

2010
2011

Summary Plan Description for the DMC Medical and Prescription Plan

Summary of Your Health and Medical Benefits
& Prescription Drug Plan

BARBARA ANN
KARMANOS
CANCER INSTITUTE
Wayne State University

800-543-0161
www.dmc-care.org

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Section 1 – Overview

Welcome

Dear Karmanos Cancer Institute Employee:

Welcome to the DMC Care Benefit Plan, a program offered under The Karmanos Cancer Institute Health Care Benefits Plan. This booklet describes the benefits to which you are entitled as a DMC Care participant. These benefits are effective on January 1, 2010.

We are available to answer your questions and assist you in filing claims and collecting the benefits to which you are entitled. Please let us know if we can help.

We know you will appreciate the security which the DMC Care Benefit 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

PHARMACY BENEFIT MANAGER

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

BEHAVIORAL HEALTH & SUBSTANCE ABUSE

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

Important Points to Understand

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

It makes sense to choose Participating Providers.

For COBRA continuation coverage and other important information about your participation in the DMC Care Benefit Plan, please check with your human resources department.

Most benefits under the DMC Care Benefit Plan can be provided by Participating Providers. Participating Providers are providers that have contracted with DMC Care. The DMC Care Benefit Plan provides greater benefits when services are performed by a Participating Provider. See page 8 for details.

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.

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.

2010 Medical Benefit Summary Major Changes

| Benefit Description | 2009 Benefit | 2010 Benefit Limitation(s) |
|---|-------------------------------|--|
| Power Operated Wheelchairs or Vehicles | No limitation | <ul style="list-style-type: none"> •One (1) per lifetime - Prior Auth Required •One every 5 years (3 years -17 years of age), Prior Auth Required |
| 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> <p>1) When the donor has medical coverage, the donor's health plan will pay primary.</p> <p>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.</p> <p>3) If the donor has no insurance DMC Care will provide coverage for transplant at DMC facility only.</p> <p>4) Donor DMC Care coverage is limited to 30 days post-op.</p> |
| Transplant Services - Not Available at the DMC | No restriction | <p>Transplant Services not available at DMC Tier 1 facilities are limited to a "Preferred Network" of Providers - Prior Auth Required is required for all transplant services.</p> <p>▶ Services provided outside of the "Preferred Network" are subject to significant member co-insurance responsibility (High \$\$\$ Out of Pocket).</p> |

| Benefit Description | 2009 Benefit | 2010 Benefit Exclusion(s) |
|--|---------------------|----------------------------------|
| 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 | <ul style="list-style-type: none"> ▶ Prior authorization change: 60* visits (combined) per condition - within a 12 month period beginning with the first date of service. Authorization required after 30 visits to continue OT/PT/ST. |
| MRI/MRA/CT Scan | No Authorization required if done at a DMC Facility | <ul style="list-style-type: none"> ▶ Prior authorization required even if done at DMC facility. ▶ Non Coverage Notice: MRI/MRA/CT Scans performed at a physician's office will not be covered |
| 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. |
| 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 | |
|--|-------------------|-------------------------------|--|
| | | In Network | Out of Network |
| IV Infusion (Excludes Chemotherapy) – Home Health Care | None | 5% | 60% of eligible charges after deductible |
| IV Infusion (Excludes Chemotherapy) – Infusion Center | None | 5% | 60% of eligible charges after deductible |
| Home Health Care Services | None | 5% | 60% of eligible charges after deductible |
| Dialysis Treatments | None | 5% | 60% of eligible charges after deductible |

Section 2 – Health & Medical Benefits

Overview of Section

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

Member Responsibility

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

- Medical Benefits
- Co-pay and Deductible requirements
- DMC Care Contracted Providers
- Appeal 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.

The DMC Care Provider Directory is available on the DMC Care Website at 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. Please contact the DMC Care Customer Service Department at (800) 543-0161 for a copy of the provider directory or to verify whether or not your physician is still a DMC Care Participating Provider.

Make sure you know the details of the plan.

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

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

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.

Deductibles and Out-of-Pocket Expenses

There is a mandatory \$10 co-pay for each physician office visit.

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.

Again, it makes sense to choose Participating Providers.

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 two types of costs which you may incur. You are responsible for expenses such as deductibles and co-pays as described below. For out-of-network benefits, DMC Care pays a percentage of the Covered Medical Expenses (60% of eligible charges after deductible). You are responsible for paying the balance. There are no out of pocket maximums.

