



**PLEASE READ
IMMEDIATELY!!**

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FY2009-10 PPO PLAN DESIGN ADJUSTMENTS

This packet contains vital information concerning changes and new options to your MCSIG PPO plan. Some changes are effective July 1, 2009 and some are effective January 1, 2010. It is important that you read all this material so you will understand how these changes may affect your options and out-of-pocket costs starting July 1, 2009. These changes affect all PPO plans.

Nationally, insurance premiums and medical costs continue to spiral upward. MCSIG is experiencing a 5% trend for self-funded claims during FY09 and a 7% claims trend is forecast for FY10. Premiums for the fully-insured programs (chiropractic, mental health and stop-loss) are trending 22%. By implementing the plan changes described in this mailer, we were able to reduce the FY10 actuarially calculated premium increase from 15.24% to 11.74%.

Your Executive Committee and Full Board's primary objectives in implementing these plan design adjustments were to help control claims costs while, at the same time, providing our members with choices.

The next few pages provide detailed information about each plan design change. Information is printed on both sides of each sheet of paper in this packet. Our customer service representatives are trained and available to help you understand these plan design adjustments. Please feel free to call them at 831-755-8055 or 800-287-1442 should you have any questions.

!!! These documents describe changes to your MCSIG PPO medical plan. These are legally binding documents. Please keep these documents with your PPO plan booklet!!!

EMERGENCY ROOM CO-PAY

Effective July 1, 2009, the Emergency Room co-pay will change from \$50 to \$250. This co-pay will apply to each ER admission. Also effective July 1, 2009 we have expanded the conditions in which the ER co-pay can be waived or reimbursed (described below).

The Emergency Room Visit Co-pay in the **SCHEDULE OF BENEFITS** section of your PPO medical plan booklet is amended to read:

	Options I, II, III Participating Providers	Options I, II, III Non-Participating Providers
	YOU PAY	YOU PAY
Emergency Room Visit Co-pay (Outpatient)	\$250 (may be waived or reimbursed as provided in the ADDITIONAL CO-PAYS section of this plan booklet). The ER co-pay does NOT accrue to your annual deductible or out-of-pocket maximum.	\$250 (may be waived or reimbursed as provided in the ADDITIONAL CO-PAYS section of this plan booklet) PLUS 40% of customer and reasonable charge PLUS charges in excess of covered expense. The ER co-pay does NOT accrue to your annual deductible or out-of-pocket maximum.

Paragraph #1 under the **ADDITIONAL CO-PAYS** section of your PPO medical plan booklet is amended to read:

Each time you visit an emergency room for treatment you will be responsible for paying the \$250 Emergency Room Co-pay. The ER co-pay does NOT accrue to your annual deductible or out-of-pocket maximum. The ER co-pay may be waived or reimbursed, with appropriate proof, under the following circumstances:

- The reason for the ER visit meets the definition of “Emergency” under the **DEFINITIONS** section of your PPO medical plan booklet
- The patient was admitted
- A medical provider advised the patient to call 911 or go to the ER
- The ER visit was for the diagnosis and/or treatment of any life threatening symptom associated with any of the ConditionCare Primary Conditions (Asthma, Coronary Artery Disease, Heart Failure, Chronic Obstructive Pulmonary Disease and Diabetes) AND
 - The patient is currently enrolled and actively participating in the ConditionCare Program, or
 - The patient subsequently immediately enrolls in the ConditionCare program and actively participates for one year (co-pay to be refunded at the end of the year).

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DURABLE MEDICAL EQUIPMENT BENEFIT

Effective July 1, 2009, MCSIG's durable medical equipment benefit will change as follows:

The **SCHEDULE OF BENEFITS** section of your PPO medical plan booklet is amended in pertinent part to read:

	Options I, II, III Participating Providers	Options I, II, III Non-Participating Providers
	YOU PAY	YOU PAY
Durable Medical Equip- ment	20% of Prudent Buyer Plan negotiated rate. \$5,000 per member per year plan limit applies. Any single item over \$2,000 requires pre-certification review.	40% of customary and reasonable charge PLUS charges in excess of covered expense. \$5,000 per member per year plan limit applies. Any single item over \$2,000 requires pre-certification review.

