

January 6, 2011

Please refer to Section 7 - Amendments  
for Material Modifications made to this  
SPD Document.

2010  
2011

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# Summary Plan Description for the DMC Medical and Prescription Plan

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Summary of Your Health and Medical Benefits  
& Prescription Drug Plan

**DMC**<sup>™</sup>

**DMC Care**

DETROIT MEDICAL CENTER

800-543-0161

[www.dmc-care.org](http://www.dmc-care.org)

**Save this Booklet!**

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## Section 1 – Overview

### Welcome

Dear DMC Employee:

Welcome to the DMC Medical and Prescription Plan (the “Plan”), a program offered to eligible employees of the Detroit Medical Center and its operating units and affiliates that participate in the program (collectively referred to as the “Employer”). This booklet describes the medical and prescription benefits that are available to you as a Plan participant effective January 1, 2010.

The Employer has contracted with DMC Care to help administer the Plan. DMC Care, in turn, has contracted with the other outside organizations listed below to help administer the Plan. The primary contact is DMC Care, which is available to answer your questions and assist you in filing claims and collecting the benefits that are available to you. Please let DMC Care know how it can help you.

We know you will appreciate the security which the Plan provides and hope that through good health and good fortune you will seldom need these benefits.

Sincerely,

DMC Care  
2010

## Contacts

### DMC CARE CUSTOMER SERVICE

DMC Care Claims Department  
P.O. Box 44290  
Detroit, MI 48244  
(800) 543-0161  
[www.dmc-care.org](http://www.dmc-care.org)

### PHARMACY BENEFIT MANAGER

Navitus Health Solutions  
5 Innovation Court, Suite B  
Appleton, WI 54914  
(866) 333-2757  
[www.navitus.com](http://www.navitus.com)

### BEHAVIORAL HEALTH & SUBSTANCE ABUSE

ValueOptions  
48561 Alpha Drive  
Suite 150  
Wixom, MI 48393-3442  
(877) 362-2472  
[www.valueoptions.com/members](http://www.valueoptions.com/members)

### DMC CARE TIER 2

Cofinity (PPOM)  
P.O. Box 2720  
Farmington Hills, MI 48333  
(800) 831-1166  
[www.cofinity.net](http://www.cofinity.net)

### DMC CARE TIER 3

MultiPlan, Inc.  
115 Fifth Avenue  
New York, NY 10003  
(800) 546-3887  
[www.multiplan.com](http://www.multiplan.com)

### DMC CARE TIER 4

No provider contract  
DMC Care Customer Service  
(800) 543-0161  
[www.dmc-care.org](http://www.dmc-care.org)

## Important Points to Understand

**If you need more information, visit your Human Resources Benefits Service Center.**

**It makes sense to choose Participating Providers.**

This booklet describes the medical and prescription benefits available to you (including exclusions and limitations on such benefits), network requirements, cost-sharing requirements (e.g. deductibles, co-payments, co-insurance) and the claims procedures for reviewing your claims for benefits under the Plan. However, the Employer has prepared a separate document referred to as "*DMC Benefit Plans' General Provisions*" which describes eligibility requirements, termination of coverage provisions, COBRA and other extended coverage provisions and other important information about your participation in and legal rights under the Plan and other welfare benefit programs sponsored by the Employer, such as dental, vision, life insurance and disability benefit plans. You should read that document together with this booklet to learn about all of your rights to benefits. Together these two documents comprise the summary plan description for the DMC Care Benefit Plan.

Most benefits under the DMC Care Benefit Plan can be provided by Participating Providers. Participating Providers are providers that have contracted with DMC Care and/or its contracted networks (Cofinity & MultiPlan). The DMC Care Benefit Plan provides greater benefits when services are performed by a Participating Provider. See page 9 for details.

Your medical claims will be processed by the DMC Care Claims Department, whose personnel are trained specialists in claims processing and administration. Pharmacy claims are processed by Navitus Health Solutions of Appleton, Wisconsin.

There is a 90 day waiting period before DMC Care coverage begins for any active conditions, treatment or admissions if no previous health insurance coverage is in effect.

**While the Employer currently intends to continue offering benefits and the Plan, the Employer reserves the right to terminate, discontinue or amend the benefits and the Plan at any time, for any reason. There is no guarantee that the type or level of or employee cost for benefits will not be changed in the future, or that the Plan will continue indefinitely.**

## 2010 Medical Benefit Summary Major Changes

<b>Benefit Description</b>	<b>2009 Benefit</b>	<b>2010 Benefit Limitation(s)</b>
Power Operated Wheelchairs or Vehicles	No limitation	<ul style="list-style-type: none"> <li>•One (1) per lifetime - Prior Auth Required</li> <li>•One every 5 years (3 years -17 years of age), Prior Auth Required</li> </ul>
Bariatric Surgery	No limitation	One (1) surgery per lifetime, Prior Auth Required
Cochlear Implants	No limitation	One (1) implant - per ear - per lifetime, at DMC facility only, 12 months of age and older Prior Auth Required
Voluntary Interruption of Pregnancy	No limitation	One (1) procedure per lifetime; additional request reviewed as individual consideration (IC)
Renal Transplant /Live Donor Coverage	Individual Consideration (IC)	<p>Live donor transplant coverage limited to DMC facility only. Prior Auth Required</p> <ol style="list-style-type: none"> <li>1) When the donor has medical coverage, the donor's health plan will pay primary.</li> <li>2) If the donor's primary insurance does not cover donor expenses, DMC Care will cover donor expense at a DMC facility only. Donor's EOB/Denial of coverage documentation required.</li> <li>3) If the donor has no insurance DMC Care will provide coverage for transplant at DMC facility only.</li> <li>4) Donor DMC Care coverage is limited to 30 days post-op.</li> </ol>
Transplant Services - <b>Not Available at the DMC</b>	No restriction	<p>Transplant Services not available at DMC Tier 1 facilities are limited to a "Preferred Network" of <b>Providers - Prior Auth Required is required for all transplant services.</b></p> <p>▶ <b>Services provided outside of the "Preferred Network" are subject to significant member co-insurance responsibility (High \$\$\$ Out of Pocket).</b></p>

<b>Benefit Description</b>	<b>2009 Benefit</b>	<b>2010 Benefit Exclusion(s)</b>
Bariatric Surgery Revision (previous surgery)	Not defined	Not covered
Renal Transplant / Live Donor Transportation and Lodging	Not defined	Not covered

## 2010 Medical Benefit Summary Major Changes *(continued)*

Benefit Description	2009 Benefit	2010 Auth Changes or Material Updates
OT/PT/ST	60 visits, per condition, per year	<p>► <b>Prior authorization change:</b> 60* visits (combined) per condition - <b>within a 12 month period beginning with the first date of service. Authorization required after 30 visits to continue OT/PT/ST.</b></p>
MRI/MRA/CT Scan	No Authorization required if done at a DMC Facility	<p>► <b>Prior authorization required even if done at DMC facility.</b> ► <b>Non Coverage Notice:</b> MRI/MRA/CT Scans performed at a physician's office <b>will not be covered</b></p>
BHSA	N/A	2010 MHSA Parity updated, see Section 3 - Behavioral Health & Substance Abuse
Claim for Benefits	Not listed	Claims must be submitted within 12 months after expense was incurred; unless DMC Care is the secondary payer in which case the claim for benefits can extend 6 months from the date of the primary payer's payment.
Facility Based Physician Services Tier 2/3 or 4	No disclaimer	DMC Hospitals (Facility based ancillary providers-anesthesiologists, pathologists, radiologists and ED) pay at Tier 1. Tier 2/3/4 will pay at the Tier level of the PROVIDER.
Tier 4	"If there is no contract with a provider or a hospital, usual and customary amounts will be applied. The member is responsible for paying the balance."	<p>► <b>No Provider Contract – Tier 4</b> If no contract, Usual and Customary amounts will be applied. You will be balance billed for the full amount above Usual and Customary.</p>
Prior Authorization List 2010	Updated	Multiple Prior Authorization Grid updates, see Section 2 – Health & Medical Benefits

Benefit Description	2009 Co-insurance	2010 Co-insurance Application
IV Infusion (Excludes Chemotherapy) – Home Health Care	None	5% Basic – 5% Plus
IV Infusion (Excludes Chemotherapy) – Infusion Center	None	5% Basic – 5% Plus
Home Health Care Services	None	5% Basic – 5% Plus
Dialysis Treatments	None	5% Basic – 5% Plus

## 2010 Medical Benefit Summary

### Major Changes *(continued)*

Benefit Description	2009 Benefit	2010 Change
DMC "On Site" Pharmacies Non-Formulary Brand Name	\$25 co-pay per prescription	\$30 co-pay per prescription
Navitus Network Pharmacies Non-Formulary Brand Name	40% co-pay per prescription with \$55 minimum, \$95 maximum	40% co-pay per prescription with \$60 minimum, \$100 maximum

### Coordination of Benefits

#### DMC CARE - Rule Change Affecting Coordination of Benefits with other Plans

If you and your enrolled family members **DO NOT HAVE** other employer-sponsored coverage outside the DMC, then DMC Care-Basic and DMC Care-Plus will continue to cover both in-network and out-of-network charges according to each Plans' various Tier levels.

If, however, you and any family member (spouse, children) **HAVE** medical coverage through another employer plan **AND** you expect to use DMC Care outside the DMC network (i.e. Coordination of Benefits), then you **must have enrolled in DMC Care-Plus and purchased the COB Rider**. When you have enrolled in DMC Care-Plus and purchased the rider, DMC Care will pay your secondary up to the contracted amount. If you did not enroll in the DMC Care-Plus plan with the COB Rider, then:

- DMC Care WILL NOT pay for your dependent's "other plan" deductibles or co-insurance costs under the Tier 1 (in-network) benefit level, **AND**
- DMC Care WILL NOT pay (coordinate) your claims or your dependent's claims for services provided outside the DMC or outside the DMC Care network of doctors.

## Section 2 – Health & Medical Benefits

### Overview of Section

This section of the Benefits Guide 2010-2011 outlines the medical benefits available to you through the DMC Care Benefit Program. Your prescription drug plan benefits are described in Section 4.



**Make sure you know the details of the plan.**

**You should check occasionally to make sure your physician is still a Participating Provider.**

### Member Responsibility

**As a member of DMC Care, it is your responsibility to become familiar with your:**

- Medical Benefits
- Co-pay, co-insurance and Deductible requirements
- DMC Care Affiliated Providers
- Cofinity (Tier 2) Affiliated Providers (if applicable)
- MultiPlan (Tier 3) Affiliated Providers (if applicable)
- Claims Process

It is also your responsibility to respond to any requests for information that are necessary to process your claim, including Coordination of Benefits information.

When outside of the DMC Network, DMC Care provides an expanded network of providers through contracts with Cofinity and MultiPlan. (Cofinity and MultiPlan **are not** insurance companies.)

DMC Care and Cofinity Provider Directories are available on the DMC Care web site at [www.dmc-care.org](http://www.dmc-care.org). Although every effort is made to ensure complete and up-to-date listings, these directories are subject to change with physician participation activity.

In addition, a facility-based physician or facility-based provider such as an anesthesiologist, radiologist or emergency department physician may not participate with Cofinity or MultiPlan network. Non-participating providers may balance bill the member for amounts not paid by the plan.

Please contact the DMC Care Customer Service Department at (800)-543-0161, or the Cofinity (PPOM) Customer Service Department at (800)-831-1166, for a copy of the provider directory or to verify whether or not your physician is still a DMC Care or Cofinity (PPOM) Participating Provider.

When outside of the Cofinity network, you can contact MultiPlan (Tier 3) to determine providers or facilities at (800)-546-3887.

## Schedule of Benefits

This is only a summary which highlights some of the benefits provided by the Program. Please read the specific sections of this booklet to determine the exact benefits payable.

### Coordination of Benefits

#### DMC CARE - Rule Change Affecting Coordination of Benefits with other Plans

If you and your enrolled family members **DO NOT HAVE** other employer-sponsored coverage outside the DMC, then DMC Care-Basic and DMC Care-Plus will continue to cover both in-network and out-of-network charges according to each Plans' various Tier levels.

If, however, you and any family member (spouse, children) **HAVE** medical coverage through another employer plan **AND** you expect to use DMC Care outside the DMC network (i.e. Coordination of Benefits), then you **must have enrolled in DMC Care-Plus and purchased the COB Rider**. If you did not enroll in the DMC Care-Plus plan with the COB Rider, then:

- DMC Care WILL NOT pay for your dependent's "other plan" deductibles or co-insurance costs under the Tier 1 (in-network) benefit level, **AND**
- DMC Care WILL NOT pay (coordinate) your claims or your dependent's claims for services provided outside the DMC or outside the DMC Care network of doctors.

DMC Care-Basic and DMC Care-Plus will continue to coordinate with Medicare or other government programs.

### Coordination of Benefits Form

All DMC Care members are required to complete the Coordination of Benefits (COB) form on an annual basis. The form needs to be completed even if the employee does not have other insurance coverage. Claims may be rejected if the form has not been submitted. The form is available on the DMC Care web site at [www.dmc-care.org](http://www.dmc-care.org) (click on the Members tab, choose DMC Employees, then click on the Forms link).

### Deductibles and Out-of-Pocket Expenses

#### WHAT ARE OUT-OF-POCKET EXPENSES?

The DMC Care benefit Program shares with you the cost of covered medical expenses. Your out-of-pocket expense is the portion of Covered Medical Expenses that you must pay after your annual Deductible has been met.

There are three types of costs which you may incur. You are responsible for expenses such as deductibles, co-insurance and co-pays.