Some of your expenses are subject to an annual Deductible. **Deductibles do not apply at DMC facilities and providers.** The maximum annual Deductibles for the Calendar Year are:

| IN-NETWORK | OUT-OF-NETWORK |
|---|-------------------------------|
| Deductibles/Co-Pays are waived at DMC facilities excluding Emergency and Urgent Care | |
| \$150 per person | \$300 per person |
| \$300 per family | \$600 per family |
| \$0 per hospital admission | \$1500 per hospital admission |
| \$0 Ambulatory surgery | Ambulatory surgery‡ |
| \$0 Out-patient procedures | Out-patient procedures‡ |

‡ Out-of-Network DMC Care pays 60% of eligible charges after deductible

Out-of-Network (OON) charges will include any required deductibles and balance of charges over and above the established Fee Schedule. **The member is responsible for paying the balance. These fees may be substantial because out-of-network physicians and hospitals have not extended any discounts for these 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.

Participating Providers

Check to make sure your physician is a Participating Provider.

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

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.

DMC Care Hospitals

DMC Care Hospitals include the nine (9) Hospitals of The Detroit Medical Center:

- 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 Michigan Orthopaedic Specialty Hospital
- DMC Rehabilitation Institute of Michigan
- DMC Sinai-Grace 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 or go to the web site www.dmc-care.org.

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

Covered Medical Expenses and Benefits

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

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.

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

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

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.

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 22)
- 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)
- Well Woman Care (i.e. Pap Smear and Mammogram)
- Well Child Care

IMMUNIZATIONS**0-18 Years**

- Diphtheria, Tetanus, Pertussis: DTaP
- Inactivated Poliovirus
- Hemophilus Influenza: Hib
- Measles, Mumps, Rubella: MMR
- 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

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.

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.

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

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

| Benefit Description | In Network Co-insurance Application | Out of Network Co-insurance Application |
|--|-------------------------------------|--|
| IV Infusion (Excludes Chemotherapy) – Home Health Care | 5% | 60% of eligible charges after deductible |
| IV Infusion (Excludes Chemotherapy) – Infusion Center | 5% | 60% of eligible charges after deductible |
| Home Health Care Services | 5% | 60% of eligible charges after deductible |
| Dialysis Treatments | 5% | 60% of eligible charges after deductible |

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

Home Health Care Benefits are subject to Prior-Authorization.

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

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. Chiropractic care is available out-of-network 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 limited 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 and specialized equipment such as C-PAP, BiPAP or wound vacs.
- 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.

A 20% co-pay applies to in-network Durable Medical Equipment rentals and purchases, excluding certain supplies. For out-of-network benefits DMC Care pays a percentage or the covered medical expense (60% of eligible charges after deductible). The member is responsible for paying the balance.

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. Prior authorization is required.

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.
- Casts, splint, braces and crutches.
- Replacement prosthetics and orthotics for Covered Dependents under 18 years old if required by growth or normal use.

Hearing Aids

Examinations for the prescription, fitting and molding of a hearing aid. Benefit is limited to \$1000 every 36 months 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. Prior authorization required.

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 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.

Sterilization

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

This Infertility benefit is limited to a lifetime maximum benefit of \$15,000 for medication and treatment and is covered only within the DMC network.

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

| PHYSICAL THERAPY, SPEECH THERAPY, OCCUPATIONAL THERAPY |
|---|
| <ul style="list-style-type: none"> • Services are payable for 60 visits combined per condition per year within a 12 month period beginning with the 1st date of service. Prior authorization required after 30 visits to continue OT/PT or speech therapy regardless of age. |
| <ul style="list-style-type: none"> • The therapy must be prescribed by a Physician. |
| <ul style="list-style-type: none"> • The therapy requires the assistance and supervision of an appropriate licensed PT, OT or speech therapist. |
| <ul style="list-style-type: none"> • The therapy must be given for a condition, which is capable of significant improvement in a reasonable and generally predictable period of time. |
| <ul style="list-style-type: none"> • 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. |
| <ul style="list-style-type: none"> • Speech therapy is covered after acute conditions such as but not limited to: stroke, closed head injury, etc. |
| <ul style="list-style-type: none"> • 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. |
| <ul style="list-style-type: none"> • Applied behavioral analysis is not a covered benefit. |
| <ul style="list-style-type: none"> • 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. |

2010 Prior Authorization Requirements

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

If you go to an out-of-network provider, make sure they get prior authorization for these services and procedures.

