, and incurred for the diagnosis and treatment of malposed teeth. Benefits are payable only if such treatment is required to move and correct the position of maloccluded or malpositioned teeth, such as an overbite, maxillary and mandibular arches in either a protrusive or retrusive relation of at least one cusp, or a cross bite. Payments for orthodontia treatment will only be made if the participant is still covered under the Plan and is still receiving orthodontic treatment. Benefits will be paid in accordance with the approved treatment plan over a period of up to 8 calendar quarters.

Summary of Dental Benefits

Option I

Annual Maximum Benefit (per calendar year)	$1,000 per person
Annual Deductible (per calendar year)	$50/person $150/family

Diagnostic and Preventive Care (Class A) Services	**Plan Pays**
Periodic or comprehensive oral evaluation, limited to1 time in any 6-month period	100%
Intraoral complete series X-rays, including bitewings and 10 to 14 periapical X-rays, or panoramic film, limited to1 time in any 60-month period	100%
Bitewing X-rays (2 to 4 films), limited to 1 time in any 12-month period	100%
Dental prophylaxis, limited to1 time in any 6-month period	100%
Topical fluoride treatment,, limited to: (a) 1 time in any 6-month period; and (b) Covered dependent children less than age 14;	100%

Diagnostic and Preventive Care (Class A) Services	Plan Pays
Sealants, limited to: (a) 1 time per tooth in any 36-month period; (b) Applications made to permanent molar teeth; and (c) Covered dependent children less than age 14;	100%
Space maintainers, including all adjustments made within 6 months of installation, limited to covered dependent children less than age 19.	100%

Non-Restorative and Restorative (Class B) Services	Plan Pays
Limited oral evaluation-problem focused, considered for payment as a separate benefit only if no other treatment (except X-rays) is rendered during the visit;	80%
Intraoral periapical X-rays;	80%
Intraoral occlusal X-rays, limited to 1 film in any 6-month period;	80%
Extraoral X-rays, limited to 1 film in any 6-month period;	80%
Other X-rays (except films related to orthodontic procedures or temporomandibular joint dysfunction);	80%
Histopathological examination;	80%
Stainless steel crowns, limited: (a) 1 time in any 36-month period; (b) Teeth not restorable by an amalgam or composite filling; and (c) Covered dependent children less than age 19;	80%
Pulpotomy	80%
Root canal therapy, including all pre-operative, operative and post-operative X-rays, bacteriologic cultures, diagnostic tests, local anesthesia and routine follow-up care, limited to 1 time on the same tooth in any 24-month period;	80%

Non-Restorative and Restorative (Class B) Services	Plan Pays
Apicoectomy/periradicular surgery (anterior bicuspid, molar, each additional root), including gall pre-operative, operative X-rays, bacteriologic cultures, diagnostic tests, local anesthesia and routine follow-up care;	80%
Retrograde filling—per root	80%
Root amputation – per root	80%
Hemisection, including any root removal and an allowance for local anesthesia and routine post-operative care, does not include a benefit for root canal therapy;	80%
Periodontal scaling and root planning (per quadrant), limited to1 time per quadrant of the mouth in any 24-month period;	80%
Periodontal maintenance procedure (following active treatment) limited to 1 dental prophylaxis or 1 periodontal maintenance procedure in any 6-month period;	80%
Periodontal related services as listed below, limited to1 time per quadrant of the mouth in any 36-month period with charges combined for each of these services performed in the same quadrant within the same 36-month period: (a) Gingivectomy; (b) Osseous surgery;	80%
Osseous grafts:	80%
Pedicle grafts;	80%
Tissue grafts;	80%
Periodontal appliances, limited to 1 appliance in any 12-month period;	80%
Simple extraction;	80%
Oral surgery services as listed below, including an allowance for local anesthesia and routine post-operative care; (a) Surgical extractions (including extraction of wisdom teeth); (b) Alveoloplasty;	80%

Non-Restorative and Restorative (Class B) Services	Plan Pays
(c) Vestibuloplasty; (d) Removal of exostosis—maxilla or mandible (e) Frenulectomy (frenectomy or frenotomy); (f) Excision of hyperplastic tissue—per arch;	
Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth and/or alveolus;	80%
Extraction, erupted tooth or exposed root (elevation and/or forceps removal):	80%
Biopsy;	80%
Incision and drainage;	80%
Palliative (emergency) treatment of dental pain, considered for payment as a separate benefit only if no other treatment (except X-rays) is rendered during the visit;	80%
General anesthesia and intravenous sedation, limited as follows: (a) Considered for payment as a separate benefit only when determined medically necessary and when administered in the dentist's office or outpatient surgical center in conjunction with complex oral surgical services which are covered under the plan; (b) Benefits for general anesthesia will be based on the benefit allowed for the corresponding intravenous sedation;	80%
Consultation, including specialist consultations, limited as follows: (a) Considered for payment only if billed by a dentist who is not providing operative treatment, (b) Benefits will not be considered for payment if the purpose of the consultation is to describe the dental treatment plan;	80%
Therapeutic drug injections.	80%
Amalgam restorations, limited as follows: (a) Multiple restorations on one surface with be considered a single filling; (b) Benefits for the replacement of an existing amalgam	80%

Non-Restorative and Restorative (Class B) Services	Plan Pays
restoration will only be considered for payment if at least: (i) 12 months have passed since the existing amalgam restoration was placed if the Participant or covered dependent les less than age 19; or (ii) 36 months have passed since the exiswting amalgam restoration was placed if the Participant or covered dependent is age 19 or older; (c) Mesial, lingual, buccal (MLB) and distal, lingual, buccal (DLB) restorations will be considered single surface restorations;	
Silicate restorations	80%
Plastic restorations;	80%
Composite restorations, limited as follows: (a) Mesial-lingual, distal-lingual, mesial-buccal, and distal-buccal restorations on anterior teeth will be considered single surface restorations; (b) Acid etch is not covered as a separate procedure; (c) Benefits for the replacement of an existing composite restoration will only be considered for payment if at least: (i) 12 months have passed since the existing composite restoration was placed if the Participant or covered dependent is less than age 19; or (ii) 36 months have passed since the existing composite restoration was placed if the Participant or covered dependent is age 19 or older; (d) Benefits for composite resin restorations on posterior teeth will be based on the benefit for the corresponding amalgam restoration;	80%
Pin retention restoration, covered only in conjunction with an amalgam or composite restoration, pins limited to1 time per tooth.	80%

Non-Restorative and Restorative (Class B) Services	Plan Pays
Adjunctive prediagnostic test (cancer screening)	80%
Application of desensitizing medicament	80%
Bone replacement graft for ridge preservation	80%
Full mouth debridement	80%
Localized delivery of antimicrobial agents	80%
Office visit after regularly scheduled hours	80%
Pulp caps	80%

Major Dental Services (Class C)	Plan Pays
All benefits for the services listed below include an allowance for all temporary restorations and appliances, and 1 year follow-up care.	
Inlays and onlays; (a) Covered only when the tooth cannot be restored by an amalgam or composite filling; (b) Covered only if more than 5 years have elapsed since last placement; and (c) Limited to persons 16 years of age or older;	50%
Porcelain restorations on anterior teeth;	50%
Crowns: (a) Covered only when the tooth cannot be restored by an amalgam or composite filling; (b) Covered only if more than 5 years have elapsed since last placement; and (c) Limited to persons 16 years of age or older.	50%
Recementing inlays;	50%

Recementing crowns;	50%
Crown build-up, including pins and prefabricated posts;	50%
Post and core, covered only for endodontically treated teeth requiring crowns;	50%
Full dentures, limited as follows: (a) Limited to 1 time per arch unless: (i) 5 years have elapsed since last replacement, and (ii) The denture cannot be made serviceable; (b) Additional benefits will not be paid for personalized dentures or overdentures or associated treatment; (c) Any denture will not be paid until it is accepted by the patient;	50%
Partial dentures, including an clasps and rests and all teeth, limited as follows: (a) Limited to 1 partial denture per arch unless: (i) 5 years have elapsed since last replacement (see the Denture or Bridge Replacement/ Addition provision for exceptioins); and (ii) The partial denture cannot be made serviceable; (b) There are no benefits for precision or semi-precision attachments.	50%
Denture adjustments, limited to: (a) 1 time in any 12-month period; (b) Adjustments made more than 12 months after the insertion of the denture;	50%
Repairs to full or partial dentures, bridges, crowns and inlays, limited to repairs or adjustment performed more than 12 months after the initial insertion;	50%
Relining or rebasing dentures, limited to: (a) 1 time in any 36-month period; and (b) Relining or rebasing done more than 12 months after the insertion of the denture;	50%
Tissue conditioning, limited to repairs or adjustment performed more than 12 months after the initial insertion of the denture;	50%

Fixed bridges (including Maryland bridges), limited as follows: (a) Limited to persons over age 16; (b) Benefits for the replacement of an existing fixed bridge are payable only if the existing bridge: (i) Is more than 5 years old (see the Denture or Bridge Replacement/ Addition provision for exceptions); and (c) A fixed bridge replacing the extracted portion of a hemisected tooth is not covered; (d) The date the bridge is cemented in the mouth will be used in determined the amount that will be applied to the benefit year Maximum shown in the Plan Schedule	50%
Recementing bridges, limited to repairs or adjustment performed more than 12 months after the initial insertion;	50%
Non-surgical Temporomandibular Joint (TMJ) treatment for myofascial pain syndrome, muscular, neural, or skeletal disorder, dysfunction or disease of the Temporomandibular Joint including treatment of the chewing muscles to relieve pain or muscle spasm, TMJ X-rays, and occlusal adjustments, limited as follows: (a) Covered does not include an allowance for appliances for tooth movement or guidance, electronic diagnostic modalities, occlusal analysis, or muscle testing; (b) The Overall Maximum Benefit for Temporomandibular Joint (TMJ) Treatment and the Benefit year Maximum shown in the Schedule will apply.	50%
Implants	50%

Summary of Dental Benefits

Option II

Annual Maximum Benefit (per calendar year)	$2,000 per person
Annual Deductible (per calendar year)	$50/person $150/family
Orthodontia Maximum Benefit (per lifetime)	$2,000

Diagnostic and Preventive Care (Class A) Services	Plan Pays
Periodic or comprehensive oral evaluation, limited to1 time in any 6-month period	100%
Intraoral complete series X-rays, including bitewings and 10 to 14 periapical X-rays, or panoramic film, limited to1 time in any 60-month period	100%
Bitewing X-rays (2 to 4 films), limited to 1 time in any 12-month period	100%
Dental prophylaxis, limited to1 time in any 6-month period	100%
Topical fluoride treatment,, limited to: (a) 1 time in any 6-month period; and (b) Covered dependent children less than age 14;	100%
Sealants, limited to: (a) 1 time per tooth in any 36-month period; (b) Applications made to permanent molar teeth; and Covered dependent children less than age 14;	100%
Space maintainers, including all adjustments made within 6 months of installation, limited to covered dependent children less than age 19.	100%

Non-Restorative and Restorative (Class B) Services	Plan Pays
Limited oral evaluation-problem focused, considered for payment as a separate benefit only if no other treatment (except X-rays) is rendered during the visit;	80%
Intraoral periapical X-rays;	80%
Intraoral occlusal X-rays, limited to 1 film in any 6-month period;	80%
Extraoral X-rays, limited to 1 film in any 6-month period;	80%
Other X-rays (except films related to orthodontic procedures or temporomandibular joint dysfunction);	80%