Some of your expenses are subject to an annual Deductible. **Deductibles do not apply at DMC facilities and providers (Tier 1), co-pays and co-insurance may apply.**

**Co-pay is the designated portion of an approved amount that you are required to pay for services.**

**There is a mandatory co-pay for each physician office visit dependent on tier level.**

**Your out-of-pocket expense is the portion of Covered Medical Expenses that you must pay after your annual Deductible has been satisfied.**

**The Deductible is the amount of a Covered Medical Expense that you have to pay before the DMC Care Benefit Program begins to pay.**

**Co-insurance is the percentage of the eligible charge that you are required to pay for covered services.**

**It makes sense to use Participating Providers when possible – your benefits will usually be greater.**



**Check to make sure your physician is a Participating Provider.**

For Tier 2 and Tier 3 benefits DMC Care pays a percentage of the eligible charge after deductible. For Tier 4 benefits the plan pays usual and customary amounts based upon the DMC Care fee schedule.

MultiPlan is the nation's oldest and largest independent PPO network. DMC Care has selected MultiPlan as its Tier 3 partner to help you and the health plan keep your out-of-pocket costs to a minimum. Tier 3 eligible charges may equal the MultiPlan contract for the individual provider.

**If there is no contract with a provider or a hospital (Tier 4), usual and customary amounts will be applied. The member is responsible for paying the balance. These fees may be substantial because these out of network physicians and hospitals have not extended any discounts for services.**

Occasionally, a participating provider may require payment prior to a service, dispensing of a device or supplying of equipment. If you choose to pay out of pocket for a covered benefit (service, device, equipment, etc.) the plan **will only reimburse you up to 100% of the usual and customary amount**. All co-pays and deductibles apply according to the Tier level or the provider.

## Participating Providers

DMC Care has contracted with certain health care providers who have agreed to provide care to you. These health care providers are called **Tier 1** Participating Providers. A list of **Tier 1** Participating Providers is available for viewing on the DMC Care web site at [www.dmc-care.org](http://www.dmc-care.org), in your DMC Care Provider Directory, or by contacting DMC Care Customer Service.

The DMC has also established an Extended Network plan through Cofinity **Tier 2**, which has physicians/providers in MI, OH and IN, as well as parts of IL, KY and WI. The Cofinity **Tier 2** network of providers is available for you for health care services. Additional deductibles/co-pays apply when using the Cofinity Network. Please contact Cofinity Customer Service Department at (800)-831-1166, or visit their web site at [www.cofinity.net](http://www.cofinity.net) to review the provider listings.

DMC Care has selected MultiPlan as its **Tier 3** partner to help you and the health plan keep your out-of-pocket costs to a minimum. MultiPlan is the nation's oldest and largest independent PPO network. Visit the MultiPlan web site at: [www.multiplan.com](http://www.multiplan.com).

These three networks should provide national coverage, **yet there may be an occasion that you receive services from a provider who is not contracted (Tier 4)**. DMC Care will pay the provider at the appropriate usual and customary amount for services rendered. The member will be responsible for all co-pays, deductibles and co-insurance and the member may be balanced billed by the provider.

You can obtain Care or Treatment from any provider, whether or not the provider is a Participating Provider. If your care or treatment is from a Participating Provider, your benefits will usually be greater, because your out-of-pocket costs are lower.

## DMC Care Tier I Hospitals

Hospitals include the eight (8) Hospitals of The Detroit Medical Center and Barbara Ann Karmanos Cancer Institute:

- DMC Children's Hospital of Michigan
- DMC Detroit Receiving Hospital & University Health Center
- DMC Harper University Hospital
- DMC Huron Valley-Sinai Hospital
- DMC Hutzel Women's Hospital
- DMC Rehabilitation Institute of Michigan
- DMC Sinai-Grace Hospital
- DMC Surgery Hospital
- Barbara Ann Karmanos Cancer Institute

Also included in this category are all DMC-owned and operated outpatient facilities, clinics, and urgent care centers. Please contact DMC Care Customer Service for more detail or go to [www.dmc-care.org](http://www.dmc-care.org).

## Covered Medical Expenses and Benefits

**Covered Medical Expenses include charges for the following services performed and billed by a Physician:**

- Professional services provided at a Hospital, Outpatient Facility, Skilled Nursing Facility, Hospice, your home, or Physician's office.
- Surgical services. Charges for the usual pre-operative and post-operative care cannot be billed separately, but rather are considered to be part of the charge for the surgery.
- Obstetrical, pre-natal and post-natal care.
- Anesthesia services by a qualified anesthesiologist.
- Medical, surgical, and/or obstetrical consultation.

**Covered Medical Expenses are subject to applicable deductibles, co-insurance, co-pays, maximums and limitations.**

An expense is considered to be incurred on the date a service is rendered.

These Covered Medical Expenses may be subject to cost-sharing and other limitations as described in this booklet or the Plan document.

#### INPATIENT HOSPITAL EXPENSES

##### Covered Medical Expenses include charges for:

- Hospital room and board in a semi-private room, an intensive care unit, coronary care unit or a burn care unit.
- Use of the operating, delivery, recovery rooms, and nursery.
- Anesthetics and their administration.
- Medical and surgical supplies for use in the hospital, including surgically implanted devices that are provided and billed by the hospital. Gauze, cotton, fabric plaster and other materials used in dressing and casts, intravenous injections and solutions.
- All drugs, medicines and biologicals that are listed in the U.S. Pharmacopoeia and approved by the United States Food and Drug Administration.
- Hospital laboratory and x-ray services and their interpretation including but not limited to: radiation therapy, radium treatments, and treatments with other radioactive substances.

#### OUTPATIENT FACILITY EXPENSES

##### Covered Medical Expenses include charges by an Outpatient Facility for:

- Use of the operating and recovery rooms.
- Anesthetics and their administration.
- Medical and surgical supplies for use in the Outpatient Facility, including surgically implanted devices that are provided and billed by the outpatient facility. Gauze, cotton, fabric plaster, and other materials used in dressing and casts, intravenous injections and solutions.
- All drugs, medicines and biologicals that are listed in the U.S. Pharmacopoeia and approved by the United States Food and Drug Administration.
- Outpatient Facility's laboratory and x-ray services, radiation therapy, radium treatments and treatments with other radioactive substances.
- Preadmission or presurgical screening/testing.
- Emergency care services in an emergency department of a hospital is limited to initial exam and treatment of accidental injuries and certain medical conditions determined by DMC Care to be legitimate emergencies.

**ROUTINE COVERED SERVICES**

- Allergy testing and treatment
- Cardiac rehabilitation therapy - Phases I and II
- Diabetic Foot Care
- Diaphragms and IUD's for contraceptive use
- Elective Sterilization
- Voluntary termination of pregnancy (Limitations apply, see page 25)
- FDA approved Chemotherapy
- Hemodialysis (with authorization)
- Human heart, kidney, heart-lung, liver, cornea, skin, bone marrow and pancreas transplants (prior authorization required)
- Obstetrical, pre-natal and post-natal care
- Physician Office Visits (Primary Care Physician and Specialist)
- Preventive Care (age 19 & older) Well Woman/Well Man Care
  - Expenses related to preventive health care—including adult immunizations as listed below, routine office visits; lab services and x-rays—are covered for DMC Care members age 19 and older. Contact DMC Care Medical Management to inquire about specific preventive services.
- Preventive Care (under age 19) Well-Child Care
  - Expenses related to preventive health care—including immunizations as listed below, routine office visits, lab services and x-rays—are covered for DMC Care members under age 19. Contact DMC Care Medical Management to inquire about specific preventive services.

**IMMUNIZATIONS****0 – 18 Years:**

- Diphtheria, Tetanus, Pertussis: DTaP
- Inactivated Poliovirus
- Hemophilus Influenza: HIB
- Measles, Mumps, Rubella: MMR
- Pneumococcal (certain high risk groups)
- Hepatitis A
- Hepatitis B
- Varicella
- Meningococcal MPSV4, MCV4
- Influenza
- Rotovirus

**9 – 26 Years/Female:**

- Human Papillomavirus (HPV) Vaccine

**19 Years Or Older:**

- Tetanus
- Influenza
- Varicella
- Pneumonia
- Hepatitis A & B
- MMR
- Meningococcal MCV4

**SNF benefits are limited to 365 days per lifetime. The 365 day limit will be reduced 2 days for each day you had an acute hospitalization.**

## Skilled Nursing Facility

A Skilled Nursing Facility (SNF) is a specially qualified facility that specializes in providing skilled care. It has the staff and equipment to provide care that can only be performed by or under the supervision of licensed health professionals, such as nurses and therapists.

- The attending physician visits the patient, reviews the medical status and writes orders for the next 30 days. Progress notes are written monthly.
- Skilled nursing supervision is present on a 24-hour basis.
- Other services must be available within the facility or by satisfactory arrangement including physical therapy, speech therapy, audio therapy, occupational therapy, laboratory, pharmacy, podiatry, social, dental, and radiologist's services.

## Ambulance Service

DMC Care will cover ground ambulance service for emergency transportation to the nearest hospital where adequate care can be provided to stabilize your condition. Once stabilized, you may be transferred to a DMC facility.

Air ambulance is covered only when ground transportation is impossible or would put life or health in serious jeopardy. If a member has a medical emergency in an area not easily accessible by conventional transportation, coverage is provided for air transport to the **nearest** facility equipped to stabilize their condition. Once stabilized, authorization by the DMC Care Medical Director is required for further air or ground transfer activity.

The Plan does not cover ambulance service in non-emergency situations, other than DMC Care Medical Director authorized medical transport on an individual case basis.

Transportation service for member or physician convenience is not a covered benefit.

## Home Health Care

**Home Health Care Benefits are subject to Prior-Authorization.**

The Home Health Care program is designed to allow patients to recuperate at home in a familiar surrounding instead of in a Hospital. Home nursing care is provided when a member is considered "home-bound" and unable to access care outside of the home. A physician order indicating medical necessity is required for prior authorization of services. The following services are covered:

- Registered or licensed practical nurses (RN / LPN)
- Registered dietitian
- Social workers
- Physical, speech and/or occupational therapists
- Home health aides

**IV Infusion, Home Health Care, Dialysis**

<b>Benefit Description 2010</b>	<b>Tier 1 Co-insurance Application</b>	<b>Tier 2, Tier 3 and Tier 4 Co-insurance Application</b>
IV Infusion (Excludes Chemotherapy) – Home Health Care	5% Basic – 5% Plus	Basic and Plus – % according to the <b>provider tier</b>
IV Infusion (Excludes Chemotherapy) – Infusion Center	5% Basic – 5% Plus	Basic and Plus – % according to the <b>provider tier</b>
Home Health Care Services	5% Basic – 5% Plus	Basic and Plus – % according to the <b>provider tier</b>
Dialysis Treatments	5% Basic – 5% Plus	Basic and Plus – % according to the <b>provider tier</b>

**Chiropractic Care**

Preventive services and treatment for acute or chronic conditions are a covered benefit. Treatments may include heat, electrical stimulation, or ultrasound to help relax the person's muscles before doing a spinal adjustment. Subluxations and/or manual manipulations, x-rays, massage, and ultrasound are covered. Diagnostic studies (e.g. MRI, CT Scan) require prior authorization. Chiropractic care has a \$2000 maximum benefit per year. Benefits are payable at a Tier 2 or Tier 3 level only.

**Hospice Care**

Hospice care provides pain relief, symptom management, and supportive services to terminally ill members. Care may be provided in an in-patient hospice facility or in the member's home. Hospice care requires Prior-Authorization. Benefits are subject to a lifetime maximum of \$10,000.

**Durable Medical Equipment**

**Durable Medical Equipment is equipment that is medically necessary and conforms to generally accepted standards of usage which:**

- Can withstand repeated use (e.g. wheelchairs, hospital beds, walkers).
- Is primarily and customarily used to serve a medical purpose.
- Is generally not useful to a person in the absence of illness or injury.
- Is appropriate for use in a patient's home.

**Covered Medical Expenses for durable medical equipment include, but are not limited to, charges for:**

- The purchase or rental up to the purchase price, of durable medical equipment.

**Chiropractic treatments are limited to 38 visits per year or a total annual maximum covered cost of \$2,000**

- Oxygen and the rental of equipment for its administration.
- Durable Medical Equipment (such as C-PAP, BIPAP or Wound VACS) costing in excess of \$1,000, whether purchased or rented, is subject to Prior-Authorization.

When using Tier 1 providers for DME & Supplies, the member is responsible for 20% coinsurance. (Coinsurance applies to DMC Care member out of pocket maximum)

When using Tier 2, Tier 3 or Tier 4 providers, the member will be responsible for the DME co-pay, deductible or co-insurance according to the tier level, each time a service is used or obtained.

## Prosthetics & Orthotics

Orthotic appliances are external devices intended to correct a defect of form or function of the human body. Orthopedic braces and appliances are examples of orthotic appliances. Prosthetics may include replacement for an upper or lower extremity or a brace-type piece of equipment to support the extremity.

**Covered Medical Expenses for prosthetics and orthotics include, but are not limited to, charges for:**

- Initial (but not subsequent) artificial limbs, eyes, and other functional and non-functional prosthetics. (Prior authorization required)
- Casts, splint, braces and crutches.
- Replacement prosthetics and orthotics for Covered Dependents under 18 years old if required by growth or normal use.
- Shoe orthotics are limited to 1 pair every 5 years.

## Hearing Aids

Examinations for the prescription, fitting and molding of a hearing aid. Benefit is limited to \$1000 every 36 months (prior authorization required) based on physician re-evaluation of impairment. Children age nine (9) years or under are eligible for yearly replacement of tubing and custom ear molds when medically necessary.

## Cochlear Implants

One implant per ear, per lifetime at DMC facility only. 12 months of age or older. Prior authorization required.

## Infertility

Infertility testing and treatment is covered only if performed by a Tier 1 Participating Provider within the DMC network. Treatment of infertility includes artificial insemination and all forms of non-experimental, assisted reproductive technology and medications. Treatment also includes any laboratory or radiological testing necessary to monitor progress.

