City of Jackson
Employee & Retiree
Medical Benefit Plan

This Summary Plan Description contains only a general description of the benefits available to you under the City of Jackson's Medical Benefit Plan (referred to in this booklet as Plan). The benefits described are subject to all the terms, conditions, limitations and definitions, in the Plan. For specific information, the Plan is available for your study through your employer.

Blue Cross & Blue Shield of Mississippi, Inc. is the Claims Administrator for this Medical Benefit Plan. This Claims Administrator's address is:

3545 Lakeland Drive
P. O. Box 1043
Jackson, MS 39215-1043
Customer Service Phone: (601) 932-3704

For additional information regarding the Health Plan or to request a copy of the Benefits Booklet, please contact:

City of Jackson
City of Jackson – Department of Personnel
Insurance Section
P.O. Box 17
Jackson, MS 39205

Phone: (601) 960-1051/960-2288

Employee Assistance Program Coordinator: (601) 898-7500

GRANDFATHERED NOTICE

This group health plan believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for external review. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at 1-(601) 960-1051. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

STANDARD OPTION
SCHEDULE OF BENEFITS
JXN6

BENEFIT PERIOD		CALENDAR YEAR

ANNUAL MAXIMUM BENEFITS

PLAN YEAR EFFECTIVE 1/1/2011	$1,000,000
PLAN YEAR EFFECTIVE 1/1/2012	$1,250,000
PLAN YEAR EFFECTIVE 1/1/2013	$2,000,000
PLAN YEAR EFFECTIVE 1/1/2014	UNLIMITED

DEDUCTIBLE AMOUNTS

BENEFIT PERIOD DEDUCTIBLE AMOUNT

PER PARTICIPANT	$400
PER FAMILY (No More than 3 times the Participant Amount)	$1,200
PRESCRIPTION DRUG DEDUCTIBLE AMOUNT (PER PARTICIPANT PER CALENDAR YEAR) (APPLIES TO COMMUNITY PLUS PHARMACY AND NON-COMMUNITY PLUS PHARMACY)	$50

*BENEFIT (EXCEPT AS LIMITED HEREIN)	75%
OUT-OF-POCKET MAXIMUM (AFTER DEDUCTIBLE AMOUNT) (NO FAMILY OUT-OF-POCKET AMOUNT)	$5,000

	NETWORK PROVIDER	NON-NETWORK PROVIDER
HOSPITAL SERVICES BED, BOARD AND GENERAL NURSING SERVICES (PRIVATE, SEMIPRIVATE OR SPECIAL CARE UNIT)	75% TO OUT-OF-POCKET, THEN 100% (AFTER DEDUCTIBLE)	65% TO OUT-OF-POCKET, THEN 90% (AFTER DEDUCTIBLE)
OTHER SERVICES	75% TO OUT-OF-POCKET, THEN 100% (AFTER DEDUCTIBLE)	65% TO OUT-OF-POCKET, THEN 90% (AFTER DEDUCTIBLE)
INPATIENT NEWBORN NURSERY WELL BABY CARE	75% TO OUT-OF-POCKET, THEN 100% (AFTER DEDUCTIBLE)	65% TO OUT-OF-POCKET, THEN 90% (AFTER DEDUCTIBLE)

STANDARD OPTION
SCHEDULE OF BENEFITS
JXN6

	NETWORK PROVIDER	NON-NETWORK PROVIDER
INPATIENT REHABILITATION SERVICES (LIMITED TO 30 INPATIENT DAYS PER CALENDAR YEAR) (COVERED SERVICES MUST BE RENDERED BY A NETWORK PROVIDER AND APPROVED THROUGH CASE MANAGEMENT)	75% TO OUT-OF-POCKET, THEN 100% (AFTER DEDUCTIBLE)	65% TO OUT-OF-POCKET, THEN 90% (AFTER DEDUCTIBLE)
OUTPATIENT CARDIAC REHABILITATION (VISIT LIMITS ARE BASED ON THE SEVERITY OF PATIENT'S CONDITION, NOT TO EXCEED 36 VISITS) (CASE MANAGEMENT REQUIRED)	75% TO OUT-OF-POCKET, THEN 100% (AFTER DEDUCTIBLE))	NOT COVERED

PHYSICIAN SERVICES (M.D. AND D.O. ONLY)	NETWORK PROVIDER		NON-NETWORK PROVIDER
	PRIMARY CARE	SPECIALIST	
OFFICE VISITS (NOTE: CO-PAY DOES NOT APPLY TO ANY OTHER SERVICES RENDERED IN THE PHYSICIAN'S OFFICE.)	100% AFTER $20 CO-PAY (FAMILY PRACTICE, GENERAL, INTERNAL MEDICINE, PEDIATRICIANS, OB/GYN)	100% AFTER $30 CO-PAY	75% TO OUT-OF-POCKET, THEN 100% (AFTER DEDUCTIBLE)
OTHER SERVICES RENDERED IN THE PHYSICIAN'S OFFICE (DEDUCTIBLE DOES NOT APPLY TO SERVICES RENDERED IN A NETWORK PHYSICIAN'S OFFICE.)	75% (DEDUCTIBLE WAIVED)		75% TO OUT-OF-POCKET, THEN 100%) (AFTER DEDUCTIBLE)

STANDARD OPTION
SCHEDULE OF BENEFITS
JXN6
(cont.)

OUTPATIENT PREVENTIVE WELLNESS SERVICES LIMITED TO NETWORK PRIMARY CARE PHYSICIANS – FAMILY PRACTICE, GENERAL, INTERNAL MEDICINE, PEDIATRICIANS, OB/GYN OR NURSE PRACTITIONER)		
OFFICE VISITS (PRIMARY CARE PHYSICIANS AND NURSE PRACTITIONER)	100% AFTER $20 CO-PAY (DEDUCTIBLE WAIVED)	Not Covered
ALL OFFICE OTHER SERVICES	75% (DEDUCTIBLE WAIVED)	Not Covered
PREVENTATIVE MAMMOGRAPHY (Limited to one (1) screening per calendar year for women up to age 35 years of age) (Subject to Wellness Benefits)	75% (DEDUCTIBLE WAIVED)	Not Covered
PROSTATE SPECIFIC ANTIGEN (PSA) Test (For men age 50 and older)	100%	Not Covered
IMMUNIZATIONS FOR CHILDREN (Limited to covered dependent children through the date the child is 24 months of age)	100% (DEDUCTIBLE WAIVED)	Not Covered
PREVENTATIVE MAMMOGRAPHY (Limited to one (1) screening per calendar year for women 35 years of age or older)	100% (DEDUCTIBLE WAIVED)	Not Covered

STANDARD OPTION
SCHEDULE OF BENEFITS
JXN6
(cont.)

HOME INFUSION THERAPY (PRE-CERTIFICATION REQUIRED)		75% TO OUT-OF-POCKET, THEN 100% (AFTER DEDUCTIBLE)
SPEECH THERAPY (Limited to 20 visits per calendar year)		75% TO OUT-OF-POCKET, THEN 100% (AFTER DEDUCTIBLE)
DURABLE MEDICAL EQUIPMENT (MEDICAL NECESSITY CERTIFICATE REQUIRED)		75% TO OUT-OF-POCKET, THEN 100% (AFTER DEDUCTIBLE)
PROSTHETIC APPLIANCES (MEDICAL NECESSITY CERTIFICATE REQUIRED) (Limited to $10,000 per Calendar year)		75% TO OUT-OF-POCKET, THEN 100% (AFTER DEDUCTIBLE)
ORTHOTIC DEVICES (MEDICAL NECESSITY CERTIFICATE REQUIRED)		75% TO OUT-OF-POCKET, THEN 100% (AFTER DEDUCTIBLE)
SLEEP STUDIES (SERVICES MUST BE RENDERED BY A NETWORK FACILITY ACCREDITED BY AASM)		75% TO OUT-OF-POCKET, THEN 100% (AFTER DEDUCTIBLE)
AMBULANCE SERVICES		75% TO OUT-OF-POCKET, THEN 100% (AFTER DEDUCTIBLE)

ALLIED PRIMARY CARE HEALTH PROFESSIONAL (NURSE PRACTITIONER AND NURSE MID-WIVES)	NETWORK PROVIDER	NON-NETWORK PROVIDER
Office Visits (Note: The Co-pay does not apply to any other services rendered in the office.)	100% after $20 Co-pay	75% TO OUT-OF-POCKET, THEN 100% (AFTER DEDUCTIBLE)
Other Services rendered in the Office (Deductible does not apply to services rendered by a Network Provider.)	75% (DEDUCTIBLE WAIVED)	75% TO OUT-OF-POCKET, THEN 100% (AFTER DEDUCTIBLE)

STANDARD OPTION
SCHEDULE OF BENEFITS
JXN6
(cont.)

	NETWORK PROVIDER	NON-NETWORK PROVIDER
ALLIED SPECIALISTS		
PODIATRIST OFFICE VISITS	100% AFTER $30 COPAY	75% TO OUT-OF-POCKET, THEN 100% (AFTER DEDUCTIBLE)
PODIATRIST OFFICE SERVICES	75% (Deductible Waived)	75% TO OUT-OF POCKET, THEN 100% (AFTER DEDUCTIBLE)
PHYSICAL/OCCUPATIONAL THERAPY (Limited to 20 visits per Calendar Year. combined. After the 20 visits are exhausted additional visits are subject to Case Management approval)(Limited to 3 Modalities per visit.)	75% TO OUT-OF-POCKET, THEN 100% (AFTER DEDUCTIBLE)	75% TO OUT-OF POCKET, THEN 100% (AFTER DEDUCTIBLE)

LIMITATION

A. MENTAL AND NERVOUS CONDITIONS, DRUG AND ALCOHOL ABUSE (SERVICES RENDERED BY PSYCHOLOGISTS, PSYCHIATRISTS, LICENSED SOCIAL WORKERS, LICENSED COUNSELORS AND FAMILY THERAPISTS)	NETWORK PROVIDER	NON-NETWORK PROVIDER
Inpatient Hospital Care (Not to exceed 30 days per calendar year)	75% TO OUT-OF-POCKET, THEN 100% (AFTER DEDUCTIBLE))	65% TO OUT-OF-POCKET, THEN 90% (AFTER DEDUCTIBLE)
Inpatient Physician Visits (Not to exceed 30 days per calendar year)	75% TO OUT-OF-POCKET, THEN 100% (AFTER DEDUCTIBLE))	75% TO OUT-OF-POCKET, THEN 90% (AFTER DEDUCTIBLE)
Partial Hospitalization (Not to exceed 60 days per calendar year)	75% TO OUT-OF-POCKET, THEN 100% (AFTER DEDUCTIBLE))	65% TO OUT-OF-POCKET, THEN 90% (AFTER DEDUCTIBLE)
Outpatient Hospital Visits (Not to exceed 52 visits per calendar year - Combined with Outpatient Physician Services and Physician Office Visits)	50% (AFTER DEDUCTIBLE)	50% (AFTER DEDUCTIBLE)
Other Outpatient Physician Services	50% (AFTER DEDUCTIBLE)	50% (AFTER DEDUCTIBLE))
Physician Office Visits (Not to exceed 52 visits per Calendar Year – Combined with Outpatient Hospital Visits and Outpatient	50% (AFTER DEDUCTIBLE)	50% (AFTER DEDUCTIBLE)

Physician Services)

Other Services rendered in the Physician's office	50% (AFTER DEDUCTIBLE)	50% (AFTER DEDUCTIBLE)

B. HOME HEALTH CARE

MAXIMUM ANNUAL NUMBER OF DAYS	30 DAYS

C. HOSPICE CARE

MAXIMUM LIFETIME NUMBER OF DAYS	30 DAYS

D. CHIROPRACTIC CARE

(1) MAXIMUM ALLOWABLE CHARGE PER VISIT	$75.00
(2) MAXIMUM NUMBER OF VISITS PER CALENDAR YEAR (LIMITED TO 3 MODALITIES PER VISIT)	12 VISITS

E. PRESCRIPTION DRUGS (30 day supply) A separate $50 Prescription Drug Deductible Per Participant Per Calendar Year applies to the Community Plus Pharmacy and Non-Community Plus Pharmacy.	COMMUNITY PLUS PHARMACY (BENEFIT PERIOD)	NON-COMMUNITY PLUS PHARMACY (BENEFIT PERIOD)
Generic	100% after $10 Co-pay	100% after $20 Co-pay
Preferred Brand	100% after $25 Co-pay	100% after $50 Co-pay
Non-Preferred Brand	100% after $50 Co-pay	100% after $100 Co-pay

SPECIAL NOTE: A separate $50 Prescription Drug Deductible Per Participant Per Calendar Year applies to Prescription Drugs purchased through a Community Plus Pharmacy or a Non-Community Plus. This separate deductible along with the applicable Co-pay must be satisfied before Benefits will be provided for Prescription Drugs.

IF A HIGH QUALITY GENERIC ALTERNATIVE IS AVAILABLE, BUT THE PARTICIPANT PURCHASES THE BRAND NAME, THE PARTICIPANT WILL PAY THE APPLICABLE CO-PAY PLUS THE COST DIFFERENCE BETWEEN THE BRAND NAME DRUG AND THE GENERIC DRUG PRICES.

F. TRANSPLANT BENEFITS
(OFFICE VISIT COPAY APPLIES)

Solid Organ and Tissue Transplants	75% TO OUT-OF-POCKET, THEN 100% (AFTER DEDUCTIBLE)
Renal Transplants	75% TO OUT-OF-POCKET, THEN 100% (AFTER DEDUCTIBLE)

Donor Benefits (Limited to $25,000 lifetime maximum for Organ Transplant for transportation, meals and lodging)	100% (DEDUCTIBLE WAIVED)

STANDARD OPTION
SCHEDULE OF BENEFITS
JXN6 (cont.)

G. DIABETES TREATMENT

Equipment, Supplies for the monitoring of blood glucose and insulin administration.	75% TO OUT-OF-POCKET, THEN 100% (AFTER DEDUCTIBLE)
Dilated Eye Exam (Limited to one exam per calendar year for Diabetics) (Note: See Physician Services for Office Visit Benefit)	75% TO OUT-OF-POCKET, THEN 100% (AFTER DEDUCTIBLE)
Preventive Routine Foot Care (Limited to one visit per calendar year for Diabetics) (Note: See Physician Services for Office Visit Benefit)	75% TO OUT-OF-POCKET, THEN 100% (AFTER DEDUCTIBLE)

H. TEMPOROMANDIBULAR/ CRANIOMANDIBULAR JOINT DISORDER (TMJ)

Surgery/Diagnostic Services/ Removable Oral Appliances for TMJ	75% TO OUT-OF POCKET, THEN 100% (AFTER DEDUCTIBLE)

I. PRE-CERTIFICATION NON-COMPLIANCE

MAXIMUM PENALTY PER CONFINEMENT	UP TO $300.00

* SUBJECT TO THE DEDUCTIBLE AMOUNT, THE PLAN WILL PAY THE ALLOWABLE CHARGE, AS DETERMINED BY THE CLAIMS ADMINISTRATOR, FOR COVERED SERVICES.

*** CO-PAY AMOUNT PAID BY THE PARTICIPANT DOES NOT APPLY TO THE OUT-OF-POCKET MAXIMUM.

**** WHEN OUTPATIENT TREATMENT FOR MENTAL AND NERVOUS CONDITIONS AS WELL AS DRUG AND ALCOHOL ABUSE ARE PRE-CERTIFIED AND MANAGED BY THE EMPLOYEE ASSISTANCE PROGRAM COORDINATOR, THE BENEFIT WILL INCREASE FROM 50% OF THE ALLOWABLE CHARGE UP TO 75% OF THE ALLOWABLE CHARGE.

NOTE: CO-PAYMENT AMOUNTS DO NOT ACCRUE TOWARD THE OUT-OF-POCKET AMOUNT. CO-PAYMENT AMOUNTS ARE STILL APPLICABLE AFTER THE OUT-OF-POCKET AMOUNT IS SATISFIED.

NOTE: THE DEDUCTIBLE AMOUNT DOES NOT APPLY WHERE THERE IS A CO-PAYMENT AMOUNT. CO-PAYMENT AMOUNTS DO NOT ACCRUE TOWARDS THE DEDUCTIBLE

AMOUNT.

HOSPITAL SAVINGS - CLAIMS ADMINISTRATOR HAS ENTERED INTO PAYMENT AGREEMENTS WITH PARTICIPATING HOSPITALS TO PROVIDE SERVICES TO PERSONS ENTITLED TO PARTICIPATING HOSPITAL BENEFITS UNDER PLANS ADMINISTERED BY CLAIMS ADMINISTRATOR, INCLUDING PARTICIPANTS UNDER THE PLAN. UNDER THESE PAYMENT AGREEMENTS, THE PLAN DOES NOT ALWAYS PAY AN AMOUNT TO THE HOSPITAL WHICH CORRESPONDS TO THE BENEFIT AMOUNT. THE PAYMENT MADE BY PLAN TOGETHER WITH THE PARTICIPANT'S DEDUCTIBLE, COINSURANCE, AND/OR CO-PAYMENT MAY BE GREATER THAN OR LESS THAN COVERED CHARGES. A PARTICIPANT'S COINSURANCE IS BASED ON THE LESSER OF COVERED CHARGES OR THE AMOUNT ESTABLISHED BY CLAIMS ADMINISTRATOR AS THE MAXIMUM AMOUNT FOR PROVIDER SERVICES COVERED UNDER THE TERMS OF THE PLAN.