Non-Restorative and Restorative (Class B) Services	Plan Pays
Histopathological examination;	80%
Stainless steel crowns, limited: (a) 1 time in any 36-month period; (b) Teeth not restorable by an amalgam or composite filling; and (c) Covered dependent children less than age 19;	80%
Pulpotomy;	80%
Root canal therapy, including all pre-operative, operative and post-operative X-rays, bacteriologic cultures, diagnostic tests, local anesthesia and routine follow-up care, limited to 1 time on the same tooth in any 24-month period;	80%
Apicoectomy/periradicular surgery (anterior bicuspid, molar, each additional root), including gall pre-operative, operative X-rays, bacteriologic cultures, diagnostic tests, local anesthesia and routine follow-up care;	80%
Retrograde filling—per root	80%
Root amputation – per root	80%
Hemisection, including any root removal and an allowance for local anesthesia and routine post-operative care, does not include a benefit for root canal therapy;	80%
Periodontal scaling and root planning (per quadrant), limited to1 time per quadrant of the mouth in any 24-month period;	80%
Periodontal maintenance procedure (following active treatment) limited to 1 dental prophylaxis or 1 periodontal maintenance procedure in any 6-month period;	80%
Periodontal related services as listed below, limited to1 time per quadrant of the mouth in any 36-month period with charges combined for each of these services performed in the same quadrant within the same 36-month period: (a) Gingivectomy; (b) Osseous surgery;	80%
Osseous grafts:	80%

Non-Restorative and Restorative (Class B) Services	Plan Pays
Pedicle grafts;	80%
Tissue grafts;	80%
Periodontal appliances, limited to 1 appliance in any 12-month period;	80%
Simple extraction;	80%
Oral surgery services as listed below, including an allowance for local anesthesia and routine post-operative care; (a) Surgical extractions (including extraction of wisdom teeth); (b) Alveoloplasty; (c) Vestibuloplasty; (d) Removal of exostosis—maxilla or mandible (e) Frenulectomy (frenectomy or frenotomy); (f) Excision of hyperplastic tissue—per arch;	80%
Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth and/or alveolus;	80%
Extraction, erupted tooth or exposed root (elevation and/or forceps removal):	80%
Biopsy;	80%
Incision and drainage;	80%
Palliative (emergency) treatment of dental pain, considered for payment as a separate benefit only if no other treatment (except X-rays) is rendered during the visit;	80%
General anesthesia and intravenous sedation, limited as follows: (a) Considered for payment as a separate benefit only when determined medically necessary and when administered in the dentist's office or outpatient surgical center in conjunction with complex oral surgical services which are covered under the plan; (b) Benefits for general anesthesia will be based on the benefit allowed for the corresponding intravenous	80%

Non-Restorative and Restorative (Class B) Services	Plan Pays
sedation;	
Consultation, including specialist consultations, limited as follows: (a) Considered for payment only if billed by a dentist who is not providing operative treatment, (b) Benefits will not be considered for payment if the purpose of the consultation is to describe the dental treatment plan;	80%
Therapeutic drug injections.	80%
Amalgam restorations, limited as follows: (a) Multiple restorations on one surface with be considered a single filling; (b) Benefits for the replacement of an existing amalgam restoration will only be considered for payment if at least: (iii) 12 months have passed since the existing amalgam restoration was placed if the Participant or covered dependent les less than age 19; or (iv) 36 months have passed since the existing amalgam restoration was placed if the Participant or covered dependent is age 19 or older; (c) Mesial, lingual, buccal (MLB) and distal, lingual, buccal (DLB) restorations will be considered single surface restorations;	80%
Silicate restorations	80%
Plastic restorations;	80%
Composite restorations, limited as follows: (a) Mesial-lingual, distal-lingual, mesial-buccal, and distal-buccal restorations on anterior teeth will be considered single surface restorations; (b) Acid etch is not covered as a separate procedure; (c) Benefits for the replacement of an existing composite	80%

Non-Restorative and Restorative (Class B) Services	Plan Pays
restoration will only be considered for payment if at least: (iii) 12 months have passed since the existing composite restoration was placed if the Participant or covered dependent is less than age 19; or (iv) 36 months have passed since the existing composite restoration was placed if the Participant or covered dependent is age 19 or older; (d) Benefits for composite resin restorations on posterior teeth will be based on the benefit for the corresponding amalgam restoration;	
Pin retention restoration, covered only in conjunction with an amalgam or composite restoration, pins limited to1 time per tooth.	80%
Adjunctive prediagnostic test (cancer screening)	80%
Application of desensitizing medicament	80%
Bone replacement graft for ridge preservation	80%
Full mouth debridement	80%
Localized delivery of antimicrobial agents	80%
Office visit after regularly scheduled hours	80%
Pulp caps	80%

Major Dental Services (Class C)	Plan Pays
All benefits for the services listed below include an allowance for all temporary restorations and appliances, and 1 year follow-up care.	

Inlays and onlays; (a) Covered only when the tooth cannot be restored by an amalgam or composite filling; (b) Covered only if more than 5 years have elapsed since last placement; and (c) Limited to persons 16 years of age or older;	50%
Porcelain restorations on anterior teeth;	50%
Crowns: (a) Covered only when the tooth cannot be restored by an amalgam or composite filling; (b) Covered only if more than 5 years have elapsed since last placement; and (c) Limited to persons 16 years or age or older;	50%
Recementing inlays;	50%
Recementing crowns;	50%
Crown build-up, including pins and prefabricated posts;	50%
Post and core, covered only for endodontically treated teeth requiring crowns;	50%
Full dentures, limited as follows: (a) Limited to 1 time per arch unless: (iii) 5 years have elapsed since last replacement, and (iv) The denture cannot be made serviceable; (b) Additional benefits will not be paid for personalized dentures or overdentures or associated treatment; (c) Any denture will not be paid until it is accepted by the patient;	50%
Partial dentures, including an clasps and rests and all teeth, limited as follows: (a) Limited to 1 partial denture per arch unless: (iii) 5 years have elapsed since last replacement (see the Denture or Bridge Replacement/ Addition provision for exceptioins); and (iv) The partial denture cannot be made serviceable; (b) There are no benefits for precision or semi-precision	50%

attachments.	
Denture adjustments, limited to: (a) 1 time in any 12-month period; (b) Adjustments made more than 12 months after the insertion of the denture;	50%
Repairs to full or partial dentures, bridges, crowns and inlays, limited to repairs or adjustment performed more than 12 months after the initial insertion;	50%
Relining or rebasing dentures, limited to: (a) 1 time in any 36-month period; and (b) Relining or rebasing done more than 12 months after the insertion of the denture;	50%
Tissue conditioning, limited to repairs or adjustment performed more than 12 months after the initial insertion of the denture;	50%
Fixed bridges (including Maryland bridges), limited as follows: (a) Limited to persons over age 16; (b) Benefits for the replacement of an existing fixed bridge are payable only if the existing bridge: (ii) Is more than 5 years old (see the Denture or Bridge Replacement/ Addition provision for exceptions); and (c) A fixed bridge replacing the extracted portion of a hemisected tooth is not covered; (d) The date the bridge is cemented in the mouth will be used in determined the amount that will be applied to the benefit year Maximum shown in the Plan Schedule	50%
Recementing bridges, limited to repairs or adjustment performed more than 12 months after the initial insertion;	50%
Non-surgical Temporomandibular Joint (TMJ) treatment for myofascial pain syndrome, muscular, neural, or skeletal disorder, dysfunction or disease of the Temporomandibular Joint including treatment of the chewing muscles to relieve pain or muscle spasm, TMJ X-rays, and occlusal adjustments, limited as follows: (a) Covered does not include an allowance for appliances for tooth movement or guidance, electronic diagnostic modalities, occlusal analysis, or	50%

muscle testing; (b) The Overall Maximum Benefit for Temporomandibular Joint (TMJ) Treatment and the Benefit year Maximum shown in the Schedule will apply. Implants	50%

Orthodontia Benefits (Class D)	**Plan Pays**
Cephalometric X-Rays;	50%
Diagnostic casts, limited to casts made for orthodontic purposes;	50%
Surgical exposure of an impacted tooth, limited to services performed for orthodontic purposes;	50%
Orthodontic appliances for tooth guidance; and	50%
Fixed or removable appliances to correct harmful habits.	50%

Benefits for orthodontic treatment will be provided to covered dependent children only.

Benefits for orthodontic treatment are not payable for expenses incurred for retention of orthodontic relationships. Benefits for orthodontic treatment are payable only for active orthodontic treatment for the services listed above.

Benefits will be paid for the orthodontic services listed above when the date started for the orthodontic service occurs while the person is covered under this Plan. No payment will b e made for orthodontic treatment if the appliances or bands are inserted prior to becoming covered. Orthodontic treatment will be considered to be started on the date the bands or appliances are inserted. Any other orthodontic treatment that can be completed on the same day it is rendered is considered to be started and completed on the date the orthodontic treatment is rendered.

The benefit percentage amount shown in the Schedule will be paid after any required deductible for orthodontic services has been satisfied for the benefit year. The maximum benefit payable to each covered dependent child, while covered under the Plan, for orthodontic services is shown in the Schedule. The maximum benefit will apply even if coverage is interrupted. Benefits paid for orthodontic services will not be applied to the Benefit Year Maximum shown in the Schedule.

A payment will be made for covered orthodontic services related to the initial orthodontic treatment which consists of diagnosis, evaluation, pre-care and insertion of bands or appliances. After the payment for the initial orthodontic treatment, benefits for covered orthodontic services will be paid in equal quarterly installments over the course of the remaining orthodontic treatment. The benefit payment schedule for the initial orthodontic treatment and quarterly installments will be determined as follows:

(1) The lesser of the usual or customary charge and the orthodontist's fee will be determined and multiplied by the benefit percentage shown in the Schedule.

(2) The lesser of the amount from number 1 or the Overall Maximum Benefit for orthodontic services shown in the Schedule will be the maximum benefit payable. An initial amount of 25% of the maximum benefit payable will be paid for the initial orthodontic treatment. This amount will be payable as of the date appliances or bands are inserted.

(3) The remaining 75% of the maximum benefit payable will be divided by the number of quarters that orthodontic treatment will continue to determine the amount which will be payable for each subsequent quarter of orthodontic treatment. The subsequent quarterly payments will be made only if the covered dependent child remains covered under the Plan and provides proof that orthodontic treatment continues. If orthodontic treatment continues after the maximum benefit payable as been paid, no further benefits will be paid.

Pre-estimate

If the charge for any treatment is expected to exceed $300, it is recommended that a dental treatment plan be submitted for review before treatment begins. An estimate of the benefits payable will be sent to the Participant and the dentist.

In addition to a dental treatment plan, before orthodontic treatment begins, the Dental Claims Administrator may request any of the following information to help determine benefits payable for orthodontic services:

(1) Full mouth dental X-rays;

(2) Cephalometric X-rays and analysis

(3) Study models; and

(4) A statement specifying:

(a) Degree of overjet, overbite, crowding and open bite;

(b) Whether teeth are impacted, in crossbite, or congenitally missing;

(c) Length of orthodontic treatment, and

(d) Total orthodontic treatment charge.

In estimating the amount of benefits payable, the Plan will consider whether or not an alternate treatment may accomplish a professionally satisfactory result. If the Participant or a covered dependent and the dentist agree to a more expensive treatment than that pre-estimated under the Plan, the excess amount will not be paid.

The pre-estimate is not an agreement for payment of the dental expenses. The pre-estimate process lets the participant or a covered dependent know in advance approximately what portion of the expenses will be considered covered dental expenses under the Plan.

Alternate Treatment

If an alternate treatment can be performed to correct a dental condition, the maximum covered dental expense consider for payment under the Plan will be the most economical treatment which will, as determined by the Dental Claims Administrator, produce a professionally satisfactory result.

Special Limitations

Waiting Period for Timely Applicants: If an employee applies for dental coverage before or within 31 days of the date the employee or a dependent becomes eligible, the employee and any eligible dependents are timely applicants. Under the Waiting Period for Timely Applicants, benefits will not be paid for the following services until the Participant and covered dependents have been continuously covered under the Plan for the stated period of time:

Class C and Orthodontia Services -- 6 months

If treatment for a service listed above is started during the Waiting Period, only the portion of the treatment rendered after the end of the Waiting Period will be considered a covered dental expense.