The **MEDICAL CARE THAT IS COVERED** section of your PPO medical plan booklet is amended in pertinent part to read:

Durable Medical Equipment – Rental or purchase of dialysis equipment; dialysis supplies; purchase of a wig after a chemotherapy treatment. Rental or purchase of other medical equipment and supplies which are:

- Of no further use when medical needs ends;
- For the exclusive use of the patient;
- Not primarily for comfort, convenience or hygiene;
- Not for environmental control or for exercise; and
- Manufactured specifically for medical use

We will determine whether the item satisfies the conditions above. Prior authorization required for DME item costing \$2,000 and above. Covered rental or purchase charges will not exceed \$5,000 per year.

The **AUTHORIZATION PROGRAM** section of your PPO medical plan booklet is amended in pertinent part to read:

SERVICES REQUIRING AUTHORIZATION

Special Services

Any single item of Durable Medical Equipment costing \$2,000 and above.

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PHARMACY BENEFIT CHANGES

MCSIG is making the following changes to the pharmacy program **effective July 1, 2009:**

GENERIC MAIL-ORDER ZERO CO-PAY (All Participants)

The generic mail-order co-pay will change from \$14 to \$0. Starting 7/1/09 you can obtain 90 day supplies of generic maintenance drugs through mail-order for NO-CO-PAY!!!

RETAIL PHARMACY OPTION FOR MAINTENANCE DRUGS (effective 1/1/2010 for Medicare participants)

Your MCSIG Board considered participant feedback concerning the exclusive mail-order pharmacy benefit feature and is responding to participants' request for a retail choice for maintenance drugs. Participants may continue to enjoy savings and convenience by obtaining their maintenance medications through mail-order or participants may now fill maintenance drug prescriptions at a retail pharmacy.

Here's how the retail option for maintenance drugs will work: Similar to mail-order, participants may obtain the first two fills of a **new** maintenance medication at retail (either 30 or 60 day supplies) at the regular retail co-pays (co-pay multiplier applies to 60-day fills). Upon choosing their third and subsequent refills for their maintenance medications at retail, participants will pay a 30-day *retail maintenance co-pay* as follows: Generic: \$9.50 Brand: \$29.00 Non-Formulary: \$44.00. Sixty day retail maintenance refills are subject to the co-pay multiplier (twice the 30-day co-pay amount). Ninety day fills at retail are not available.

The higher retail maintenance co-pay is actuarially calculated to insure that the mail-order maintenance drug benefit does not subsidize the retail maintenance drug benefit and will be evaluated and adjusted annually.

DRUG QUANTITY MANAGEMENT FOR NARCOTICS

The drug quantity management program implemented last year will be expanded to include narcotics. The drug quantity management program optimizes our participants' value for their co-pay by making sure they get the FDA recommended quantity of drug for their co-pay amount. There is an additional charge for drug quantities dispensed above the FDA recommended quantity.

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SPOUSE PRIMARY COVERAGE PROVISION

Effective **January 1, 2010**, MCSIG is implementing a spouse primary coverage provision* for all PPO plans.

What is the spouse primary coverage provision? It is a new eligibility rule that requires the working spouse of a MCSIG participant to be enrolled in their employer's medical plan (if the employer pays at least 75% of the employee-only premium from any source) as a condition of being enrolled as a spouse dependent in any of MCSIG's medical PPO plans (Options I, II and III).

When does the spouse primary coverage provision take effect? The provision takes effect on January 1, 2010.

Why is the spouse primary coverage provision being implemented? The medical insurance offered by a working spouse's employer should be the primary source of payment for the working spouse's medical benefits. Some local employers pay their employees a stipend to NOT take the employer's medical coverage or the spouse simply chooses not to take their employer's coverage. The spouse primary coverage provision is designed to properly shift primary medical coverage to a working spouse's employer's medical plan.

Under what conditions may a spouse be enrolled as a dependent on a MCSIG PPO plan? A spouse may be enrolled as a spouse dependent in MCSIG under the following circumstances:

- the spouse is unemployed, self-employed, or retired; or
- the spouse is employed and the spouse's employer does not offer medical insurance coverage for the spouse, or
- the spouse's employer offers medical insurance coverage but the spouse does not meet the employer's medical insurance eligibility requirements; or
- the spouse's employer offers medical insurance coverage but the employer pays less than 75% of the employee-only premium; or
- The spouse's employer offers medical insurance coverage and the employer pays at least 75% of the employee-only premium and the spouse is enrolled in the employer's medical coverage.