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City of Jackson Employee & Retiree Medical Benefit Plan - Special Information

INTRODUCTION

How to use this booklet

This booklet briefly describes the Benefits you have under your Plan. It also tells you what payments are made for covered health care expenses.

This booklet explains your Benefits in general terms. It does not give details on all the terms in your Medical Benefit Plan.

This booklet is written in simplified language to help you and your Dependents understand your health care Benefits. Please read all sections carefully.

If you have questions, contact the person in the city who handles the Employee Medical Benefit Program. Your may also call the customer service representative at the Claims Administrator. Ask for the dedicated unit.

"Schedule of Benefits," gives a summary of Benefits provided and the percent the Plan pays for Covered Services.

Section I, "General Information", tells you who is covered, how to use your identification card, when your coverage starts, when and how to change your coverage and how to file a claim.

Section II, gives information concerning "Benefits Provided" and Covered Services, Pre-certification and Concurrent Review.

Section III, gives "Limitations and Exclusions" of the Plan.

Section IV, "Other Information", includes information concerning Coordination of Benefits, Subrogation, Termination of Coverage, COBRA and Continuation Coverage.

Section V, Summary Plan Information.

Section I

General Information

Who Is covered: If you are a full time or permanent part time employee who works 20 hours per week or a Qualified Retiree, you are eligible to enroll in the Plan after one month of continuous employment. You must complete an application, but no physical examination is needed.

You may include in your coverage your spouse of the opposite sex and your children up to the age of 26 that are not eligible to enroll in an employer-sponsored health plan other than a group health plan of a parent.

No person shall be deemed a Dependent unless the Dependent (1) was named in the application for the coverage, or (2) since execution of said application, has been reported to the Group in writing as a new or additional Dependent and has been approved as a Dependent in writing fixing the effective date of coverage and such effective date has occurred. The term "child" as used herein shall include your natural born child, any stepchild living in the same household with the Employee, legal ward and legally adopted child who depends upon Employee for support and lives with Employee in a regular parent-child relationship.

Eligibility will be continued past the limiting age for unmarried dependent children who are unable to work to support themselves due to mental retardation or physical handicap that started before age specified above and is medically certified by a Physician. The Claims Administrator may require proof of such Participant's disability from time to time.

Your Identification card: You will get an identification card to show to the hospital, physician or others when you need to use your Benefits.

Your identification card also helps in other ways. The figures show the group through which you are enrolled and your own personal identification number. All Dependents you listed share your identification number as well.

Carry your card at all times. In case of loss, you can still use your coverage. You can replace your card more quickly, however, if you know your identification number.

Legal requirements govern use of your card. You cannot let anyone who is not named in your coverage use your card.

When your coverage starts: All Eligible Persons with eligible Dependent(s) will have the opportunity to apply for coverage for such Dependent(s). The group agrees to collect any employee contributions for Dependent coverage through payroll withholding or otherwise.

If you become an eligible person after the group's effective date and apply for coverage for such Dependent(s) within 31 days of being first eligible to do so, your (and your Dependents) effective date is the first day following date of eligibility.

If you fail to apply for coverage for you and your Dependent(s) within 31 days of being first eligible, you will not be eligible to enroll at a later date unless you and your dependents are eligible for a Special Enrollment Period.

If you apply for coverage for your Dependent(s) before being eligible, the effective date for each eligible Dependent is the date of eligibility.

Eligible Person

An employee, who is absent from work due to a health condition, is still considered an Eligible Person. An Eligible Person becomes a Subscriber when enrolled for coverage under this Benefit Plan.

Special Enrollment Periods

a. Special Enrollment Periods due to loss of coverage.

If you (Eligible Person) or your Eligible Dependent lose coverage under another group health plan or health insurance coverage, you and/or your Eligible Dependent may be eligible to enroll under this Plan during a Special Enrollment Period subject to the following conditions:

(1) You must have declined coverage in writing for yourself and/or your Eligible Dependent(s) (or you as a Participant must have declined coverage for his/her Eligible Dependents) under this Plan when initially eligible. The reason for declining coverage must be due to the fact the Eligible Person or Eligible Dependent(s) was covered under another group health plan or other health insurance coverage.

(2) The loss of coverage must be due to one of the following conditions:

(a) You or your Eligible Dependent must become ineligible for coverage under another group health plan or other health insurance coverage. For the purposes of this Plan, loss of eligibility includes loss of coverage as a result of legal separation, divorce, death, termination of employment or reduction in the number of hours of employment.

(b) The employer contribution for the other group health plan was terminated.

(c) When you decline coverage for yourself and/or your Eligible Dependent(s) (or you as the Participant decline coverage for your Eligible Dependent(s)), you or your Dependent(s) has COBRA Continuation Coverage under another group health plan and the COBRA Continuation Coverage has been exhausted.

(d) An Eligible Dependent reaches the age at which dependent coverage is no longer provided under another group health plan or other health insurance coverage.

(e) An individual loses Health Maintenance Organization coverage due to the fact that he or she moves outside of the Health Maintenance Organization area.

(f) An Eligible Person or Eligible Dependent exhausts the maximum lifetime benefit amount under another group health plan or other health insurance coverage and is no longer eligible for Benefits.

(g) An Eligible Person or Eligible Dependent loses coverage under a benefit option offered by a group. He or she would need to be permitted to enroll in the group's other benefit option (if applicable).

(3) You (or where applicable you as the Participant) must submit and Claims Administrator must receive an Enrollment Form, requesting the appropriate coverage, within 31 days of the loss in coverage as described above. You (or where applicable you as the Participant) will be required to provide written confirmation of your coverage and/or your Eligible Dependent(s) coverage under another plan to Claims Administrator. If you (or where applicable you as the Participant) fails to apply within the allowed 31 day period, you will not be eligible to apply at a later date unless you qualify for another Special Enrollment Period.

(4) The Effective Date of your and/or your Dependent(s) coverage will be the first day of the first calendar month beginning after the date Claims Administrator received the applicable form (Enrollment Form or Request For Change Form).

b. Special Enrollment Period for Newly Eligible Dependents

(1) If you acquire an Eligible Dependent through birth, adoption, placement in anticipation of adoption, Guardianship, Custody or a Qualified Medical Child Support Order (hereinafter Qualifying Event), you may apply for coverage for you and your Eligible Dependent(s). You must submit and Claims Administrator must receive a Request for Change Form, applying for the appropriate coverage, within 31 days from the date of the Qualifying Event. The Effective Date of coverage for the Eligible Dependent(s) will be the date of the Qualifying Event.

(2) If you acquire an Eligible Dependent through marriage, you may apply for Coverage for yourself and your Eligible Dependent(s). You must submit and Claims Administrator must receive a Request For Change Form, applying for the appropriate coverage, within 31 days from the date of the Qualifying event. The Effective Date of the Eligible Person and Dependent(s) will be the first day of the first calendar month beginning after the date the Claims Administrator received the Request For Change Form.

(3) If you do not submit and Claims Administrator does not receive the Request for Change Form within 31 days of the date of the Qualifying Event as outlined in the paragraph above, you will not be eligible to enroll your Dependent(s) at a later date unless you qualify for another Special Enrollment Period.

c. Special Enrollment Period for Non-Covered Eligible Person Acquiring a Newly Eligible Dependent

(1) If you are a non-covered Eligible Person acquiring an Eligible Dependent through birth, adoption, placement in anticipation of adoption, Guardianship, Custody or a Qualifying Medical Child Support Order (hereinafter Qualifying Event), you may apply for coverage for yourself, the Eligible Dependent and other Eligible Dependent(s). You must submit and Claims Administrator must receive an Enrollment Form, applying for the appropriate coverage, within 31 days of the Qualifying Event. The Effective Date of Coverage for You and the Eligible Dependent will be the date of the Qualifying Event. Note: In order to qualify for this special Enrollment Period, you must apply for coverage for yourself and your newly Eligible Dependent.

(2) If you acquire an Eligible Dependent through marriage, you may apply for Coverage for you and your Eligible Dependent(s). You must submit and Claims Administrator must receive a Request For Change Form, applying for the appropriate coverage, within 31 days from the date of the Qualifying event. The Effective Date of your and hour Dependent(s) coverage will be the first day of the first Calendar Month beginning after the date the Claims Administrator received the Request For Change Form.

(3) If you do not submit and Claims Administrator does not receive the Enrollment Form within 31 days of the date of the Qualifying Event as outlined in the paragraph above, you will not be eligible to enroll at a later date unless you qualify for another Special Enrollment Period.

d. Special Enrollment Period for Non-Covered Eligible Person or Eligible Dependent losing coverage under the Children's Health Insurance Program or Medicaid

(1) If a Non-Covered Eligible Person or their Eligible Dependent loses coverage under the Children's Health Insurance Program (CHIP) or Medicaid, the Non-Covered Eligible Person may apply for coverage for himself, herself and the Eligible Dependent. The Non-Covered Eligible Person must submit and Claims Administrator must receive an Enrollment Form, applying for the appropriate coverage within 60 days after the loss of eligibility under Medicaid or CHIP. If the Eligible Person fails to

apply within the 60 day period, he or she, as well as the Eligible Dependent, will not be eligible to apply until the Group's Open Enrollment Period as defined in this Section E.

(2) The effective date of coverage for the Non-Covered Eligible Person or their Eligible Dependent will be the first day of the first calendar month beginning after the date the Claims Administrator receives the Enrollment Form.

Claims Filing and Request for Services

1. Within one year from the date the Covered Service is rendered to you, a claim must be filed with the Claims Administrator in a form and manner that effectively provides notice to the Claims Administrator that the Covered Service has been rendered. A claim will be considered incurred on the date the service or supply is actually rendered or provided to you.

2. A claim for a Covered Service that has been provided by a Participating or Network Provider must be filed directly with the Claims Administrator by such Provider within one year from the date the service is rendered.

3. Nonparticipating and Non-Network Providers may file the claim for a Covered Service if you ask them to do so. If they do not file the claim, it is your responsibility to submit the claim to the Claims Administrator on a standard claim form that is appropriate for the services rendered. It is your responsibility to assure that any claim for a Covered Service that has been provided by Nonparticipating or Non-Network Provider is filed with the Claims Administrator within one year from the date the service is rendered.

Review of Claims Denied in Whole or in Part

1. Defined Terms (Applicable Only To This Section)

   a. Designation of Authorized Representative: You may designate an Authorized Representative to act on your behalf. A designated Authorized Representative may be any individual who is not otherwise included under the same coverage as you. A natural parent of a minor dependent and a provider of services for you may act on behalf of you without obtaining a formal designation. Any designation of an Authorized Representative must be submitted to the Claims Administrator on a form that will be provided by the Claims Administrator upon your request. This Designation of Authorized Representative form must be signed by the person whose claim is involved and submitted to CLAIMS REVIEW at the address specified on the form. Once an Authorized Representative has been formally designated by you, all communications pertaining to the claim at issue will be directed to the Authorized Representative. Anyone acting as an Authorized Representative for you must adhere to all procedures and requirements contained herein which are otherwise the responsibility and obligation of the Participant.

   b. Post-Service Claim: A claim that is submitted for medical services that have already been rendered to you. You will receive an Explanation of Benefit form reflecting the initial Benefit determination for claims that have been processed.

2. Initial Benefit Determination Procedures

   a. Following the procedures outlined in the Utilization Management section of the Plan, your Provider or you (when utilizing a Non-Network or Non-Participating Provider) will certify an Emergency Admission, request for Pre-Certification, Prior Authorization or Prior Approval

of services where required.

b. Once a claim or request for a Covered Service is received by the Claims Administrator, you or the Provider may be advised if additional information is needed to finalize the claim processing. Claims Administrator has the right to deny any claim where additional information (i.e. medical records, etc.) is not received within the timeframes provided for making an initial Benefit determination.

   NOTE: If you disagree with any pharmacy service and the Claims Administrator does not provide an Explanation of Benefits for the transaction, you must submit written notice of an initial claim to the Pharmacy Benefit Management Department.

c. Time Lines for initial Benefit determinations

   (1) Certification of Emergency Admissions

      (a) When your Provider or you (only when utilizing a Non-network or Nonparticipating Provider) requests Certification of an Emergency Admission in accordance with the Utilization Management section of the Plan, Claims Administrator will advise your Provider of a decision as soon as possible taking into account the medical urgency, and in no case later than 72 hours after the request for Certification. Claims Administrator will provide oral notice of approval to the Provider. If the request is denied, the Claims Administrator will provide the Participant written notification of the decision within three days.

   (2) Notice of Initial Benefit Decision for Pre-Certification, Prior Authorization or Prior Approval of Services

      (a) Only when you or the your Provider submits a request for services not yet rendered and the terms of the Utilization Management or Transplant sections of the Plan require Pre-Certification, Prior Authorization or Prior Approval, a notification of a determination will be made within a reasonable period of time appropriate to the medical circumstances, but no later than 15 days from receipt of the request for services. The Claims Administrator has discretion (but is under no obligation) to extend the 15 day time period for reasons beyond the control of the Claims Administrator.

      (b) If the request for Pre-Certification, Prior Authorization or Prior Approval of medical services is approved, Claims Administrator will advise your Provider of the approval. If the request for Prior Authorization of pharmacy services is approved, Claims Administrator will advise you or the Provider of this decision. If the request for Pre-Certification, Prior Authorization or Prior Approval of either medical or pharmacy services is denied, Claims Administrator will provide you with written notification.

   (3) Notice of Initial Benefit Decision for Claims

      (a) When a claim is submitted for services that already have been rendered, a notification of a determination will be sent within a reasonable time period but not longer than 30 days from receipt of the claim. The Claims Administrator has the discretion (but is under no obligation) to extend the 30 day time period for reasons beyond the control of the Claims Administrator.

d. Appeal Procedures

   (1) You or your properly designated Authorized Representative will be entitled to request an appeal of an adverse Benefit determination. An appeal must be filed within 180 days from the receipt of the notice of an initial Benefit determination.

   (2) A request for an appeal must be submitted in writing to CLAIMS REVIEW at the address specified in the initial benefit determination notification or the Explanation of

Benefit form.

(3) Your request for an appeal should state why the decision is incorrect. You will have the opportunity to submit written comments, documents, or other information in support of the appeal. Once a request for an appeal is received by the Claims Administrator, you or the Provider may be advised if additional information is needed to finalize the decision. Claims Administrator has the right to deny any appeal where additional information (medical records, etc.) is not received within the timeframes provided for making a decision on an appeal.

(4) Upon request and free of charge, you will have access to and be provided copies of relevant documents. The review of the initial Benefit determination will take into account all new information, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination.

(5) The appeal will be conducted by a representative of the Claims Administrator who is neither the individual who made the initial Benefit determination nor the subordinate of such individual. If the appeal involves a medical judgment question, the Claims Administrator will consult with an appropriately qualified health care practitioner with training and experience in the field of medicine involved in the medical judgment.

(6) A final decision on an appeal will be made within the time periods specified below:

(a) Appeal of an Emergency Admission

In the event the request for Certification of the Emergency Admission is denied, your Provider may request an expedited review of the Certification. This request should be made by telephone, facsimile, or similarly rapid communication method. Utilizing the same communication method, Claims Administrator will notify your Provider as soon as possible, but in no less than 72 hours after the receipt of the expedited review of the Claims Administrator's approval or continued denial of the services. You will be notified of the continued denial of services.

(b) Appeal of Pre-Certification, Prior Authorization or Prior Approval of Services

When you request an appeal of the Pre-Certification, Prior Authorization or Prior Approval of services, you will be notified of the determination within a reasonable period of time taking into account the medical circumstances, but no later than 30 days from the date the request is received.

(c) Appeal of Claims

When you request an appeal of a claim denial, you will be notified of the determination or status within a reasonable period of time but no later than 60 days from the date the request is received.

e. Contents of notification for adverse decisions for Pre-Certification, Prior Authorization, Prior Approval of services, claims and appeals.

(1) The notice of initial Benefit determination for adverse decisions for Pre-Certification, Prior Authorizations or Prior Approvals, claims and appeals will contain the following information:

(a) the specific reason or reasons for the adverse determination;

(b) a reference to the Claims Administrator’s claims review procedures;

(c) state whether the denial is based on a medical necessity exclusion or limitation and advise that the Participant will be provided with an explanation of the determination free of charge upon request.

(2) In addition, the notification of an adverse decision for Pre-Certification, Prior Authorization, Prior Approval of services and appeals will disclose whether any internal rule, guideline or protocol was relied on in making the adverse determination and provide that a copy of such information will be made available free of charge upon request. It will reference the specific plan provision on which the Benefit determination is based.

(3) Notifications for Pre-Certification, Prior Authorization or Prior Approvals will also indicate whether additional material or information is needed to perfect the request for services. Notifications for appeals will provide that you are entitled to receive upon request and free of charge reasonable access to and copies of all documents, records and other information relevant to the claim for Benefits.

(4) The notice of initial Benefit determination for adverse claims will also indicate whether additional material or information is needed to perfect the claim.