**This Infertility benefit is limited to a lifetime maximum benefit of \$15,000 for medication and treatment and is only covered at a Tier 1 DMC Network Level.**

**Speech, Physical and Occupational therapy require prior authorization for patients under 18 years old.**

## Sterilization

Elective Sterilization (tubal ligation / vasectomy) is a covered benefit.

### PHYSICAL THERAPY, SPEECH THERAPY, OCCUPATIONAL THERAPY

- Services are payable for 60 visits combined per condition within a 12 month period beginning with the 1st date of service. Prior authorization is required (regardless of age) after 30 visits to continue occupational therapy/physical therapy or speech therapy.
- The therapy must be prescribed by a Physician.
- The therapy requires the assistance and supervision of an appropriate licensed occupational/physical or speech therapist.
- The therapy must be given for a condition, which is capable of significant improvement in a reasonable and generally predictable period of time.
- Speech therapy by a certified speech therapist to restore speech loss, to correct an impairment due to a congenital defect for which corrective surgery has been performed.
- Speech therapy is covered after acute conditions such as but not limited to: stroke, closed head injury, etc.
- Treatment for developmental delays/disabilities are not a covered benefit. A condition which falls under the responsibilities of a member's school district or other public agency is not a covered benefit.
- Applied behavioral analysis is not a covered benefit.
- Work hardening programs are considered not medically necessary, as they are for the purpose of conditioning for a return to work and not for the treatment of a medical condition.



**“Prior Authorization” means you must get approval for these procedures before receiving them.**

**If you go to a Tier 2 Cofinity or a Tier 3 MultiPlan provider, make sure they get prior authorization for these services and procedures. You will be responsible for all assigned co-insurance. If you utilize a Tier 4 provider you receive the lowest benefit reimbursement by the plan & can be balance billed by the provider.**

**Authorization does not eliminate the member's responsibility for co-pays, deductibles or coinsurance.**

**Authorization does not guarantee payment.**

**If authorization is not obtained prior to the date of service, payment can be denied by DMC Care.**

## 2010 Prior Authorization Requirements

You must call **877-501-0958** for pre-authorization **before** you or your covered dependents receive the following medical services marked with an X:

INPATIENT CARE	Tier 1	Tier 2*	Tier 3*	Tier 4*
All Elective In-Patient Hospital Admissions (Requires notification prior to admission)	X	X	X	X
Emergency / Urgent Admissions (Requires notification prior to admission)	X	X	X	X
All Rehab Admissions (prior to admission)	X	X	X	X
All Skilled Nursing Facility Admissions (prior to admission)	X	X	X	X
All Sub-Acute Admissions (prior to admission)	X	X	X	X
OUTPATIENT DIAGNOSTIC PROCEDURES	Tier 1	Tier 2*	Tier 3*	Tier 4*
CT Scan (any anatomic location)	Not Required	X	X	X
MRI/MRA (any anatomic location)	X	X	X	X
PET Scan	Not Required	X	X	X
CTA (Computed Tomographic Angiography) (Non- Cardiac)	Not Required	X	X	X
CTA/CCTA(Computed Coronary Tomography Angiography)* <b>*MUST BE ORDERED BY CARDIOLOGIST*</b>	X	X	X	X
Capsule Endoscopy	X	X	X	X
<b>Following services provided in a doctor's office will not be covered: MRI/MRA, CT Scan, PET Scan, CTA, CCTA, Nuclear Testing</b>	Not Covered	Not Covered	Not Covered	Not Covered
SURGICAL PROCEDURES	Tier 1	Tier 2*	Tier 3*	Tier 4*
All Outpatient Surgical Procedures ( <b>Facility Only</b> )	Not Required	X**	X**	X**
Sclerotherapy/Ligation of Varicose Veins ( <b>All Treatments/Surgery</b> )	X	X	X	X
Breast Repair and/or Reconstruction ( <b>Related to non-cancer diagnosis or history</b> )	X	X	X	X
Breast Reduction -Mammoplasty	X	X	X	X
Uterine Artery Embolization	Not Required	X	X	X
Bariatric Surgery	X	Not Covered	Not Covered	Not Covered

<b>SURGICAL PROCEDURES</b>	<b>Tier 1</b>	<b>Tier 2*</b>	<b>Tier 3*</b>	<b>Tier 4*</b>
Cochlear Implants (Age restrictions)	X	Not Covered	Not Covered	Not Covered
All Spinal (Back) Surgery	X	X	X	X
Any Cosmetic Procedure- <b>Facility Only</b> (Does not include mole removal, skin lesion removal or skin tag removal)	X	X	X	X
Transplants (Organ, Bone Marrow & Corneal) & Related Services	X	X***	Not Covered	Not Covered
<b>REHABILITATION THERAPY</b>	<b>Tier 1</b>	<b>Tier 2*</b>	<b>Tier 3*</b>	<b>Tier 4*</b>
Physical Therapy, Occupational Therapy or Speech Therapy (under <u>18</u> years of age)	X	X	X	X
Physical Therapy, Occupational Therapy or Speech Therapy ( <b>Extension Beyond 30 visits-regardless of age</b> )	X	X	X	X
Cardiac Rehab	X	X	Not Covered	Not Covered
<b>HOME HEALTH CARE</b>	<b>Tier 1</b>	<b>Tier 2*</b>	<b>Tier 3*</b>	<b>Tier 4*</b>
Hospice (Inpatient/Home)	X	X	X	X
Home Care (Skilled Nurse, Social Worker, Home Health Aide, Other)	X	X	X	X
Physical Therapy/ Occupational Therapy/ Speech Therapy	X	X	X	X
Infusion Therapy	X	X	X	X
<b>OTHER</b>	<b>Tier 1</b>	<b>Tier 2*</b>	<b>Tier 3*</b>	<b>Tier 4*</b>
Hemodialysis / Home Dialysis/ CAPD (Continuous Ambulatory Peritoneal Dialysis)	X	X	X	X
Infusion Therapy ( <b>Facility Based or Infusion Center only</b> ) other than chemotherapy	X	X	X	Not Covered
Infusion Therapy ( <b>Physician Office</b> )	Not Covered	Not Covered	Not Covered	Not Covered
In-office Botulinum Toxin (Botox/Myobloc)	X	X	X	X
Hyperbaric Oxygen Therapy	X	X	X	X
Unique Services/Procedures (Including Not Available at <b>any</b> DMC Facility)	X	X	X	X
Donor Transplant Related Services	X	Not Covered	Not Covered	Not Covered
<b>DURABLE MEDICAL EQUIPMENT (DME)</b>	<b>Tier 1</b>	<b>Tier 2*</b>	<b>Tier 3*</b>	<b>Tier 4*</b>
Durable Medical Equipment (DME) ( <b>Costs/purchase price greater than \$1,000</b> )	X	X	X	X
<b>All DME Rentals</b> including but not limited to C-PAP, BiPAP, Oxygen Therapy, Insulin Pumps	X	X	X	X

<b>DURABLE MEDICAL EQUIPMENT (DME)</b>	<b>Tier 1</b>	<b>Tier 2*</b>	<b>Tier 3*</b>	<b>Tier 4*</b>
Prosthetic and Orthotic Appliances over \$1,000 (Including Shoe Orthotics)	X	X	X	X
Ventilators	X	X	X	X
Wound Vacuums	X	X	X	X
Enteral Formula	X	X	X	X
Communication Devices	X	X	X	X
<b>GENETIC TESTING</b>	<b>Tier 1</b>	<b>Tier 2*</b>	<b>Tier 3*</b>	<b>Tier 4*</b>
Oncotype DX Breast Cancer Assay ( <b>Breast Cancer only</b> )	X	X	X	Not Covered
Breast Cancer: BRCA 1 & BRCA 2 Genetic Testing	X	X	X	X
Genetic Testing ( <b>All Types</b> )	X	X	X	X

\* = Tier 2, 3, & 4 services will result in higher out of pocket costs for the member (co-pays & co-insurance)

\*\* = Member or Provider Notification 30 days prior to surgery

\*\*\* = Limited Network Coverage

**Mental Health/Behavioral Health Services** – CALL VALUEOPTIONS (877-362-2472) prior to starting treatment or services for mental health, behavioral health or substance abuse needs.

Please note: Authorization of a service/procedure does not eliminate the member's responsibility for co-pays, deductibles or coinsurance. Authorization of a service DOES NOT guarantee payment.

This list may be updated throughout the year. Please check [www.dmc-care.org](http://www.dmc-care.org) or call 800-543-0161 for the most current listing.

<b>Cosmetic Services: Not Covered</b> (includes but is not limited to the following)	
• Cervicoplasty (Neck Lift)	• Osteoplasty, facial bones; reduction
• Blepharoplasty (Lower eyelid)	• Mesotherapy (Lipodissolve)
• Brow Ptosis Repair	• Rhinoplasty; Primary, Secondary, Nasal tip work
• Latisse (Eyelash Growth)	• Single or multiple injections of sclerosing solutions (spider veins); limb, trunk, face, legs
• Rhytidectomy (Face Lift)	• Otoplasty (Protruding ear with or without size reduction)
• Lipectomy/Liposuction (Suction Assisted Lipectomy)	• Subcutaneous injection of filling material (e.g. collagen)
• Excision, excessive skin and subcutaneous	• Dermabrasion, abrasion, chemical peel, and salabrasion
• Abdominoplasty	• Hair Transplant Services
• Mastopexy (Breast Lift)	

### **Prior Authorization information required to Support Decision-Making**

- PCP or Specialist progress or consultation notes
  - History and/or physical examination that addresses the problem
  - Current notes that show requested service will be ordered or include a prescription for services
  - Any other pertinent clinical information to support the request
  - Please note that all services require prior authorization.
- For eligibility and benefits, please call our Customer Service department at 1-800-543-0161 M-F, 8:00 am - 5:00 pm.

## Bariatric Surgery

Bariatric surgery for morbid obesity is an alternative to traditional weight loss methods when such methods have failed to yield sufficient weight loss in members who are at great risk of complications due to obesity.

Bariatric surgery is a benefit for DMC Care Basic and DMC Care Plus members with the following limitations and exclusions:

LIMITATIONS:
<ul style="list-style-type: none"> <li>• The bariatric surgery benefit is limited to a lifetime maximum benefit of \$20,000. Costs in excess of \$20,000 will be the member's responsibility.</li> </ul>
<ul style="list-style-type: none"> <li>• The bariatric surgery benefit is limited to one surgery per lifetime.</li> </ul>
<ul style="list-style-type: none"> <li>• Prior authorization is required; member must meet DMC Care criteria for bariatric surgery.</li> </ul>
<ul style="list-style-type: none"> <li>• The bariatric procedure must be performed at a DMC facility approved for bariatric surgery utilizing a multidisciplinary approach, involving a physician specializing in obesity, a dietician, a psychologist or psychiatrist specializing in behavior modification and eating disorders and a DMC surgeon with experience in all aspects of bariatric procedures.</li> </ul>
<ul style="list-style-type: none"> <li>• Member must be 18 years of age or older.</li> </ul>
EXCLUSIONS:
<ul style="list-style-type: none"> <li>• Procedures performed for cosmetic re-sculpting of the body after bariatric surgery.</li> </ul>
<ul style="list-style-type: none"> <li>• Nutritional supplements for post-operative, long term nutritional care following bariatric surgery.</li> </ul>
<ul style="list-style-type: none"> <li>• Vertical Banding, Gastric Balloon and Stapling, Gastric Sleeve and new experimental procedures are excluded from this benefit.</li> </ul>
<ul style="list-style-type: none"> <li>• Bariatric surgery revision (previous surgery) is not a covered benefit.</li> </ul>

Qualifying criteria may be revised as necessary. Please check the [www.dmc-care.org](http://www.dmc-care.org) web site for updates.

### Bariatric Surgery (*continued*)

QUALIFYING MEDICAL CRITERIA:
1. Member must be 18 years of age or older.
2. Members with BMI of > 40 with or without co-morbid conditions
3. Members with BMI of > 35 and two (2) life threatening co-morbidities. Co-morbidities include but are not limited to:
a. Poorly controlled diabetes mellitus
b. Symptomatic sleep apnea not controlled by C-Pap
c. Severe cardio-pulmonary condition
d. Uncontrolled Hypertension with optimal conventional treatment.
e. Uncontrolled Hyperlipidemia not amenable to optimal conventional treatment.
4. Member must have passed surgeon's screening criteria.
5. Member must have documentation of participation in a medical weight loss program which consists of a multidisciplinary team, with regular attendance and compliance for a period of one consecutive year. Program must consist of <u>all</u> of the following:
a. Exercise program
b. Behavioral modification
c. Nutritional counseling
d. A documented weight reduction of at least 10%
e. Documentation of exercise and dietary log/diary maintained by member
6. As an alternative to a structured weight loss program, <b>DMC Care may accept clinical notes from the member's primary care physician that specifically record a period of one consecutive year of:</b>
a. bi-weekly visits for consultation and counseling regarding weight loss with weight recording
b. dietary change recommendations
c. exercise program participation
d. bi-weekly weigh-in recording
e. copies of a daily dietary and exercise log/diary maintained by the member during the year of consultation
7. A DMC Care approved psychological evaluation must be performed in order to establish the member's emotional stability and ability to comply with post-surgical limitations.
8. The initial evaluation and surgical procedure must be performed at a DMC facility, utilizing a multidisciplinary approach. (American Society of Metabolic and Bariatric Surgeons [ASMBS] Centers of Excellence preferred).
9. Members with one or more of the following conditions are excluded:
a. Active substance abuse
b. Non-compliance with previous medical care
c. Terminal disease
d. Pregnancy
e. Severe psychopathology

## Exclusions and Limitations

There are situations where benefits may be limited or not provided by the DMC Care benefit program. This section lists some of the exclusions and limitations which may apply to all types of services. The following charges are not covered medical expenses.