Services that are not prior authorized can be denied for payment by the plan.

Authorization does not guarantee payment.

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

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 | IN NETWORK | OUT OF NETWORK* |
|---|--------------|-------------------------|
| All Elective In-Patient Hospital Admissions (Requires notification prior to admission) | X | X |
| Emergency / Urgent Admissions (Requires notification prior to admission) | X | X |
| All Rehab Admissions (prior to admission) | X | X |
| All Skilled Nursing Facility Admissions (prior to admission) | X | X |
| All Sub-Acute Admissions (prior to admission) | X | X |
| OUTPATIENT DIAGNOSTIC PROCEDURES | IN NETWORK | OUT OF NETWORK* |
| CT Scan (any anatomic location) | Not Required | X |
| MRI/MRA (any anatomic location) | X | X |
| PET Scan | Not Required | X |
| CTA (Computed Tomographic Angiography) (Non- Cardiac) | Not Required | X |
| CTA/CCTA(Computed Coronary Tomography Angiography)* *MUST BE ORDERED BY CARDIOLOGIST* | X | X |
| Capsule Endoscopy | X | X |
| Following services provided in a doctor’s office will not be covered: MRI/MRA, CT Scan, PET Scan, CTA, CCTA, Nuclear Testing | Not Covered | Not Covered |
| SURGICAL PROCEDURES | IN NETWORK | OUT OF NETWORK* |
| All Outpatient Surgical Procedures (Facility Only) | Not Required | Notification Required** |
| Sclerotherapy/Ligation of Varicose Veins (All Treatments/Surgery) | X | X |
| Breast Repair and/or Reconstruction (Related to non-cancer diagnosis or history) | X | X |
| Breast Reduction -Mammoplasty | X | X |
| Uterine Artery Embolization | Not Required | X |
| Bariatric Surgery | X | Not Covered |
| Cochlear Implants (Age restrictions) | X | Not Covered |
| All Spinal (Back) Surgery | X | X |
| Any Cosmetic Procedure-Facility Only (Does not include mole removal, skin lesion removal or skin tag removal) | X | X |
| Transplants (Organ, Bone Marrow & Corneal) & Related Services | X | Limited Network*** |

| REHABILITATION THERAPY | IN NETWORK | OUT OF NETWORK* |
|--|-------------------|------------------------|
| Physical Therapy, Occupational Therapy or Speech Therapy (under 18 years of age) | X | X |
| Physical Therapy, Occupational Therapy or Speech Therapy (Extension Beyond 30 visits-regardless of age) | X | X |
| Cardiac Rehab | X | X |
| HOME HEALTH CARE | IN NETWORK | OUT OF NETWORK* |
| Hospice (Inpatient/Home) | X | X |
| Home Care (Skilled Nurse, Social Worker, Home Health Aide, Other) | X | X |
| Physical Therapy/Occupational Therapy/Speech Therapy | X | X |
| Infusion Therapy | X | X |
| OTHER | IN NETWORK | OUT OF NETWORK* |
| Hemodialysis / Home Dialysis/ CAPD (Continuous Ambulatory Peritoneal Dialysis) | X | X |
| Infusion Therapy (Facility Based or Infusion Center only) other than chemotherapy | X | X |
| Infusion Therapy (Physician Office) | Not Covered | Not Covered |
| In-office Botulinum Toxin (Botox/ Myobloc) | X | X |
| Hyperbaric Oxygen Therapy | X | X |
| Unique Services/Procedures (Including Not Available at any DMC Facility) | X | X |
| Donor Transplant Related Services | X | Not Covered |
| DURABLE MEDICAL EQUIPMENT (DME) | IN NETWORK | OUT OF NETWORK* |
| Durable Medical Equipment (DME) (Costs/purchase price greater than \$1,000) | X | X |
| All DME Rentals including but not limited to C-PAP, BiPAP, Oxygen Therapy, Insulin Pumps, T.E.N.S. Units | X | X |
| Prosthetic and Orthotic Appliances over \$1,000 (Including Shoe Orthotics) | X | X |
| Ventilators | X | X |
| Wound Vacuums | X | X |
| Enteral Formula | X | X |
| Communication Devices | X | X |
| GENETIC TESTING | IN NETWORK | OUT OF NETWORK* |
| Oncotype DX Breast Cancer Assay (Breast Cancer only) - Genomic Health Inc. | X | X |
| Breast Cancer: BRCA 1 & BRCA 2 Genetic Testing | X | X |
| Genetic Testing (All Types) | X | X |

* = Out of Network 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

SECTION

2

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.