Late Entrant Limitation: If an employee applies for dental coverage more than 31 days after the employee or any eligible dependents first become eligible or after participation in the Plan ended because a required contribution was not paid, the employee and any eligible dependents are late entrants. The benefits for the first 24 months of coverage for late entrants will be limited as follows:

(a) Until the late entrant has been covered under the Plan for 6 months in a row, benefits will include coverage for only Class A Dental Services;

(b) Until the late entrant has been covered under the Plan for 12 months in a row, benefits for the second 6 months will then include coverage for only Class A and Class B Restorative Dental services; and

(c) Until the late entrant has been covered under the Plan for 24 months in a row, benefits for the second 12 months will then include coverage for only Class A and Class B Non-Restorative and Restorative Dental Services.

If treatment for a service limited under this provision is started during the Late Entrant Limitation period, only the portion of the treatment rendered after the end of the Late Entrant Limitation period will be considered a covered dental expense.

Denture or Bridge Replacement/Addition: As stated in the Covered Dental Expenses section, benefits will not be paid for the replacement of a full denture, partial denture, fixed bridge or for teeth added to a partial denture unless:

(a) 5 years have elapsed since last replacement of the denture or bridge; and

(b) The denture or bridge cannot be made serviceable;

(c) The Participant or covered dependent has participated in the Plan for 24 consecutive months;

However, the following exceptions will apply:

(a) Benefits for the replacement of an existing partial denture that is less than 5 years old will be payable if there is a dentally necessary extraction of an additional functions natural tooth;

(b) Benefits for the replacement of an existing fixed bridge that is less than 5 years old will be payable if:

‘(i) there is a dentally necessary extraction of an additional functioning natural tooth; and

‘(ii) the extracted tooth was not an abutment to an existing bridge.

Dental Exclusions

Benefits will not be paid for expenses incurred for any of the following:

(1) Treatment which:

(a) Is not included in the list of covered dental expenses;

(b) Is not dentally necessary

(c) Is experimental in nature; or

(d) Does not have uniform professional endorsement;

(2) Appliances, inlays, cast restoration, crowns, or other laboratory prepared restorations used primarily for the purpose of splinting;

(3) Any treatment or appliance, the sole or primary purpose of which relates to:

(a) The change or maintenance of vertical dimension;

(b) The alteration or restoration of occlusion except for occlusal adjustment in conjunction with periodontal surgery or temporomandibular joint disorder.

(c) Bite registration; or

(d) Bite analysis;

(4) Replacement of a lost or stolen appliance or prosthesis;

(5) Educational procedures, including, but not limited to oral hygiene, plaque control, nutritional counseling, or dietary instructions;

(6) Completion of claim forms or missed dental appointments;

(7) Personal supplies or equipment, including but not limited to water piks, toothbrushes, or floss holders;

(8) Treatment for a jaw fracture;

(9) Treatment provided by a dentist, dental hygienist, denturist or doctor who is:

(a) An immediate family member or a person who ordinarily resides with the Participant or a covered dependent

(b) An employee of the Employer, or

(c) An Employer;

(10) Hospital or facility charges for room, supplies or emergency room expenses or routine chest X-rays and medical exams prior to oral surgery;

(11) Treatment performed outside the United States, except for emergency dental care. The maximum benefit payable to any person during a benefit year for covered dental expenses related to emergency dental care performed outside the United States if $100;

(12) Treatment resulting from or in the course of the Participant's or a covered dependent's regular occupation for pay or profit for which the Participant or covered dependent are entitled to benefits under any Workers' Compensation Law, Employer's Liability Law or similar law. The Participant must promptly claim and notify the Plan of all such benefits:

(13) Treatment for which these conditions exist:

(a) Charges are payable or reimbursable by or through a plan or program or any governmental agency, except if the charge is related to a non-military service disability and treatment is provided by a government agency of the United States. However, any state or local medical assistance (Medicaid) agency for covered dental expenses will always be reimbursed;

(b) Charges are not imposed against the person or for which the person is not liable;

(c) Charges are reimbursable by Medicare Part A and Part B.* If a person at any time was entitled to enroll in the Medicare program (including Part B) but did not do so, his benefits under the Plan will be reduced by an amount that would have been reimbursed by Medicare, where permitted by law;

*However, for persons covered under Employers who employed 20 or more employees during the previous year, this exclusion will not apply to an actively working Participant and/or his spouse who is age 65 or older if the Participant elects to participate under the Plan instead of obtaining coverage under Medicare.

(14) Treatment provided primarily for cosmetic purposes;

(15) Treatment which may not reasonably be expected to successfully correct the person's dental condition for a period of at least 3 years, as determined by the Dental Claims Administrator;

(16) Crowns, inlays, cast restorations, or other laboratory prepared restorations on teeth which may be restored with an amalgam or composite resin filling;

(a) The treatment was completed during the prior plan's extension of benefits.

For More Information

If you have a question about a covered dental service, or for more information about a specific procedure described above, contact the claims administrator at the number listed on the back of your dental ID card.

Your Flexible Spending Account Benefits

Your Health Care Flexible Spending Account

The Health Care Flexible Spending Account offers you a convenient way to pay for eligible, unreimbursed health care expenses using pre-tax dollars. You “fund” your account by directing a portion of your pay to your Flexible Spending Account.

Health Care Expense Account

If you elect to participate in the Health Care Flexible Spending Account, a Health Care Expense Account will be established for you. This account will be maintained for bookkeeping purposes only to keep track of contributions and reimbursements, and to determine forfeitures. It will not be funded by the employer.

Your Health Care Expense Account will be credited with the amount you authorize to be deducted from your pay and debited with any amount reimbursed to you for allowable medical care expenses.

Maximum Annual Amount

The maximum annual benefit amount that you may elect under the Health Care Flexible Spending Account for a calendar year is $2,550.

The Plan Administrator has discretion to change the maximum and/or minimum contributions in subsequent years.

Eligible Medical Expenses

The Health Care Flexible Spending Account will pay only claims incurred during the year that are for eligible “Medical Expenses”, as that term is defined in Code Section 213(d), but only to the extent that the expense has not been reimbursed through insurance or otherwise. Expenses may be submitted for you, your spouse, and your “qualified dependents”, as such term is defined in Internal Revenue Code Section 152.

The following expenses do not qualify for reimbursement:

- any expense you claim as an itemized deduction on your Federal income tax return;
- premium payments for other health care coverage, including COBRA premiums;
- weight loss programs or dietary supplements;
- hair replacement treatments;
- over-the-counter drugs or medicines unless the purchase was obtained by prescription;
- cosmetic surgery or dentistry procedures, unless related to a congenital abnormality, a personal injury resulting from accident or trauma, or a disfiguring disease; or
- any expense determined to be ineligible as determined by the Plan Administrator.

For a list of eligible expenses, contact the Plan Administrator. Allowable Medical Expenses may also be found in IRS Publication 502 Medical and Dental Expenses or on the IRS Web site at www.irs.gov.

Payment of Health Care Expense Account Claims

The maximum amount available to you for reimbursement will be the lesser of:

- The amount of allowable medical expenses submitted for reimbursement; or
- The total annual Salary Reduction Contribution you elected for the year, less any prior reimbursements.

The Plan will reimburse only those allowable medical expenses which have been incurred by you and/or your dependents that are in excess of any payments or other reimbursements made under any other health care plan. Advance reimbursement will not be made for projected or future expenses.

Continuation Coverage Upon Termination

If your coverage in the Health Care Flexible Spending Account terminates due to a COBRA qualifying event, you will be given the opportunity to continue (on a self-pay basis) the same coverage you had in effect the day before the qualifying event prescribed by COBRA. However, you will be eligible for COBRA Continuation Coverage only if you have a positive Health Care Expense Account balance at the time of the COBRA qualifying event (taking into account all claims submitted before the date of the qualifying event). If COBRA is elected, it will be available only for the remainder of the year in which the qualifying event occurs and will cease at the end of that year. Your Health Care Flexible Spending Account coverage cannot be continued for the next year.

Qualified Reservist Distribution

In accordance with the “Heroes Earning Assistance and Relief Tax Act of 2008” (“HEART Act”), a qualified reservist distribution (QRD) is permitted for all or part of any unused Health Care FSA amounts if you are a reservist called to active duty provided that:

- You are called up for a period of 180 days or more or for an indefinite period of time; and
- The request for a distribution is made during the period of time between when the order or call is made and the last day that a reimbursement could be made from the Health Care FSA for that plan year.

To receive a QRD of all or part of any unused Health Care FSA amounts, you must give notice by contacting the Plan Administrator as soon as you receive your orders or are called to active duty. For additional information on how to request a qualified distribution, contact the claims administrator.

Your Dependent Care Flexible Spending Account

The Dependent Care Flexible Spending Account offers you a convenient way to pay for eligible, unreimbursed day care expenses for your eligible dependents using pre-tax dollars. You “fund” your account by directing a portion of your pay to your Flexible Spending Account.

Dependent Care Expense Account

If you elect to participate in the Dependent Care Flexible Spending Account, a Dependent Care Expense Account will be established for you. This account will be maintained for bookkeeping purposes only to keep track of contributions and reimbursements, and to determine forfeitures. It will not be funded.

The Dependent Care Expense Account will be credited with the amount you authorize to be deducted from your pay each pay period and debited with amounts reimbursed to you for eligible dependent care expenses.

Maximum Annual Amount

The maximum annual benefit amount that you may elect under the Dependent Care Flexible Spending Account for a calendar year is the smallest of the following amounts: 1) $5,000 ($2,500 if you are married and filed your Federal tax return as Married – Filing Separately); or 2) the lesser of the calendar year earned income limitation for you or your spouse described in Section 129(b) of the Code. If your spouse is not employed and is either 1) physically or mentally incapable of self-care; or 2) a student during a month in which you incur a dependent care expense, Earned Income shall be the amount specified in Code Section 21(d)(2).

The Plan Administrator has discretion to change the maximum and/or minimum contributions in subsequent years.

Eligible Dependent Care Expenses

You may use the Dependent Care FSA to pay certain dependent care expenses that are necessary to allow you – and your spouse, if you are married – to work or attend school full-time. The Plan will reimburse all employment-related expenses defined by Section 21(b)(2) of the Code, incurred by you on behalf of a qualifying dependent. These include payments to babysitters or companions inside or outside the home, licensed day care centers, as well as Federal and state taxes which you pay for providers of dependent care. For purposes of this Section, a qualifying dependent will be defined by Section 21(b)(1) of the Internal Revenue Code.

Reimbursement will be made upon your submission of documentation that such expenses were incurred to enable you to be gainfully employed for any period during which there was one or more qualifying dependents, provided however that:

- If such amounts are paid for expenses incurred outside your household, they shall constitute employment-related expenses only if incurred for a qualifying dependent under Section 21(b) of the code, who regularly spends at least 8 hours per day in your household;
- If the expense is incurred outside your home at a facility that provides care for a fee, payment, or grant for more than six individuals who do not regularly reside at the facility, the facility must comply with all state and local laws and regulations, including licensing requirements, if any; and

- Employment-related expenses for you do not include amounts paid or incurred to your child over the age of 19 or to an individual who is a dependent of you or your spouse.

NOTE: The Family Support Act of 1988 requires that you provide the name, address, and taxpayer identification number (or Social Security number) of your provider. You must include this information when you submit a claim for reimbursement.

The following expenses do not qualify for reimbursement:

- Transportation expenses to or from the day care center;
- Care provided by an individual who could be claimed as a dependent on your or your spouse's Federal tax return;
- Services which are eligible for reimbursement under any other plan or program;
- Clothing, education, or food, unless food and education are provided by the day care center or nursery school as part of its prescribed care services. Food and education expenses are not covered for kindergarten or higher;
- Tuition;
- Overnight camp expenses;
- Expenses for days when you are not working (such as sick or vacation days) or any other day when you do not meet the eligibility requirements.

A complete list of allowable dependent care expenses can be found in IRS Publication 503 Child and Dependent Care Expenses or on the IRS Web site at www.irs.gov.

If you have questions about what is considered an eligible expense under the Dependent Care Flexible Spending Account, contact the Plan Administrator.