### GENERAL EXCLUSIONS

- Charges related to a Sickness or Injury that is covered under a worker's compensation, employer liability or similar law.
- Services rendered to a newborn that is not eligible to enroll in the DMC Care Benefit Program, such as a grandchild.
- Charges related to the Covered Individual's commission of an assault or felony, participation in a riot, or illegal occupation.
- Fees assessed for copies of medical records or for preparing and completing forms.
- Services or supplies which were rendered before you became a Covered Individual.
- Charges incurred after you stopped being a Covered Individual, unless you were confined in a Hospital on that date, in which case the Hospital charges are a covered benefit until the date of your release.
- Charges which you are not legally required to pay or which you would not be required to pay if you did not have benefits under this DMC Care Benefit Plan, such as charges for services rendered in a Veteran's Administration Hospital.
- Charges to the extent of coverage required by, or available through, any federal, state, municipal or other governmental law, regulation, or program (including a governmental plan of health insurance).
- Charges which are payable by a third-party because it is legally liable for the expense.
- Charges incurred as a result of war or an act of war, whether declared or undeclared or incurred while in the armed services of any country or international organization.
- Comfort or convenience items, such as Hospital charges for television, telephone or guest beds and certain DME items.
- Services provided by a relative.
- Charges for pre-marital, pre-employment, insurance examination, travel examination, or paternity testing.
- Hypnotherapy and biofeedback training.
- Donor expenses, except as listed on page 25.
- Charges for donor sperm or donor eggs.
- Charges by a Christian Science Practitioner, nurse or facility.
- Charges related to the pregnancy of a surrogate mother.
- Treatment related to reversal of sterilization.
- In vitro fertilization after voluntary sterilization.
- Charges related to sexual surgery or treatment for gender reassignment.
- Charges for over-the-counter vitamins taken orally, dietary drugs, food, or food supplements.
- Charges for radial keratotomy, lasik or other corneal procedures.
- Coordination of Benefits (COB) if not enrolled in DMC Care-Plus and have not purchased the COB rider.

**Make sure you understand what is and isn't covered by the Plan.**

## Exclusions and Limitations *(continued)*

**Experimental treatments are not covered.**

**DMC Employees who have an exposure while at work must receive treatment through DMC Occupational Health.**

**Custodial Care – care designed to assist an individual in the activities of daily living – is not covered.**

**Misuse or abuse of equipment, whether intentional or unintentional, may not be covered.**

### Experimental Treatment

Services, treatment methods, drugs or procedures, which are experimental, educational, investigative, controversial, or not recognized as accepted medical practice by appropriate medical specialty organizations are not covered.

### Immunizations

- Yellow Fever, Malaria, Typhoid, other vaccines specific for travel.

### Skilled Nursing Facility

Benefits are limited to 365 days per lifetime. The 365-day limit will be reduced by 2 days for each day you had an acute hospitalization. Skilled Nursing Facility benefits are subject to Prior-Authorization.

Custodial Care is not a covered benefit: Custodial Care is the type of care, wherever furnished, which is designed to assist the member in activities of daily living.

### Home Health Care

Benefits are only available when a member is considered “home bound” and unable to access care outside of the home. Home Health Care Benefits are subject to Prior-Authorization. Private Duty Nursing is not a covered benefit.

### Chiropractic Care

Chiropractic care is limited to 38 visits per year. Benefits are subject to a limit of \$2000 per year. Diagnostic studies such as MRI and CT Scan require prior authorization. Chiropractic care benefits are payable at a Tier 2 or Tier 3 level only.

### Hospice

Benefits are subject to a maximum of \$10,000 lifetime and require prior authorization.

### Durable Medical Equipment

- All wheelchairs require prior authorization.
- Power operated wheelchairs or vehicles are limited to one per lifetime (prior authorization required), or one every 5 years for members 3-17 years of age (prior authorization required).
- Insulin Pumps are limited to one every 4 years (prior authorization required).
- Examples of non-covered equipment include but are not limited to: exercise bicycles, ergometers, other exercise equipment, diet scales, and environmental control equipment.
- Repair and maintenance is subject to Prior Authorization, and a \$300 maximum within the first two years of rental/purchase of Durable Medical Equipment.

## Exclusions and Limitations *(continued)*

### Podiatry

- Treatment for corns, calluses, or toenails is not covered unless you are a diabetic patient.
- Treatment for weak, strained or flat feet, instability or imbalance of the feet, tarsalgia, metatarsalgia is not covered, except for related surgical procedures.

### Cosmetic Services

Cosmetic care, treatment, drugs, or surgery is not covered unless it is necessary to ameliorate a deformity arising from or directly related to a congenital abnormality, a functional impairment or the result of a mastectomy.

- Hair replacement including wigs and the costs of topical solution for hair growth (i.e. Minoxidil) is not covered.
- Hair removal procedures such as Laser or electrolysis are not covered.

### Dental Care

**The DMC Care Benefit Program is not a dental insurance. The following conditions are not covered:**

- Treatment for temporomandibular joint syndrome (i.e. TMJ).
- Charges for services performed on or to the teeth, for gingival, or for alveolar processes, except for tumors.
- Appliances, restorations or procedures for the purpose of altering vertical dimension, restoring or maintaining occlusion or splinting or replacing tooth structure lost as a result of abrasion or attrition.
- Treatment of periodontal or periapical disease or any other condition (except malignant tumors) involving teeth, surrounding tissue or structure.
- The extraction of third molars or wisdom teeth is considered dental in nature and is not a covered benefit.

### Physical Therapy, Speech Therapy, Occupational Therapy

**PT, OT and ST are limited to 60 visits combined, per condition, within a 12 month period beginning with the first date of service.**

**PT, OT, and / or Speech Therapy is not covered for:**

- Congenital or inherited speech abnormalities in the absence of corrective surgery.
- Developmental conditions and learning disabilities.
- Vocational, music, remedial reading or recreational therapy.
- Inpatient Hospital admissions primarily for speech and language therapy.
- Return to sports.
- Return to work.

**Cosmetic procedures are not covered.**

**The Plan does not cover dental care.**

**Prior authorization is required for all therapies for members under 18 years of age and after 30 visits (regardless of age) to continue OT/PT or ST.**

**Prosthetics and orthotics are subject to Prior-Authorization.**

## Exclusions and Limitations *(continued)*

### Prosthetics & Orthotics

- Replacement prosthetics and orthotics are not covered if they are damaged as a result of abuse whether intentional or unintentional.
- Replacement prosthetics and orthotics are only covered for Covered Dependent children if purchased from Participating Providers.
- Corrective shoes are covered only when attached to a brace.
- Orthotics must be prescribed by a Physician.
- Shoe orthotics are limited to one pair every 5 years.
- Prosthetics and orthotics for participation in sports activities is not covered.

### Sterilization Reversal

Surgical reversal of a previous Sterilization is not a benefit.

### Infertility

In vitro fertilization after voluntary sterilization is not a covered benefit. The infertility benefit is limited to a lifetime maximum of \$15,000 for medication and treatment at DMC facilities only. Elective Sterilization using Vasclip® is not a covered benefit.

### Voluntary Interruption of Pregnancy

One procedure per lifetime; additional request requires prior authorization.

### Organ Donor Services

Live organ donor coverage is a benefit in the following individual consideration circumstances. Live donor coverage limited to DMC facility only. Prior authorization required.

- When the donor has medical coverage, the donor's health plan will pay primary.
- If the donor's primary insurance does not cover donor expenses, DMC Care will cover donor expenses at a DMC facility only. Donor's EOB/Denial of coverage documentation required.
- If the donor has no insurance DMC Care will provide coverage for transplant at DMC facility only.
- Donor DMC Care coverage is limited to 30 days post-op.
- Donor transportation and lodging are not a covered benefit.

Transplant services not available in the Tier 1 network are limited to a "preferred network" of providers. Prior authorization is required for all transplant services.

Bone marrow donor search is limited to 1st degree relatives.

## Benefit Summary Grid

DMC Care BASIC 2010 Primary Benefit	DMC Care - BASIC			
	DMC Tier 1	Cofinity Tier 2 <sup>1</sup>	MultiPlan Tier 3 <sup>2</sup>	No Provider Contract Tier 4 <sup>3</sup>
Annual Deductible	\$0		\$300 – Individual	\$600 - Family
DMC Benefit Coverage	80% - 100%	60%	50%	50%
Annual Out Of Pocket	\$10,000 – Individual	\$20,000 – Family	(Only eligible expenses apply) <sup>3</sup>	
Per Admission Deductible (Not apply to annual out of pocket max)	\$0	\$1,000	\$1,500	\$1,500
Hospital coverage	100%	60% of eligible charge after admission deductible	50% of eligible charge after admission deductible	50% of eligible charge after admission deductible (Member can be Balance Billed for Facility & Provider's charges)
Office Visits	\$15 Copay	\$30 Copay	50% of eligible charge after deductible	50% of eligible charge after deductible (Member can be Balance Billed for Facility & Provider's charges)
Urgent Care Visit	\$25 Copay	\$40 Copay	50% of eligible charge after deductible	50% of eligible charge after deductible (Member can be Balance Billed for Facility & Provider's charges)
ER Visit	\$50 Copay	\$150 Copay	\$150 Copay	\$150 Copay
Emergency Admission	100%	70% of eligible charge; ER copay waived; Per admission deductible applies		70% of eligible charge; ER copay waived; Per admission deductible applies (Member can be Balance Billed for Facility & Provider's charges)
Home Health Care, Infusion and Dialysis	95%	60% of eligible charge after deductible	50% of eligible charge after deductible	50% of eligible charge after deductible (Member can be Balance Billed for Facility & Provider's charges)
DME and Medical Supplies	80%	60% of eligible charge after deductible	50% of eligible charge after deductible	50% of eligible charge after deductible (Member can be Balance Billed for Facility & Provider's charges)
PT/OT/ST	\$5 Copay	\$30 Copay	50% of eligible charge after deductible	50% of eligible charge after deductible (Member can be Balance Billed for Facility & Provider's charges)
Diagnostic Services, except lab services	100%	60% of eligible charge after deductible	50% of eligible charge after deductible	50% of eligible charge after deductible (Member can be Balance Billed for Facility & Provider's charges)
Diagnostic Lab Services	100%	\$20 Copay	50% of eligible charge after deductible	50% of eligible charge after deductible (Member can be Balance Billed for Facility & Provider's charges)
International Benefits	Emergency Services Only (IC) <sup>3</sup>			

<sup>1</sup> Tier 2 Eligible Charge equals the Cofinity Approved Amount as defined by the Cofinity contract for the individual provider.

<sup>2</sup> Tier 3 Eligible Charge equals the MultiPlan Approved Amount as defined by the MultiPlan contract for the individual provider.

<sup>3</sup> Tier 4 If no contract, Usual and Customary amounts will be applied. You will be balanced billed for the full amount above Usual and Customary.

To avoid co-pays when having lab work done at your physician's office, notify the office to use DMC UL or JVHL laboratories.

DMC Care PLUS 2010 Primary Benefit	DMC Care - Plus			
	DMC Tier 1	Cofinity Tier 2 <sup>1</sup>	MultiPlan Tier 3 <sup>2</sup>	No Provider Contract Tier 4 <sup>3</sup>
Annual Deductible	\$0		\$200 – Individual	\$400 - Family
DMC Benefit Coverage	80% - 100%	80%	60%	60%
Annual Out Of Pocket	\$5,600 – Individual \$11,200 – Family (Only eligible expenses apply) <sup>3</sup>			
Per Admission Deductible (Not apply to annual out of pocket max)	\$0	\$750	\$1,500	\$1,500
Hospital coverage	100%	80% of eligible charge after admission deductible	60% of eligible charge after admission deductible	60% of eligible charge after admission deductible (Member can be Balance Billed for Facility & Provider's charges)
Office Visits	\$15 Copay	\$25 Copay	60% of eligible charge after deductible	60% of eligible charge after deductible (Member can be Balance Billed for Facility & Provider's charges)
Urgent Care Visit	\$25 Copay	\$30 Copay	60% of eligible charge after deductible	60% of eligible charge after deductible (Member can be Balance Billed for Facility & Provider's charges)
ER Visit	\$50 Copay	\$125 Copay	\$125 Copay	\$125 Copay
Emergency Admission	100%	90% of eligible charge; ER copay waived; Per admission deductible applies		90% of eligible charge; ER copay waived; Per admission deductible applies (Member can be Balance Billed for Facility & Provider's charges)
Home Health Care, Infusion and Dialysis	95%	80% of eligible charge after deductible	60% of eligible charge after deductible	60% of eligible charge after deductible (Member can be Balance Billed for Facility & Provider's charges)
DME and Medical Supplies	80%	80%	60% of eligible charge after deductible	60% of eligible charge after deductible (Member can be Balance Billed for Facility & Provider's charges)
PT/OT/ST	\$5 Copay	\$25 Copay	60% of eligible charge after deductible	60% of eligible charge after deductible (Member can be Balance Billed for Facility & Provider's charges)
Diagnostic Services, except lab services	100%	80% of Eligible Charge After Deductible	60% of eligible charge after deductible	60% of eligible charge after deductible (Member can be Balance Billed for Facility & Provider's charges)
Diagnostic Lab Services	100%	\$10 Copay	60% of eligible charge after deductible	60% of eligible charge after deductible (Member can be Balance Billed for Facility & Provider's charges)
International Benefits	Emergency Services Only (IC) <sup>3</sup>			

<sup>1</sup> Tier 2 Eligible Charge equals the Cofinity Approved Amount as defined by the Cofinity contract for the individual provider.