Legal Action

The Participant may not bring a lawsuit to recover Benefits under this Plan until the Participant has exhausted the administrative process described in the “Review of Claims Denied in Whole and in Part” section above. No action may be brought at all unless brought no later than 3 years following a final decision on the claim for Benefits by the Plan. The 3-year statute of limitations on suits for all Benefits shall apply in any forum where the Participant may initiate such suit.

Nonparticipating Benefits
And Direct Payment To Participant

1. All Benefits payable under the Plan and any amendment hereto are personal to you or your Dependent and are not assignable in whole or in part, but the Plan, through the Claims Administrator, has the right to make payment to a Hospital, Physician, or other Provider (instead of to you or your Dependent) for Covered Services which they provide while there is in effect between the Claims Administrator and any such Hospital, Physician, or other Provider an agreement calling for the Claims Administrator to make payment directly to them. In the absence of such an agreement for direct payment, the Plan, through the Claims Administrator will pay to you or your Dependent and only you or your Dependent those Benefits called for herein and the Claims Administrator will not recognize a Participant's attempted assignment to, or direction to pay, another.

2. Hospitals, Physicians, and other Providers which have agreed with the Claims Administrator or another Blue Cross and Blue Shield Plan for such direct payment are, by reason of such agreements, "Participating Hospitals," "Participating Physicians," or "Participating other Providers," respectively, and are referred to collectively as "Participating Providers." Those Hospitals, Physicians, and other Providers which do not have such agreements for direct payment are "Nonparticipating Hospitals," "Nonparticipating Physicians," and "Nonparticipating other Providers," respectively, and are referred to collectively as "Nonparticipating Providers."

3. If the Claims Administrator has offered a Hospital, Physician or other Provider an agreement for direct payment by the Claims Administrator, but there is no such agreement in effect when Covered Services are rendered to you or your Dependent by such Hospital, Physician or other Provider, the Claims Administrator will not recognize you or your Dependent's attempted assignment to, or direction to pay, such Hospital, Physician or other Provider, but the Plan, through the Claims Administrator will pay to you or your Dependent and only you or your Dependent those Benefits called for in this booklet and any amendment hereto.

4. If a Hospital, Physician or other Provider meets the Claims Administrator criteria for participating status but has not yet been offered an agreement for direct payment by the Claims Administrator at the time Covered Services are rendered to you or your Dependent, the Claims Administrator will recognize you or your Dependent's direction to pay such Hospital, Physician or other Provider.

5. The Claims Administrator reserves the right to select the Hospitals, Physicians, and other Providers with which it will make agreements for direct payment by the Plan, through the Claims Administrator, for Covered Services they render to you, based on criteria which include the Claims Administrator's need in the locality, Utilization Management practices of the Hospital, Physician, or other Provider, quality of services, and the like.

6. When a Hospital without an agreement with the Claims Administrator for direct payment by the Plan, through the Claims Administrator, that is, a Nonparticipating Hospital, renders Covered Services to you or your dependent, the level of Benefits payable by the Plan, through the Claims Administrator under the Plan and any amendment hereto, for such services will be ten percent (10%) less than the level of Benefits that would be payable if such Hospital were a Participating Hospital, provided such Hospital otherwise meets the Claims Administrator criteria for participating status.

7. The Deductible Amount and Annual Maximum Benefit will remain the same as specified herein and will not be increased or reduced by this provision.

Definitions

Note: Many of the Definitions contain in this section disclaim different types of services or supplies which may not be covered services under this Plan. For full details of covered services and non-covered services please refer to the Benefit sections and the Limitation and Exclusions section.

1. **Allied Health Professional** – A person other than a medical doctor, or doctor of Osteopathy who is licensed by the appropriate state agency, where required and/or approved by Claims Administrator to render Covered Services. An Allied Health Professional includes dentists, psychologists, certified nurse practitioners, optometrists, chiropractors, podiatrists and any other health professional which is mandated by state law for specified services. For purposes of this Plan, Allied Health Professionals are divided into two types:

   A. Allied Primary Care Health Professionals – A person who is licensed by the appropriate state agency and approved by Claims Administrator to render Covered Services, which are within the lawful scope of his or her license to Members. For purposes of this Plan, Nurse Practitioners will be designated as Allied Primary Care Health Professionals.

   B. Allied Specialist – An Allied Health Professional, other than a Nurse Practitioner, who is licensed by the appropriate state agency and approved by Claims Administrator to render Covered Services, which are within the lawful scope of his or her license to Members. For the purposes of this Plan, Allied Health Professionals, other than Nurse Practitioners, will be designated as Allied Specialist.

2. **Allowable Charge** - The lesser of the: (1) Covered Charges or (2) the amount established by Claims Administrator as the maximum amount for Provider services covered under the terms of the Plan.

3. **Alternative Benefits** - Benefits for services not routinely covered under this Plan but which may be provided by agreement through Case Management.

4. **Ambulance Service** - Medically Necessary transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured.

5. **Annual Maximum** - The maximum amount the Claims Administrator will pay on behalf of the Member for all Covered Services per Calendar Year.

6. **Assistant at Surgery** - A Physician, Physician Assistant, Nurse Practitioner or Certified Registered Nurse First Assistants who assists the primary surgeon in the performance of a covered surgical procedure.

7. **Benefit** - The amount provided under the Plan for Covered Services. Benefits are based on the Allowable Charge minus any applicable Deductible Amount, Coinsurance or Co-payment.

8. **Benefit Period** - A period of one calendar year commencing each January 1.

9. **Billed Charges** - The total charges submitted by a Provider for all Covered Services and Non-covered Services provided to a Participant.

10. **Birthing Center Care** - Birthing services rendered in a facility which is designed to provide a homelike atmosphere without sacrificing the necessary safe guards of a hospital.

11. **Case Management** - A component of the Claims Administrator's Utilization Management programs. Case Management is the development of a comprehensive plan of action for Members with complex health care needs. Case managers collaborate with Members, their families, doctors, hospital social workers/case managers and other health care providers to minimize unnecessary medical and service complications, promote care in the least restrictive

setting, and facilitate efficient, appropriate and cost effective care. The goal of Case Management process is to provide effective, appropriate and quality controlled management of high cost and/or catastrophic cases.

12. **Chiropractic Services** - All services customarily provided by a chiropractor which shall include spinal adjustments, subluxations and manipulation and all services related or complementary thereto.

13. **Claims Administrator** - The organization appointed by the Group to administer claims and to provide certain other services as described in an agreement between the Claims Administrator and the Group.

14. **COBRA** - The Consolidated Omnibus Budget Reconciliation Act of 1985, commonly referred to as COBRA, requires that employers allow certain persons deemed "Qualified Beneficiaries," who would otherwise lose their group health coverage due to certain "Qualifying Events" to continue that coverage for a certain period of time (See General Provisions Section).

15. **Coinsurance** - That portion of the Allowable Charge expressed as a percentage for which the Participant is financially responsible under the Plan in addition to any applicable Deductible Amount.

16. **Co-paymen**t - That portion of the Allowable Charge expressed as an amount for which the Participant is financially responsible under the Plan in addition to the Deductible Amount when applicable.

17. **Community PLUS Pharmacy** - A pharmacy which has entered into an agreement with Claims Administrator (and has met the criteria for the Community PLUS Network) wherein the Community PLUS Pharmacy as a Participating Provider (where applicable), a Preferred Provider (where applicable) or a Network Provider (where applicable) agrees to render pharmaceutical services to Members of the Plan.

18. **Convalescent Care** - Care for a patient who is recovering from a disease, surgical operation, or injury in a Convalescent Nursing Home facility licensed by the State and approved by the Claims Administrator.

19. **Convalescent Nursing Home**

    The term Convalescent Nursing Home means only an institution meeting the following requirements:

    1. Operates pursuant to law and is primarily engaged in providing for compensation from its patients for the following services for persons (convalescing from sickness or injury): room, board and twenty-four (24) hour-a-day nursing service by one or more professional nurses and such other nursing personnel as are needed to provided adequate medical care.

    2. Provides restorative services to help patients meet a goal of self-care in daily living activities.

    3. Provides such services under the full-time supervision of a proprietor or employee who is a physician or a registered graduate nurse (RN).

    4. Maintains adequate medical records and if not supervised by a physician, under an established agreement has the services of a physician available.

The term Convalescent Nursing Home shall not include any institution, or part thereof, which is principally used as a rest facility, a facility for the aged or a facility used principally for the care of alcohol or drug abuse.

20. **Cosmetic Surgery** - Any operative procedure or any portion of an operative procedure intended solely to improve physical appearance. Exceptions to the above procedures are those procedures which restore bodily function or correct deformity resulting from disease, trauma or complications of previous Surgery.

21. **Coverages**

    a. Employee Only Coverage - Coverage for an individual only.

    b. Employee and One Dependent Coverage - means coverage for the Employee and One Dependent.

    c. Family Coverage - Coverage for the Employee and Dependents subject to the conditions hereinafter set forth.

22. **Covered Charges** - Provider Charges for Covered Services. Covered Charges are Billed Charges minus Non-covered Charges.

23. **Covered Service** - A service or supply specified in the Plan for which Benefits are available when rendered by a Provider. A charge for a Covered Service is considered to have been incurred on the date the service or supply was provided to the Participant.

24. **Deductible Amount**

    a. Benefit Period Deductible Amount - The dollar amount, as shown in the Schedule of Benefits, of Covered Services first hereunder incurred in connection with a Participants' injury or illness within a Benefit Period. No more than three (3) times the Deductible Amount must be satisfied in each Benefit Period for a family under Family Coverage. However, no family member may contribute more than the Deductible Amount to satisfy the maximum amount required of a family in each Benefit Period.

    b. Prescription Drug Deductible Amount – The Dollar Amount, as shown in the Schedule of Benefits, which applies to the Community Plus Pharmacy benefit, per Participant, per Calendar Year.

25. **Dependent** - The husband or wife of an Employee or any child of the Employee who is under the age of 26 who is not eligible to enroll in an employer-sponsored health plan other than a group health plan of a parent; however, no person shall be deemed a Dependent unless the Dependent (1) was named in the application for the coverage, or (2) since execution of said application, has been reported to the Group in writing as a new or additional Dependent and has been approved as a Dependent in writing fixing the effective date of coverage and such effective has occurred. The term "child" as used herein shall include any stepchild living in the same household with the Employee, legal ward and legally adopted child who depends upon Employee for support and lives with Employee in a regular parent-child relationship.

26. **Diabetes** - Diabetes mellitus is a disorder of carbohydrate metabolism, characterized by hyperglycemia and glycosuria and resulting from inadequate production or utilization of insulin.

27. **Disease Management** - Systematic approach to medical care which incorporates development and implementation of clinical practice guidelines, patient education, and provider education to improve the quality of care for selective disease states. Through the Claims Administrator's Utilization Management program, the Claims Administrator seeks to identify Members who would qualify for Disease Management. The Claims Administrator will work with the Member, their Physician and family, to assess treatment alternatives and available benefits through Case Management.

28. **Disease Specific Drugs** – Drugs or medications for the prevention or treatment of a chronic complex disease state which include, but are not limited to: (a) Multiple Sclerosis; (b) RSV Prevention; (c) Rheumatoid Arthritis; (d) Crohn's Disease; and (e) Metabolic Disorders.

29. **Disease Specific Pharmacy** - a provider that has an area of expertise in disease states as well as the drugs and medications used to treat disease states. In order to be considered a Disease Specific Pharmacy under this Plan, Claims Administrator must have a Disease Specific Pharmacy Arrangement with the Provider.

30. **Drug Utilization Management** - A program which is part of Utilization Management. Through this program, the Claims Administrator will determine the Medical Necessity of Prescription Drugs. The Claims Administrator's determination of Medical Necessity will be based upon established pharmaceutical policy.

32. **Elective Admission** - That admission, whether it be for surgical or medical care, for which a reasonable delay will not affect the outcome of the treatment unfavorably.

33. **Emergency Admission** - An "Emergency Medical Admission" or "Emergency Psychiatric Admission."

    a. Emergency Medical Admission - An inpatient admission to a Hospital resulting from the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate inpatient hospital care could reasonable result in: (1) permanently placing the patient's health in jeopardy; (2) serious impairment to bodily functions; or (3) serious and permanent dysfunction of any bodily organ or part, or other serious medical consequences.

    b. Emergency Psychiatric Admission - An inpatient admission to a Hospital resulting fro a mental or nervous condition or drug or alcohol abuse with presenting symptoms of severity, that in the absence of immediate intervention, could reasonably result in (1) permanently placing the patient's mental health in jeopardy, (2) a serious threat to the physical welfare of the patient and/or others, or (3) serious or permanent mental dysfunctions or other medical or psychiatric consequences. The acute symptoms must be of such severity to cause a person to seek medical or psychiatric assistance regardless of the hour of the day or night.

34. **Experimental/Investigative** - Any treatment procedure, facility, equipment, drug, device, or supply not yet recognized as accepted medical practice for the treatment of the condition being treated, and therefore, not considered Medically Necessary.

35. **Generic Drug** – A copy of the original brand-name product with the same medicine in the same strength. The U. S. Food and Drug Administration ensures the quality of generic drugs.

36. **Group** - City of Jackson, Mississippi.

37. **Home Health Care** - Health Services rendered in the individual's place of residence by an organization licensed as a home health provider by the appropriate state agency and/or approved by the Claims Administrator. These organizations are primarily engaged in providing to individuals, at the written direction of a licensed Physician, in the individual's place of residence, skilled nursing services by or under the supervision of a Registered Nurse licensed to practice in the state. Home Health Care shall not include private duty nursing.

38. **Home Infusion Therapy** - Services and Supplies required for the administration of a Home Infusion Therapy regimen. These services and supplies must be (1) Medically Necessary for the treatment of the disease; (2) ordered by a Physician; (3) as determined by Claims Administrator, capable of safe administration in the home; (4) ordinarily in lieu of Inpatient Hospital Therapy; and (5) more cost effective than Inpatient Therapy.

39. **Hospice Care** - Provision of an integrated set of services and supplies designed to provide palliative and supportive care to meet the special needs of Participants and their families during the final stages of terminal illness, normally six months or less. Full scope health services are centrally coordinated through an interdisciplinary team directed by a Physician and provided by or through a Hospice Care agency licensed by the state and approved by the Claims Administrator.

40. **Hospital** - short-term, acute-care, general hospital which:

    A. is a licensed institution;

    B. provides inpatient services and is compensated by or on behalf of its patients;

    C. provides surgical and medical facilities primarily to diagnose, treat, and care for the injured and sick; except that a psychiatric hospital will not be required to have surgical facilities;

    D. has a staff of physicians licensed to practice medicine; and

    E. provides 24 hour nursing care by registered nurses.

    A facility which serves, other than incidentally, as a nursing home, custodial care home, rest home, rehabilitative facility, Residential Treatment Facility or place for the aged is not considered a Hospital. Although a Facility may be designated as a hospital through their state license, Claims Administrator, BCBSMS, will determine whether the facility is a hospital for purposes of Benefits under this Benefit Plan. This determination will be based on the services that the facility provides to the Member.

41. **Incapacitated Coverage** - Coverage provided for a Dependent who became mentally retarded or permanently physically handicapped prior to the attainment of the maximum age as specified in this contract, who is not married, who is so incapacitated as to be incapable of self-sustaining employment and who is dependent upon the Employee for more than one-half support. Neither a reduction in work capacity nor inability to find employment is sufficient qualification for eligibility.

42. **Inpatient Rehabilitation Services –** rehabilitation services that can not be adequately performed in an Outpatient setting. These services must have Case Management approval as well as comply with the Claims Administrator's criteria for Inpatient Rehabilitation Care.

43. **Medical Policy** – Claims Administrator develops formal written guidelines regarding new and existing medical and surgical procedures, products, drugs, technology and tests. These guidelines are determined by review of currently available peer reviewed scientific literature as well as input from practicing professionals. Claims Administrator relies on medical policy for reaching decisions on matters of: 1) Medical Necessity, 2) Covered Services under this Plan, 3) appropriate adjudication of claims, 4) Utilization Management, and 5) quality assessment programs. The specific guidelines found in the Medical Policy are not set out in their entirety in this Plan.

44. **Medically Necessary** - The services or supplies required to identify or treat the illness or injury which a Physician has diagnosed or reasonably suspects. The services or supplies must be (1) consistent with the diagnosis or treatment of the patient's condition, illness, or injury; (2) in accordance with the standards of good medical practice; (3) required for reasons other than the convenience of the patient or his physician; and (4) the most appropriate supply or level of service which can be safely provided to the patient. When applied to the care of an inpatient, it further means that the Participant's medical symptoms or condition require that the services cannot safely be provided to the Participant as an outpatient. The fact that a Physician has prescribed, ordered, recommended or approved a service or supply does not, in itself, make it Medically Necessary.

45. **Medical Supplement Coverage** - The coverage offered to retired employees (non-active) under the Plan who are eligible for Medicare, regardless of whether they are enrolled in Medicare. (Exception: Fire and Police 20 year Retirees, who are not eligible for Medicare, may not be eligible for this coverage.)

46. **Non-covered Charges** - Provider charges for Non-covered Services.

47. **Non-covered Services** - Health care or other services and supplies provided to a Participant for which Benefits are not available under the Plan.

48. **Non-Preferred Brand** – a Prescription Drug or medication which is not included in the Prescription Drug Formulary. The Participant will be responsible for a higher co-payment amount when purchasing a Non-Preferred Brand.