Payment of Dependent Care Expense Account Claims

The maximum amount available for reimbursement at any time from a Dependent Care Expense Account shall be the lesser of:

- The amount of allowable dependent care expenses submitted for reimbursement; or
- The amount credited to the Participant's Dependent Care Expense Account at that time, reduced by previous reimbursements during the year.

Your Dependent Care Expense Account will be reduced by the amount of the reimbursement paid. Advance reimbursement shall not be made for projected or future expenses.

Dependent Care Expense Account Annual Statement of Benefits

On or before January 31 of each calendar year, as required by applicable law and regulations, the Plan Administrator will provide you with a summary of all Dependent Care Expense Account benefits paid to you during the previous calendar year.

Child Care Tax Credit

The IRS allows you to claim work-related dependent care expenses for credit on your Federal income tax return. The tax credit is determined by applying a percentage to your total work-related dependent care expenses. You may use both a dependent care flexible

spending account and the tax credit, provided you do not claim the same expenses for both. You must also adjust your tax credit by the amount you contribute to the Dependent Care Flexible Spending Account. For more information about the child care tax credit, see IRS Publication 503 or IRS Form 2441 and the accompanying instructions. You may also wish to consult with your tax advisor to determine which option is best for your particular tax situation.

Your Benny Card

When you enroll in a Flexible Spending Account, you will automatically receive a debit card for use in paying for eligible expenses directly from your Expense Account, without having to file a claim form. However, dependent care expenses may not be reimbursed before the expenses are incurred. If your provider requires payment before dependent care services are provided, the expenses cannot be paid using the debit card.

When you receive your card, read the terms and conditions found on the card insert, then sign the back of your card. If you choose to activate your card, you will need to call the toll-free number indicated on the sticker affixed to the card and follow the voice prompts to activate. The card will then be ready to use.

Your card may be used at any approved provider or merchant with a point-of-service (POS) bankcard terminal. Examples of qualified locations and providers include: hospitals, physician and dental offices, vision care providers, retail pharmacies, as well as many child and adult day care facilities.

Using Your Benny Card

In order to use your card, follow the instructions included with your card. It can be used at any POS bankcard terminal, just as if you were purchasing an item using a credit card. Your Flexible Spending Account and debit card are regulated by the IRS, therefore it is your responsibility to retain all itemized receipts. If a payment must be verified, the Plan Administrator also may request this receipt from you to ensure that payment was made for a qualified expense. Credit card receipts that do not itemize expenses are not sufficient to verify payment. Amounts paid that cannot be verified may be considered taxable income to you.

A transaction that includes non-eligible items or services will be denied completely, even though a portion of the transaction may be eligible. If you are purchasing non-eligible expenses at a location, you will need to purchase these items in a separate transaction.

Your card can be used for co-payments, deductibles, and coinsurance at many physician locations. However, the card does not determine any patient responsibility or eligible benefits.

When you use your card at a POS bankcard terminal, your available benefit balance is verified. The card validates your purchases real-time and automatically debits your Expense Account based on the guidelines established by the IRS and the terms of the Plan.

For questions about using your card, or to report a lost or stolen card or request additional cards, contact the claims administrator.

Submitting a Claim for Reimbursement

You may submit a claim form to the claims administrator to request reimbursement of incurred expenses. The claims administrator may utilize forms and require documentation of costs or other evidence as may be necessary to verify the claims submitted. All claims must include the name of the person on whose behalf the claim has been incurred, the nature and date of the incurred expense, a statement that the expense has not otherwise been reimbursed, and such other information required to process the claim, such as bills, invoices, or other similar documentation.

Expenses are incurred at the time the service is received, not when the care or service is billed, charged, or paid. All claims for reimbursement will be paid in the order in which they are approved. Once paid, a claim will not be reprocessed or otherwise re-characterized. Reimbursement payments shall be payable to you.

The claims administrator will provide a summary with each reimbursement that shows the amount reimbursed and your current balance. You can also request information about your account balance by contacting the claims administrator.

Claims Submission and Cut-Off

The Plan Administrator will establish and communicate to all participants the cut-off date by which all claims for the year must be submitted. Claims submitted after that date will not be eligible for reimbursement and will be forfeited.

Health Care Flexible Spending Account Carryovers and Forfeitures

The amount that may be carried over to the following plan year is equal to the **lesser of**:

- Any unused amounts from the immediately preceding plan year, or
- $500.

Any unused amount in excess of $500 remaining at the end of the run-out period for the plan year will be forfeited. Any unused amount remaining in an employee's health FSA as of termination of employment will also be forfeited (unless the employee elects COBRA coverage with respect to the health FSA).

Administrative Information

The following sections contain legal and administrative information you may need to contact the right person for information or help. Although you may not use this information often, it can be helpful if you want to know:

- how to contact the Plan Administrator;
- how to contact the claims administrators;
- what to do if a benefit claim is denied; and
- your rights under Federal laws such as COBRA.

Plan Sponsor and Administrator

City of Gulfport is the Plan Sponsor and the Plan Administrator for this Plan. You may contact the Plan Administrator at the following address and telephone number.

Plan Administrator

City of Gulfport
Hardy Building
1410 24th Avenue
Gulfport, MS 39503
228-868-5831

The Plan Administrator will administer this Plan and will be the “Named Fiduciary” for the Plan. The Plan Administrator will have control of the day-to-day administration of this Plan and will serve without additional remuneration if such individual is an employee of the Company. The Plan Administrator will have the following duties and authority with respect to the Plan:

- To prepare and file with governmental agencies all reports, returns, and all documents and information required under applicable law;
- To prepare and furnish appropriate information to eligible employees and Plan participants;
- To prescribe uniform procedures to be followed by eligible employees and participants in making elections, filing claims, and other administrative functions in order to properly administer the Plan;
- To receive such information or representations from the Company, eligible employees, and participants necessary for the proper administration of the Plan and to rely on such information or representations unless the Plan Administrator has actual knowledge that the information or representations are false;
- To properly administer the Plan in accordance with all applicable laws governing fiduciary standards;
- To maintain and preserve appropriate Plan records; and
- To accept all other responsibilities and duties of the administrator of the Plan.

In addition, the Plan Administrator has the discretionary authority to determine eligibility under all provisions of the Plan; correct defects, supply omissions, and reconcile

inconsistencies in the Plan; ensure that all benefits are paid according to the Plan; interpret Plan provisions for all participants and beneficiaries; and decide issues of credibility necessary to carry out and operate the Plan. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the applicant is entitled to them.

Plan Year

The Plan Year is January 1 through December 31.

Type of Plan

This Plan is an employee “welfare plan”, which helps to protect you against financial loss in case of sickness or injury.

Identification Numbers

The Employer Identification Number (EIN) and Plan number for the Plan is:

EIN: 64-6000413 PLAN NUMBER: 501

Plan Funding and Type of Administration

Funding and administration of the Plan is as follows.

Type of Administration	Benefits are self-funded and are administered through contracts with third-party administrators.
Funding	The Company and employees both contribute to the Plan. Assets of the Plan are used for the exclusive purpose of providing benefits to Plan participants and their beneficiaries. Any premium contributions will remain part of the general assets of the Company and benefits will be paid solely from those general assets.

Claims Administrators

The Plan Administrator has contracted with the following companies to administer benefits and pay claims. You may contact the appropriate claims administrator directly, using the information listed below. Your claims administrator is listed on your ID card.

The Plan Administrator has also contracted with different third-party administrators, to handle certain day-to-day administrative functions such as utilization review, provider contracting and prescription benefit management for the Plan. While these service providers make every attempt to provide accurate information, mistakes can occur. It is important to understand that Federal law requires that the Plan documents always control, even if their terms conflict with information given to you by a service provider.

Medical /COBRA /Utilization Review/Dental

Claims Administrator

Select Administrative Services
14110 Airport Road, Suite 100
Gulfport, MS 39503
228-864-0514
www.selectadministrativeservices.com

Prescription Drug Administrator

Magellan Rx
14110 Airport Road; Suite 100
Gulfport, MS 39503
228-864-0514
www.magellanrx.com

Flexible Spending Account Administration

Select Administrative Services
Flexible Spending Account Administration
14110 Airport Road; Suite 100
Gulfport, MS 39503
228-865-0514
www.selectadministrativeservices.com

Agent for Service of Legal Process

If any disputes arise under the Plan, papers may be served upon:

City of Gulfport
Hardy Building
1410 24th Avenue
Gulfport, MS 39503
228-868-5831

Service of legal process also can be made upon the Plan Administrator.

No Obligation to Continue Employment

The Plan does not create an obligation for the Company to continue your employment or interfere with the Company's right to terminate your employment, with or without cause.

Non-Alienation of Benefits

With the exception of a Qualified Medical Child Support Order, your right to any benefit under this Plan cannot be sold, assigned, transferred, pledged or garnished. The Plan Administrator has procedures for determining whether an order qualifies as a QMCSO; participants or beneficiaries may obtain a copy without charge by contacting the Plan Administrator.

Severability

If any provision of this Plan is held by a court of competent jurisdiction to be invalid or unenforceable, the remaining provisions shall continue to be fully effective.

Payment of Benefits

All benefits are payable when the Plan Administrator receives written proof of loss. Benefits will be payable to the covered participant, unless otherwise assigned.

Payment of Benefits to Others

The Plan Administrator, in its discretion, may authorize any payments due to be paid to the parent or legal guardian of any individual who is either a minor or legally incompetent and unable to handle his or her own affairs.

Expenses

All expenses incurred in connection with the administration of the Plan, will be paid by the Plan except to the extent that the Company elects to pay such expenses.

Fraud

No payments under the Plan will be made if the participant or the provider of services attempts to perpetrate a fraud upon the Plan with respect to any such claim. The Plan Administrator will have the right to make the final determination of whether a fraud has been attempted or committed upon the Plan or if a misrepresentation of fact has been made. The Plan will have the right to recover any amounts, with interest, improperly paid by the Plan by reason of fraud. Any employee or his or her covered dependent who attempts or commits fraud upon the Plan may have their coverage terminated and may be subject to disciplinary action by the Company, up to and including termination of employment.

Indemnity

To the full extent permitted by law, the Company will indemnify the Plan Administrator and each other employee who acts in the capacity of an agent, delegate, or representative (“Plan Administration Employee”) of the Plan Administrator against any and all losses, liabilities, costs and expenses incurred by the Plan Administration Employee in connection with or arising out of any pending, threatened, or anticipated action, suit or other proceeding in which the Employee may be involved by having been a Plan Administration Employee.

Compliance with Federal Mandates

The Plan is designed to comply to the extent possible with the requirement of all applicable laws, including but not limited to: COBRA, USERRA, HIPAA, the Newborns’ and Mothers’ Health Protection Act of 1996 (NMHPA), WHCRA, FMLA, the Mental Health Parity and Addiction Equity Act of 2008, PPACA, HITECH, Michelle’s Law, and Title I of GINA.

Non-discrimination

In accordance with IRC Section 125, the Plan is intended not to discriminate in favor of Key Employees (as defined in Code Section 416) or Highly Compensated Individuals as to eligibility to participate; or in favor of Highly Compensated Participants as to contributions and benefits, nor to provide more statutory nontaxable benefits than permitted under applicable law to Key Employees. The Plan Administrator will take such actions necessary to ensure that the Plan does not discriminate in favor of Key Employees, Highly Compensated Individuals, or Highly Compensated Participants.

Future of the Plan

The Company expects that the Plan will continue indefinitely. However, the Company has the sole right to amend, modify, suspend, or terminate all or part of the Plan at any time.

The Company may also change the level of benefits provided under the Plan at any time. If a change is made, benefits for claims incurred after the date the change takes effect will be paid according to the revised Plan provisions. In other words, once a change is made, there are no rights to benefits based on earlier Plan provisions.

Claims Procedures

This section describes what you must do to file or appeal a claim for services received in- and out-of-network.

In-Network Claims — Generally, no claim forms are necessary when you use in-network (participating) providers. Benefits for in-network covered services always are paid to the provider. If you pay the provider for a covered service, you must contact the provider to request a refund.