<sup>2</sup> Tier 3 Eligible Charge equals the MultiPlan Approved Amount as defined by the MultiPlan contract for the individual provider.

<sup>3</sup> Tier 4 If no contract, Usual and Customary amounts will be applied. You will be balanced billed for the full amount above Usual and Customary.

## Benefit Maximums

- Total Lifetime Benefit Maximum (Mental Health Included): \$2,000,000
- Bariatric Lifetime Benefit Maximum: \$20,000
- Infertility Lifetime Benefit Maximum: \$15,000 at DMC only
- Skilled Nursing Facility Maximum: 365 days per lifetime – reduced by 2 days for each acute day hospitalization while a DMC Care member
- Hospice Lifetime Benefit Maximum: \$10,000
- Chiropractic Care: \$2,000 / year
- Hearing Aid: \$1,000 every 3 years

## Important Rights Under Federal Law

Covered Medical Expenses payable under the Plan for any hospital stay in connection with childbirth for the mother or newborn child will not be restricted to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, the mother's (or newborn's) attending provider may, after consulting with the mother, discharge the mother or her newborn earlier than 48 hours (or 96 hours if applicable).

Also, as part of the Women's Health and Cancer Right's Act, the coverage described below is available under the Plan. Notice provisions in the law require written notification to Plan participants on an annual basis, even though the Plan already covers these types of services.

Coverage will be provided to a Plan participant who has had a medically necessary mastectomy and elects breast reconstruction after the mastectomy for:

- Reconstruction of the breast on which the mastectomy was performed,
- Surgery and reconstruction of the other breast to produce symmetrical appearance, and
- Coverage for prosthesis and treatment of physical complications of all stages of mastectomies, including lymphedemas.

This coverage will be subject to all deductibles, coinsurances, co-payments and other Plan provisions in effect at the time of claim for the type of service provided. Contact DMC Care Customer Service for more information.

## Section 3 – Behavioral Health & Substance Abuse

**Behavioral Health and Substance Abuse services are provided through ValueOptions.**

**Do not use the Cofinity or MultiPlan directory for BH/SA services.**

**Mental health included in Lifetime Maximum Benefits of \$2,000,000.**

**Remember to use only ValueOptions providers for Behavioral Health and Substance Abuse services.**

ValueOptions is the case management organization that has been contracted with DMC Care for both the DMC Care Basic and DMC Care Plus plans, to provide triage and Prior-Authorization for the Mental Health or Substance Abuse benefit.

### PRIOR-AUTHORIZATION

**All in-patient, emergency room, and out-patient services require Prior-Authorization through ValueOptions at (877) 362-2472.**

ValueOptions is available to take calls twenty-four hours a day, seven days a week.

All Behavioral Health and Substance Abuse (BH/SA) services must be provided through ValueOptions. Do not utilize the Cofinity (PPOM) directory for BH/SA services. Failure to call Value Options may result in additional cost to you.

**The following Behavioral Health and Substance Abuse services are not covered:**

- Marriage Counseling.
- All inpatient services and all in-network, outpatient services that are not Prior-Authorized.
- Non-emergency, out-of-network, and out-of-area treatment, if ValueOptions determines that appropriate services are available within the network.
- Treatment of chronic Behavioral Health Disorders. A Chronic Condition means a condition which is of perpetual or constantly recurring nature, has a history of being resistant to any and all efforts to cure and has been determined by medical evaluation that the condition would not be amenable to favorable modification upon further treatment; except that benefits shall be payable to determine that such condition is not amenable to favorable modification.
- Evaluation and treatment of learning disabilities.
- Neuropsychiatric testing (testing to determine cognitive ability).
- Residential Treatment beyond 30 days of care, per year. Behavioral health only. Accredited setting.

BHSA Benefit 2010	DMC Care - Basic		
	DMC Tier 1	Value Options Tier 2	Out of Value Options Network Tier 3
Annual Deductible	\$0	\$300 – Individual	\$600 - Family
Annual Out Of Pocket Maximum	\$10,000 – Individual \$20,000 – Family (Only eligible expenses apply)		
Per Admission Deductible (Not apply to annual out of pocket max)	\$0	\$500	\$1,000
Hospital coverage	100%	70% of eligible charge after admission deductible	50% of eligible charge after admission deductible (member can be balance billed)
Office Visits	\$15 Copay	\$30 Copay	50% of eligible charge (member can be balance billed)
Residential Treatment (Behavioral Health only)	365 Day Lifetime Limitation – Reduced by 2 Days for Each Day of Acute Hospitalization		
International Benefits	Emergency Services Only (IC)		

BHSA Benefit 2010	DMC Care - Plus		
	DMC Tier 1	Value Options Tier 2	Out of Value Options Network Tier 3
Annual Deductible	\$0	\$200 – Individual	\$400 - Family
Annual Out Of Pocket	\$5,600 – Individual \$11,200 – Family (Only eligible expenses apply)		
Per Admission Deductible (Not apply to annual out of pocket max)	\$0	\$250	\$1,000
Hospital coverage	100%	90% of eligible charge after admission deductible	60% of eligible charge after admission deductible (member can be balance billed)
Office Visits	\$15 Copay	\$25 Copay	60% of eligible charge (member can be balance billed)
Residential Treatment (Behavioral Health only)	365 Day Lifetime Limitation – Reduced by 2 Days for Each Day of Acute Hospitalization		
International Benefits	Emergency Services Only (IC)		

## Section 4 – Prescription Drugs

### Overview of Section

This section of the Benefits Guide 2010 outlines the prescription drug benefits available to you through the DMC Care Benefit Program. Your health and medical benefits are described in Section 2.

### Covered Pharmacy Expenses

Covered Expenses under the Prescription Drug Plan include charges for selected formulary medications when prescribed by a Physician and dispensed by a licensed pharmacy.

Diabetic diagnostic supplies may be obtained through either the pharmacy or the durable medical equipment (DME) benefit.

**Prior Authorization Forms are available on the DMC Care web site at [www.dmc-care.org](http://www.dmc-care.org). A link will take you to [navitus.com](http://navitus.com) for access to the forms.**

### Prior Authorization

Some products on the DMC Care Formulary are only covered with a prior authorization approval. The pharmacy will also alert members if the medication prescribed requires prior authorization. The Navitus Prior Authorization List is updated throughout the year. Please check the [www.dmc-care.org](http://www.dmc-care.org) web site for the most recent listing, or contact Navitus at (866) 333-2727.

### Dispense As Written (DAW)

When a prescription is written “DAW” (dispense as written) or a member requests Brand Name drugs when generic equivalents are available, the costs will be higher.

If your physician indicates Dispense As Written (DAW) on the prescription:

- Your prescription will be filled with the brand-name drug specified by your physician.
- You must pay the difference in cost between the brand-name and the generic medication, in addition to the co-pay assigned to the level in which the drug is classified. This is also your out-of-pocket cost when you choose to have your prescription filled with a brand-name drug without the (DAW) order from your physician, when a generic substitute is available.

**The costs are higher for brand name drugs when generic equivalents are available.**

## Three-Tier Pharmacy Co-Pay Structure

For your convenience, the DMC Care Benefit Program allows you to select your prescription from one of three classifications, or tiers, of drugs. Each classification reflects a different co-pay amount.

**Generic drugs are safe, effective and chemically equivalent to brand-name drugs.**

### Generic Drugs / Tier 1

- FDA approved medications that are safe, effective and chemically equivalent to brand-name drugs. These drugs contain the same active ingredients as their brand-name equivalents, and must meet the same safety, production and performance standards.
- Generic drug substitutes will be dispensed whenever available and legally permitted.

### Preferred Brand Drugs / Tier 2

- Preferred brand drugs are single-source and multi-source brand medications for which no generic equivalent is available due to patent and product-trademark protection.
- After the designated patent time frame ends, a generic drug equivalent is allowed to be manufactured and dispensed by pharmaceutical companies. In this case, there may be several generic drugs produced by different manufacturers for each drug class. These drugs may have varying prices but have equal therapeutic value.

### Non-Preferred Brand / Tier 3

- Non-preferred brand medications are not currently listed on the health plan formulary as a preferred agent, where there are preferred alternatives available.
- New drugs approved by the FDA will be considered brand name non-formulary until the drug is reviewed for formulary consideration and placement, by the Navitus Pharmacy and Therapeutics Committee.

## 2010-2011 Prescription Drug Plan

### DMC "On-Site" Pharmacies

#### Generic Drugs

\$5 co-pay per prescription

#### Formulary Brand Name

\$15 co-pay per prescription

#### Non-Formulary Brand Name

\$30 co-pay per prescription

### DMC Pharmacy Mail Service – USA Addresses Only

DMC Care participants may fill and refill prescriptions through the DMC Mail Service Pharmacy. The Mail Service order form is available at any DMC On-site Pharmacy, Human Resource Forms Rack or, for faster service, use the online electronic form at [www.dmc-care.org](http://www.dmc-care.org) (click on the Pharmacy tab in the upper right hand drop down box, then on the Pharmacy Mail Service tab).

**Save money by using the mail-order pharmacy service.**

- 3 months supply for the cost of 2 months co-pay (you save one month's co-pay)
- No standing in line
- Fast delivery (1-3 days) direct to your home – for delivery to USA addresses only
- Transfers accepted from other pharmacies

**90 DAY SUPPLY**

A 90-day supply for maintenance drugs will only be available from the DMC Pharmacy Mail Service.

Maintenance drugs are those prescription medications that your doctor anticipates will be required for at least six months to treat chronic conditions such as arthritis, high blood pressure, high cholesterol, diabetes and ulcers, for example.

**Navitus Network Pharmacies**

<b>Generic Drugs</b>	\$15 co-pay per prescription
<b>Formulary Brand Name</b>	30% co-pay per prescription with \$30 minimum, \$45 maximum
<b>Non-Formulary Brand Name</b>	40% co-pay per prescription with \$60 minimum, \$100 maximum

**Pharmacies Outside the Navitus Network**

<b>Generic Drugs</b>	\$15 co-pay per prescription
<b>Formulary Brand Name</b>	30% co-pay per prescription with no maximum
<b>Non-Formulary Brand Name</b>	40% co-pay per prescription with no maximum

If a DMC Care member is out of state and requires a prescription, but cannot obtain access to a DMC or Navitus Network Pharmacy, the member will have to pay for the drug in full at the time the prescription is filled. Then the member can request reimbursement by submitting the Direct Member Reimbursement claim form with receipts attached to the address on the form. The form is available at [www.dmc-care.org](http://www.dmc-care.org) or any Human Resource Forms Rack.

**Please note: The Navitus Preferred Pharmacy Network does not include any CVS Pharmacies. You will need to use another pharmacy in the network or you will be subject to an out of network copay.**

**DAW (dispense as written)**

When a prescription is written DAW (dispense as written) or a member requests Brand Name drugs when a generic is available, the cost will be the co-pay plus the difference between the generic and brand amount.

**For More Information**

For more information about your pharmacy benefits, please call DMC-Care customer service at **(800) 543-0161** or refer to the DMC Care Benefit Summary online at **www.dmc-care.org**. To learn more about Navitus, please visit their web site at **www.navitus.com**, or call Navitus Health Solutions Customer Care at (866)-333-2757.

**Exclusions and Limitations**

**Exclusions**

**The following are not Covered Expenses under the Pharmacy Benefit:**

- Contraceptive jellies, ointments, foams or devices and condoms.
- Therapeutic devices, appliances or other non-medicinal substances, regardless of their intended use.
- Over-the-counter products and non-legend drugs.
- Medications to be taken by or administered to you while you receive services in a Hospital, a Skilled Nursing Facility, or an Outpatient Facility.
- Any drug labeled: "Caution: Limited by Federal Law to Investigational Use."
- Experimental drugs.
- Food Supplements (prescribed or over-the-counter).

<b>EXCLUDED DRUG CLASSES FOR 2010</b>	
Obsolete Drugs	Anabolic Steroids
Biologicals	Topical Minoxidil
Vitamins (Prenatal covered)	Hair Growth Products
Relenza	Tamiflu
Non Reimbursable Cosmetic Usage	Nutritional/Dietary

The forms you'll need are available online at [www.dmc-care.org](http://www.dmc-care.org)

## Limitations

- Prescription drugs dispensed by an out-of-network pharmacy will require payment in full at the time the prescription is filled. The Drug Reimbursement Form is available in hard copy at the various site Human Resources Service Centers or on the [www.dmc-care.org](http://www.dmc-care.org) web site.
- Navitus Preferred Pharmacy Network does not include any CVS Pharmacies. Member subject to out of network co-pay.
- The supply of drugs per prescription or authorized refill is limited to a maximum of 100 unit doses or a 34-day supply, whichever is greater. Prescriptions may be filled through the Mail Order Program which offers a 90-day (3-month) supply with (2) co-pays charged. The DMC pharmacy mail service order form is available at any DMC on-site pharmacy, human resources forms rack or, for faster service, use the online electronic form at [www.dmc-care.org](http://www.dmc-care.org).
- **Infertility drugs have a 50 percent co-pay at DMC pharmacies. All other pharmacies member is responsible for full payment.**
- Infertility drugs that require compounding that cannot be done at a DMC Pharmacy require prior authorization. Contact Navitus at (866) 333-2757.
- Prescriptions may be refilled only if the refill is authorized and the refill occurs within 1-year of the original order (or within a lesser time established by state law).
- Any combination of Life Style Drugs ( e.g., Levitra, Cialis, Viagra), limited to 36-doses per calendar year (6 doses/ month for 6 months).
- Smoking cessation drugs by prescription only.

## Section 5 - Medical Claims Procedures

### How to Submit a Claim

You should submit claims as soon as you receive covered services. Generally, if you submit claims beyond the applicable time limit, they will be denied. The time limit is twelve months after the date of service for benefit claims.

If you do not have claim forms, contact DMC Care Customer Service.