NOTE: This list may be updated throughout the year. Please check www.dmc-care.org or call 800-543-0161 for the most current listing.

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 members with the following limitations and exclusions:

LIMITATIONS:

- 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.
- The bariatric surgery benefit is limited to one surgery per lifetime.
- Prior authorization is required; member must meet DMC Care criteria for bariatric surgery.
- 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.
- Member must be 18 years of age or older.

EXCLUSIONS:

- Procedures performed for cosmetic re-sculpting of the body after bariatric surgery.
- Nutritional supplements for post-operative, long term nutritional care following bariatric surgery.
- Vertical Banding, Gastric Balloon and Stapling procedures are excluded from this benefit.
- Bariatric surgery revision (previous surgery) is not a covered benefit.

Bariatric Surgery *(continued)*

Qualifying criteria may be revised as necessary. Please check the www.dmc-care.org website for updates.

| 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 all 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, DMC Care may accept clinical notes from the member's primary care physician that specifically record a period of one consecutive year of: |
| 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, including charges by blood donors and organ donors
- 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.
- 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.
- Charges by a Christian Science Practitioner, nurse or facility.

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

Exclusions and Limitations *(continued)*

Experimental treatments are not covered.

Karmanos Cancer Institute Employees who have an exposure while at work must receive treatment through Karmanos Cancer Institute 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 is payable at an out-of-network benefit level only.

Hospice

Benefits are subject to a maximum of \$10,000 lifetime. Prior authorization required.

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 member age 3-17 years of age/prior authorization required).
- Insulin Pumps are limited to one every 4 years and require prior authorization.
- 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 with in 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 / 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.
- OT/PT/ST limited to 60 visits combined, per condition for one year from 1st date of service.

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.

Prior authorization is required after 30 visits to continue OT/PT/ST, regardless of age.

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 and are paid only at 75% of the DMC Care Fee Schedule.
- 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

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 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

Deductibles

| | DMC CARE BASIC NETWORK | OUT OF BASIC NETWORK |
|----------------|---------------------------|-------------------------|
| Per Subscriber | \$150 | \$300 |
| Per Family | \$300 | \$600 |

Inpatient Hospital Care

| | DMC CARE BASIC NETWORK | OUT OF BASIC NETWORK |
|--------------|---------------------------|-------------------------|
| Days of Care | 365 | 365 |
| Deductible* | 0 | \$1,500* |

* DMC Care Inpatient Hospital Care Deductible is applied per admission.

Maternity Care

| | DMC CARE BASIC NETWORK | OUT OF BASIC NETWORK |
|--------------|---------------------------|-------------------------|
| Days of Care | 365 | 365 |
| Deductible* | 0 | \$1,500‡ |

‡ Out-of-Network DMC Care pays 60% eligible charges after deductible

Hospital Outpatient/Outpatient Facilities

| | DMC CARE BASIC NETWORK | OUT OF BASIC NETWORK |
|---------------------------|--|---------------------------------------|
| Emergency Care Deductible | \$50 Emergency care co-pay waived if admitted | \$150 |
| Urgent Care Deductible | \$10 | \$25 |
| Ambulatory Surgery | 0 | 60% eligible charges after deductible |
| Out Patient Procedures | 0 | 60% eligible charges after deductible |

Physician Services

| | DMC CARE BASIC NETWORK | OUT OF BASIC NETWORK |
|---|---------------------------|-------------------------|
| Office Visit Co-Pay | \$10 | ‡ |
| Well Child Office Visit (Infant to 2 yrs) | \$10 | ‡ |
| Annual Physical Adults & Children >age 2 | \$10 | ‡ |
| GYN Office Visit | \$10 | ‡ |
| Specialist Office Visit | \$10 | ‡ |
| Podiatric Office Visit | \$10 | ‡ |
| Pre/Post Natal Office Visit | \$10* | ‡ |
| Allergy Injections | No Co-Pay | ‡ |

* First visit only.