Out-of-Network Claims—If you use out-of-network (non-participating) providers, you might need to pay them when you receive services, including any coinsurance amount. You must then submit a claim form along with an itemized bill to the appropriate claims administrator. In most cases, the claims administrator will reimburse you directly. Occasionally, however, the claims administrator may reimburse the provider directly for covered expenses. If this happens to you and you already have paid your provider, you must request a refund from your provider.

The steps described below will guide you through the process of submitting your out-of-network claim. To obtain a form, contact your claims administrator. Complete a separate claim form for each covered family member who has expenses. If you already paid all or a portion of the fee to the provider, indicate the amount paid on the claim form.

If a member requires emergency medical services outside of the United States, the provider may not be willing to submit a claim. The member may be required to pay for the services in full and then file a claim for reimbursement. The member should keep all records and receipts. In order to file a claim for reimbursement the member will need to provide the following:

- The member must have an itemized bill, invoice, or claim form in order to file a claim for reimbursement.
- Obtain as much clinical information in writing as possible. This must be translated into English prior to the claim submission.
- The charges for services must be converted into U. S. dollars. The member will also need to obtain same-date currency exchange rates. (These may be found in the local newspaper on the date the services are paid.)
- Complete a Claim Form for Reimbursement and submit to with the supporting documentation in English and US dollars.

For medical expenses, your claims administrator will send you an Explanation of Benefits (EOB) showing what the Plan covered. You may receive a bill from the provider for the remainder of the expense, which will be your responsibility to pay. Send the completed claim form to the appropriate claims administrator listed on your ID card along with any proof of payment (i.e., a receipt).

To be eligible for reimbursement under the Plan, a claim must be submitted within the time frames established by the Plan Administrator. Claims filed after that time may be reduced or denied. If you are unable to file a claim within the prescribed time frame, the Plan Administrator may elect to approve the claim after reviewing any extenuating circumstances if the claim is filed as soon as possible.

Time Frames for Processing a Claim

Claims are divided into urgent care claims, concurrent care claims, pre-service health claims, and post-service health claims. If you or your representative fail to follow the Plan's procedures for filing a claim or if you file an incomplete claim, the Plan will notify you or your representative of the failure according to the time frames shown in the following chart.

If an initial claim is denied in whole or in part, you or your representative will receive written notice from the Plan Administrator. This notice will include the reasons for denial, the specific Plan provision involved, an explanation of how claims are reviewed, the procedure for requesting a review of the denied claim, a description of any additional material or information that must be submitted with the appeal, and an explanation of why it is necessary. If your claim for benefits is denied, you or your representative may file a written appeal for review of a denied claim with the Plan Administrator.

The chart below shows the time frames for filing different types of claims with the Plan. If you have any questions about what type of claim you may have or the timing requirements that apply to your claim, please contact your claims administrator at the number shown on your ID cards.

Time Frames for Processing a Claim				
Claim Process	**Urgent Care Claim**	**Concurrent Care Claim**	**Pre-Service Health Claim**	**Post-Service Health Claim**
Claims administrator determines initial claim is improperly filed (not filed according to Plan procedures) or is not complete	Within 24 hours after receipt of improper or incomplete claim (notification may be oral unless you or your representative request otherwise)	Within 24 hours after receipt of request for extension of urgent concurrent care	Within 5 days after receipt of improper or incomplete claim (notification may be oral unless you or your representative request otherwise)	Not applicable
Claims administrator determines that you must submit additional information required to complete claim	Within 48 hours after receipt of notice that your claim is incomplete	Not applicable	Within 45 days after receipt of notice that additional information is required	Within 45 days after receipt of notice that additional information is required
Claims administrator reviews claim and makes determination of:		For urgent care claims, within 24 hours after receipt of the claim, provided request is submitted at least 24 hours prior to expiration of prescribed period of time or number of treatments. If not submitted within 24 hours prior to expiration of prescribed period of time or number of treatments, not later than 72 hours after receipt of claim.* For non-urgent care claims, determination will be made within time frame designated for type of claim (pre- or post-service) and prior to expiration of prescribed period of time or number of treatments.*		
complete/proper claim	Within 48 hours after the earlier of: receipt of requested information, or at end of period allowed for you to provide information		Within 15 days after the earlier of: receipt of requested information, or at end of 45-day period allowed for you to provide information	Within 30 days after the earlier of: receipt of requested information, or at end of 45-day period allowed for you to provide information
initial claim	Within 24 hours of receipt of initial claim		Within 15 days of date initial claim is received	Within 30 days of date initial claim is received
Extension period,** if required due to special circumstances beyond control of claims administrator	Not applicable	Not applicable	Additional 15 days if Plan requires more information from you and provides an extension notice during initial 15-day period	Additional 15 days if Plan requires more information from you and provides an extension notice during initial 30-day period

* A request for extension of treatment will be deemed to be an initial claim. A reduction or termination of approved, ongoing treatment will be deemed to be an adverse claim decision. If the claims administrator makes an adverse decision, you will be notified of the reduction/termination within a time frame that allows you to submit an appeal and have a determination on the appeal prior to the expiration of the prescribed period of time or number of treatments.

** Whenever an extension is required, the Plan must notify you before the current determination period expires. The notice must state the circumstances requiring the extension and the date a determination is expected to be made.

How to Appeal a Claim

To appeal a denied claim or to review administrative documents pertinent to the claim, you or your representative must send a written request to the Plan. The time frames for appealing a claim are shown in the following chart.

If you or your representative submit an appeal, state why you think your claim should be reviewed and include any data, documents, questions, or comments, along with copies of itemized bills and claim forms relating to your claim. You may request, free-of-charge, copies of all documents, records, and other information relevant to your claim. A reviewer who did not make the initial claim determination will be responsible for reviewing your appeal. Also, you will be notified of any expert advice obtained on behalf of the Plan in reviewing the denied claim, regardless of whether such advice was relied upon in reviewing your claim. Such experts will not be individuals who were consulted in making the initial claim determination.

Time Frames for Appealing Denied Claims				
Appeal Process	**Urgent Care Claim**	**Concurrent Care Claim**	**Pre-Service Health Claim**	**Post-Service Health Claim**
You may submit an appeal of denied initial claim to the claims administrator	Within 180 days of receiving notice of denied claim	You will be notified of reduction or termination of benefit in time to submit appeal and receive determination before benefit ends	Within 180 days of receiving notice of denied claim	Within 180 days of receiving notice of denied claim
Claims administrator reviews your first appeal and makes determination	Within 72 hours after appeal is received	Prior to reduction or termination of benefit	Within 15 days of date appeal is received	Within 30 days of date appeal is received
You may submit a second appeal to the Plan Administrator	N/A	N/A	Within 180 days of receiving notice of denied claim	Within 180 days of receiving notice of denied claim
The Plan Administrator reviews your second appeal and makes final determination	N/A	N/A	Within 15 days of date appeal is received	Within 30 days of date appeal is received

Exhaustion Required

If you do not file a claim, follow the claims procedures, or appeal a claim within the timeframes permitted, you will give up all legal rights, including your right to file suit in Federal court, as you will not have exhausted your internal administrative appeal rights. Participants or claimants must exhaust all remedies available to them under the Plan before bringing legal action. Additionally, legal action may not be brought against the Plan more than one year after a final decision on appeal has been reviewed under the Plan.

External Review Rights/ Independent Review Organization (“IRO”)

On August 23, 2010, the U.S. Departments of Labor (DOL), Health and Human Services (HHS), and Treasury collectively released interim guidance to establish procedures for the Federal external review process required by healthcare reform.

Until the final procedure becomes available, the Plan will make every effort to comply with the limited-enforcement safe harbor provisions established by DOL Technical Release 2010-01 which provides guidance on the interim review process for self-funded group health plans.

If your final appeal for a claim is denied, you will be notified in writing that your claim is eligible for an external review and you will be informed of the time frames and the steps necessary to request an external review. You must complete all levels of the internal claims and appeal procedure before you can request a voluntary external review.

If you decide to seek external review, an independent external review organization (an "IRO") will be assigned your claim, and the IRO will work with a neutral, independent clinical reviewer with appropriate medical expertise. The IRO does not have to give deference to any earlier claims and appeals decisions, but it must observe the written terms of the Plan document. In other words, the IRO is not bound by any previous decision made on your claim. The ultimate decision of the IRO will be binding on you, the Claims Administrator, and the Plan.

For additional information about the external IRO process, contact the Claims Administrator at the telephone number shown on your ID card.

Coordination of Benefits

This section describes how benefits under this Plan are coordinated with other benefits to which you or a covered dependent might be entitled.

Non-Duplication of Benefits / Coordination of Benefits

If a Plan participant is covered by another employer's plan, the two plans work together to avoid duplicating payments. This is called non-duplication or coordination of benefits.

Your medical benefits are coordinated with benefits from:

- other employers' plans;
- certain government plans; and
- motor vehicle plans when required by law.

Non-duplication of benefits does not apply to prescription drug benefits.

How Non-Duplication Works

When an expense is covered by two plans, the following apply:

- the primary plan is determined and pays the full amount it normally would pay;
- the secondary plan calculates the amount it normally would pay and then pays any portion of that amount not paid by the primary plan; and
- you pay any remaining expenses.

If another plan is primary and this plan is secondary, the Plan will calculate the amount it would pay as if there were no other coverage, subtract the amount payable by the primary plan, and then pay any eligible remaining amount.

Determining Primary and Secondary Plans

Primary and secondary plans are determined as follows.

- A plan that does not contain a coordination of benefits provision is primary.
- If you are the employee, this Plan normally is primary when you have a covered expense.
- If your covered spouse is the patient, your spouse's company plan (if applicable) is primary. Your spouse should submit expenses to that plan first, wait for the payment, and then submit the claim under this Plan with copies of the expenses and the primary plan's Explanation of Benefits (EOB).
- When both parents' plans cover an eligible dependent child, the plan of the parent whose birthday (month and day) comes first in the calendar year is primary. For example, if your spouse's birthday is March 15 and your birthday is September 28, your spouse's plan is primary. If both parents were born on the same day, the plan of the parent who has had coverage in effect the longest will be primary. However, if the other plan does not have this birthday rule and, as a result, the plans do not agree on the order of benefits, the rule of the other plan will determine the order of benefits.

- When parents who are legally separated or divorced both cover an eligible dependent child, the following rules apply.
    - If the parents have joint custody and there is no court decree stating which parent is responsible for health care expenses, the birthday rule previously stated will apply.
    - If one parent has custody, his or her plan is primary and the other parent's plan is secondary. If the parent with custody remarries, the stepparent's plan becomes secondary and will pay before the plan of the parent without custody (the third plan).
    - If the remarried parent with custody has no health care coverage, the stepparent's plan is primary and the plan of the parent without custody is secondary.
    - Regardless of which parent has custody, whenever a court decree specifies the parent who is financially responsible for the child's health care expenses and that parent has enrolled the child in his or her plan, that parent's plan is primary.
    - When none of the previous rules applies, the plan that has covered the patient for the longer period is primary.
- Allowable expense means a medically necessary, usual, reasonable and customary item of expense for health care; when the item of expense is covered at least in part by one or more plans covering the member for whom claim is made. When the plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the plans is not an allowable expense. The following are not allowable expenses:
    a. The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an allowable expense under the above definition unless the patient's stay in a private room is medically necessary either in terms of generally accepted medical practice, or an specifically defined in the plan.
    b. If a person is covered by two or more plans that compute their benefit payments on the basis of usual and customary fees, any amount in excess of the highest of the usual and customary fees for a specific benefit is not an allowable expense.
    c. If a person is covered by two or more plans that provide benefits and services on the basis of negotiated fees, an amount in excess of the highest negotiated fee is not an allowable expense.
    d. If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary fees and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangements shall be the allowable expense for all plans.
    e. When benefits are reduced under a primary plan because a member does not comply with the plan provisions, the amount of such reduction will not be

considered an allowable expense. Examples of such provisions are those related to second surgical opinions or precertification of admissions or services.