49. **Outpatient Cardiac Rehabilitation** - The process by which a person with Cardiovascular Disease is restored to their optimal function states, including their physiological, psychological, social, vocational, and emotional states. Cardiac Rehabilitation services include formal exercise sessions, risk factor education, and behavior modification counseling.

50. **Participant** - A covered Employee or Dependent who has satisfied the specifications of the Schedule of Eligibility and has enrolled for coverage under the Plan.

51. **Physician** - A Doctor of Medicine (M.D.) Or Doctor of Osteopath (D.O.) who is legally qualified and licensed to practice medicine and perform surgery at the time and place service is rendered. A Doctor of Dental Surgery (D.D.S.), doctor of Medical Dentistry (D.M.D.), Doctor of Surgical Chiropody (D.S.C.), Doctor of Podiatry (Pod. D.), Clinical Psychologist (Ph. D.), Chiropractor (D.C.), and an Optometrist (O.D.), when duly licensed and practicing within the scope of his/her license, is deemed to be a Physician for purposes of the Plan. No other practitioners are deemed to be Physicians.

52. **Plan** - This Medical Benefit Plan.

53. **Preferred Brand** – A Prescription Drug or medication which has been identified by a committee of Network physicians and Network pharmacists as a high quality and effective product. Claims Administrator has included this Prescription drug or medication in the Prescription Drug Formulary.

54. **Prescription Drug Formulary** - A list of Prescription Drugs covered by Claims Administrator. The Prescription Drug Formulary provides coverage, clinical and cost comparison information to providers servicing Claims Administrator’s Members. In addition to being an information source on drugs, the use of the Prescription Drug Formulary may generate savings from drug manufacturers. These savings are generated from Prescription Drug claims. Any savings as a result of the Prescription Drug Formulary are utilized in the financing of this Benefit Plan. A Member’s Coinsurance/Co-payment for the Prescription Drug is based on the cost of the drug before Claims Administrator receives the savings from the Prescription Drug Formulary.

55. **Preventive Health Services** - Services designed to effectively prevent or screen for a disease for which there is an effective treatment when discovered in an early stage.

56. **Provider** - A Hospital, Allied Health Facility, Physician, or Allied Health Professional, licensed where required, performing within the scope of license, and approved by the Claims Administrator.

    A. Participating Provider - A Provider that has an agreement with the Claims Administrator

pertaining to payment for Covered Services rendered to a Member.

B. Nonparticipating Provider - A Provider that does not have an agreement with the Claims Administrator pertaining to payment for Covered Services rendered to a Member.

C. Network Provider - A Hospital that has a Hospital Agreement with Claims Administrator and is designated a Network Hospital for the purposes of this Plan, or Physician who has a Participating Provider Agreement with Claims Administrator or an Allied Health Professional or Allied Health Facility who has a Participating Provider Agreement with Claims Administrator pertaining to Covered Services rendered to a Member under this Plan. A Network Provider will file claims for a Member and will not bill the Member for any charges above the Allowable Charge except for any non-covered expenses, any Deductible Amount, Coinsurance and/or Co-payment Amount required by the Plan.

D. Non-Network Provider - A Hospital that does not have a Network Hospital Agreement with Claims Administrator for the purposes of this Plan or Physician who does not have a Participating Provider Agreement with Claims Administrator or an Allied Health Professional or Allied Health Facility which does not have a Participating Provider Agreement with Claims Administrator pertaining to Covered Services rendered to a Member under this Plan (Payment for Covered Services and Supplies, as provided in this Plan, are limited when provided by a Non-Network Provider as stated in the Schedule of Benefits section of this Plan).

NOTE: A pharmacy with a Community Pharmacy Agreement that meets Company's criteria for participating in the Community PLUS Network is a Participating Provider (where applicable) a Preferred Provider (where applicable) or a Network Provider (where applicable). A pharmacy that is not designated as a Community PLUS Pharmacy is a Non-Participating Provider (where applicable), Non-Preferred Provider (where applicable) or Non-Network Provider (where applicable).

57. **Qualified Beneficiaries** - For purposes of COBRA only, these are individuals who are entitled to elect COBRA Continuation Coverage as a result of the loss of employer provided group health coverage (known as a "Qualifying Event"). Individuals who may be Qualified Beneficiaries are the spouse and dependant children of a Participant and in certain circumstances, the Participant (See General Provisions Section).

58. **Qualifying Event** - For purposes of COBRA only, a Qualifying Event is any of the following events that cause a loss of coverage: (1) termination of employment or reduction in hours of employment; (2) death of a Participant; (3) divorce or legal separation; (4) a Participant's entitlement to Medicare; (5) a dependent child's loss of dependent status; or (6) loss of coverage due to the employer's filing of a bankruptcy proceeding (See General Provisions Section).

59. **Rehabilitative Care/Acute Care** -

a. Rehabilitative Care - The coordinated use of medical, social, educational or vocational services, beyond the acute care stage of disease or injury, for the purposes of upgrading the physical functional ability of a patient disabled by disease or injury so that the patient may independently carry out ordinary daily activities.

b. Acute Care - The type of short-term, diagnostic and therapeutic services ordinarily provided in a general hospital to a patient who is ill from a disease or injury which has an

acute nature or a sudden onset requiring immediate medical or surgical treatment.

60. **Retiree** –

    a. All City of Jackson Retirees and their Dependents under age 65 (Retirees and their Dependents under age 65 or entitled to Medicare due to disability are not eligible for coverage).

    b. Jackson Police Officers or Fire Fighters and their Dependents retired under the 20 year plan and not eligible for or entitled to Medicare Benefits.

    NOTE: Effective March 1, 2007, the City of Jackson eliminated all Medicare Supplement Plans.

61. **Semi-private Rate** - The rate charged by the Hospital for a room containing 2 or more beds, when a private room is occupied, Semi-private Rate shall be deemed to be the hospital's average semi-private room rate; where the hospital does not maintain semi-private rooms, the Semi-private Rate shall be deemed to be 75% of the weighted average of the hospital's usual charges for all private room.

62. **Subrogation** - The substitution of the Plan in the place of the Participant with reference to a lawful claim, demand or right so that the Plan succeeds to the rights of the Participant in relation to the debt or claim, and its rights, remedies or securities.

63. **Temporomandibular/Craniomandibular Joint Disorder** - Disorders resulting in pain and dysfunction of the temporomandibular/craniomandibular joint which arise out of rheumatic disease, dental occlusive disorders, and internal and external joint stress.

Section II

Benefits Provided

Your Medical Benefit Plan covers a wide range of health care expenses whether incurred in or out of the hospital.

Annual Maximum Benefits

Benefits are provided up to the amount shown in the Schedule of Benefits for you and each covered Dependent.

In the event the maximum Benefits are exhausted, $2,000 for use in future Benefit Periods shall be restored each January 1 following the Calendar Year in which the maximum Benefits were paid.

The Benefit Period

The Benefit period is a calendar year, January 1 through December 31.

Deductible Amount

Deductible is the amount each Participant must pay annually, as shown in the Schedule of Benefits, before Benefits are available for Covered Services.

Maximum Family Deductible - not more than three (3) times the Deductible Amount must be satisfied in each Benefit Period for a family. No family member may contribute more than the Deductible Amount toward the maximum amount required of a family in each Benefit Period. The Maximum Family Deductible does not apply to the Prescription Drug Deductible. Each Participant must satisfy the Prescription Drug Deductible for prescriptions received at a Community Plus Pharmacy.

Plan Pays/You Pay

If you or your covered Dependent(s) incur Covered Charges for Covered Services in excess of the "Deductible Amount" during a calendar year, Plan will pay the percentage amount shown in the Schedule of Benefits for the Allowable Charge for such Covered Services of the remainder of the calendar year.

After The Out-of-Pocket Limit Plan Pays 100%

When Out-of-pocket expenses for Coinsurance for Covered Services for a Participant reach the out-of-pocket amount shown in the Schedule of Benefits, Plan will pay one hundred (100) percent of the Allowable Charges for Covered Services during the remainder of the Benefit Period.

Coinsurance for Covered Services incurred for outpatient treatment and care of nervous and mental

conditions, alcohol abuse and drug abuse cannot be used toward satisfying the out-of-pocket limit of this coverage.

Covered Services

Your program provides Benefits shown in the Schedule of Benefits toward the Allowable Charge, as determined by Claims Administrator, for any of the following services when they are prescribed by a physician and are Medically Necessary.

Hospital Services and Supplies as follows:

-- Room and Board allowance - See Schedule of Benefits (Hospital's average semiprivate room rate allowed toward private room.)

-- Use of operating or treatment rooms

-- Anesthetics and their administration

-- Intravenous injections and solutions

-- Rehabilitation Care necessary for the restoration of bodily function

-- Therapy
Physical, radiation, occupational and speech therapy, If such treatment is necessary to restore bodily functions

-- Oxygen and its administration

-- Diagnostic services
Including clinical laboratory examinations, X-ray examinations, electrocardiograms, and electroencephalograms.

-- Drugs and medicines

-- Dressings and supplies, sterile trays, casts, orthopedic supplies and appliances, etc.

-- Blood transfusions
Including the cost of whole blood, blood plasma and expanders, processing charges, administrative charges, equipment and supplies.

-- Psychological testing
When ordered by the attending physician and performed by a full-time employee of the hospital.

-- Intensive, coronary and burn care unit services

-- Emergency Room Services

Covered Physician Services:

-- In-hospital medical care

-- Medical care
In the physician's office, the patient's home or elsewhere.

-- Surgery, including surgical supplies

-- Administration of anesthesia

-- Diagnostic services
Including clinical laboratory examinations, X-ray examinations, electrocardiograms, electroencephalograms.

-- Radiation therapy

-- Consultations

-- Psychiatric and psychological service for nervous and mental conditions (subject to limitations listed in Schedule of Benefits).

-- Physicians assisting in surgery

-- Emergency care or surgical services rendered in the physician's office Including such items as surgical and medical supplies, dressings, casts, anesthetics, tetanus serum and X-rays.

Other Covered Services:

-- Services of a Birthing Center

-- Prescription Drug Benefits

Based on the Allowable Charge established by the Claims Administrator, Benefits as specified in the Schedule of Benefits will be available for drugs that under Federal law may be dispensed only by written prescription and which are approved for general use by the Food and Drug Administration. The drugs must be dispensed on or after the Participant's Effective Date by a licensed pharmacist upon the prescription of a Physician. These Benefits will be subject to the following:

1. Only those Prescription Drugs which are determined by the Claims Administrator to be Medically Necessary for the treatment of illness or injury will be covered.

2. Benefits for Prescription Drugs will be limited to a 30-day supply per dispensing.

3. Benefits will be provided for injectable insulin and necessary insulin syringes.

4. The Participant's Co-payment cannot be used to satisfy the Out-of-pocket amount.

5. Benefits paid for covered Prescription Drugs are applied to the Annual Maximum.

6. Prescription Drug benefits are not subject to the Pre-existing Condition limitations of the Plan; however, the condition for which the Prescription Drug is prescribed remains subject to any Pre-existing Condition limitation.

7. Participants will not receive Benefits for refills of Prescription Drugs until 75% of the last dispensed applicable day supply is exhausted by the Participant.

8. When filing claims for Outpatient Prescription Drugs, Participant(s) must utilize the Prescription Drug Claim Form or the acceptable attachment must be completed and signed by the dispensing pharmacist. The claim form should then be sent to the Claims Administrator.

9. As specified in the Schedule of Benefits in the Prescription Drug section, Prescription Drug Benefits will be provided for diabetic supplies (e.g. blood testing supplies, urine testing supplies and lancets) approved by the Claims Administrator.

10. Due to the nature and use of certain Prescription Drugs, Claims Administrator classifies these drugs as Drug Therapy or Infusion Therapy. The aforementioned drugs are not considered retail prescription drugs. See Article VIII, Section C for Infusion Therapy and Drug Therapy.

11. Drugs or medication for the prevention or treatment of a chronic complex disease state must be prescribed by a Physician and dispensed by a Disease Specific Pharmacy approved by Claims Administrator. These drugs or medications will not be considered retail Prescription Drugs. No Benefits will be provided for these drugs or medications unless the Network Provider or the Member, when utilizing a Non-Network Provider, receives Prior Authorization from Claims Administrator.

-- Ambulatory Surgical Facility

-- Services of a qualified licensed professional physical therapist

-- Outpatient hospital rehabilitative care

-- Rental of durable equipment for temporary therapeutic use

-- Prosthetic appliances

-- Ambulance Service Benefits

-- Benefits as specified in the Schedule of Benefits will be available for the following covered Ambulance Services when Medically Necessary:

1. Medically Necessary transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured;

   a. from the place where the Participant is injured by accident or stricken by illness to the nearest Hospital where treatment is to be given;

   b. from a Hospital where a Participant is an Inpatient to another Hospital or free-standing facility to receive specialized diagnostic or therapeutic services not available at the Hospital of origin and back to the Hospital of origin after such services have been rendered;

   c. from a Hospital to another Hospital when the discharging Hospital has inadequate treatment facilities and the receiving Hospital has appropriate treatment facilities;

   d. to a Hospital, a Physician's office or Ambulatory Surgical Facility for Outpatient care of an Accidental Injury or a Medical Emergency.

2. Ambulance Service also includes transportation by air ambulance when, as determined by the Claims Administrator, Participants condition or urgency of needed medical care

precludes travel by surface transportation. Air ambulance service is helicopter transportation to the nearest institution with appropriate facilities for treatment of the Participant's injury or illness. Fixed wing air transportation is for long distance travel only and is not ordinarily considered to be an air ambulance service.

3. Ambulance Service Benefits will not be provided for a Participant's comfort or convenience.

-- Assistant at Surgery

1. The assistant is a professional (Physician, Physician Assistants, Nurse Practitioners or Certified Registered Nurse First Assistants) who assists the primary surgeon in the performance of a covered surgical procedure. Benefits for an assistant at surgery will be provided only if Claims Administrator determines the Medical Necessity of an assistant at surgery is warranted and the assistant is acting within the scope of his or her license.

2. The Physician Assistant, Nurse Practitioner, or Certified Registered First Assistant must be an employee of the primary surgeon's clinic.

3. When the need for an assistant surgeon is documented to be Medically Necessary, Benefits will be based on 20% of the Allowable Charge for the primary surgical procedure.

-- **Maternity Benefits**

Regular contract benefits (subject to Deductible Amount and coinsurance features of this coverage) are available for maternity on covered female Employees and covered Dependent spouses of male Employees the same as for other illnesses.

- Newborn Well Baby Care

  1. Physician's Initial examination of a well newborn or, when delivery is by Cesarean section, one Consultation for standby resuscitation and infant care in the operating room by a Physician other than the operating surgeon. Benefits will also be provided for subsequent visits by the Physician while the well newborn is in the hospital with the mother. These Benefits will not extend beyond the mother's stay.

  2. Routine Hospital nursery care of a well newborn for the mother's authorized routine length of stay for an uncomplicated vaginal delivery or Cesarean section.

-- **Dental Services for Dental Care and Treatment and Dental Surgery:** No Benefits will be provided for dental care and treatment and dental surgery as defined in the Plan, regardless of medical necessity, except for the following services or procedures:

- Dental care and treatment including surgery and dental appliances required to correct accidental injuries of the jaws, cheeks, lips, tongue, roof or floor of mouth, and of sound and natural teeth while coverage is in effect. Accidental means any injury caused by external force. The act of chewing does not constitute an injury caused by external force. Treatment must begin within 30 days of injury.

- Excision of tumors or cysts; excision of bony outgrowths of the jaws and hard palate; incision and drainage of abscesses; incision of accessory sinuses, salivary glands, and salivary ducts; and surgical procedures related to undersized and oversized jaw.

- Removal of impacted teeth and excision of unerupted teeth.

- Hospital admissions made necessary to safeguard health while receiving treatment for non-covered dental conditions.

- Surgery on the Temporomandibular Joint only for Temporomandibular Joint Disorder. No Benefits will be provided for any other services for Temporomandibular Joint Disorder.

- When a Member has a nondental organic disease or condition which makes an alternative treatment setting (hospital or ambulatory surgical facility) necessary to safeguard health while undergoing treatment for non-covered Dental Care and Treatment, Benefits will be provided for room, board, and other necessary services if Claims Administrator, BLUE CROSS & BLUE SHIELD OF MISSISSIPPI, determines that: (1) the alternative treatment setting is Medically Necessary and (2) the Covered Services required to treat the non-dental organic disease or condition are Medically Necessary. No Benefits will be provided for the alternative setting or the Covered Services needed to treat the nondental organic disease unless the Member's dentist pre-certifies with Claims Administrator, BLUE CROSS & BLUE SHIELD OF MISSISSIPPI, the Medical Necessity of the alternative setting and the Covered Services needed to treat the non-dental organic disease.

-- **Home Infusion Therapy/Drug Therapy**

1. Benefits as specified in the Schedule of Benefits and this section will be available for Medically Necessary Infusion Therapy and Drug Therapy in the Member's home.

2. Covered Services are limited to drugs, intravenous solutions, Durable Medical Equipment, pharmacy compounding and dispensing services, fees associated with drawing blood for the purpose of monitoring response to therapy, therapist services, ancillary medical supplies, and nursing visits, including initiation of Home Infusion Therapy, intravenous restarts and Emergency care when Medically Necessary to provide Home Infusion Therapy.