If you receive medical or prescription services from network providers, the provider will submit the initial claim for benefits to the Plan on your behalf.

However, if you receive services from out-of-network providers, or you receive care from out of the country, you may be required to file your own claims. In this case, please follow the steps listed below:

#### Step 1:

Obtain itemized statements from the provider that includes the following relevant information:

- Name of the patient and date of birth
- The DMC employee's name and address
- Contract number (from your ID card) or the last four digits of your social security number
- Name and address of the provider
- Provider's federal tax ID number
- Description of services
- Diagnosis (nature of illness or injury)
- Date of each service
- Dates of admission and discharge (if admitted to a hospital)

**Note:** If you receive benefit services out of the country, you will need to pay the bill and get an itemized receipt. Try to have all receipts written in English and in U.S. currency.

#### Step 2:

Complete a separate claim form for each family member. Multiple services for the same patient may be attached to one claim form.

#### Step 3:

Attach all itemized receipts and statements to the claim form. Make sure your name and contract number are on all receipts and attachments. You may include cash register receipts, canceled checks, or money order stubs with your itemized receipt, but they do not substitute for an itemized receipt.

#### Step 4:

Review all claim forms to be sure they are accurate and complete. Incomplete forms will cause your payment to be delayed or denied. Be sure to sign and date each claim. Always keep a copy of your claims and receipts because DMC Care cannot return them to you.

#### Step 5:

Mail all claim forms to the address shown on the form.

## Coverage When You Travel

Remember to carry your ID card with you at all times. The Plan's covered and excluded benefits are the same when you travel as when you receive services from your local doctor, hospital or dentist, but the cost-sharing may be different.

If your out-of-state provider does not participate in a covered network, ask if he or she will bill DMC Care directly. If not, you will need to pay the bill directly and then get an itemized receipt from the provider and send it to DMC Care for reimbursement.

**Your coverage applies no matter where you are only if:**

- The hospital is accredited
- The physician is licensed

International benefits are limited to emergency services only. Most hospitals and doctors in foreign countries will ask you to pay the bill. Try to get itemized receipts, preferably written in English. **Out of the country services are covered for emergent situations only.**

When you submit your claim(s), please indicate if the charges are in U.S. or foreign currency. DMC Care will pay the approved amount for covered services at the rate of exchange in effect on the date you received your services, less any deductibles or co-payments that may apply. Benefit payment(s) will be made directly to you if you are submitting the claim for reimbursement. Please refer to "How to Submit a Claim" on page 36.

## Initial Claim or Benefit Authorization Decisions

Generally, DMC Care (or its delegate) will accept or deny your initial claim or authorization for benefits (or your provider's initial claim or authorization made on your behalf) as soon as practicable, but in no event later than the timeframe required under ERISA. The deadline for deciding an initial claim or authorization under ERISA depends on the type of claim or authorization, as follows:

### Urgent Care

An urgent care claim or authorization is a claim or authorization in which a delayed determination (i) could seriously jeopardize the life or health of the affected individual or the ability of the individual to regain maximum function, or (ii) in the opinion of an informed physician, would subject the individual to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim or authorization.

Approval or denial of an initial urgent care claim or authorization will be furnished to you as soon as possible taking into account the medical urgency, but not later than **72 hours** after receipt of the claim or authorization request. Any denial will contain a description of the expedited review process. This notice may be given orally, in which case a written notice will be sent within 3 days of the oral notice.

If more information is needed from you, DMC Care will notify you not later than 24 hours after receipt of the claim or authorization of the specific information necessary to complete the claim or authorization. You then have at least 48 hours to provide the information. DMC Care will notify you of the decision not later than 48 hours after the earlier of (i) the receipt of the specified information, or (ii) the end of the period afforded to you to provide the additional information.

### **Concurrent Care**

If DMC Care has approved an ongoing course of treatment to be provided over a period of time or number of treatments and DMC Care makes a decision to reduce or terminate such course of treatment (other than by plan amendment or plan termination) before the end of the period of time or number of treatments, then DMC Care will notify you sufficiently in advance of the reduction or termination of the benefit to allow you to appeal and obtain a decision on review before the benefit is reduced or terminated.

If DMC Care receives a request by you to extend beyond the approved period of time or approved number of treatments a course of treatment that qualifies as "urgent care", DMC Care will notify you of its determination no later than 24 hours after receipt of the claim or authorization, provided the claim or authorization is made at least 24 hours before the course of treatment otherwise is scheduled to terminate.

### **Pre-Service Claim or Authorization**

A pre-service claim or authorization is a claim or authorization that requires pre-approval as a condition of coverage. Approval or denial of an initial pre-service claim or authorization will be sent to you within **15 calendar days** after receipt of the claim or authorization, unless an extension is required.

The 15-day period may be extended once up to 15 calendar days. You will be notified of any such extension before the expiration of the initial 15 day period. If the extension is required due to your failure to provide the necessary information, DMC Care will describe the required information. You will have at least **45 calendar days** from receipt of the notice to provide the information. If you fail to submit the necessary information within this 45-day period, then your claim or authorization will be denied.

If you fail to follow the Plan's procedures for filing a pre-service claim or authorization request, DMC Care will notify you of such failure no later than 5 days (24 hours if the pre-service claim or authorization also is an urgent care claim or authorization) following receipt of the claim or authorization request. The preceding sentence only will apply in the case of a claim or authorization that (i) is received by the person responsible for handling benefit matters; and (ii) names a specific claimant, a specific medical condition or symptom and a specific treatment, service or product.

## Post-Service Claim or Authorization

A post-service claim is a claim that does not require pre-approval as a condition of coverage. Approval or denial of an initial post-service claim will be sent to you within **30 calendar days** after receipt of the claim, unless an extension is required. The 30-day period may be extended once up to 15 calendar days. If the extension is required due to your failure to provide the necessary information, DMC Care will describe the required information. You will have at least **45 calendar days** from receipt of the notice to provide the information. If you fail to submit the necessary information within this 45-day period, then your claim will be denied.

## What to Do if a Claim or Authorization is Denied

If your claim or authorization for payment is denied in whole or in part, your *Explanation of Benefits* (EOB) or other formal denial letter from the Plan will indicate the reason for the nonpayment.

If you think that DMC Care incorrectly denied all or part of your claim or authorization, you or your provider should contact DMC Care and ask them to check the claim or authorization to make sure it was processed correctly.

## 1st Level of Appeal to DMC Care

If DMC Care indicates that your claim or authorization has been processed correctly, you can submit your claim or authorization for a formal review. **Your first formal request for review of a denied claim or authorization must be submitted to DMC Care (not to the Employer) within 180 days of receipt of denial of your initial claim or authorization.** Send your request in writing and mail it to DMC Care, 4707 St. Antoine, Detroit, Michigan 48201. If you fail to timely submit your claim or appeal within this 180-day period, you will waive your appeal rights under this Plan and may forfeit your right to bring a civil action in court regarding the denied claim or authorization.

Include the patient's name and address, the employee's DMC ID number, the reason you believe the claim or authorization was wrongly denied, a reference to the type of benefit involved, and any other information you would like considered about the claim or authorization.

DMC Care will review your disputed claim or authorization appeal. If your claim or authorization is still completely or partially denied, DMC Care will notify you within the timeframes set forth below for Final Benefit Determination.

If DMC Care denies your claim or authorization during this 1st Level of Appeal and you would like to pursue further review of your denied claim or authorization, you have the following options:

## Voluntary 2nd Level of Appeal to DMC Care

DMC Care is required to render a decision regarding your appeal within timeframes set by law. Unfortunately, DMC Care often is required to deny a request for review because it has not received from you or your provider all information necessary to accept the claim or authorization within the timeframe set by law to render a decision. As a result, the Plan is offering you the opportunity to voluntarily resubmit your denied claim or authorization to DMC Care for its reconsideration. You must resubmit your claim or authorization request for reconsideration to DMC Care no later than **60 days** of receipt of DMC Care's denial of your claim or authorization during the first level of review. DMC Care will notify you of its decision on reconsideration within the timeframes set forth below for Final Benefit Determination. Again, this voluntary appeal option gives you or your provider the additional time needed to submit all requested information for DMC Care's consideration in rendering its final decision. However, you are not required to resubmit your claim or authorization request to DMC Care and may instead make a final appeal directly to the Employer as described below.

## Final and Mandatory Level of Appeal by the Employer

If you decide to forego the Voluntary 2nd Level of Appeal to DMC Care as described above, or, if DMC Care denies your claim or authorization during such a voluntary appeal, you have the right to submit your denied claim or authorization to the Benefits Committee of the Employer for final review. Please mail or e-mail your request for final review to:

Detroit Medical Center  
Benefits Committee  
c/o David Weiner  
3663 Woodward Ave., Ste. 200  
Detroit, Michigan 48201  
Benefitscommittee@dmc.org

You must make a request, either in writing or electronically, within **60 days** following receipt of the denial from DMC Care (i.e. within 60 days of DMC's denial of your claim or authorization during the 1st Level of Appeal to DMC Care, if you have decided to forego the Voluntary 2nd Level of Appeal to DMC Care, or within 60 days of DMC's denial of your claim or authorization during the Voluntary 2nd Level of Appeal). If you fail to timely submit your claim or authorization request within this 60-day period, you will waive your appeal rights under this Plan and you may forfeit your right to bring a civil action in court regarding the adverse benefit determination.

**With regard to review of your denied claim or authorization, the following provisions apply:**

- When you request DMC Care to review your claim or authorization request during the 1st Level of Appeal or when you request the Benefits Committee of the Employer to review your claim or authorization request during the Final and Mandatory Level of Appeal, DMC Care and/or the Benefits Committee will not afford deference to DMC Care's initial decision to deny your claim or authorization. Also, any review of your denied claim or authorization during the 1st Level of Appeal and/or the Final and Mandatory Level of Appeal will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the initial denial, nor the subordinate of such individual.
- The request for review at any stage may include comments, documents, records and other information relating to the claim or authorization for benefits.
- During any stage of a review, the claimant may represent himself or appoint a representative to do so, and you will have the right to inspect all documents, records and other information that is relevant to the claim or authorization.
- The review of the adverse benefit determination shall take into account all comments, documents, records and other information submitted relating to the claim or authorization, without regard to whether such information was submitted or considered in the initial benefit determination.
- In the review of an adverse benefit determination, that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or whether or not the same was medically necessary or appropriate, the reviewer shall consult with a Health Care Professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal nor the subordinate of any such individual.
- You have the right to request that the Plan identify the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination; such identity will be disclosed upon your request without regard to whether the advice was actually relied upon in making the benefit determination.
- In the case of a claim or authorization involving urgent care, there will be an expedited review process pursuant to which a request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by you and all necessary information, including the Plan's benefit determination on review, shall be transmitted between the Plan and the claimant by telephone, facsimile or other available similarly expeditious method.
- With regard to the Voluntary 2nd Level of Appeal to DMC Care, (i) the Plan will not assert a failure to exhaust administrative remedies if you elect to forego the Voluntary 2nd Level of Appeal and instead pursue your denied claim or authorization directly with the Employer and thereafter in court; (ii) the Plan agrees that any statute of limitations applicable to pursuing your claim or authorization in court will be tolled during the period of the voluntary appeal process; and (iii) there will no fees charged by the Plan as part of the voluntary appeal process.

## Final Benefit Determination

DMC Care (for the 1st or Voluntary 2nd Level of Appeal of your denied claim or authorization) and the Benefits Committee of the Employer (for the Final and Mandatory Level of Appeal of your denied claim or authorization) will notify the claimant of the benefit determination on review in accordance with the following, whichever is appropriate.

- In the case of a claim or authorization involving **urgent care**, the reviewer shall notify the claimant of the Plan's benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than **72 hours** after receipt of the claim or authorization and the claimant's request for review of an adverse benefit determination.
- In the case of a **pre-service claim or authorization**, the reviewer will notify the claimant of the Plan's determination on review within a reasonable period of time appropriate to the medical circumstances, but in no case later than **15 days** after receipt by the Plan of the claimant's request for review of an adverse benefit determination.
- In the case of a **post-service claim**, the reviewer will notify the claimant of the Plan's benefit determination on review within a reasonable period of time, but in no case later than **30 days** after receipt by the Plan of the claimant's request for an adverse benefit determination.

## Information That Will Be Provided To You Regarding Denied Claims or Authorizations

If you are denied a benefit under the Plan, DMC Care (or its delegate) typically will provide you written or electronic notice of the following:

- the specific reason for the denial;
- a reference to the pertinent Plan provisions on which the denial is based;
- a statement providing you reasonable access (free of charge upon request) to copies of all documents, records and other information relevant to your claim or authorization for benefits;
- a description of any additional material or information necessary for you to complete the claim or authorization and explain why such information is necessary;
- a description of the Plan's appeal procedures and time limits applicable to the procedures;
- a statement that a copy of the internal rule, guideline, protocol, or other similar criterion relied upon in making the denial on review is available free of charge upon request;
- an explanation of the scientific or clinical judgment used for making the denial on review of a case involving medical necessity or that is based on an experimental treatment or a similar exclusion or limit is available free of charge upon request; and
- a statement of your right to bring a civil action under Section 502(a) of ERISA following a final adverse benefit determination.

## General Claim or Authorization Provisions

DMC Care (or its delegate) and/or the Benefits Committee of the Employer has full discretion in determining any matter regarding a claim or authorization for benefits under the Plan and their decision upon review will be binding on you, your heirs and assigns, and all other persons claiming by, through or under you.

Any suit brought to contest or set aside an adverse benefit determination is to be filed in a court of competent jurisdiction within one year from the date of the receipt of written or electronic notice of the Employer's final decision. Service of legal process shall be made upon the Plan by service upon the agent for service of legal process or upon the Benefits Committee.