Coordination with Medicare

If you are actively employed after becoming eligible for Medicare, your coverage under the Plan will continue and this Plan will be your primary coverage, with Medicare as secondary coverage. If you choose to have Medicare as your primary coverage, your coverage under this Plan will terminate. When Medicare is designated as the primary payer, the Plan will base its payment upon benefits payable under Medicare Parts A and B, regardless of whether the participant has enrolled under both Parts.

The Plan also coordinates with Medicare as follows.

- End-stage renal disease—If you or a covered dependent is eligible for Medicare due to end-stage renal disease, this Plan will be primary for the first 30 months of dialysis treatment; after this period, this Plan will be secondary to Medicare for this disease only.
- Mandated coverage under another group plan—If a person is covered under another group plan and Federal law requires the other group plan to pay primary to Medicare, this Plan will be tertiary (third payer) to both the other plan and Medicare.

Coordination with Auto Insurance Plans

First-party auto insurance coverage is considered primary. This Plan coordinates its benefits with the first-party benefits from an auto insurance plan without regard to fault for the same covered expense. This also applies to the benefit that an auto insurance plan would pay if auto insurance is legally required but not in force.

If you or your covered dependent incurs covered expenses as a result of an automobile accident (either as driver, passenger, or pedestrian), the amount of covered expenses that the Plan will pay is limited to:

- any deductible under the automobile coverage;
- any co-payment under the automobile coverage;
- any expense properly denied by the automobile coverage that is a covered expense; and
- any expense that the Plan is required to pay by law.

For Maximum Benefit

Generally, claims should be filed promptly with all plans to receive the maximum allowable benefits. You must supply the claim information needed to administer coordination of benefits. If you receive more payment than you should when benefits are coordinated, you will be expected to repay any overpayment.

Subrogation and Reimbursement

If you or your dependent receives benefits in excess of the amount payable under the Plan, the Company has a right to subrogation and reimbursement, as defined in the following sections.

Right of Recovery

The Plan has the right to recover benefits it has paid on your or your dependent's behalf that were:

- made in error;
- due to a mistake in fact;
- advanced during the time period you were meeting the calendar year deductible; or
- advanced during the time period you were meeting the out-of-pocket maximum for the calendar year.

Benefits paid because you or your dependent misrepresented facts also are subject to recovery. If the Plan provides a benefit for you or your dependent that exceeds the amount that should have been paid, the Plan will:

- require that the overpayment be returned when requested; or
- reduce a future benefit payment for you or your dependent by the amount of the overpayment.

Right to Subrogation

The right to subrogation means the Plan is substituted to any legal claims that you may be entitled to pursue for benefits that the Plan has paid. Subrogation applies when the Plan has paid benefits for a sickness or injury for which a third party is considered responsible (e.g., an insurance carrier if you are involved in an auto accident).

The Plan will be subrogated to, and will succeed to, all rights of recovery from any or all third parties, under any legal theory of any type, for 100 percent of any services and benefits the Plan has paid on your behalf relating to any sickness or injury caused by any third party.

Right to Reimbursement

The right to reimbursement means that if a third party causes a sickness or injury for which you receive a settlement, judgment, or other recovery, you must use those proceeds to return to the Plan 100 percent of any benefits you received for that sickness or injury.

Third Parties

The following persons and entities are considered third parties:

- a person or entity alleged to have caused you to suffer a sickness, injury, or damages, or who is legally responsible for the sickness, injury, or damages; or
- any person or entity who is or may be obligated to provide you with benefits or payments under:
    - underinsured or uninsured motorist insurance;

- medical provisions of no-fault or traditional insurance (auto, homeowners, or otherwise);
- Workers' Compensation coverage; or
- any other insurance carrier or third party administrator.

When This Provision Applies To You

If you or any of your covered dependents, or anyone who receives benefits under this plan, becomes ill or is injured and is entitled to receive money from any source, including but not limited to any party's liability insurance or uninsured/underinsured motorist proceeds, then the benefits provided or to be provided by the Plan will be paid only if you fully cooperate with the terms and conditions of the Plan.

As a condition of receiving benefits under this Plan, you agree that acceptance of benefits for you and/or your dependents is constructive notice of this provision in its entirety and agree to reimburse the Plan 100 percent of any benefits provided or to be provided without reduction for attorney's fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise. You further agree that the Plan shall have an equitable lien on any funds received by you or your dependents, and/or you or your attorney, if any, from any source for any purpose and shall be held in trust until such time as the obligation under this provision is fully satisfied. If you or your dependent retains an attorney, then you and your dependents agree to only retain one who will not assert the Common Fund or Made-Whole Doctrines. Reimbursement shall be made immediately upon collection of any sum(s) recovered regardless of its legal, financial or other sufficiency. If the injured person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to this provision regardless of state law and/or whether the minor's representative has access or control of any recovery funds.

You or your covered dependent agrees to sign any documents requested by the Plan including but not limited to a reimbursement and/or subrogation agreement, or accident questionnaire, as the Plan or its agent(s) may request. You and your covered dependent also agree to furnish any other information as may be requested by the Plan or its agent(s). Failure to sign and return any requested documentation or information may result in the Plan's denial of claims. However, such failure or refusal to execute such agreements or furnish information does not preclude the Plan from exercising its right to subrogation or obtaining full reimbursement. Any settlement or recovery received, regardless of how characterized, shall first be deemed for reimbursement of expenses paid by the Plan. Any excess after 100 percent reimbursement to the Plan may be divided between you or your dependent (the covered person) and your attorney if applicable. Any accident-related claims made after satisfaction of this obligation shall be paid by you or your dependent and not the Plan.

You and/or your covered dependents agree to take no action which in any way prejudices the rights of the Plan. If it becomes necessary for the Plan to enforce this provision by initiating any action against you or your dependent (the covered person), then you and/or your dependent agree to pay the Plan's attorney's fees and costs associated with the action regardless of the action's outcome.

The Plan Administrator has sole discretion to interpret the terms of this provision in its entirety and reserves the right to make changes as it deems necessary. Furthermore, the Plan may reduce or deny any future benefits by the amount of any recovery received, but not reimbursed, by you or your covered dependent for an accident or injury for which the Plan paid benefits.

If you and/or your covered dependent take no action to recover money from any source, then you and/or your dependent agree to allow the Plan to initiate its own direct action for reimbursement.

Your HIPAA/COBRA Rights

Health Insurance Portability and Accountability Act (HIPAA)

Title II of the Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations at 45 CFR Parts 160 through 164 (HIPAA) contain provisions governing the use and disclosure of Protected Health Information (PHI) by group health plans, and provide privacy rights to participants in those plans. This section provides an overview of those rights. You will receive from the Plan Administrator a separate “Notice of Privacy Provisions” which contains additional information about how your individually identifiable health information is protected and who you should contact with questions or concerns.

HIPAA applies to medical and prescription drug plans. These plans are commonly referred to as “HIPAA Plans” and are administered to comply with the applicable provisions of HIPAA.

Protected Health Information (PHI) is information created or received by the HIPAA Plans that relates to an individual’s physical or mental health or condition (including genetic information as provided under the Genetic Information Nondiscrimination Act), the provision of health care to an individual, or payment for the provision of health care to an individual. Typically, the information identifies the individual, the diagnosis, and the treatment or supplies used in the course of treatment. It includes information held or transmitted in any form or media, whether electronic, paper, or oral.

The Plan will comply with all privacy requirements defined in the HIPAA Privacy Policy and will use or disclose PHI only if the use or disclosure is permitted or required by HIPAA Regulations and any other applicable Federal, state, or local law.

The HIPAA Plans may disclose PHI to the Plan sponsor only for limited purposes as defined in the HIPAA Privacy Rules. The Plan sponsor agrees to use and disclose PHI only as permitted or required by HIPAA. PHI may be used or disclosed for Plan administration functions that the Plan sponsor performs on behalf of the HIPAA Plans. Such functions include:

- enrollment of eligible individuals;
- eligibility determinations;
- payment for coverage;
- claim payment activities;
- coordination of benefits; and
- claim appeals.

If a Plan participant wants to exercise any of his or her rights concerning PHI, he or she should contact the specific claims administrator involved with the PHI in question. The claims administrator will advise the Plan participant of the procedures to be followed.

The Plan will require any agents, including subcontractors, to whom it provides PHI to agree to the same restrictions and conditions that apply to the Company or Plan sponsor with respect to such information. The Company or Plan sponsor will report to the Plan any use or disclosure of PHI it knows is other than as permitted by the Plan and HIPAA Regulations.

Any HIPAA Plan will maintain policies and procedures that govern the HIPAA Plan's use and disclosure of PHI. These policies and procedures include provisions to restrict access solely to the previously listed positions/departments and only for the functions listed previously. The HIPAA Plan's policies and procedures will also include a mechanism for resolving issues of noncompliance.

In accordance with the Health Breach Notification Rule (16 CFR Part 18), the Plan sponsor agrees to notify both participants and the Federal Trade Commission of the use or disclosure of any PHI or electronic PHI provided for Plan Administration purposes that is inconsistent with the uses or disclosures provided for, or that represents a PHI Security Incident, of which the Plan sponsor or any Business Associate of the Plan sponsor becomes aware.

Certificate of Creditable Coverage

HIPAA also requires that participants automatically receive a certificate of creditable coverage within a reasonable period of time after coverage ceases (if not eligible for COBRA continuation coverage) or after COBRA coverage ends (including any grace period for non-payment of COBRA premiums). For participants who are eligible to elect COBRA continuation coverage, the certificate will be provided no later than 44 days after a qualifying event (See Continuing Health Care Coverage through COBRA below.)

The standard certificate includes basic health plan participation information and a statement as to whether you and your covered dependent(s) had at least 18 months of coverage without a significant break (more than 63 days). If you or your dependent(s) had less than 18 months of coverage, the statement will include the date coverage began and ended as well as the date of any waiting period.

A certificate never will cover longer than an 18-month period without a 63-day break, which is the maximum creditable coverage that an individual would need under the pre-existing condition exclusion rules and the rules for access to the individual market. You automatically will receive the standard statement when coverage ends. A single certificate may be used for all covered persons in a family who are losing coverage at the same time.

If you need to establish creditable coverage to reduce any pre-existing exclusion imposed by any subsequent health plan for mental health/substance abuse treatment and/or prescription drugs, an alternative certificate also is available by request.

To request another copy of the standard certificate and/or the alternative certificate, contact the Plan Administrator within 24 months after the end of a period of continuous coverage. Your certificate will be sent in a reasonable and prompt fashion or, alternatively, if all parties agree, the Plan Administrator may provide this information by phone.

Continuing Health Care Coverage through COBRA

In special situations, you or your covered dependent(s) may continue health care coverage at your or your dependent's expense when it otherwise would end. The Consolidated Omnibus Budget Reconciliation Act (COBRA) allows a continuation of health care coverage to qualified beneficiaries for a specific length of time. This section provides an overview of COBRA continuation coverage. The coverage described may change as permitted or required by applicable law. When you first enroll in coverage, you will receive from the Plan

Administrator/COBRA Administrator your initial COBRA notice. This notice and subsequent notices you receive will contain current requirements applicable for you to continue coverage.

The length of COBRA continuation coverage (COBRA coverage) depends on the reason that coverage ends, called the "qualifying event." These events and the applicable COBRA continuation period are described below.

If you and/or your eligible dependent(s) choose COBRA coverage, the Company is required to offer the same medical and prescription drug coverage that is offered to similarly situated employees. Proof of insurability is not required to elect COBRA coverage. In other words, you and your covered dependents may continue the same health care coverage you had under the Plan before the COBRA qualifying event.

If you have a new child during the COBRA continuation period by birth, adoption, or placement for adoption, your new child is considered a qualified beneficiary. Your new child is entitled to receive coverage upon his or her date of birth, adoption, or placement for adoption, provided you enroll the child within 30 days of the child's birth/adoption/placement for adoption. If you do not enroll the child under your coverage within 30 days, you will have to wait until the next open enrollment period to enroll your child.