3. Limitations in connection with Infusion Therapy and Drug Therapy

    a. No Benefits are payable under any other section of this Benefit Plan for services, drugs, equipment or supplies used in Infusion Therapy or Drug Therapy, except as provided for in this section.

    b. No Benefits are payable for the supervision of self-administered medications or family-administered medications.

    c. No Benefits are payable for any charges for nursing visits, care, services or supplies associated with Infusion Therapy other than as stipulated in the per day Allowable Charge.

    d. No Benefits are payable for other services required to administer Infusion Therapy or Drug Therapy in the home setting but which do not involve direct patient contact, including but not limited to delivery charges and record keeping.

4. Pre-certification/Continuing Certification

    It is the sole responsibility of the Participant(s) to ensure that an approved Home Infusion Therapy Provider, or a representative thereof, notifies the Claims Administrator (using the appropriate Home Infusion Therapy Pre-certification form) of all Home Infusion Therapy services and supplies 24 hours prior to the initiation of Home Infusion Therapy Services. Only those services furnished after pre-certification has been approved will be considered for Benefits. Benefits will not be allowed for services furnished prior to pre-certification. If Home Infusion Therapy services are not pre-certified prior to the initiation of therapy, the Participant will be responsible for 50% of the daily rate up to a maximum of $2,000 (this penalty shall not apply to the deductible or out-of-pocket) as well as any deductible and coinsurance amounts required in the Plan. The Participant(s) will also be responsible for

all charges not specifically listed as Covered Services.

During the certification process a review date will be set to determine the appropriateness of continued Home Infusion Therapy beyond the initial approved length of therapy. In the event of continued therapy, it is the responsibility of the Participant(s) to ensure that an approved Home Infusion therapy Provider, or a representative thereof, contacts the Claims Administrator 24 hours before the assigned review date.

If continued therapy at the current level of care is not documented to be Medically Necessary, the Claims Administrator will notify the Participant(s), Home Infusion Therapy Provider and the attending physician. This notification will be given at least twenty-four (24) hours in advance of terminating the authorization for Home Infusion Therapy Services.

If either the Participant(s), Home Infusion Therapy Provider or attending physician disagrees with the decision, any one of these three parties may appeal the decision by contacting the Claims Administrator in writing within 30 days of notice of the decision. If Claims Administrator does not reverse the decision, the Participant(s) will be responsible for payment of non-approved services if he/she elects to continue therapy.

-- **Specified Human Organ Transplant Benefits**

a. Regular Benefits of the Plan will be provided for treatment and care as a result of or directly related to the following human organ transplant procedures: Kidney, liver, heart, heart/lung, and pancreas.

(1) In addition to regular Plan Benefits, the following Benefits will be provided for those transplant procedures listed in Paragraph a. immediately above:

(a) Benefits for the surgical, storage, and transportation expenses incurred and directly related to the donation of an organ or tissue used in a covered organ or tissue transplant procedure are limited to $25,000 per specific transplant type. The $25,000 is included in the Annual Maximum for each specific transplant type as defined in Paragraph a above.

(2) Benefits for human organ transplants listed in Paragraph a. above shall be limited as follows:

(a) No Benefits shall be provided hereunder unless a written pre-admission certification is obtained from Claims Administrator. Claims Administrator shall be advised of the proposed transplant surgery prior to admission and a written request for pre-admission certification shall be filed with Claims Administrator. Claims Administrator shall be provided with adequate information so that it might verify coverage, determine medical necessity, and approve of the facility at which the transplant surgery will occur. Claims Administrator will forward written pre-admission certification to Participant and providers.

(b) Benefits shall be provided only for a period consisting of five days immediately prior to and one year following a covered organ transplant procedure.

b. All Benefits provided hereunder shall be subject to the Annual Maximum Benefits available under the Plan.

-- **Outpatient Preventive/Wellness Services**

Benefits for Outpatient Preventive/Wellness Care as specified and limited in the Schedule of Benefits and this section shall be available for services designed to effectively screen for a disease for which there is a treatment or a cure when discovered in an early stage.

1. Outpatient Preventive/Wellness Services are limited to:

    a. Physical examinations (including well child care).

    b. Immunizations (well child vaccinations, flu shots, etc.).

    c. Diagnostic services and tests (PAP Smear, Blood, Urinalysis, and Mammography for women under age 35, etc.)

2. Outpatient Preventive/Wellness Services do not include:

    a. Vision (exams or eye glasses).

    b. Hearing (exams or hearing aids).

    c. Dental

-- **Surgery for Mastectomy and Reconstruction of the Breast**

When the Claims Administrator determines the Medically Necessity of medical and surgical benefits with respect to a Participant's mastectomy, Benefits will be provided for breast reconstruction when such Covered Service is elected by the Participant. In accordance with the terms and provisions of this Plan, including but not limited to Benefit Period Deductible Amount, Out-of-Pocket Amount and applicable benefit and coinsurance amounts, the following benefits will be provided:

1. Reconstruction of the breast on which the mastectomy has been performed;

2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

3. Prostheses and physical complications all stages of mastectomy, including lymphedemas.

-- **Diabetes Treatment**

Benefits as specified in the Schedule of Benefits and this section will be available for Diabetes Treatment. These Benefits will be subject to the following provisions:

1. Benefits will be provided for equipment and supplies used in connection with the monitoring of blood glucose and insulin administration.

2. Benefits will be provided for a dilated eye exam for Members with a diagnosis of Diabetes. Dilated eye exams are limited to one (1) exam per Calendar Year.

3. Benefits will be provided for preventive or routine foot care rendered to a Member by a Provider practicing within the scope of his/her license and who is approved by the Claims Administrator, BCBSMS. The Member must have a diagnosis of Diabetes. Preventive or routine foot care is limited to one (1) visit per Calendar Year.

4. Benefits will be provided for care of corns, bunions, calluses, or debridement of nails rendered to a Member by a Provider practicing within the scope of his/her license and who is approved by the Claims Administrator, BCBSMS,. The Member must have diagnosis of Diabetes with complications of neuropathy or peripheral vascular disease making such care Medically Necessary. Insulin dependency is not required.

-- **Immunizations for Children**

Benefits as specified in the Schedule of Benefits and this section will be provided for immunizations for covered dependent children through the date the child is 24 months of age.

1. Covered Services include immunizations against:

   a. Diphtheria;
   b. Hepatitis B;
   c. Measles;
   d. Mumps;
   e. Pertussis;
   f. Polio;
   g. Rubella;
   h. Tetanus;
   i. Varicella; and
   j. Hemophilus Influenza B (HIB)
   k. Prevnar
   l. Influenza
   m. Any other immunizations that meet established American Academy of Pediatrics or the Centers for Disease Control (CDC) recommendations and are approved by Claims Administrator, Blue Cross & Blue Shield of Mississippi.

2. No Benefits are provided for immunizations when rendered by a Non-Network or Non-Participating Provider.

-- **Mammography**

Benefits as specified in the Schedule of Benefits and this section will be provided for screening by Low Dose Mammography. These Benefits will be subject to the following provisions:

1. Benefits are limited to women who are 35 years of age or older and are covered under the Benefit Plan.

2. Screenings are limited to one (1) per Calendar Year.

3. Low Dose Mammography is defined as the x-ray examination of the breast using equipment dedicated specifically for mammography, including the x-ray tube, filter, compression device, screens, films and cassettes with a radiation exposure (radiation exposure must be in keeping with the recommended "Average Patient Exposure Guides As Published By The Conference Of Radiation Control Program Directors, Inc.")

-- **Inpatient Rehabilitation Services**

Benefits as specified in the Schedule of Benefits and this section will be available for Inpatient

Rehabilitation Services.

1. Benefits for Inpatient Rehabilitation Services will only be provided when Covered Services are determined to be Medically Necessary by Claims Administrator.

2. Covered Services must be recommended by the Member's treating Physician.

3. A treatment plan outlining the goals of the Inpatient Rehabilitation Services must be submitted to Claims Administrator, BCBSMS, by the Network Provider before the initiation of the service.

4. The Covered Services must have Case Management approval.

5. Benefits are limited to 30 Inpatient days per Member per Calendar Year.

6. The facility providing the Inpatient Rehabilitation Services must be accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the Commission on Accreditation of Rehabilitation Facilities (CARF).

7. The facility providing the Inpatient Rehabilitation Services must be a Network Provider. No Benefits will be provided when a Member receives services from a Non-Network Provider.

-- **Outpatient Cardiac Rehabilitation**

Benefits as specified in the Schedule of Benefits and this section will be provided for Outpatient Cardiac Rehabilitation (Phase II).

1. No Benefits will be provided unless the Member receives Case Management approval for Covered Services from Claims Administrator.

2. Covered Services must be rendered by a facility that is a Network Provider and holds a current certification from the American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR). No Benefits will be provided when a Member receives services from a Non-Network Provider.

3. Benefits must be recommended by the Member's treating Physician.

4. A treatment plan outlining the goals of the Outpatient Cardiac Rehabilitation must be submitted to Claims Administrator by the Network Provider before the initiation of the services.

5. Outpatient Cardiac Rehabilitation Services must be initiated within 3 months after the Member's discharge from the Hospital.

6. The number of visits for Outpatient Cardiac Rehabilitation Services are based on the severity of the Member's condition; however, Covered Services cannot exceed 36 visits per Member per Calendar Year.

-- **Sleep Studies**

Benefits as specified in the Schedule of Benefits and this section will be available for sleep studies to assist in the diagnosis of sleep disorders.

1. Benefits for Sleep Studies will only be provided when Covered Services are determined to

be Medically Necessary by Claims Administrator, Blue Cross & Blue Shield of Mississippi.

2. Covered Services must be recommended by the Member's treating Physician.

3. Polysomnography and Multiple Sleep Latency testing (MSLT) as well as any other Covered Services approved by Claims Administrator, Blue Cross & Blue Shield of Mississippi, must be performed in an approved sleep disorders center. Sleep disorder centers are facilities in which illnesses are diagnosed through the study of sleep.

4. The sleep disorder center must be either affiliated with a hospital or freestanding and be accredited as a sleep disorder center by the American Academy of Sleep Medicine (AASM).

5. Network accredited facilities must adhere to Claims Administrator's Medical Policy in order to support Medical Necessity for the Sleep Study.

-- UTILIZATION MANAGEMENT

A. Utilization Management is a Claims Administrator, Blue Cross & Blue Shield of Mississippi, program designed to review and determine whether services provided, or to be provided, are Medically Necessary and are Covered Services under the Benefit Plan. Utilization Management includes, but is not limited to, the following: (1) Pre-Certification (2) Case Management; and (3) Drug Utilization Management.

B. SPECIAL NOTE: NOTWITHSTANDING THE UTILIZATION MANAGEMENT PROGRAM DESCRIBED HEREIN, CLAIMS ADMINISTRATOR, BCBSMS, RESERVES THE RIGHT TO DENY CLAIMS FOR SERVICES AT ANY TIME DURING THE CLAIMS REVIEW PROCESS. THE CLAIMS ADMINISTRATOR, BLUE CROSS & BLUE SHIELD OF MISSISSIPPI, DETERMINATION THAT AN ADMISSION IS PRE-CERTIFIED DOES NOT MEAN THAT SERVICES RENDERED DURING THE ADMISSION ARE COVERED SERVICES PAYABLE UNDER THIS BENEFIT PLAN, BUT MERELY MEANS THAT THE HOSPITAL SETTING IS APPROPRIATE FOR RENDERING THOSE SERVICES. CLAIMS ADMINISTRATOR, BLUE CROSS & BLUE SHIELD OF MISSISSIPPI, MAKES ALL CLAIMS PAYMENT DECISION RETROSPECTIVELY DURING THE CLAIMS REVIEW PROCESS.

C. Pre-Certification of Admissions and Outpatient Procedures

   1. Pre-Certification of Elective Admissions

      a. When a Member uses a Non-Participating (or Non-Network) Provider, it is the sole responsibility of the Member to ensure that his/her Non-Participating Physician (or Non-Network) or Hospital, or a representative thereof, notifies Claims Administrator, Blue Cross & Blue Shield of Mississippi, of any elective or non-emergency Inpatient Hospital Admission. Claims Administrator, Blue Cross & Blue Shield of Mississippi, must be notified prior to the Admission regarding the nature and purpose of any Elective Admission or non-Emergency Admission to a Hospital's Inpatient department. The most appropriate setting for the elective service and the appropriate length of stay will be agreed upon when the Hospital Inpatient setting is documented to be Medically Necessary (In addition to any Deductible Amount, Coinsurance amount or Co-payment amount required in this Benefit Plan, the Member will be responsible for all charges not specifically listed

as Covered Services and for up to $300 of the Covered Services if such Elective Admission is not pre-certified.). Additionally, all days not pre-certified will be reviewed for Medical Necessity.

b. When a Member uses a Participating (or Network) Provider, it is the responsibility of the Physician or Hospital, or a representative thereof, to notify Claims Administrator, Blue Cross & Blue Shield of Mississippi, of any elective, Emergency or non-Emergency Inpatient Hospital Admission in the Hospital. It is also the responsibility of the Physician or Hospital, or a representative thereof, to contact Claims Administrator, Blue Cross & Blue Shield of Mississippi, in the event additional days of Inpatient care are needed beyond the amount originally certified. When a Participating (or Network) Provider fails to notify the Claims Administrator, Blue Cross & Blue Shield of Mississippi, of any elective emergency or non-emergency Inpatient Hospital Admission, the payment amount to the Participating (or Network) Hospital will be reduced by a $300 penalty. The Participating (or Network) Hospital will hold the Member harmless for the $300 penalty.

c. Although Pre-certification is not required for maternity admissions, Claims Administrator, Blue Cross & Blue Shield of Mississippi, monitors its Members for potential pregnancy complications. A maternity risk assessment is completed by Physicians (participating in the Claims Administrator's Networks) for all pregnant Members during the first trimester of pregnancy. Maternity risk assessments for those Members who are identified by the Physician (participating in the Claims Administrator's Networks) to be at high risk for developing complications during pregnancy are provided to Claims Administrator, Blue Cross & Blue Shield of Mississippi, for initiation of high risk Case Management. Federal law prohibits Claims Administrator, Blue Cross & Blue Shield of Mississippi, from restricting Benefits or requiring Pre-certification or Certification of a maternity admission for which the maternity admission is not in excess of forty-eight (48) hours for a normal vaginal delivery or ninety-six (96) for a caesarean section. In the event the attending Physician, after consultation with the mother, decides to discharge the mother and her newborn child prior to the expiration of the forty-eight (48) or ninety-six (96) hour stay, Claims Administrator, Blue Cross & Blue Shield of Mississippi, will only provide benefits for the applicable period of the stay. If a Physician believes that it is Medically Necessary for hospitalization in connection with childbirth to extend beyond the length of time of forty-eight (48) hours following a normal vaginal delivery or ninety-six (96) hours following a caesarean section, the Physician must request the additional days. Claims Administrator, Blue Cross & Blue Shield of Mississippi, will determine the Medical Necessity of the additional days.

2. Certification of Emergency Admissions

a. When a Member uses a Non-Participating (or Non-Network) Provider, it is the sole responsibility of the Member to ensure that his/her Physician or Hospital, or a representative thereof, notifies Claims Administrator, Blue Cross & Blue Shield of Mississippi, of all Emergency Inpatient Hospital Admissions. Within one (1) working day of the Emergency Admission, Claims Administrator, BCBSMS, must be notified regarding the nature and purpose of the Emergency Admission. In the event that the end of the notification period falls on a holiday or weekend Claims Administrator, Blue Cross & Blue Shield of Mississippi, must be notified on its next working day. The appropriate length of stay for the Emergency Admission will be agreed upon when the Hospital Inpatient setting is documented to be Medically Necessary (In addition to any Deductible Amount, Coinsurance amount or Co-payment amount required in this Benefit Plan, the Member will be responsible for all charges not specifically listed as Covered Services and for up

to $300 of the Covered Services if such Emergency Admission is not certified within the time frame as specified above.). Additionally, all days not certified will be reviewed for Medical Necessity.

b. Network Provider (See Section 1.b. above).

3. Durable Medical Equipment

a. All Durable Medical Equipment submitted for Benefits requires a Medical Necessity Certification Form completed by the prescribing Physician that documents:

(1) prescribed equipment,

(2) Medical Necessity of the equipment, and

(3) required time period for use.

b. Certain Durable Medical Equipment will require periodic re-certification during use to evaluate significant therapeutic improvement in the Member's condition in order to determine the continued Medical Necessity for the equipment.

c. Requests for deluxe items require documentation of Medical Necessity for deluxe features (including mechanical or electrical features). Benefits for deluxe equipment will only be provided when Medically Necessary.

4. Home Infusion Therapy/Drug Therapy

The Member’s attending Physician or the approved Home Infusion Therapy Provider is required to pre-certify all Home Infusion Therapy Services and supplies or all Drug Therapy services and supplies prior to the initiation of any Home Infusion Therapy services or Drug Therapy services. Only those services furnished after Pre-Certification has been approved will be considered for Benefits. Benefits will not be allowed for services furnished prior to Pre-Certification.