No legal action to recover Plan benefits or to enforce or clarify rights under the Plan can be commenced under ERISA, or under any other provision of law, whether or not statutory, until a claimant first exhausts the claims and review procedures available to him or her under this Plan.

## Forfeiture of Uncashed Checks

If the Plan (through the Employer or its third party administrator) makes payment to you (and/or to your dependents or to a provider on your behalf) of an approved benefit claim and the check for such benefit claim remains uncashed (regardless of the reason) for a period of more than **one (1) year** after the issue date of the check, then you (and/or your dependents or the provider) will forfeit all rights for reimbursement or payment of such benefit claim under the terms of Plan and you will not be entitled to reinstate your rights with respect to such benefit claim at anytime thereafter. Also, the Plan requires that you submit your initial claim for payment within 12 months after the date of service for benefit claims. If you submit your claim after this 12-month period, then you (or your dependents or the provider acting on your behalf) will forfeit all rights to payment or reimbursement under the Plan, and the Plan will deny such benefit claim.

## Section 6 - Glossary

<b>Ambulatory Surgery Facility</b>	An Ambulatory Surgery Facility is a separate outpatient facility that is not part of a hospital, where surgery is performed and care related to the surgery is given. The procedures performed in this facility can be performed safely without overnight inpatient hospital care.
<b>Coinsurance</b>	The percentage of the eligible charge the Member is required to pay for covered services.  Coinsurance <b>does</b> go towards the member out-of-pocket maximum.
<b>Co-pays</b>	Co-pay is a flat dollar amount you pay each time you use the service.  Co-pays <b>do not</b> go towards the member out-of-pocket maximum.  You will not have a Co-Pay and Deductible for the same service.
<b>Deductible</b>	A specified amount that the Member pays during each benefit period for services before the Plan begins to pay.  The annual deductible <b>does</b> go towards the member out-of-pocket maximum.
<b>Fee Schedule</b>	A contractual arrangement in which participating providers agree to accept a list of specific fees as the total fees for health care services provided.
<b>Individual Circumstance (IC)</b>	A set of facts to be considered, concerning an individual's benefits, arising out of a situation or event that is similar in nature.
<b>Per-Admission Deductible</b>	For each admission, the member will be responsible for a set or flat dollar amount before the Plan begins to pay.  The amount of the Per-Admission Deductible is determined by the employee's choice of Basic or Plus and the Tier of the provider.  Per-Admission Deductible does <b>NOT</b> apply to the member out-of-pocket maximum.

<b>Out-of-Pocket</b>	<p>The maximum the Member will pay during the calendar year. This includes deductibles and coinsurance.</p> <p>However, it does not include any co-pays and amounts above the eligible charge that the Member may pay if they visit out-of-network providers, or any amounts for certain covered services that may be subject to limitations as outlined in the SPD.</p>
<b>Tier 1</b>	<p>Best benefit level &amp; lowest out of pocket</p> <ul style="list-style-type: none"> <li>▶ DMC Facilities</li> </ul> <p>Same benefit for Basic &amp; Plus</p>
<b>Tier 2</b>	<p>High \$\$\$ out of your pocket for co-insurance</p> <ul style="list-style-type: none"> <li>▶ Cofinity Facilities</li> </ul>
<b>Tier 3</b>	<p>Higher \$\$\$\$ out of your pocket for co-insurance</p> <ul style="list-style-type: none"> <li>▶ MultiPlan Facilities</li> </ul>
<b>Tier 4</b>	<p>Highest \$\$\$\$\$ out of your pocket for co-insurance</p> <ul style="list-style-type: none"> <li>▶ No Contracts</li> <li>▶ No OOP Protection</li> </ul>
<b>Usual and Customary Payment</b>	<p>The payment for a health care service that is consistent with the average rate or charge for identical or similar services in a certain geographical area.</p>

## Section 7 - Amendments



**2010 - 2011 DMC Care SPD Amendments / Summary of Material Modifications:**

- 1) Tier 3 Contacts
- 2) Important Points to Understand
- 3) Power Operated Wheelchair, Cochlear Implants, Pharmacy
- 4) Coordination of Benefits
- 5) Tier 3 Provider
- 6) Coordination of Benefits
- 7) Tier 3 Provider
- 8) Immunization Update
- 9) Immunization Addition
- 10) Skilled Nursing Facility Benefit
- 11) Chiropractic Care
- 12) Hospice Care
- 13) Cochlear Implants
- 14) Tier 3 Provider
- 15) 2011 Prior Authorization List (Exhibit A)
- 16) Bariatric Surgery (Exhibit B)
- 17) Skilled Nursing Facility & DME – Power Operated Wheelchair
- 18) Hospice Benefit
- 19) Podiatry Benefit
- 20) Cosmetic Services
- 21) Sterilization
- 22) Infertility
- 23) 2011 BASIC Benefit Summary Grid Co-pay Changes
- 24) 2011 PLUS Benefit Summary Grid Co-pay Changes
- 25) Benefit Maximums
- 26) Behavioral Health and Substance Abuse (BHSA)
- 27) BHSA BASIC Benefit Summary Grid
- 28) BHSA PLUS Benefit Summary Grid
- 29) Prescription Drug Plan

1. **Page 2; Section 1 – Contacts – DMC Care Tier 3**  
(New provider)

**Should Read:** HealthSmart Holding, Inc.  
Headquarters: 222 W. Las Colinas Blvd., Suite 500N  
Irving, Texas 75039  
866-687-0500  
www.healthsmart.com

2. **Page 3, Section 1 – Important Points to Understand, paragraph two**  
(Change of provider)

**Should read:** (Cofinity & HealthSmart)

3. **Pages 4 – 6, 2010 Medical Benefit Summary Major Changes**

(Addition of 2011; Update to Power Operated Wheelchairs or Vehicles limitation and Cochlear Implants)  
(Reference to 2011 Pharmacy Co-pay Changes)

**Should read:** 2010 – 2011 Medical Benefit Summary Major Changes

**Should read:** Power Operated Wheelchairs or Vehicles  
•One (1) every 5 years – Prior Auth Require

**Should read:** Cochlear Implant  
•PLUS Benefit Only

**Should read:** DMC Onsite & Navitus Network Pharmacies – See *Summary of Material Modifications # 24.*

4. **Page 6, Section 2 – Coordination of Benefits, Paragraph two**  
(Remove COB Rider and correct language)

**Should read:** If, however, your dependents HAVE medical coverage that is primary through another employer plan AND expect to use *DMC Care benefits* (i.e. Coordination of Benefits), then you must have enrolled in *DMC Care PLUS*. When you have enrolled in DMC Care PLUS, DMC Care will pay your secondary up to the contracted amount. If you did not enroll in the *DMC Care PLUS plan then:*

- DMC Care WILL NOT pay for your dependent’s “other plan” deductibles or co-insurance costs under the Tier 1 (in-network) benefit level , AND
- DMC Care WILL NOT pay (coordinate) your dependent’s claims for services

5. **Page 7, Section 2 – Health & Medical Benefits, Member Responsibility**  
(Delete all (5) references to MultiPlan)

**Should read:** HealthSmart (5 entries)  
HealthSmart contact number (866) 511-4757

6. **Page 8, Section 2 – Schedule of Benefits, Coordination of Benefits**  
(Update; remove COB and COB Rider language)

**Should read:** See # 4

7. **Page 9, Section 2 – Schedule of Benefits**  
(Delete paragraph two regarding MultiPlan)

**Should read:** HealthSmart has over a quarter century of experience in offering customized plans for self-insured employer groups. DMC Care has selected Health Smart as its Tier 3 partner to help you and the health plan keep your out of pocket costs to a minimum. Tier 3 eligible charges may equal the HealthSmart contract for the individual provider

8. **Page 12, Section 2 – Immunizations**  
(Update HPV Vaccine)

**Should read:**

<b>9 – 26 Years/Female and Male:</b>
--------------------------------------

9. **Page 12, Section 2 – Immunizations**  
(Addition of Herpes Zoster Vaccine)

**Should read:**

<b>60 Years or Older:</b>
•Herpes Zoster Vaccine

10. **Page 13, Section 2, Skilled Nursing Facility Sidebar**  
(Delete the words per lifetime and insert the word annually)

**Should read:** SNF benefits are limited to 365 days annually. The 365 day limit will be reduced 2 days...

11. **Page 14, Section 2, Chiropractic Care, last sentence of paragraph.**  
(Addition of Tier 4)

**Should read:** Benefits are payable at a Tier 2, Tier 3 and Tier 4 level only.

12. **Page 14, Section 2, Hospice Care, last sentence of paragraph.**

(Remove the word lifetime and insert the word annual)

**Should read:** Benefits are subject to an annual maximum of \$10,000.

13. **Page 15, Section 2, Cochlear Implants**

(Addition of DMC Care PLUS requirement)

**Should read:** One implant per lifetime at DMC Facility only. 12 months of age or older. Prior authorization required. Purchase of DMC Care PLUS required.

14. **Page 17, Section 2, 2010 Prior Authorization Requirements, Sidebar, paragraph two**

(Delete MultiPlan; insert HealthSmart)

**Should read:** If you go to a Tier 2 Cofinity or a Tier 3 HealthSmart provider, make sure...

15. **Pages 17 – 19, Section 2, 2010 Prior Authorization Requirements**

(Change year to 2011 and reference 2011 Prior Authorization Requirements)

**Should read:** 2011 Prior Authorization Requirements

**See: EXHIBIT A – 2011 DMC Care Prior Authorization Requirements**

16. **Page 21, Section 2, Bariatric Surgery (continued), Qualifying Medical Criteria**

(Delete Qualifying Medical Criteria 1 – 9)

(Insert Bariatric Surgery Candidate Clinical Assessment Screening Checklist)

**Should read:** Bariatric Surgery Candidate Clinical Assessment Screening Checklist

**See: EXHIBIT B – Bariatric Surgery Candidate Clinical Assessment Screening Checklist**

17. **Page 23, Section 2, Exclusions and Limitations – Skilled Nursing Facility (SNF), 1<sup>st</sup> sentence**

**Page 23, Section 2, Exclusions and Limitations – Durable Medical Equipment, Power Operated WC**

(SNF: delete the words per lifetime; insert the word annually. WC: delete the word lifetime: insert every 5 years)

**Should read:** Benefits are limited to 365 days annually.

Power Operated Wheelchairs or vehicles are limited to one every 5 years (prior auth required)

18. **Page 24, Section 2, Exclusions and Limitations – Hospice**

(Delete the word lifetime and insert the word annually)

**Should read:** Benefits are subject to a maximum of \$10,000 annually and require prior authorization.

19. **Page 24, Section 2, Exclusions and Limitations – Podiatry, 1<sup>st</sup> bullet**

(Addition of the word routine)

**Should read:** •Routine treatment for corns, calluses, or toenails is not covered unless you are...

20. **Page 24, Section 2 – Exclusions and Limitations, Cosmetic Services**

(Insert 3<sup>rd</sup> bullet regarding coverage limitation after receiving a service that is not a covered benefit)

**Should read:**

•Complications associated with cosmetic services that are “**not a covered benefit**” will not be covered until the 31<sup>st</sup> day post service

21. **Page 25, Section 2, Exclusions and Limitations – Sterilization Reversal**  
(Title change and sentence addition)

**Should read: Sterilization and Sterilization Reversal**

Elective Sterilization using Vasclip® is not a covered benefit.  
Surgical reversal of a previous Sterilization is not a benefit.

22. **Page 25, Section 2, Exclusions and Limitations – Infertility, last sentence in paragraph**  
(Delete last sentence; add excluded procedure as last sentence in paragraph)

**Should read:** Thawing of cryo-preserved embryo is not a covered benefit.

23. **Page 26, Section 2, Benefit Summary Grid, DMC Care Basic**  
(Update Office Visit, Urgent Care, ER Visit Co-pays)  
(Add one time annual, adult, routine physical exam co-pay elimination at Tier 1 providers only)  
(Footnote #2, delete MultiPlan; insert HealthSmart)

**Should read:**

DMC Care Basic 2011	DMC Tier 1	Cofinity (PPOM) Tier 2	OON Tier 3 <sup>2</sup>	No Provider Contract Tier 4
Office Visits	\$20 Co-pay	\$35 Co-pay	No Change	No Change
Adult Routine Physical Exam (once annually)	\$0 Co-pay	\$35 Co-pay	No Change	No Change
Urgent Care Visits	\$30 Co-pay	\$45 Co-pay	No Change	No Change
ER Visit	\$55 Co-pay	\$155 Co-pay	\$155 Co-pay	\$155 Co-pay

<sup>2</sup> Tier 2 Eligible Charge equals the HealthSmart Approved Amount as defined by the HealthSmart contract...

24. **Page 26, Section 2, Benefit Summary Grid, DMC Care Plus**  
(Update Office Visit, Urgent Care, ER Visit Co-pays)  
(Add one time annual, adult, routine physical exam co-pay elimination at Tier 1 providers only)  
(Footnote #2, delete MultiPlan; insert HealthSmart)

**Should read:**

DMC Care – Plus 2011	DMC Tier 1	Cofinity (PPOM) Tier 2	OON Tier 3 <sup>2</sup>	No Provider Contract Tier 4
Office Visits	\$20 Co-pay	\$30 Co-pay	No Change	No Change
Adult Routine Physical Exam (once annually)	\$0 Co-pay	\$30 Co-pay	No Change	No Change
Urgent Care Visits	\$30 Co-pay	\$35 Co-pay	No Change	No Change
ER Visit	\$55 Co-pay	\$130 Co-pay	\$130 Co-pay	\$130 Co-pay

<sup>2</sup> Tier 2 Eligible Charge equals the HealthSmart Approved Amount as defined by the HealthSmart contract...