What do I need to do to comply with this new provision? Over the next few months, all enrolled spouses will receive a Spouse Primary Coverage Form to complete and return to MCSIG. If you have a working spouse enrolled as a dependent on the MCSIG plan and are claiming one of the exceptions described above, you will be required to submit a letter from your employer verifying the exemption. If you have a working spouse whose employer offers medical insurance and pays at least 75% of the employee-only premium (from any source) you have to provide proof of the spouse's enrollment in their employer's medical plan as a condition of enrolling the spouse as a dependent on MCSIG.

What if my spouse participates in a Section 125 (cafeteria) plan? Most Section 125 (cafeteria) plans hold an open enrollment just prior to the beginning of each plan year (which usually start January 1). If your spouse's employer offers an open enrollment prior to January 1, 2010 and your spouse's employer offers a medical plan for which they pay at least 75% of the employee-only premium and you wish to keep your spouse enrolled as a spouse dependent in MCSIG then your spouse should enroll in their employer's medical plan during open enrollment.

*The spouse primary coverage provision also applies to domestic partners.

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SPOUSE PRIMARY COVERAGE PROVISION (CONTINUED)

Effective **January 1, 2010**, Section 2 and 2a of the **WHEN BENEFITS BEGIN** section of your PPO medical plan booklet are amended in pertinent part to read:

2. Your lawful Spouse of the opposite sex as defined in the Definitions Section is eligible for coverage on the first of the month following enrollment if:
 - An enrollment form has been submitted by you, and
 - A certified copy of your marriage certificate is submitted by you, and
 - The spouse affidavit of coverage form has been submitted and evidences that:
 - The spouse is unemployed, self-employed, or retired; or
 - The spouse is employed and the spouse's employer does not offer medical insurance coverage for the spouse, or
 - The spouse is employed and the spouse's employer does offer medical insurance coverage for the spouse but the spouse does not meet the employer's medical insurance eligibility requirements; or
 - The spouse is employed and the spouse's employer does offer medical insurance coverage for the spouse but the employer pays less than 75% of the employee-only premium, or
 - The spouse is employed and the employer pays at least 75% of the employee-only medical premium through any source (such as direct payment or through a Section 125 benefits plan) and the spouse is currently enrolled in their employer's medical insurance coverage.
- 2a. Your lawful dependents as defined in the Definitions Section are eligible for coverage at the same time as you if:
 - An enrollment form has been submitted by you, and
 - A certified copy of the dependent's birth certificate or other documentation evidencing qualifying relationship to the MCSIG participant is submitted by you (e.g., adoption or guardianship papers, marriage certificate establishing step-parentage, etc). In some cases multiple documents may be required.

Effective **January 1, 2010**, the first paragraph of Section 4 of the **WHEN BENEFITS BEGIN** section of your PPO medical plan booklet is amended in pertinent part to read:

4. Your Domestic Partner is eligible for coverage on the first of the month following enrollment if:
 - An enrollment form has been submitted by you, and
 - A copy of the recorded Declaration of Domestic Partnership filed with the State of California has been submitted by you, and
 - The domestic partner affidavit of coverage form has been submitted and evidences that:
 - The domestic partner is unemployed or self-employed, or retired; or
 - The domestic partner is employed and the domestic partner's employer does not offer medical insurance coverage for the domestic partner, or
 - The domestic partner is employed and the domestic partner's employer does offer medical insurance coverage for the domestic partner but the domestic partner does not meet the employer's medical insurance eligibility requirements; or
 - The domestic partner is employed and the domestic partner's employer does offer medical insurance coverage for the domestic partner but the employer pays less than 75% of the employee-only premium, or
 - The domestic partner is employed and the employer pays at least 75% of the employee-only medical premium through any source (such as direct payment or through a Section 125 benefits plan) and the domestic partner is currently enrolled in their employer's medical insurance coverage.