‡ Out-of-Network DMC Care pays 60% of eligible charges after deductible

Laboratory Services for all DMC Care Plans

| | |
|-----------------------------|--|
| DMC University Labs/JVHL | No Co-Pay |
| Out-of-Network Laboratories | DMC Care pays 60% of eligible charges after deductible |

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

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.

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 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. 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. Accredited setting only.

| BHSA Benefit 2010 | DMC Care | |
|--|--|---|
| | DMC / Value Options In-Network | Value Options Out-of-Network |
| Annual Deductible | In-Network \$150 – Individual \$300 – Family | Out of Network \$300 – Individual \$600 – Family |
| Annual Out Of Pocket Limit | No Out of Pocket Limit | |
| Per Admission Deductible | DMC Facility \$0 / Admission | |
| | Value Options Facility \$300 / Admission | \$1,000 Per admission |
| Hospital coverage | 100% | 90% of fee schedule after admission deductible (Member can be balance billed) |
| Office Visits | \$10 Co-pay per visit | 50% of eligible charge after deductible (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

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 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.

Prior Authorization Forms are available via the DMC Care website at www.dmc-care.org. A link will take you to navitus.com for form access.

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

Three-Level Pharmacy Co-Pay Structure

For your convenience, the DMC Care Benefit Program allows you to select your prescription from one of three classifications, or levels, 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.

Brand Name Formulary Drugs / Tier 2

- Brand name formulary 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.

Brand Name Non-Formulary / Tier 3

- Brand name non-formulary 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.

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

\$25 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 (click on the Pharmacy tab in the upper right hand drop down box, then on the Pharmacy Mail Service tab).

- 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 examples.

Navitus Network Pharmacies

Generic Drugs

\$15 co-pay per prescription

Formulary Brand Name

30% co-pay per prescription with \$30 minimum, \$45 maximum

Non-Formulary Brand Name

40% co-pay per prescription with \$55 minimum, \$95 maximum

Pharmacies Outside the Navitus Network

Generic Drugs

\$15 co-pay per prescription

Formulary Brand Name

30% co-pay per prescription with no maximum

Non-Formulary Brand Name

40% co-pay per prescription with no maximum

Save money by using the mail-order pharmacy service.

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 or any Human Resource Forms Rack.

Please note: The Navitus preferred 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 co-pay.

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**, 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).

EXCLUDED DRUG CLASSES FOR 2010

| | |
|---------------------------------|----------------------|
| Obsolete Drugs | Anabolic Steroids |
| Biologicals | Topical Minoxidil |
| Vitamins (Prenatal covered) | Hair Growth Products |
| Relenza | Tamiflu |
| Non Reimbursable Cosmetic Usage | Nutritional/Dietary |

Limitations

The forms you'll need are available online at www.dmc-care.org

- 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 website.
- Navitus Preferred Network does not include any CVS pharmacies. Member will be subject to out of network co-pays.
- 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.
- 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 the DMC require prior authorization.
- 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

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 31.

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:

Karmanos Cancer Institute
Amy Ryder, Director
Human Resource Operations
4100 John R
Detroit, MI 48201

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 by the claim or authorization and 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 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

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| Ambulatory Surgery Facility | 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. |
| Coinsurance | The percentage of the eligible charge the Member is required to pay for covered services. Coinsurance does go towards the member out-of-pocket maximum. |
| Co-pays | Co-pay is a flat dollar amount you pay each time you use the service. Co-pays do not go towards the member out-of-pocket maximum. You will not have a Co-Pay and Deductible for the same service. |
| Deductible | A specified amount that the Member pays during each benefit period for services before the Plan begins to pay. The annual deductible does go towards the member out-of-pocket maximum. |
| Fee Schedule | A contractual arrangement in which participating providers agree to accept a list of specific fees as the total fees for health care services provided. |
| Individual Circumstance (IC) | A set of facts to be considered, concerning an individual's benefits, arising out of a situation or event that is similar in nature. |
| Per-Admission Deductible | 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 NOT apply to the member out-of-pocket maximum. |

Section 6 - Glossary *(continued)*

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| Out-of-Pocket | <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> |
| Usual and Customary Payment | <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

BARBARA ANN
KARMANOS
CANCER INSTITUTE
Wayne State University

800-543-0161
www.dmc-care.org