25. **Page 28, Section 2, Benefit Maximums, 1<sup>st</sup>, 4<sup>th</sup>, 5<sup>th</sup> bullets**

(Delete the word lifetime or per lifetime; add the word annual or annually)  
 (Insert Voluntary Interruption of Pregnancy (VIP) as 8<sup>th</sup> bullet)

**Should read:** 1<sup>st</sup> Bullet: •Total Annual Benefit Maximum (Mental Health included) \$2,000,000  
 4<sup>th</sup> Bullet: •Skilled Nursing Facility Maximum: 365 days annually, reduced by 2 days...  
 5<sup>th</sup> Bullet: •Hospice Annual Benefit Maximum: \$10,000  
 8<sup>th</sup> Bullet: •VIP Maximum: One procedure per lifetime; additional procedures require prior auth

26. **Page 29, Section 3, Behavioral Health & Substance Abuse, 3<sup>rd</sup> Sidebar**

(Delete the word Lifetime and insert the word Annual)

**Should read:** Mental health included in Annual Maximum Benefits of \$2,000,000.

27. **Page 30, Section 3, Behavioral Health & Substance Abuse, DMC Care Basic Grid**

(Under Residential Treatment (Behavioral Health only) delete the word Lifetime and insert the word Annual)

**Should read:**

BHSA Benefit 2010 – 2011 – Basic	DMC Tier 1	Value Options Tier 2	Out of Value Options Network Tier 3
Residential Treatment (Behavioral Health only)	365 Day Annual Limitation – Reduced by 2 Days for Each Day of Acute Hospitalization		

28. **Page 30, Section 3, Behavioral Health & Substance Abuse, DMC Care Plus Grid**

**Should read:**

BHSA Benefit 2010 – 2011 – Plus	DMC Tier 1	Value Options Tier 2	Out of Value Options Network Tier 3
Residential Treatment (Behavioral Health only)	365 Day Annual Limitation – Reduced by 2 Days for Each Day of Acute Hospitalization		

29. **Pages 32 – 33, Section 4 – Prescription Drugs, 2010-2011 Prescription Drug Plan, DMC “On Site” Pharmacies, Navitus Network Pharmacies and Pharmacies Outside the Navitus Network**  
(Co-pay changes for Generic Drugs, Formulary Brand Name and Non-Formulary Brand Name)

**Should Read: DMC “On-Site” Pharmacies**

**Generic Drugs**

\$7 co-pay per prescription

**Formulary Brand Name**

\$17 co-pay per prescription

**Non-Formulary Brand Name**

\$35 co-pay per prescription

**Navitus Network Pharmacies**

**Generic Drugs**

\$17 co-pay per prescription

**Formulary Brand Name**

30% co-pay per prescription with \$35 minimum, \$50 maximum

**Non-Formulary Brand Name**

40% co-pay per prescription with \$65 minimum, \$105 maximum

**Pharmacies Outside the Navitus Network**

**Generic Drugs**

\$17 co-pay per prescription

**Formulary Brand Name**

No Change

**Non-Formulary Brand Name**

No Change

**Attachments (2):**

**Exhibit A** – DMC Care 2011 Prior Authorizations Requirements

**Exhibit B** – Bariatric Surgery Candidate Clinical Assessment Screening Checklist

Section 7 Amendments to the 2010 – 2011 Summary Plan Description for the DMC Medical and Prescription Plan booklet will be available online at: [www.dmc-care.org](http://www.dmc-care.org).

# 2011 DMC Care Prior Authorization List

# EXHIBIT A

You must call 877-501-0958 for pre-authorization before you or any of your covered dependents receive the following medical services marked with an X:

<b>INPATIENT CARE (All inpatient admissions require notification prior to admission)</b>	<b>Tier 1</b>	<b>Tier 2*</b>	<b>Tier 3*</b>	<b>Tier 4*</b>
All Elective In-Patient Hospital Admissions	X	X	X	X
Emergency / Urgent Admissions	X	X	X	X
Obstetrical (OB) Admissions (exceeding 48 hrs LOS for vaginal delivery & 96 hours for C-Section delivery) <sup>1</sup>	X	X	X	X
All Rehab Admissions (prior to admission)	X	X	X	X
All Skilled Nursing Facility Admissions (prior to admission)	X	X	X	X
All Sub-Acute Admissions (prior to admission)	X	X	X	X
<b>OUTPATIENT DIAGNOSTIC PROCEDURES</b>	<b>Tier 1</b>	<b>Tier 2*</b>	<b>Tier 3*</b>	<b>Tier 4*</b>
CT Scan (any anatomic location)	<b>Not Required</b>	X	X	X
MRI/MRA (any anatomic location)	X	X	X	X
PET Scan	<b>Not Required</b>	X	X	X
CTA (Computed Tomographic Angiography) (Non- Cardiac)	<b>Not Required</b>	X	X	X
CTA/CCTA(Computed Coronary Tomography Angiography) <sup>2</sup>	X	X	X	X
Capsule Endoscopy	X	X	X	X
Cardiac Event Monitors (Real-time continuous)	X	X	X	X
<b>Following services provided in a doctor's office will not be covered: MRI/MRA, CT Scan, PET Scan, CTA, CCTA, Nuclear Testing <sup>3</sup></b>	<b>Not Covered</b>	<b>Not Covered</b>	<b>Not Covered</b>	<b>Not Covered</b>
<b>SURGICAL PROCEDURES</b>	<b>Tier 1</b>	<b>Tier 2*</b>	<b>Tier 3*</b>	<b>Tier 4*</b>
Sclerotherapy/Ligation of Varicose Veins ( <b>All Treatments/Surgery</b> )	X	X	X	X
Breast Repair and/or Reconstruction ( <b>Related to non-cancer diagnosis or history</b> )	X	X	X	X
Breast Reduction -Mammoplasty	X	X	X	X
Uterine Artery Embolization	<b>Not Required</b>	X	X	X
Bariatric Surgery	X	<b>Not Covered</b>	<b>Not Covered</b>	<b>Not Covered</b>
Cochlear Implants (Age Restrictions, Coverage: DMC Care Plus Only)	X	<b>Not Covered</b>	<b>Not Covered</b>	<b>Not Covered</b>
<b>All Spinal (Back)</b>	X	X	X	X
Any Cosmetic Procedure- ( <b>Performed at a Facility</b> ) (See list per SPD Manual. Does not include mole removal, skin lesion removal or skin tag removal)	X	X	X	X
Transplants (Organ, Bone Marrow & Corneal) & Related Services <sup>4</sup>	X	X	X	X
Keloids (Surgery)	X	X	X	X
<b>REHABILITATION THERAPY</b>	<b>Tier 1</b>	<b>Tier 2*</b>	<b>Tier 3*</b>	<b>Tier 4*</b>
Physical Therapy, Occupational Therapy or Speech Therapy ( <b>17 years of age and under</b> )	X	X	X	X
Physical Therapy, Occupational Therapy or Speech Therapy ( <b>Extension Beyond 30 visits-regardless of age</b> )	X	X	X	X
Cardiac and Pulmonary Rehabilitation Services	X	X	<b>Not Covered</b>	<b>Not Covered</b>
<b>HOME HEALTH CARE</b>	<b>Tier 1</b>	<b>Tier 2*</b>	<b>Tier 3*</b>	<b>Tier 4*</b>
Hospice (Inpatient/Home)	X	X	X	X
Home Care (Skilled Nurse, Social Worker, Home Health Aide, Other)	X	X	X	X
Physical Therapy/Occupational Therapy/Speech Therapy	X	X	X	X
Infusion Therapy	X	X	X	X
<b>OTHER</b>	<b>Tier 1</b>	<b>Tier 2*</b>	<b>Tier 3*</b>	<b>Tier 4*</b>
Hemodialysis / Home Dialysis/ CAPD (Continuous Ambulatory Peritoneal Dialysis)	X	X	X	X
Infusion Therapy ( <b>Covered only for Facility Based or Infusion Center</b> )	X	X	X	<b>Not Covered</b>
<b>Exception: chemotherapy for cancer related care</b>				
Botulinum Toxin (Botox/Myobloc) ( <b>Physician Office</b> )	X	X	X	X
Hyperbaric Oxygen Therapy	X	X	X	X
Unique Services/Procedures (Including Not Available at <b>any</b> DMC Facility)	X	X	X	X
Donor Transplant Related Services	X	<b>Not Covered</b>	<b>Not Covered</b>	<b>Not Covered</b>
<b>DURABLE MEDICAL EQUIPMENT (DME)</b>	<b>Tier 1</b>	<b>Tier 2*</b>	<b>Tier 3*</b>	<b>Tier 4*</b>
Durable Medical Equipment (DME) <b>(Single purchase items with costs/purchase price greater than \$1,000)</b>	X	X	X	X
<b>All DME Rentals</b> including but not limited to C-PAP, BiPAP, Oxygen, Insulin Pumps, Ventilators, Wound Vacuums	X	X	X	X
Prosthetics and Orthotics (including braces) over \$1,000 per item	X	X	X	X
Vagus Nerve Stimulator, Bone Growth Stimulator, Sacral Nerve Stimulator, Neuromuscular Electrical Stimulator, Spinal Stimulator, Electrical Stimulators	X	X	X	X
Continuous Glucose Monitoring Devices	X	X	<b>Not Covered</b>	<b>Not Covered</b>
Enteral Formula	X	X	X	X
Communication Devices	X	X	X	X
<b>GENETIC TESTING</b>	<b>Tier 1</b>	<b>Tier 2*</b>	<b>Tier 3*</b>	<b>Tier 4*</b>
Oncotype DX Breast Cancer Assay ( <b>Breast Cancer only</b> )	X	X	X	<b>Not Covered</b>
Breast Cancer: BRCA 1 & BRCA 2 Genetic Testing	X	X	X	X
Genetic Testing ( <b>All Types</b> )	X	X	X	X

**Please note:** Authorization of a service/procedure does not eliminate the member's responsibility for co-pays, deductibles or coinsurance.

**Authorization of a service DOES NOT guarantee payment.**

\* Tier 2, 3, & 4 services will result in higher out of pocket costs for the member (co-pays & co-insurance)

**REVIEW LIMITATIONS/EXCLUSIONS FOR CERTAIN SERVICES AS DETAILED IN THE DMC CARE SUMMARY DESCRIPTION PLAN (SPD) BOOKLET AND ADDENDUMS FOR 2010-2011.**

**AUTHORIZATION EXCEPTIONS:**

<sup>1</sup> Authorization is required for OB deliveries that exceed the standard admission timelines: 48 hours for Vaginal & 96 hours for C-Section

<sup>2</sup> Coronary CTA must be ordered by a Cardiologist

<sup>3</sup> Nuclear cardiac stress tests performed in a Tier 1 Cardiology/Cardiovascular office may be covered; Refer to the DMC Care website @ [dmc-care.org](http://dmc-care.org) for additional information

<sup>4</sup> Tier 2, 3, & 4 Transplant services managed per DMC Care Transplant Network

**Mental Health/Behavioral Health Services – CALL VALUEOPTIONS (877-362-2472) prior to starting treatment or services for mental health, behavioral health or substance abuse needs.**

**NOTE:** This list may be updated throughout the year. Please visit the DMC Care website at <http://www.dmc-care.org> or call 1-800-543-0161 for the most current listing.

DMC CARE BARIATRIC SURGERY CANDIDATE CLINICAL ASSESSMENT  
SCREENING CHECK LIST

EXHIBIT B

Date of Request: \_\_\_\_\_

Member Name: _____	<input type="checkbox"/> DMC Care Plus
Member ID #: _____	<input type="checkbox"/> DMC Care Basic
DOB: _____	Age: _____
Physician/Surgeon: _____	

The DMC Care Bariatric Surgery benefit requires that specific qualifying medical criteria must be met to support the medical necessity for the surgical procedure. Documentation must be submitted to DMC Care Medical Management for review and formal authorization by the plan's Medical Director before the surgery can be done.

DMC Care Medical Management Contact Information: Phone: 1-877-501-0958 Fax: 313-745-0930

1. BMI \_\_\_\_\_

2. Co-morbidities (Check all that apply):

- |   |  |
|---|--|
| <input type="checkbox"/> Cardiovascular Disease | <input type="checkbox"/> Coronary Artery Disease |
| <input type="checkbox"/> Type 2 Diabetes        | <input type="checkbox"/> Pulmonary Hypertension  |
| <input type="checkbox"/> Hypertension           | <input type="checkbox"/> Sleep Apnea             |

3. Active participation **within the last two years** in a weight loss program for a **minimum of 6 consecutive months** under the supervision of a physician or registered dietitian (See below for required documentation):

a. Weight Management Program:

- Weight Watchers  Jenny Craig  Medical Weight Loss  
 Other: \_\_\_\_\_

b. Dates of Participation: From: \_\_\_\_\_ To: \_\_\_\_\_

c. Name of Physician/Dietitian: \_\_\_\_\_

4. Monthly records for a period of **at least 6 consecutive months** documenting participation in a weight management program that meets **ALL** of the following criteria:

- Weight measurements done  
 Compliance with dietary regimen attempted  
 Compliance with exercise regimen attempted  
 Behavioral modification

5. Evaluation within the last 12 months which includes **ALL** of the following:

- Evaluation by bariatric surgeon recommending surgery  
 Medical clearance from a physician other than bariatric surgeon  
 Clearance for bariatric surgery by a mental health provider: psychological evaluation  
 Nutritional evaluation by a physician or registered dietitian  
 Letter from primary care doctor

6. Medical documentation supports that Member does not have **ANY** of the following conditions that would exclude them from the benefit

- Active substance abuse
- Non-compliance with previous medical care
- Terminal disease
- Pregnancy
- Severe psychopathology

**DMC**<sup>™</sup>

**DMC Care**

DETROIT MEDICAL CENTER

800-543-0161  
[www.dmc-care.org](http://www.dmc-care.org)

1/2010