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HEALTHPLACE AMERICA SURGERY BENEFIT

MCSIG is adding a new surgery benefit option.

By no later than September 2009, a new surgery option, Healthplace America Surgery Benefit, will be available to participants in all PPO medical plans. The Healthplace America Surgery Benefit will provide our members with additional hospital options for many elective (non-emergency) surgical procedures at medical centers of excellence located throughout the U.S. As an added incentive, participants' will have all deductibles and co-insurance waived for surgeries performed through the Healthplace America Surgery Benefit program.

Other features of the Healthplace America program include:

- A Personal Care Coordinator to coordinate your travel, hospital admission and after-care
- Fully paid reasonable travel and hotel costs for the participant and a companion
- A stipend for food and incidental costs
- Expert second opinion
- Participant's choice from among Healthplace America U.S. Medical Centers of Excellence offering the patient's surgical need

We will soon announce the availability date (no later than September 2009) and distribute more information about the Healthplace America Surgery Benefit. In the meantime you can explore their website at www.healthplaceamerica.com.

Effective July 1, 2009, the following paragraph is added to the **ADDITIONAL BENEFITS** section of your PPO medical plan booklet:

HEALTHPLACE AMERICA SURGERY BENEFIT

The Healthplace America Surgery Benefit (Surgery Benefit) is provided through Healthplace America. Surgeries provided through the Surgery Benefit will not be subject to the annual deductible or co-payment provisions of the plan. In addition, reasonable travel costs for the patient and one companion are arranged by, and paid for, through the Surgery Benefit. Call MCSIG Customer Service at 800-287-1442 for more information.

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CHOMP/SVMH ELECTIVE SURGERY CO-PAY

Effective September 1, 2009 MCSIG is adding a new \$500 per surgery co-pay for elective surgeries that participants choose to have performed at Community Hospital of the Monterey Peninsula (CHOMP) or Salinas Valley Memorial Hospital (SVMH) if that same surgery is available through the Healthplace America Surgery Benefit Program. This \$500 per surgery co-pay for CHOMP/SVMH will **not** accrue towards the participant's annual deductible or out-of-pocket maximum.

Effective September 1, 2009, the following is added as a new Hospital Benefits category to the **SCHEDULE OF BENEFITS** section of your PPO medical plan booklet:

	Options I, II, III Participating Providers	Options I, II, III Non-Participating Providers
	YOU PAY	YOU PAY
Elective (non-emergency) Surgery Co-pay (applies to CHOMP & SVMH only)	\$500 per elective (non-emergency) surgery conducted at CHOMP or SVMH for surgeries available through the Healthplace America Surgery Benefit. (Does not accrue towards annual deductible or out-of-pocket maximum).	N/A

Effective September 1, 2009, the following paragraph is added to the **ADDITIONAL CO-PAYS** section of your PPO medical plan booklet:

- Each time you choose to have an elective (non-emergency) surgery performed at Community Hospital of the Monterey Peninsula or Salinas Valley Memorial Hospital and that surgery is available through the Healthplace America Surgery Benefit program you will be responsible for paying a \$500 CHOMP/SVMH surgery co-pay. This co-pay will **not** accrue towards your annual co-pay or out-of-pocket maximum.

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LIFETIME MAXIMUM

In recognition of the ever increasing cost of medical services and to protect our members from catastrophic medical costs, the lifetime maximum benefit has been increased from \$2 million to \$5 million for all PPO medical options.

Effective July 1, 2008, the Lifetime Maximum in the **SCHEDULE OF BENEFITS** section of your PPO medical plan booklet is amended to read as follows:

	Options I, II, III Participating Providers	Options I, II, III Non-Participating Providers
Lifetime Maximum	\$5,000,000	

Effective July 1, 2008, the **MEDICAL BENEFIT MAXIMUMS** section of your PPO medical plan booklet is amended to read:

We do not make benefit payments for any Member in excess of any of the Medical Benefit Maximums. Your **\$5,000,000** Lifetime Maximum under this Plan will be reduced by any benefits we paid to you or on your behalf under any other health plan provided by BC Life, or any of its affiliates, which is sponsored by MCSIG. This amount also includes any benefits paid by Medicare that would have been paid to a Member without Medicare.

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