COBRA Qualifying Events and Length of Coverage

Each person enrolled in benefits will have the right to elect to continue health benefits upon the occurrence of a qualifying event that would otherwise result in such person losing health benefits. Qualifying events and the length of COBRA continuation are as follows:

18-Month Continuation

Health care coverage for you and your eligible dependent(s) may continue for 18 months after the date of the qualifying event if your:

- employment ends for any reason other than gross misconduct; or
- hours of employment are reduced.

18-Month Continuation Plus 11-Month Extension

If you or your eligible dependent is disabled at the time your employment ends or your hours are reduced, the disabled person may receive an extra 11 months of coverage in addition to the 18-month continuation period (for a total of 29 months of coverage). If the individual entitled to the disability extension has non-disabled family members who have COBRA coverage due to the same qualifying event, those non-disabled family members will also be entitled to the 11-month extension, including any child born or placed for adoption within the first 60 days of COBRA coverage.

The 11-month extension is available to any COBRA participant who meets all of the following requirements:

- he or she becomes disabled before or within the first 60 days of the initial 18-month coverage period; and
- he or she notifies the Plan Administrator (or its designated COBRA Administrator) within 60 days of the date on the Social Security Administration determination letter, and provides a copy of the disability determination; and
- he or she notifies the Plan Administrator (or its designated COBRA Administrator) before the initial 18-month COBRA coverage period ends.

You must also notify the Plan Administrator (or its designated COBRA Administrator) within 30 days of the date Social Security Administration determines that you or your dependent is no longer disabled.

36-Month Continuation

Coverage for your eligible dependent(s) may continue for up to 36 months if coverage is lost due to your:

- death;
- divorce or legal separation;
- eligibility for Medicare coverage; or
- dependent child's loss of eligible dependent status under this Plan

Note: If any of these events (other than Medicare entitlement) occur while your dependents are covered under COBRA (because of an 18-month or 18-month plus extension qualifying event), coverage for the second qualifying event may continue for up to a total of 36 months from the date of the first COBRA qualifying event. In no case, however, will COBRA coverage be continued for more than 36 months in total.

If you become eligible for Medicare before a reduction in hours or your employment terminates, coverage for your dependents may be continued for up to 18 months from the date of your reduction in hours or termination of employment, or for up to 36 months from the date you became covered by Medicare, whichever is longer.

COBRA Notifications

If you or your covered dependents lose coverage under the Plan because your employment status changes, you become entitled to Medicare, or you die, the Plan Administrator (or its designated COBRA administrator) will automatically provide you or your dependents with additional information about COBRA continuation coverage, including what actions you must take by specific deadlines.

If your covered dependent loses coverage as a result of your divorce, legal separation or a dependent child's loss of eligibility under the Plan, you or your dependent must notify the Company within 60 days of the qualifying event. The Plan Administrator (or its designated COBRA administrator) will automatically send you or your dependent, as applicable, COBRA enrollment information. If you or your dependent fails to provide notification of the event within 60 days, you or your dependent forfeits all continuation of coverage rights under COBRA. To continue COBRA coverage, you and/or your eligible dependents must elect and pay the required cost for COBRA coverage.

Cost of COBRA Coverage

You or your eligible dependent pays the full cost for health care coverage under COBRA, plus an administrative fee of two percent, or 102 percent of the full premium cost, except in the case of an 11-month disability extension where you must pay 150 percent of the full premium cost for coverage.

COBRA Continuation Coverage Payments

Each qualified beneficiary may make an independent coverage election. You must elect COBRA coverage by completing and returning your COBRA enrollment form as instructed in your enrollment materials within 60 days of the date you receive information about your COBRA rights or, if later, the date of your qualifying event.

The first COBRA premium payment is due no later than 45 days from the date COBRA coverage is elected. Although COBRA coverage is retroactive to the date of the initial qualifying event, no benefits will be paid until the full premium payment is received. Each month's premium is due prior to the first day of the month of coverage. You or your dependent is responsible for making timely payments.

If you or your dependent fails to make the first payment within 45 days of the COBRA election, or subsequent payments within 30 days of the due date (the grace period), COBRA coverage will be canceled permanently, retroactive to the last date for which premiums were paid. COBRA coverage cannot be reinstated once it is terminated. Other important information you need to know about the required COBRA coverage payments follows.

COBRA premium payments that are returned by the bank for insufficient funds will result in termination of your COBRA coverage if a replacement payment in the form of a cashier's check, certified check, or money order is not made within the grace period.

COBRA premium payments must be mailed to the address indicated on your premium notice. Even if you do not receive your premium notice, it is your responsibility to contact the COBRA administrator. Your COBRA coverage will end if payment is not made by the due date on your notice. It is your responsibility to ensure that your current address is on file.

You may be eligible for state or local assistance to pay the COBRA premium. For more information, contact your local Medicaid office or the office of your state insurance commissioner.

How Benefit Extensions Impact COBRA

If you have a qualifying event that could cause you to lose your coverage, the length of any benefit extension period is generally considered part of your COBRA continuation coverage period and runs concurrently with your COBRA coverage. (Also see "Coverage While You Are Not at Work" in the Plan Overview for additional information.)

If you take a leave under the Family and Medical Leave Act (FMLA), COBRA begins;

- at the end of the leave if you do not return after the leave; or
- on the date of termination if you decide to terminate your employment during the leave.

When COBRA Coverage Ends

COBRA coverage for a covered individual will end when any of the following occur:

- The premium for COBRA coverage is not paid on a timely basis (monthly payments must be postmarked within the 30-day grace period, your initial payment must be postmarked within 45 days of your initial election).

- The maximum period of COBRA coverage, as it applies to the qualifying event, expires.
- The individual becomes covered under any other group medical plan, even though the subsequent plan has a pre-existing condition exclusion, so long as the individual has enough creditable coverage to satisfy the subsequent plan's pre-existing condition exclusion. If the individual does not have enough creditable coverage to meet the new plan's requirement, he or she may continue to purchase COBRA coverage until the earlier of the day he or she is eligible for the new coverage, or 36 months.
- The individual becomes entitled to Medicare.
- The Company terminates its group health plan coverage for all employees.
- Social Security determines that an individual is no longer disabled during the 11-month extension period.

Definitions

Accident

An unexpected or reasonably unforeseen occurrence or event that is definite as to time and place.

Actively at Work

A participant is considered actively at work if he or she:

- is presently at work on a scheduled workday performing the regular duties of his or her job for the hours he or she is normally scheduled to work; or
- was present at work on the last scheduled working day before:
    - a scheduled vacation;
    - an absence due to a paid holiday, paid jury or witness day, or a paid bereavement day;
    - a scheduled day off within the participant's working schedule; or
    - an absence excused by the Company.

Birthing Center

A facility that provides prenatal, labor, delivery, and postpartum care for medically uncomplicated pregnancies.

Centers of Excellence

Centers of Excellence are medical centers/hospitals throughout the country that frequently perform highly specialized medical care and achieve the highest success rates in patient outcomes and care. They are selected on the basis of quality indicators, such as survival rates and morbidity, as well as cost efficiencies (based on national average costs for similar procedures). Typically, the procedures performed by these Centers include heart, lung, liver, pancreas-kidney, and bone marrow transplants.

Certified Nurse-Midwife

A registered nurse (R.N.) certified by the American College of Nurse-Midwives. For services to be covered, the nurse-midwife must work under the direction of a doctor, bill for services under the doctor's taxpayer ID, and provide services in line with nurse-midwife certification.

Chiropractic Care

Services provided by a Chiropractor (D.C.) or licensed physician (M.D. Or D.O.) including office visits, diagnostic xrays, manipulations, supplies, heat treatment, cold treatment and massages.

COBRA

The Consolidated Omnibus Budget Reconciliation Act. This Federal law allows a continuation of health care coverage in certain circumstances.

Coinsurance

The percentage of the cost of covered expenses a participant must pay after meeting any applicable deductible.

Complete Claim (Proper Claim)

A previously incomplete claim for which a participant has submitted the missing or additional information required for the Plan to make a determination.

Concurrent Care Claim

A claim for a benefit that involves an ongoing course of treatment.

Co-payment

The fixed dollar amount of covered expenses a participant must pay before Plan pays.

Custodial Care

Services and/or care not intended primarily to treat a specific injury or illness (including mental health and substance abuse). Services and care include, but are not limited to:

- services related to watching or protecting a person;
- services related to performing or assisting a person in performing any activities of daily living, such as walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating, preparing foods, or taking medications that usually can be self-administered; and
- services not required to be performed by trained or skilled medical or paramedical personnel.

Deductible

The dollar amount (for individual or family) a participant must pay each year before the Plan begins to pay benefits.

Diagnostic Service

A test or procedure performed for specified symptoms to detect or to monitor a disease or illness and ordered by a physician or professional provider.

Doctor/Physician

A doctor of medicine (M.D.) or doctor of osteopathy (D.O.). The term also includes a chiropractor (D.C.), dentist (D.M.D. or D.D.S.), or a podiatrist (D.P.M.). In all cases, the person must be legally qualified and licensed to perform a service at the time and place of the service.

Durable Medical Equipment

Equipment such as braces, crutches, hospital beds, etc, that is primarily and customarily used to serve a medical purpose that:

- can stand repeated use;
- generally is not useful to a person in the absence of an illness or injury;
- is appropriate for use in the home.

Eligible Provider

Any practitioner or facility offering covered services and acting within the scope of the appropriate license; examples include a licensed doctor, osteopath, podiatrist, chiropractor, hospital, or laboratory.

Employee

A person who works for the Company in an employer-employee relationship.

Experimental or Investigational Services

Medical, surgical, diagnostic, psychiatric, substance abuse, or other health care services, technologies, supplies, treatments, procedures, drug therapies, or devices that, at the time the Plan makes a determination regarding coverage in a particular case, are determined to be:

- not approved by the U.S. Food & Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use;
- subject to review and approval by any institutional review board for the proposed use;
- the subject of an ongoing clinical trial that meets the definition of a phase 1, 2, or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial actually is subject to FDA oversight; or
- not demonstrated through authoritative medical or scientific literature published in the U.S. to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

Family and Medical Leave Act

The Family and Medical Leave Act (FMLA) is a Federal law that provides for an unpaid leave of absence for up to 12 weeks per year for:

- the birth or adoption of a child or placement of a foster child in a participant's home;
- the care of a child, spouse or parent (not including parents-in-law), as defined by Federal law, who has a serious health condition;
- a participant's own serious health condition; or
- any qualifying exigency arising from an employee's spouse, son, daughter, or parent being a member of the military on "covered active duty". Additional military caregiver leave is available to care for a covered service member with a serious injury or illness who is the spouse, son, daughter, parent, or next of kin to the employee.

Generally, you are eligible for coverage under FMLA if you have worked for your Company for at least one year; you have worked at least 1,250 hours during the previous 12 months; your Company has at least 50 employees within 75 miles of your worksite; and you continue to pay any required premium during your leave as determined by the Company. You should contact the Company with any questions you have regarding eligibility for FMLA coverage or how it applies to you.

Formulary

A list of prescription drugs that represent safe, effective therapeutic medications covered by the Plan.

Generic Drug Alternative

A generic drug that is not the exact equivalent of the brand-name drug, but can be used to treat that medical condition. For example, there are generic options to treat high cholesterol.

Generic Drug Equivalent

A generic drug that has the exact same active ingredients as the brand-name drug. When a drug patent expires, other companies may produce a generic version of the brand-name drug. A generic medication, also approved by the Federal Drug Administration (FDA), is basically a copy of the brand-name drug and is marketed under its chemical name. A generic may have a different color or shape than the brand name, but it must have the same active ingredients, strength, and dosage form (i.e., pill, liquid, or injection), and provide the same effectiveness and safety.

Genetic Information

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

GINA

The Genetic Information Nondiscrimination Act of 2008, as amended.