5. Solid Organ and Tissue Transplant

No Benefits will be provided hereunder unless a written Pre-Certification is obtained from Blue Cross & Blue Shield of Mississippi and services are rendered by a Hospital which has been approved by Claims Administrator. Blue Cross & Blue Shield of Mississippi will be advised of the proposed transplant Surgery prior to Admission and a written request for Pre-Certification will be filed with the Claims Administrator. Blue Cross & Blue Shield of Mississippi will be provided with adequate information so that it might verify coverage, determine that Medical Necessity is documented, and approve of the Hospital at which the transplant Surgery will occur Blue Cross & Blue Shield of Mississippi will forward written Pre-Certification to Member and Providers.

6. Outpatient Procedures

When a Member utilizes a Network or Non-Network Provider, it is the Providers responsibility to ensure compliance with all Medical Policy related to outpatient diagnostic and surgical procedures. It is within Blue Cross & Blue Shield of Mississippi’s discretion to require the Provider or the Member to pre-certify certain outpatient diagnostic and surgical procedures.

7. Disease Specific Drugs or Medications

   a. When a Member uses a Non-Network Provider who prescribes a disease specific drug or medication, it is the sole responsibility of the Member to ensure that the Non-Network Provider receives Prior Authorization from Blue Cross & Blue Shield of Mississippi for the disease specific medication. No Benefits will be provided for a disease specific drug or medication unless the Member receives Prior Authorization from Blue Cross & Blue Shield of Mississippi and the drug or medication is issued by a Disease Specific Pharmacy.

   b. When a Member uses a Network Provider who prescribes a disease specific drug or medication, it is the responsibility of the Network Provider to obtain Prior Authorization from Blue Cross & Blue Shield of Mississippi for the disease specific drug or medication. No Benefits will be provided for the disease specific drugs or medications unless the Network Provider receives Prior Authorization from Blue Cross & Blue Shield of Mississippi§ and the drug or medication is issued by a Disease Specific Pharmacy.

8. Prior Authorization of Prescription Drugs

   a. As a part of Utilization Management, Blue Cross & Blue Shield of Mississippi has identified certain Prescription Drugs and medications which require Prior Authorization due to the fact that (1) the drug or medication may not be the most appropriate product for the Member's specific illness, injury, or disease state, or; (2) the drug or medication is being prescribed by a Provider for a Non-covered Service.

   b. When a Member uses a Non-Network Provider who prescribes one of the identified Prescription Drugs or medications, it is the sole responsibility of the Member to ensure that the Non-Network Provider obtains Prior Authorization from Blue Cross & Blue Shield of Mississippi. No Benefits will be provided for the drug or medication unless Member receives Prior Authorization from Blue Cross & Blue Shield of Mississippi.

   c. When a Member uses a Network Provider who prescribes one of the identified Prescription Drugs or medications, it is the sole responsibility of the Network Provider to obtain Prior Authorization from Blue Cross & Blue Shield of Mississippi. No Benefits will be provided for the drug or medication unless the Network Provider receives Prior Authorization from the Claims Administrator.

Section III

Limitations and Exclusions

Notwithstanding any other provision of the Plan, Benefits will be limited and excluded as follows:

1. No Benefits shall be provided hereunder for services or supplies:

   a. Pre-existing Condition - A Pre-existing Condition means any injury, illness or congenital defect, or condition related to injury, illness, or congenital defect for which a person received medical care, treatment, consultation, or prescribed drugs during the 6-month period immediately preceding:

      (1) the date an individual becomes an Eligible Person and submits an Enrollment Form under this Plan, or

      (2) if the individual is subject to a probationary period, the first day of the individual's probationary period.

      No Benefits will be provided under this Plan for any Pre-existing Condition until twelve consecutive months elapse from the date an individual becomes an Eligible Person and submits an Enrollment Form under this Plan. After the twelve consecutive months have elapsed, Benefits of this Plan will be provided for Covered Services for such Pre-existing Condition. Note: This exclusion is subject to the following provisions:

      (1) The twelve consecutive months is calculated from the first day of the individual's probationary period.

      (2) The Pre-existing Condition exclusion does not apply to Participants and Dependents under the age of 19 at the time of enrollment.

      (3) The Pre-existing Condition exclusion does not apply to pregnancy.

      (4) The twelve consecutive months of the Pre-existing Condition exclusion period will be reduced by the number of days of prior creditable coverage the Participant has as of his or her effective date (or the first day of the probationary period) Note: See the "Certification of Coverage" section in the GENERAL PROVISIONS section of the Plan.

          The Plan will not take into account any days of creditable coverage that precede a significant break in coverage of 63 days or more. The probationary period of this Plan

is not taken into account in determining a significant break in coverage.

(5) Creditable coverage includes prior coverage under the following:

1. Group or Individual Health Insurance Coverage
2. Medicare
3. Medicaid
4. CHAMPUS
5. HMO

(6) Creditable coverage does not include coverage consisting solely of “excepted benefits.” Examples of “excepted benefits” include, but are not limited to, coverage solely for dental or vision benefits, hospital indemnity policies, cancer or specified disease policies and supplemental policies.

b. Because of any injury arising out of or in the course of employment of any sickness entitling the Participant to Benefits under any Workers' Compensation or Employer Liability Law, or where the employer accepts liability.

c. By any governmental hospital such as a charity hospital, mental institution, sanatorium, or veteran's hospital except in those cases where enforcement of this exclusion would be prohibited by Federal law.

d. Furnished, paid for, or for which Benefits are provided or required by reason of the past or present service of any person in the armed forces of a government.

e. For dental care, treatment and surgery, except as provided in Section II, Dental Services for Dental Care and Treatment and Dental Surgery.

f. For eyeglasses, hearing aids or for examination or fittings.

g. To improve appearance or for cosmetic purposes except for correction for defect incurred by the patient while covered hereunder through traumatic injuries or diseases requiring surgery.

h. Which are determined to be not Medically Necessary for treatment of injury or illness.

i. For procedures which are Experimental/Investigative in nature.

j. For convalescent care (except as provided in the Schedule of Benefits), custodial or domiciliary care or rest cures, including room and board, with or without routine nursing care, training in personal hygiene and other forms of self-care or supervisory care by a Physician for an Employee or Dependent who is mentally or physically disabled as a result of retarded development or body infirmity, or who is not under specific medical, surgical or psychiatric treatment to reduce his disability to the extent necessary to enable him to live outside an institution providing care; neither shall Benefits be provided if Claims Administrator determines that Participant was admitted to a Hospital for his or her own convenience, or that the care or treatment provided did not relate to the condition for which the patient was hospitalized, or that the hospital stay was excessive for the nature of the injury or illness, it being the intent of the Plan to provide Benefits only for the service required in relation to the condition for which the patient was hospitalized and then only during such time as such services are Medically Necessary.

k. For reversal of a voluntary sterilization procedure.

l. Under any federal, state or governmental plan or law including but not limited to Medicare

if the Employee or Dependent is eligible for Medicare Part A or B (Title XVIII, Social Security Act, as amended) to the extent charges for such services or supplies are paid or payable under Medicare, whether or not the patient has such Medicare coverage, whether or not Medicare benefits are claims or received, and whether or not the patient has elected to obtain such Medicare Coverage if eligible therefore, however, Benefits of the Plan will be provided when so required by Federal law.

m. For nervous or mental conditions, drug or alcohol abuse, except as shown in the Schedule of Benefits.

n. For podiatry services, supplies or treatments not constituting or not in association with "surgery" within the general accepted meaning of that term by the medical profession; non-covered services include, but are not limited to, the following: treatment of subluxations of the foot and routine foot care, such as cutting or removal of corns or calluses, the trimming of nails, routine hygiene care and the like.

o. For any injury growing out of a wrongful act or omission of another party for which injury that party or some other party is legally responsible or makes settlement; provided, however, that if the Participant is unable to recover from the responsible party, Benefits of the Plan will be provided.

p. Under more than one part of the Plan, including any amendatory riders hereto, whether issued simultaneously herewith or later. Benefits will be allowed only on the basis of the part providing the greatest allowance, except where any Amendatory Rider provides Benefits in addition to (rather than in lieu of) those herein, and in such an instance the cumulative Benefits shall not exceed the charges for Covered Services.

q. By a private duty nurse or a Home health Agency for private duty nursing services, whether as an inpatient or at home.

r. For services or supplies which constitute personal comfort, or beautification items, such as sex change operations.

s. For any intentionally self-inflicted injury or sickness.

t. For social workers including a psychological or psychiatric social worker.

u. For the services of any person who is a Participant of the Participant's immediate family or who ordinarily resides in the Participant's house.

v. For exogenous obesity, including any prescription drugs, surgery or other treatment.

w. For artificial insemination or in vitro fertilization.

x. For learning disabilities, behavior problems, or attention deficit disorders, or congenital speech anomalies.

y. For sickness or injury suffered in connection with or arising from the violation of any law.

2. In addition, no Benefits shall be provided hereunder for the following:

   a. Deductible Amount as shown in the Schedule of Benefits.

   b. Services or supplies not specifically listed as Covered Services in Section II, Benefits Provided.

c. Travel, whether or not recommended by a Physician except as provided in Section II, Benefits Provided.

d. That portion of any charge which Claims Administrator determines to be in excess of the Allowable Charge.

e. Services rendered by a Physician not practicing within the scope of his license.

f. Inpatient hospitalization primarily for X-ray examination, laboratory examinations or electrocardiograms where not Medically Necessary.

g. Benefits will not be provided for prescription drugs that are determined by the Claims Administrator not to be Medically Necessary for the treatment of illness or injury. These drugs include but are not limited to the following:

   (1) Drugs used for cosmetic purposes or weight reduction.

   (2) Any medication not proven effective in general medical practice including any drug used for smoking cessation.

   (3) Investigative drugs and drugs used other than for the FDA approved diagnosis.

   (4) Fertility drugs.

   (5) Minerals and vitamins (exception - (1) pre-natal vitamins (2) prescription vitamins which are not available over the counter).

   (6) Nutritional supplements.

   (7) Immunizations for prevention of infectious diseases (measles, polio, etc.) except as provided in this Plan.

   (8) Drugs that do not require a prescription.

   (9) Prescription Drugs if an equivalent product is available over the counter.

   (10) Refills in excess of the number specified by the Physician or any refills dispensed more than one year after the date of Physician's original prescription.

   (11) Contraceptive devices (Exception: prescription contraceptives including oral, injectable, diaphragms, IUDs, subdermal progestin implants, transedermal patches and other FDA-approved contraceptives.)

h. Inpatient Hospital services and supplies for Rehabilitative Care and treatment except as provided in this Plan (See Hospital Benefits).

i. Dental Implants.

j. Hot tubs, swimming pools, whirlpools, lift chairs, and air purifiers, regardless of the Provider’s recommendation.

k. No Benefits will be provided for Prosthetic Appliances which are required by the Member for the specific purpose of participating in recreational or sporting activities.

Section IV

Other Information

Coordination of Benefits

(Group and Individual Coverage)

Your group coverage contains Coordination of Benefits provisions between this group coverage and other group or individual coverage.

This provision is used when you, or your spouse or your covered Dependents are eligible for payment under more than one health care program. The object of Coordination of Benefits is to ensure that your Covered Expenses will be paid, but that the combined payment of all the programs does not exceed the actual cost of your care.

Here is how the Coordination of Benefits provision in your coverage works:

- When your other coverage does not mention "Coordination of Benefits," that coverage pays first, and this Plan pays secondary.

- When this Plan and another coverage both contain Coordination of Benefits provisions, the one providing group benefits will pay first.

- When the person who received care is covered as an employee or subscriber under one contract, and as a Dependent under another, then the employee or subscriber coverage pays first.

- When a dependent child is covered under two contracts, the benefits of the contract of the parent whose birthday falls earlier in the year pays first before those of the parent whose birthday falls later in that year, but if both parents have the same birthday the benefits of the contract which covered the parent longer pays first unless the dependent child's parents are separated or divorced. Then the following applies:

1. If the parent with custody of the child has not married, the coverage of the parent with custody pays first.

2. When a divorced parent with custody has remarried, the coverage of the parent with custody pays first and the stepparent's coverage pays second before the coverage of the parent who does not have custody.

3. Regardless of which parent has custody, whenever a court decree specifies the parent who is financially responsible for the child's health care expenses, the coverage of that parent pays first.

- If you are covered as a retired employee through this Plan and are covered as an active employee of another group plan, coverage of this Plan will be secondary on you and your Dependents covered under both plans.

- When none of the above circumstances apply, the coverage you have had for the longest time pays first.

- If you received more than you should have when your Benefits are coordinated, you will be expected to repay any overpayment.

  Plan has the right to deny all claims unless and until you provide plan with the requested facts and any insurance information needed to apply the Coordination of Benefits Rules.

Coordination of Benefits prevents duplication and works to the advantage of all Participants of the group.

Change of Address

You must ensure that your current address is provided to the Plan Administrator. In the event, your address changes, you must immediately provide notification of the new address to the Plan Administrator. Plan Administrator, in its discretion may utilize an U.S. Postal Service approved third party vendor to update and verify your address.

Provider Network Directory

You may request a copy of the Network Provider Directory by visiting Blue Cross & Blue Shield of Mississippi's web site at *www.bcbsms.com* or by contacting Blue Cross & Blue Shield of Mississippi's Customer Service Department. This directory includes Physicians, Hospitals, and Allied Providers that have a business agreement with Blue Cross & Blue Shield of Mississippi. This directory will be provided at no charge to you.

Qualified Medical Child Support Orders

The Omnibus Budget Reconciliation Act of 1993 (OBRA 93) mandates that group health plans provide Benefits according to Qualified Medical Child Support Order (QMCSO) requirements. QMCSO's are judgments, decrees, or court orders that create or recognize a child's right to receive benefits under a group health plan. QMCSO's must contain:

1. The name and last known address of the participant and each

covered by the order;

2. Type of coverage the group will provide to each child;

3. The period of time that the order covers; and

4. Each plan (medical, dental)

You may request from the Plan Administrator the written procedures for QMCSO. This information is available at no charge to the Member.

Subrogation

- Subrogation-Work Related

1. In order to provide Benefits and/or where Benefits have already been provided for Covered Services under the terms of the Plan for any injury, illness or condition for which a claim has been or will be pursued under any worker's compensation laws, which would otherwise be excluded under the Plan, an Accident Questionnaire must be completed and submitted by the Participant or one authorized by law to act on the Participant's behalf. Payments of any Benefits with notice to the worker's compensation carrier will allow Plan to be subrogated to and succeed to the rights of the Participant for recovery against the employer or carrier. Nothing contained in this Section will be deemed to change, modify or vary the terms of the Coordination of Benefits section of the Plan.

2. Pursuant to the above provision, the Participant agrees to provide Claims Administrator with prior notice of and opportunity to participate in any settlement of Participant's claim and further agrees that, as a part of any worker's compensation settlement, Plan will be reimbursed in accordance with applicable laws for Benefits paid under the Plan.

3. Participant will take such action, furnish such information and assistance and execute such papers as Claims Administrator may require to facilitate enforcement of Plan's rights and will take no action prejudicing the rights and interest of Plan.

4. The Participant must immediately notify the Claims Administrator or any injury, illness or condition for which a claim has been or will be pursued under any applicable worker's compensation laws.

- Subrogation-Third Party

1. In order to provide Benefits and/or where Benefits have already been provided for Covered Services under the terms of the Plan for injuries growing out of any act or omission of another party for which a claim or recovery is or will be pursued, which would otherwise be excluded under the Plan, an Accident Questionnaire must be completed and submitted by the Participant or one authorized by law to act on the Participant's behalf within thirty (30) days of receipt of same.

2. Payments of any Benefits will allow Claims Administrator to be subrogated to and succeed to the rights of the Participant for recovery against any person, organization or carrier in accordance with applicable laws. In the event the Participant is a minor, Chancery Court approval must be obtained prior to the payment of any Benefits. Any subrogation claim shall be a first priority lien on the full or partial proceeds of any settlement, judgment or other payment recovered by or on behalf of the Participant to the extent allowed by law. Also, to the extent permitted by law, this lien applies whether or not the covered person has been fully compensated for all of his

or her losses. To the extent allowed by law, Claims Administrator's rights under this provision cannot be defeated by allocating the proceeds, in whole or in part, to non-medical damages. Nothing contained in this Section will be deemed to change, modify or vary the terms of the Coordination of Benefits section of this Plan.

3. Pursuant to the above provision, the Participant agrees to provide Claims Administrator with prior notice of and opportunity to participate in any settlement of Participant's claim and further agrees that, as a part of any settlement, Claims Administrator will be reimbursed in accordance with applicable laws for Benefits paid under this Plan.

4. Participant will take such action, furnish such information and assistance and execute such papers as Claims Administrator may require to facilitate enforcement of its rights and will take no action prejudicing the rights and interest of the Claims Administrator under this Plan.

5. The Participant must immediately notify the Claims Administrator of any claim or recovery which will be pursued as a result of an act or omission of another party.

6. The right to recover by subrogation shall apply to settlements or recoveries of deceased persons, disabled Subscribers, minor dependents of a Subscriber, or disabled Eligible Dependents.

- Contractual Right To Reimbursement

1. In order to provide Benefits and/or where Benefits have already been provided for Covered Services under the terms of the Plan for injuries growing out of any act or omission of another party for which a claim or recovery is or will be pursued, which would otherwise be excluded under the Plan, an Accident Questionnaire must be completed and submitted by the Participant or one authorized by law to act on the Participant's behalf within thirty (30) days of receipt of same.