HIPAA

Health Insurance Portability and Accountability Act of 1996, as amended.

HITECH

The Health Information Technology for Economic and Clinical Health Act, as amended.

Hospice

A licensed (if required by the state in which it is located) facility set up to give terminally ill patients a coordinated program of inpatient, outpatient, and home care. The Plan must approve the hospice and treatment plan supervised by a physician.

Hospital

A legally licensed facility that:

- is accredited as a hospital under the Hospital Accreditation Program of the Joint Commission on Accreditation of Hospitals; or
- provides a broad range of 24-hour-a-day medical and surgical services by or under the direction of a staff of doctors and is engaged primarily in providing either:
    - general inpatient medical care and treatment through medical, diagnostic, and major surgical facilities on its premises or under its control; or
    - specialized inpatient medical care and treatment through medical and diagnostic facilities (including X-ray and laboratory) on its premises, under its control, or through a written agreement with a hospital that itself qualifies under the above description, or with a specialized provider of these facilities.

The term hospital does not include a facility that primarily is a place for rest, a place for the aged, or a nursing home.

Illness (or Disease)

A pathological condition of the body that presents a group of clinical signs and symptoms and laboratory finding peculiar to it and that sets the condition apart as an abnormal entity differing from other normal or pathological body states.

Improper Claim

A claim that is not filed according to Plan procedures. A participant or his or her representative will be notified if a claim is determined to be filed improperly. The notice will contain the steps and the time frame that must be followed to resubmit the claim for a determination.

Incomplete Claim

A claim that does not contain sufficient information for a determination to be made. A participant or his or her representative will be notified if a claim is determined to be incomplete. The notice will contain a description of the additional information required and the time frame that must be followed to resubmit the claim for a determination.

Injury

An accidental bodily injury that is the sole and direct result of an accident or a reasonably unforeseeable consequence of a voluntary act by the person. :

In-Network Provider

A health care professional or facility that is contracted by the Plan to provide health care benefits under the Plan.

Leased Employee

Leased employee as defined in the Internal Revenue Code, section 414(n), as amended.

Managed Care

A type of health care delivery system that combines doctor choice and access with lower costs, less paperwork, and prescribed standards for medically necessary treatment.

Medical Condition

A condition for which the individual has sought and received medical treatment.

Medically Necessary

To be medically necessary, all care must be:

- in accordance with standards of good medical practice;
- consistent in type, frequency, and duration of treatment with scientifically based guidelines, as accepted by the Plan;
- required for reasons other than the convenience of the health care provider or the comfort or convenience of the patient;
- provided in a cost-efficient manner and type of setting appropriate for the delivery of that service/supply;
- consistent with the eligible diagnosis of the condition;
- not experimental or investigational, as determined by the Plan; and
- demonstrated through authoritative medical literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

The fact that a doctor performs or prescribes a procedure or treatment or that it may be the only treatment for a particular condition does not mean that it is medically necessary as defined here.

The Plan reserves the right to conduct a utilization review to determine whether services are medically necessary for the proper treatment of the participant and may also require the participant to be independently examined while a claim is pending.

Medicare

The program of health care for the aged established by Title XVIII of the Social Security Act of 1965, as amended.

Network

A group of doctors, hospitals, and other providers contracted by the Plan to provide health care services for the Plan's members at agreed-upon rates.

Network Pharmacy

A pharmacy contracted by the Plan to provide prescription drug benefits under the Plan.

Out-of-Pocket Maximum

The maximum amount a participant pays for covered medical expenses (including expenses for covered dependents) in a **calendar** year. When the out-of-pocket maximum is reached, the Plan pays 100% of eligible covered expenses for the rest of the calendar year.

Participant

An eligible employee who elects to participate in the Plan by completing the necessary enrollment forms.

Post-Service Health Claim

A claim for a benefit under the Plan that is not a pre-service claim.

PPACA

The Patient Protection and Affordable Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010.

Pre-Service Health Claim

A claim for a benefit that, under the terms of the Plan, requires a participant to receive, in whole or in part, prior approval from the Plan as a condition to receive the benefit.

Prudent Layperson

An individual who possesses an average knowledge of health and medicine and, therefore, is able to determine that the absence of immediate medical attention may result in a serious medical condition for an ill or injured person.

Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN)

Any court order that: 1) provides for child support with respect to the employee's child or directs the employee to provide coverage under a health benefit plan under a state domestic relations law, or 2) enforces a law relating to medical child support described in the Social Security Act, Section 1908, with respect to a group health plan. A QMCSO or an NMSN also may be issued through an administrative process established under state law. A participant must notify the Plan Administrator if he or she is subject to a QMCSO or an NMSN.

Skilled Nursing Facility

A facility that qualifies under the Health Insurance of the Aged and Disabled provisions of the United States Social Security Act (Medicare), as amended; and is approved by the Plan.

Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

A Federal law covering the rights of participants who have a qualified uniformed services leave.

Urgent Care Claim

A claim for medical treatment which, if the regular time periods observed for claims were adhered to, 1) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or 2) would, in the opinion of a physician with knowledge of the claimant's medical condition, subject the claimant to severe pain that cannot be adequately managed. Any claim that a physician with knowledge of the claimant's medical condition determines to be a "claim involving urgent care" will be deemed to be an urgent care claim. Otherwise, whether a claim is an urgent care claim or not will be determined by an individual acting on behalf of the Plan, and applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

WHCRA

The Women's Health and Cancer Rights Act of 1998, as amended.

Adoption of the Plan

The City of Gulfport employee Health and Welfare Benefit Plan, as stated herein, is hereby adopted as of 01/01/2013. This document constitutes the basis for administration of the Plan.

IN WITNESS WHEREOF, the parties have caused this document to be executed on this _____ day of _____, 201 .

BY: _____

TITLE: _____

APPENDIX A

Continuation Coverage Rights Under COBRA

Introduction

You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the City of Gulfport, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Select Administrative Services, 14110 Airport Road, Suite 100, Gulfport, MS 39503.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

COBRA Administrator
Select Administrative Services
14110 Airport Road, Suite 100
Gulfport, MS 39503
228-865-0514

City of Gulfport

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW CAREFULLY.

Our Pledge to You

This notice is intended to inform you of the privacy practices followed by the **City of Gulfport** (the Plan) and the Plan's legal obligations regarding your protected health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The notice also explains the privacy rights you and your family members have as participants of the Plan. It is effective on June 1, 2009.

The Plan often needs access to your protected health information in order to provide payment for health services and perform plan administrative functions. We want to assure the plan participants covered under the Plan that we comply with federal privacy laws and respect your right to privacy. City of Gulfport requires all members of our workforce and third parties that are provided access to protected health information to comply with the privacy practices outlined below.

Protected Health Information

Your protected health information is protected by the HIPAA Privacy Rule. Generally, protected health information is information that identifies an individual created or received by a health care provider, health plan or an employer on behalf of a group health plan that relates to physical or mental health conditions, provision of health care, or payment for health care, whether past, present or future.

How We May Use Your Protected Health Information

Under the HIPAA Privacy Rule, we may use or disclose your protected health information for certain purposes without your permission. This section describes the ways we can use and disclose your protected health information.

Payment. We use or disclose your protected health information without your written authorization in order to determine eligibility for benefits, seek reimbursement from a third party, or coordinate benefits with another health plan under which you are covered. For example, a health care provider that provided treatment to you will provide us with your

health information. We use that information in order to determine whether those services are eligible for payment under our group health plan.

Health Care Operations. We use and disclose your protected health information in order to perform plan administration functions such as quality assurance activities, resolution of internal grievances, and evaluating plan performance. For example, we review claims experience in order to understand participant utilization and to make plan design changes that are intended to control health care costs.

Treatment. Although the law allows use and disclosure of your protected health information for purposes of treatment, as a health plan we generally do not need to disclose your information for treatment purposes. Your physician or health care provider is required to provide you with an explanation of how they use and share your health information for purposes of treatment, payment, and health care operations.

***As permitted or required by law*.** We may also use or disclose your protected health information without your written authorization for other reasons as *permitted* by law. We are *permitted* by law to share information, subject to certain requirements, in order to communicate information on health-related benefits or services that may be of interest to you, respond to a court order, or provide information to further public health activities (e.g., preventing the spread of disease) without your written authorization. We are also permitted to share protected health information during a corporate restructuring such as a merger, sale, or acquisition. We will also disclose health information about you when *required* by law, for example, in order to prevent serious harm to you or others.

Pursuant to your Authorization. When required by law, we will ask for your written authorization before using or disclosing your protected health information. If you choose to sign an authorization to disclose information, you can later revoke that authorization to prevent any future uses or disclosures.

To Business Associates. We may enter into contracts with entities known as Business Associates that provide services to or perform functions on behalf of the Plan. We may disclose protected health information to Business Associates once they have agreed in writing to safeguard the protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims. Business Associates are also required by law to protect protected health information.

To the Plan Sponsor. We may disclose protected health information to certain employees of **City of Gulfport** for the purpose of administering the Plan. These employees will use or disclose the protected health information only as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized additional disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Your Rights

Right to Inspect and Copy. In most cases, you have the right to inspect and copy the protected health information we maintain about you. If you request copies, we will charge you a reasonable fee to cover the costs of copying, mailing, or other expenses associated with your request. Your request to inspect or review your health information must be submitted in writing to the person listed below. In some circumstances, we may deny your request to inspect and copy your health information. To the extent your information is held in an electronic health record, you may be able to receive the information in an electronic format.

Right to Amend. If you believe that information within your records is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information. Your request to amend your health information must be submitted in writing to the person listed below. In some circumstances, we may deny your request to amend your health information. If we deny your request, you may file a statement of disagreement with us for inclusion in any future disclosures of the disputed information.

Right to an Accounting of Disclosures. You have the right to receive an accounting of certain disclosures of your protected health information. The accounting will not include disclosures that were made (1) for purposes of treatment, payment or health care operations; (2) to you; (3) pursuant to your authorization; (4) to your friends or family in your presence or because of an emergency; (5) for national security purposes; or (6) incidental to otherwise permissible disclosures.

Your request to for an accounting must be submitted in writing to the person listed below. You may request an accounting of disclosures made within the last six years. You may request one accounting free of charge within a 12-month period.

Right to Request Restrictions. You have the right to request that we not use or disclose information for treatment, payment, or other administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. You also have the right to request that we limit the protected health information that we disclose to someone involved in your care or the payment for your care, such as a family member or friend.

Your request for restrictions must be submitted in writing to the person listed below. We will consider your request, but in most cases are not legally obligated to agree to those restrictions. However, we will comply with any restriction request if the disclosure is to a health plan for purposes of payment or health care operations (not for treatment) and the protected health information pertains solely to a health care item or service that has been paid for out-of-pocket and in full.

Right to Request Confidential Communications. You have the right to receive confidential communications containing your health information. Your request for restrictions must be submitted in writing to the person listed below. We are required to accommodate reasonable requests. For example, you may ask that we contact you at your place of employment or send communications regarding treatment to an alternate address.

Right to be Notified of a Breach. You have the right to be notified in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information. Notice of any such breach will be made in accordance with federal requirements.

Right to Receive a Paper Copy of this Notice. If you have agreed to accept this notice electronically, you also have a right to obtain a paper copy of this notice from us upon request. To obtain a paper copy of this notice, please contact the person listed below.

Our Legal Responsibilities

We are required by law to protect the privacy of your protected health information, provide you with certain rights with respect to your protected health information, provide you with this notice about our privacy practices, and follow the information practices that are described in this notice.

We may change our policies at any time. In the event that we make a significant change in our policies, we will provide you with a revised copy of this notice. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

If you have any questions or complaints, please contact:

Manager of Human Resources
City of Gulfport

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed above. You also may send a written complaint to the U.S. Department of Health and Human Services — Office of Civil Rights. The person listed above can provide you with the appropriate address upon request or you may visit www.hhs.gov/ocr for further information. You will not be penalized or retaliated against for filing a complaint with the Office of Civil Rights or with us.