2. In the event a Participant receives full or partial proceeds from any other source for Covered Services for an Illness or Injury, Claims Administrator has a contractual right of reimbursement to the extent Benefits were paid under this Contract for the same Illness or Injury. To the extent permitted by law, this contractual right shall be a first priority lien on the full or partial proceeds of any settlement, judgment or other payment recovered by or on behalf of the Participant. To the extent allowed by law, this lien applies whether or not the covered person has been fully compensated for all of his or her losses.

3. Such proceeds may include any settlement; judgment; payments made under group auto insurance; individual or group no-fault auto insurance; another person's uninsured, underinsured or medical payment insurance; or proceeds otherwise paid by a third party. This contractual right to reimbursement is in addition to, and separate from, the subrogation right. To the extent allowed by law, Claims Administrator's rights shall not be defeated by allocating the proceeds in whole or in part, to non-medical damages.

4. The right to recover by reimbursement shall apply to settlements or recoveries of deceased persons, disabled Subscribers, minor dependents of a Subscriber, or disabled Eligible Dependents. In the event the Participant is a minor, Chancery Court Approval must be attained prior to the payment of any benefits.

5. The Participant agrees to fully cooperate and assist in any way necessary to recover such payments, including but not limited to notifying Claims Administrator of a claim

or lawsuit filed on his or her behalf or on behalf of any Eligible Dependents for an Injury or Illness. The Participant or an authorized representative shall contact Claims Administrator prior to settling any claim or lawsuit to obtain an updated itemization of its subrogation claim or reimbursement amount due. To the extent allowed by law, upon receiving any proceeds subject to this Section, the Participant or an authorized representative must hold in trust proceeds in an amount equal to Benefits paid by Claims Administrator in connection with injuries growing out of any act or omission of another party until such time as the proceeds can be transferred to the Claims Administrator. Such party holding the funds that rightfully belong to the Claims Administrator shall not interrupt or prejudice the Claims Administrator's recovery under this Section.

Termination of Coverage

Employee Termination Date

Your coverage shall cease at the earliest time indicated below except as provided in the Continuation Coverage Provisions:

- Later of the date of termination of your employment or the end of your last pay period, or
- The date you cease to be in a class of employees eligible for coverage, or
- The date you fail to make required contributions for coverage, or
- The date the Plan is terminated, or
- The date the Claims Administrator terminates your coverage, or
- The date you die.

Dependent Termination Date

The coverage of any Covered Dependent shall automatically cease at the earliest time indicated below, except as provided in the Continuation Coverage Provisions:

- Later of the date of termination of your employment or the end of your last pay period, or
- The date you cease to be in a class of employees eligible for coverage, or
- The date you fail to make any required contribution, or
- The date the Plan is terminated, or

- The date the Claims Administrator terminates your coverage, or
- The date you die, or
- The date the Dependent loses eligible status.

If your coverage would terminate as provided in the first paragraph due to disability, then coverage will not terminate until the end of the period for which sick pay is available.

After the expiration of the sick pay period, you may obtain an approved leave of absence for a period not to exceed 1 year. Also, any non-disabled employee may obtain an approved leave of absence for up to 1 year. The entire cost of coverage for both you and the Dependents must be paid by you. After such 1 year period, coverage will terminate except as provided in the Continuation of Coverage Provisions.

If a terminating Employee is considered an eligible Retiree according to a non-discriminatory definition established by the Group, then such Retiree may continue coverage under the Plan until he or she reaches age 65 or eligibility for Medicare. This age limit does not apply to Jackson Police Officers and Fire Fighters with at least 20 years of service. The Retiree must continue to pay the full expected cost of such coverage. If the Retiree does not make the necessary contributions required within 31 days of the due date of each monthly contribution, then such coverage will immediately terminate and such Retiree will not have the option to rejoin the Plan.

If a retired employee dies or an active employee dies who was eligible for continued Retiree coverage, then the spouse of such deceased individual may continue coverage for their Dependents and themselves until such date of remarriage of the spouse or until the spouse reaches age 65 or eligibility for Medicare. This age limit does not apply to Jackson Police Officers and Fire Fighters with at least 20 years of service. The spouse must continue to pay the full expected cost of such coverage. If the spouse does not make the necessary contribution, then such coverage will immediately terminate and the spouse will not have the option to rejoin the Plan.

Termination Of Plan

This Plan may be terminated at any time by the Group. Termination of the Plan will immediately terminate all rights, provisions and Benefits provided herein and all employees and Dependents coverage will also terminate as of such termination date. However, any Benefits incurred prior to the Plan termination date should be payable as if the Plan had remained in force.

Amendment Of Plan

This Plan may be amended or modified at any time at the sole discretion of the Group without any requirement as to prior notification to employees or Dependents. Such amendment or modification will apply to all covered persons, covered Benefits, exclusions, limitations, for any medical expenses occurring on or after the effective date of the amendment of the Plan.

Continuation Coverage

1. The Consolidated Omnibus Budget Reconciliation Act of 1985 (hereinafter referred to as COBRA) consists of health care continuation requirements that apply to all group health plans maintained by employers with (20) twenty or more employees on more than (50%) fifty percent of the typical business days during the previous calendar year. Group health plans that are not subject to COBRA are: 1) small-employer plans (employers with fewer than 20 employees during the preceding calendar year), 2) church plans (as defined by COBRA), and 3) governmental plans (as defined by COBRA).

    a. When COBRA is applicable to the Plan, the Participant, satisfying the requirements of a Qualified Beneficiary (See Definition Section), will have the option to elect COBRA

Continuation Coverage under this Plan when he or she experiences a Qualifying Event. See the Qualifying Events listed below:

(1) If the Participant is the employee, he or she has the right to choose COBRA Continuation Coverage in the event loss of coverage under this Plan is due to:

   (a) a reduction in his or her hours of employment below the minimum required to participate in the Plan (Example: employee changes from full-time employment to part-time employment). The Participant (Qualified Beneficiary) will be eligible to stay on the Plan for up to 18 months.

   (b) voluntary or involuntary loss of his or her job, including retirement from the job. The Participant (Qualified Beneficiary) will be eligible to stay on the Plan for up to 18 months.

   SPECIAL NOTE: If an employee is terminated from employment due to a finding of "gross misconduct," the loss of employment is not a Qualifying Event for COBRA Continuation Coverage. The Participant will not be eligible to continue coverage under the Plan.

   (c) A Participant's loss of coverage due to Family Medical Leave Act is not a Qualifying Event for COBRA Continuation Coverage.

(2) If the Participant is the legal spouse of the employee, he or she has the right to choose COBRA Continuation Coverage in the event loss of coverage is due to:

   (a) the death of the employee. The legal spouse (Qualified Beneficiary) will be eligible to stay on the Plan for up to 36 months;

   (b) termination of the employee's employment (for reasons other than gross misconduct) or reduction in the employee's hours of employment. The legal spouse (Qualified Beneficiary) is eligible to stay on the Plan for up to 18 months;

   (c) divorce or legal separation from the employee. The legal spouse (Qualified Beneficiary) is eligible to stay on the Plan for up to 36 months;

   (d) the employee becoming entitled to Medicare. Entitlement means enrollment in either Part A or Part B, not merely the employee becoming eligible to enroll in either Part A or Part B of Medicare. The legal spouse (Qualified Beneficiary) is eligible to stay on the Plan for up to 36 months.

(3) If the Participant is the covered dependent child of the employee, he or she has the right to choose COBRA Continuation Coverage in the event loss of coverage is due to:

   (a) the death of the employee. The covered dependent child is eligible to stay on the Plan for up to 36 months;

   (b) termination of the employee's employment (for reasons other than gross misconduct) or reduction, in the employee's hours of employment. The covered dependent child is eligible to stay on the Plan for 18 months;

   (c) the employee's divorce or legal separation from the covered dependent child's parent where the divorce or legal separation results in a loss of coverage for the covered dependent child. The covered dependent child (Qualified Beneficiary) is eligible to stay on the Plan for a period of 36 months;

(d) the employee becoming entitled to Medicare. Entitlement means enrollment in either Part A or Part B of Medicare. The covered dependent child (Qualified Beneficiary) is eligible to stay on the Plan for up to 36 months;

(e) the covered dependent child reaches an age (age 26 under this Plan) or condition which makes he or she no longer eligible to be covered under the Plan. The covered dependent child (Qualified Beneficiary) is eligible to stay on the Plan for a period of 36 months;

(f) a child born to an employee, or a child who is placed for adoption with the Participant, during the Participant's COBRA Continuation Coverage, will be eligible to become a Qualified Beneficiary. In accordance with the terms of the Plan and the requirements of the federal law, this child can be added to the COBRA Continuation Coverage upon proper notification to the Group and Claims Administrator.

b. How to obtain COBRA Continuation Coverage.

(1) Under the Law, the Group (employer) or the Group's Plan Administrator, where applicable, has the responsibility to provide the Notice of COBRA Continuation Coverage Rights (Notice of COBRA), containing information about COBRA Continuation Coverage rights, to the employee and his or her spouse, within a 90 day period from the date the employee first becomes covered under the Plan.

(2) Under the law, the covered employee and his or her dependents have the responsibility to inform the Group (employer) or the Group's Plan Administrator, where applicable (See Important Information Section in the back of the Summary Plan Description), of a divorce, legal separation, a covered dependent child losing dependent status under this Plan, a determination of disability or a change of disability status has been made by the Social Security Administration, or of a second Qualifying Event, within 60 days of the later of: (1) the date of one of the aforementioned events or (2) the date on which coverage would otherwise end under this Plan because of the event, (3) the date that the Qualified Beneficiary receives notice (via the Summary Plan Description or Notice of COBRA) of his or her obligation to furnish notice of the Qualifying Event and the procedures for furnishing that notice. In order to notify the Group (employer) or the Group's Plan Administrator, where applicable, of a possible Qualifying Event, the covered employee and his or her dependents should complete the COBRA Qualified Beneficiary Notice which contains the Participant's and/or Qualified Beneficiaries' name, address, identification number, and a brief description of the event which may be a Qualifying Event for COBRA Continuation Coverage. The covered employee and his or her dependents should forward the COBRA Qualified Beneficiary Notice to the Group (employer) or where applicable the Group's Plan Administrator.

(3) Under the Law, the Group (employer) has the responsibility of notifying the Plan Administrator of the employee's termination of employment or reduction in hours, the employee's death, the employee's becoming entitled to Medicare, or the commencement of a proceeding in bankruptcy with respect to the employer. The Group (employer) must make this notification to the Plan Administrator within 30 days of the event as outlined above.

(4) When the Plan Administrator is notified that one of these events (listed in the paragraph above) has occurred, the Plan Administrator will, in turn, notify the Qualified Beneficiary that he or she has the right to choose COBRA Continuation Coverage. Notification to the Qualified Beneficiary will be in the form of a COBRA Continuation Coverage Election Notice (Election Notice). The Plan Administrator must send the Election Notice within 14 days of being notified of the event by the Group or the Qualified Beneficiary. Under the law, when the Group (employer) acts as the Plan Administrator, the Group must send the Election Notice within 44 days of the date on which the Qualified Beneficiary loses

coverage under the Benefit Plan due to a Qualifying Event.

(5) A Qualified Beneficiary has 60 days from the date that he or she loses coverage because of one of the Qualifying Events outlined above, or from the date the Election Notice is sent to the Qualified Beneficiary, whichever is later, to inform the Plan Administrator that he or she wants COBRA Continuation Coverage.

(6) In the event the Qualified Beneficiary does not choose COBRA Continuation Coverage, his or her coverage under this Plan will end. A Qualified Beneficiary can only waive COBRA Continuation Coverage for himself or herself.

(7) If the Qualified Beneficiary chooses COBRA Continuation Coverage, he or she will have the same coverage under this Plan as he or she had on the day before the Qualifying Event.

(8) If the covered employee or covered dependent is entitled to Medicare at the time he or she has a qualifying event for continuation coverage under COBRA, the employee or dependent will have the option to continue coverage under the Plan. The COBRA Continuation Coverage rules will apply.

(9) If the Group (employer) or the Group's Plan Administrator, where applicable, receives any notice of a Qualifying Event from a Participant or Qualified Beneficiary, who is not eligible to receive COBRA Continuation Coverage, the Group (employer) or the Plan Administrator, where applicable, will provide a Notice of Unavailability of Continuation Coverage to the individual explaining why he or she is not entitled to COBRA Continuation Coverage. The Group (employer) or the Group's Plan Administrator, where applicable, will provide the Notice of Unavailability of Continuation Coverage to the individual within 14 days after receiving notice of a qualifying event from the individual.

(10) Under the Law, a covered employee and his or her dependents, who are certified eligible for trade adjustment assistance pursuant to the Trade Act of 2002 and did not elect continuation coverage during the standard 60-day COBRA election period as a direct consequence of the trade adjustment assistance related loss of coverage, shall be provided a second 60-day COBRA enrollment period. This second enrollment period begins on the first day of the month in which the covered employee and his or her dependents are determined to be a trade act assistance eligible person, provided that such enrollment is made not later than six (6) months after the date of the trade assistance act related loss of coverage. Any coverage so elected will begin on the first day of the second election period, and not on the date on which coverage originally lapsed.

c. Payment for COBRA Continuation Coverage.

(1) The Qualified Beneficiary's payment for COBRA Continuation Coverage can not exceed 102% of the applicable premium for similarly situation Participants (An exception to this rule is if COBRA Continuation Coverage is extended due to disability, see below).

(2) Insured Plans (like this Plan) may charge total premium (employee's and employer's contribution) plus 2%.

(3) Premium payments are owed from the date of the Qualifying Event and must be paid within 45 days of the date the Participant or covered Dependent elects COBRA Continuation Coverage.

(4) Premiums, after the first premiums, are due on a monthly basis. The Qualified Beneficiary is allowed a 30 day grace period every month for premium payment. The grace period begins on the first day of the coverage period.

d. Extending the Maximum Period

(1) Any Qualified Beneficiary determined to be disabled under Title II or Title XVI of the Social Security Act is entitled to a total of 29 months of COBRA Continuation Coverage, rather than the 18 months. To receive the disability extension, the Qualified Beneficiary must meet the following requirements:

(a) The Qualified Beneficiary must experience an 18 month Qualifying Event.

(b) The Social Security Administration must have determined that the individual (Qualified Beneficiary) was disabled (disability "onset" date) either before the Qualifying Event or within the first 60 days of the 18 month COBRA Continuation Coverage.

(c) The Group (employer) or the Group's Plan Administrator, where applicable, (see the Important Information Section of the Summary Plan Description) must have been provided with a copy of the Social Security determination of disability:

(i) before the end of the Qualified Beneficiary's initial 18 months of COBRA Continuation Coverage, and

(ii) within 60 days after the latest of:

(1) the date of the Social Security Administration disability determination;

(2) the date on which the Qualifying Event occurs;

(3) the date on which the Qualified Beneficiary loses coverage; or

(4) the date on which the Qualified Beneficiary is informed of the obligation to provide disability notice.

(d) In the event the Qualified Beneficiary receives the 29 month disability extension, the Plan is permitted to request a payment amount that does not exceed 150 percent of the applicable premium for any period of COBRA Continuation Coverage covering a disabled Qualified Beneficiary, if the coverage would not be required to be made available in the absence of the disability extension.

(e) If the Qualified Beneficiary entitled to the disability extension has non-disabled family members who are entitled to COBRA Continuation Coverage, then non-disabled family members are also entitled to the 29 month disability extension.

(f) The Qualified Beneficiary must notify the Plan Administrator (See the Important Information Section of the Summary Plan Description) within 30 days of any final determination that the individual is no longer disabled.

(2) Multiple Qualifying Events

A Multiple Qualifying Event is when a Qualifying Event (example: termination of employment) that gives rise to an 18 month maximum coverage period is followed by another Qualifying Event within the 18 month COBRA Continuation Coverage period. The second Qualifying Event (e.g. death of the employee) gives the Qualified Beneficiary a 36 month maximum coverage period. In this case the original 18 months period is expanded to 36 months from the original Qualifying Event date, but only for those individuals who were Qualified Beneficiaries under the Plan in connection with the first Qualifying Event and who are still Qualified Beneficiaries at the time of the second Qualifying Event. NOTE: The Qualified Beneficiaries only receive the remaining balance of the 36 month period.

Termination of the employee's employment following a reduction in hours event is considered a single 18 month Qualifying Event. These events together are not considered Multiple Qualifying Events.

e. Termination of COBRA Continuation Coverage.

(1) COBRA Continuation Coverage will be terminated when:

(a) the maximum available period of COBRA Continuation Coverage has been exhausted by the individual (example: the 18, 29, or 36 month period has run out);

(b) the Qualified Beneficiary fails to make a timely premium payment as specified in this Plan;

(c) the Qualified Beneficiary becomes covered by another group health plan after he or she has elected COBRA Continuation Coverage under this Plan. The only exception to this rule is the following:

(1) The Qualified Beneficiary may continue COBRA Continuation Coverage under this Plan if the new group health plan that the individual is enrolling in has an exclusion or limitation that applies to a Pre-existing Condition of the Qualified Beneficiary.

(2) An exception to (1) above is if the Qualified Beneficiary has 18 months of prior Creditable Coverage, with no break in coverage, prior to obtaining coverage under a new group health plan. In this instance, the Qualified Beneficiary's COBRA Continuation Coverage can be terminated.

(d) The Qualified Beneficiary becomes entitled to Medicare. Entitlement means enrollment in either Part A or Part B, not merely the individual becoming eligible to enroll in Part A or Part B of Medicare.

(e) The employer ceases to provide any group health plan to any employees.

(f) The Qualified Beneficiary ceases to be disabled according to the Social Security Administration after the Qualified Beneficiary's 11 month disability extension has begun.

(2) In the event of any termination of COBRA Continuation Coverage before the maximum available COBRA period has been exhausted, the Group (employer) or Group's Plan Administrator, where applicable, will provide a Notice of Termination of COBRA Coverage to the Qualified Beneficiary. This notice will explain the reason the coverage has been terminated, provide the date of the termination, and describe any right that the Qualified Beneficiary may have to elect alternative group or individual coverage.

Counting Creditable Coverage

1. Claims Administrator must reduce a Participant's Pre-existing Condition exclusion period under this Plan by the number of days of a Participant's prior creditable coverage. For the purposes of reducing the Pre-existing Condition exclusion period, Claims Administrator will determine the amount of creditable coverage by counting all the days that the individual has under one or more types of creditable coverage (If on a particular day an individual has creditable coverage from more than one source, all the creditable coverage on that

day is counted as one day). Claims Administrator will assist Member in obtaining a Certification of Coverage if needed. Claims Administrator will use the information on the Participant's Certification of Coverage to determine the prior creditable coverage.

2. The term creditable coverage means prior aggregate continuous coverage of a Participant under any of the following:

   a. A group health plan (including governmental and church plans).

   b. Health insurance coverage (including group, individual and short-term, limited duration coverage).

   c. Medicare and Medicaid.

   d. CHAMPUS.

   e. A Medical program of the Indian Health Services or a tribal organization.

   f. A state health benefits risk pool for uninsurable individuals.

   g. The Federal Employees Health Benefit Program.

   h. Plans established by state or local government to provide health insurance for enrolled individuals.

   i. Health benefit plans offered by the Peace Corps.

   j State Children's Health Insurance Program.

   k. Public health plans established by the Federal Government.

   l. Public health plans established by foreign governments (National health care programs).

   m. TRICARE.

   n. Continuation Coverage under the Consolidated Omnibus Reconciliation Act of 1985 (COBRA).

3. The term creditable coverage does not include coverage consisting solely of "excepted benefits." This type of coverage is never credited against the Pre-existing Condition exclusion period. A list of some of these coverages is provided below:

   a. Accident Insurance.

   b. Disability income insurance.

   c. Automobile liability insurance.

   d. General liability insurance.

   e. Medical benefits that are a supplement to liability insurance.

   f. Workers' Compensation.

g. Credit Insurance.

h. Coverage through clinics operated in workplaces by employers.

i. Limited scope vision and dental benefits, and long term care benefits may be "excepted benefits" if they are not an integral part of a group health plan. Benefits are not integral if:

(1) an individual has the right to elect not to receive coverage for the benefits, and

(2) the individual pays an extra premium contribution if they elect coverage under the benefits.

(3) Dental benefits are provided under a separate policy, contract or rider from the general medical benefits under the group health plan. Additionally, the benefits must be limited to narrowly defined services that are generally excluded from the general medical or surgical benefits.

(4) Long term care benefits are provided under long term care insurance that is regulated by the State or that meet the requirements of the Internal Revenue Code.

j. Benefits that are not coordinated with health insurance. These types of policies include specified or dread disease policies, hospital indemnity policies, Medicare supplemental insurance and insurance that supplements CHAMPUS.

4. Claims Administrator does not have to count an individual's days of creditable coverage that occur before a significant break in coverage. A significant break in coverage means a period of 63 consecutive days or more in which the individual does not have any creditable coverage. A probationary period or an affiliation period is not taken into account in determining a significant break in coverage.

5. Claims Administrator will not count any days in a probationary period for a plan or policy as creditable coverage.

6. Under the Law, a second COBRA election period may be required for trade assistance act eligible individuals and their dependents. When such a second COBRA enrollment period is provided, the time between a certified trade assistance act related loss in coverage and the start of the second election period will not be counted for the purposes of determining whether the individual has had a significant break in coverage which is defined as a 63 day loss in coverage.

7. At any time, if a Participant believes that he or she has creditable coverage that might reduce the Pre-existing Condition exclusion period under this Plan , he or she can submit at any time a Certification of Creditable Coverage (hereinafter Certificate) or other evidence of creditable coverage to the Plan. The Plan will review the Certificate or other evidence of prior creditable coverage and determine within a reasonable time period the number of days of prior creditable coverage as well as the time period which is reduced from the Participant's Pre-existing Condition exclusion period.

Certification of Coverage

1. A Participant will utilize the Certification of Coverage (hereinafter Certificate) to

demonstrate prior creditable coverage for a new group health plan. Claims Administrator will issue a Certificate to a Participant in accordance with the following provisions:

(a) The Participant experiences a loss of coverage under the Plan. Claims Administrator will issue a certificate within a reasonable time period after Claims Administrator has notice that the Participant has had a loss of coverage.

(b) The Participant exhausts COBRA Continuation Coverage. Claims Administrator will issue a Certificate within a reasonable time period after Claims Administrator has notice that the Participant's COBRA Continuation Coverage has been exhausted.

(c) The Participant exhausts Continuation of Coverage (As required by Section 83-9-51 as amended, Mississippi Code of 1972), Claims Administrator will issue a Certificate within a reasonable time period after Claims Administrator has notice that the Participant's Continuation Coverage has been exhausted.

(d) The Participant requests a Certificate within 24 months after his or her coverage under the Plan ceases. Claims Administrator will issue the Certificate within a reasonable time period after Claims Administrator receives the request from the Participant or another designated party, if authorized by the Participant. The Participant may request a Certificate by contacting Claims Administrator's Customer Service Representatives.

2. Claims Administrator is not required to issue a Certificate that was provided by another party, the Group or another carrier.

3. Claims Administrator is not required to automatically issue a Certificate when the Group replaces this Plan with the coverage of another carrier.

Out-Of-Area Services

Claims Administrator has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever the Member obtains healthcare services outside of Claim Administrator's service area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard Program.

Typically, when accessing care outside Claims Administrator's service area, the Member will obtain care from healthcare providers that have a contractual agreement (i.e., are "Network Providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, the Member may obtain care from Non-Network Providers. Claims Administrator's payment practices in both instances are described below.

1. BlueCard® Program

   Under the BlueCard® Program, when the Member accesses covered healthcare services within the geographic area served by a Host Blue, Claims Administrator will remain responsible for fulfilling our contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its Network Providers.

   Whenever the Member accesses covered healthcare services outside Claims

Administrator's service area and the claim is processed through the BlueCard Program, the amount the Member pays for covered healthcare services is calculated based on the lower of:

a. The billed covered charges for the Member's Covered Services; or

b. The negotiated price that the Host Blue makes available to Claims Administrator.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the Member's healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with the Member's healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price Claims Administrator uses for the Member's claim because they will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to the Member's calculation. If any state laws mandate other liability calculation methods, including a surcharge, Claims Administrator would then calculate the Member's liability for any covered healthcare services according to applicable law.

2. Non-Network Providers Outside Claims Administrator's Service Area

a. Member Liability Calculation

When covered healthcare services are provided outside of Claims Administrator's service area by Non-Network Providers, the amount the Member pays for such services will generally be based on either the Host Blue's Non-Network Provider local payment or the pricing arrangements required by applicable state law. In these situations, the Member may be liable for the difference between the amount that the Non-Network Provider bills and the payment Claims Administrator will make for the covered services as set forth in this paragraph.

b. Exceptions

In certain situations, Claims Administrator may use other payment basis, such as billed covered charges, the payment Claims Administrator would make if the healthcare services had been obtained within Claims Administrator's service area, or a special negotiated payment, as permitted under Inter-Plan Programs Policies, to determine the amount Claims Administrator will pay for services rendered by Non-Network Providers. In these situations, the Member may be liable for the difference between the amount that the Non-Network Provider bills and the payment Claims Administrator will make for the covered services as set forth in this paragraph.

Newborns' and Mothers'
Health Protection Act of 1996

Group health plans may not, under federal law, restrict benefits for any hospital length of stay in connection with the childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours if applicable).

SECTION V
Summary Plan Description

Plan Name
City of Jackson's Medical Benefit Plan

Plan Sponsor
City of Jackson, Mississippi

Plan administrator
Mayor
City of Jackson

Agent for service of legal process
Legal Department (City Attorney)
City of Jackson

Employer Identification number
64-6000503

Plan Year Ends
December 31

Plan costs
Contributory

Third Party Administrator/TPA/
Claims Administrator

Blue Cross & Blue Shield of Mississippi

3545 Lakeland Drive
Jackson, MS 39232

P. O. Box 1043
Jackson, MS 39215

(601) 932-3800

Department of Labor Office

Department of Labor
61 Forsyth Street, Suite 7B54
Atlanta, GA 30303
(404) 302-3900

Washington, DC Office
(866) 487-2365

Contact the Department of Labor for assistance and information on an individual's rights under HIPAA.

Claim procedure,
How to file a claim

Contact your local Personnel Office to obtain Claims Forms and instructions for making Claim for the Benefits under the Plan.

Notice

For employers having 20 or more active employees, federal law and regulations require that, each active employee, age 65 or older, and each active employee's spouse, age 65 or older, may elect to have coverage under the group plan or under Medicare.

a. Where such employee or such spouse elects coverage under the group plan, the group plan will be the primary payor of Benefits with the Medicare program the secondary payor.

b. This group plan will not provide Benefits to supplement Medicare payments for an active employee age 65 or older or for a spouse age 65 or older of an active employee where such employee or such spouse elects to have the Medicare program as the primary payor.

Under federal law if an active employee under age 65 or an active employee's Dependent under age 65 is covered under a group plan of an employer with 100 or more employees and also has coverage under the Medicare program by reason of social security disability, the group plan is the primary payor and Medicare is the secondary payor.

For persons under age 65 who are covered under this Plan and who also have coverage under the Medicare Program solely by reason of end-stage renal disease, the Medicare program will be the primary payor and this Plan the secondary payor except that during the first 21-month period that such persons are eligible for Medicare Benefits solely by reason of end-stage renal disease, this Plan will be the primary payor and Medicare the secondary payor.

Effective August 10, 1993, if a person is eligible for or entitled to Medicare based on end-stage renal disease, the Medicare Program will be the secondary payor and this Plan will be the primary payor during the first 21 months of end-stage disease-based eligibility or entitlement or the portion of that period occurring after August 9, 1993, even if the person is also entitled to Medicare based on age or disability (NOTE: An exception to this rule is when this Plan is permissibly paying secondary to the Medicare program for a person who is entitled to the Medicare program due to age or disability. In these instances, the Medicare program remains the primary payor even if the person subsequently becomes eligible for the Medicare program based on end-stage renal disease).

CITY OF JACKSON HEALTH PLAN
Group Numbers

078901	RETIRED FIRE (STANDARD)
078904	RETIRED POLICE (STANDARD)
078907	FIRE
078910	POLICE
078913	COBRA
078916	REGULAR RETIREE**
078919	REGULAR ACTIVE**

CITY OF JACKSON DENTAL PLAN
GROUP NUMBERS

01659	RETIRED FIRE
01693	RETIRED POLICE
01696	ACTIVE FIRE
01699	ACTIVE POLICE
01703	COBRA
01706	REGULAR RETIREE**
01708	REGULAR ACTIVE**

**** REGULAR MEANS ALL OTHER DEPARTMENTS EXCEPT FIRE & POLICE**

Notice of Opt-Out of Some Federal Regulations

The City of Jackson Medical Benefit Plan has elected to "opt-out" of certain federal regulations including: the Health Insurance Portability & Accountability Act of 1996 as amended by the Patient Protection and Affordable Care Act (HIPAA), the Newborns' and Mothers' Health Protection Act of 1996 (NMHPA), the Mental Health Parity Act of 1996 (MHPA), and the Mental Health Parity and Addition Equity Act of 2008. The Plan complies with HIPAA pre-existing condition exclusion rules, special enrollment rules and rules concerning discrimination based on health status rules.

Health Insurance Portability and Accountability Act:

Many of the provisions of HIPAA do not apply to the Plan or the Plan is already in compliance with these provisions. For example, HIPAA requires a special enrollment period for employees who incur a Change-In-Status Event concerning eligibility of family members. This benefit has always been offered under the Plan. HIPAA also prohibits group health plans from discriminating against employees on the basis of health status. The Plan has never imposed discriminatory rules.

Current Employees who have already served the 31-day waiting period for coverage to become effective on the first of the following month and the 12-month Pre-Existing Condition Exclusion waiting period, as explained in your Benefits Booklet, will not be affected by the HIPAA opt-out.

New Employees are required to serve the 31-day waiting period for coverage to become effective. **New Employees** and **New Dependents** are required to serve the 12-month waiting period under the Pre-Existing Condition Exclusion. This is explained in your Benefits Booklet. Certificates of prior coverage from a previous insurance plan are accepted to reduce the Pre-Existing Condition waiting period you are required to serve under the Plan. This is explained in the City's Benefit Booklet. You must file a certificate of creditable coverage with the Department of Personnel Management, Benefit Section, to obtain credit.

Departing Employees or Dependents No Longer Eligible will be provided certification of coverage from this Plan that can be submitted to offset the waiting period for coverage of pre-existing conditions under a new health plan. Departing employees and dependents no longer eligible for coverage will be entitled to COBRA continuation of coverage.

Mental Health Parity Act of 1996 (MHPA):

The Mental Health Parity Act does not allow plans to establish financial limits on mental health treatment but does allow Plans to establish limits on the number of out-patient office visits, in-patient days, coverage of prescription drugs to treat mental health conditions, or elimination of mental health treatment altogether. The City's Plan provides treatment for mental and nervous conditions as well as substance abuse, with specific limitations. You and your physician should discuss treatment and verify coverage with Blue Cross Blue Shield of Mississippi before incurring charges.

Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA):

The MHPAEA expands MHPA by establishing parity of mental health and substance use benefits to include substance use disorder benefits as well as mental health benefits; prohibits applying financial requirements or treatment limitations that are more restrictive than the predominant financial requirement or treatment limitations that apply to substantially all medical and surgical benefits. The City of Jackson Medical Benefit Plan does not provide parity and has limits on certain services and treatments. These limits are explained in the Medical Benefit Plan Booklet. You should read this booklet carefully to understand the benefits offered. You should consult with your medical provider and Blue Cross and Blue Shield of Mississippi to coordinate your care within the benefits offered by the Plan.

Privacy Notice

The City of Jackson Medical Benefit Plan and associates like Blue Cross Blue Shield of Mississippi adhere to and comply with the Privacy Act. The Plan and its associates have adopted practices and procedures to protect the privacy of your medical information. The Plan's privacy policy in its entirety is available from the Department of Personnel Management, Benefit Section, at the City of Jackson. Blue Cross Blue Shield of Mississippi also states their privacy policy on the company website (www.bcbsms.com).

City of Jackson
Department of Personnel Management
Benefits Section
711 West Capital Street, Room #201
Jackson, MS 39205

Medicaid and the Children's Health Insurance Program (CHIP)
Offers Free or Low-Cost Health Coverage to Children and Families

If you are eligible for coverage through the City of Jackson Medical Benefit Plan but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office to find out how to apply. Additional assistance can be obtained dialing –

1-877-KIDS NOW or **www.insurekidsnow.gov**

If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**.

To see if you live in a State that has a premium assistance program or for more information on special enrollment rights, you can contact:

U.S. Department of Labor
U.S. Department of Health & Human Services
Employee Benefits Security Administration
Centers for Medicare & Medicaid Services
www.dol.gov/ebsa and www.cms.hhs.gov

1-866-444-3272
1-877-267-2323 ext 61565

Mississippi Division of Medicaid

1-877-543-7669

Section 125 Premium Conversion Plan

The Section 125 Premium Conversion Plan allows you to pay your Employee Contribution for the Plan with pre-tax dollars through salary reduction. The Employee Contribution is deducted from your paycheck before taxes are taken out. This allows you to increase your spendable income by reducing your taxes (your Social Security retirement benefit may be slightly reduced). All Eligible Employees are automatically enrolled in the Section 125 Plan. You may change your election for pre-tax premiums for the coming year during the Open Enrollment Period or during the Plan Year if you incur a Change-In-Status Event.

Member responsibility for a Change-in-Status

It is required that you notify the City of Jackson's Department of Personnel Management - Benefits Section if you have certain change-in-status events including:

- Marriage
- Divorce
- Child reaching age 26 years
- A child over 19 years of age who is eligible for employer sponsored health coverage through the child's employment

It is the member's responsibility to notify the City's Department of Personnel Management - Benefits Section when a change occurs. Failure to provide notice within 30 days of the change will result in the employee becoming liable for claims paid by the City's Health & Dental Plans in behalf of an ineligible individual.

Even in the case of a divorce when the employee is court ordered to provide health insurance for the divorced spouse, the employee is required to notify the Department of Personnel Management - Benefits Section of the divorce so the ex-spouse is removed from the employee's heath plan contract. The City will then offer the ex-spouse the opportunity to keep the coverage through the COBRA continuation.