



**PLEASE READ
IMMEDIATELY!!**

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FY2010-11 PPO PLAN DESIGN ADJUSTMENTS

This packet contains vital information concerning changes to your MCSIG PPO plans as well as information concerning a new Exclusive Provider Option (EPO) plan. Some changes are effective July 1, 2010 and some are effective January 1, 2011. 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, 2010. These changes affect PPO Options I & II only. There are no changes to the PPO Option III plan.

Nationally, insurance premiums and medical costs continue to spiral upward. Medical inflation is trending at 9%. By implementing the plan changes described in this mailer, we were able to reduce the FY10-11 actuarially calculated premium increases.

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!!!

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!!! NEW MEDICAL PLAN !!!

Exclusive Provider Option

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Effective July 1, 2010 MCSIG is offering a new Exclusive Provider Option or EPO plan.

Q What benefits will the new EPO plan have?

A The EPO plan benefits will be the same as the PPO Option III in-network benefits.

Q How is the new EPO plan different from the current PPO plans?

A The main difference is that, unlike our PPO plans, the EPO plan pays no out-of-network benefits. This means that if you are in the EPO plan and you utilize providers that are not in the Prudent Buyer network (out-of-network) then the plan will pay no benefits and you will have to pay the provider out of your pocket at their full billed charges.

Q What network will the new EPO plan use?

A Although we are utilizing the same network (Prudent Buyer through Anthem Blue Cross) as the PPO plans we have made two very important changes: Community Hospital of the Monterey Peninsula (CHOMP) and Salinas Valley Memorial Hospital (SVMH) are non-networked for the EPO plan only. Also, the EPO plan will only coordinate benefits with another EPO plan. The EPO plan will NOT coordinate benefits with a PPO plan.

Q Why are CHOMP and SVMH non-network for the EPO plan?

A The goal of the MCSIG Board was to offer an Option III in-network look-alike plan with lower premiums. Carving CHOMP and SVMH out of the EPO network will generate savings that will allow the EPO plan to be offered at lower premiums.

Q What if I require emergency treatment at CHOMP or SVMH?

A For true emergency services at CHOMP or SVMH, you will receive regular in-network benefits for treatment of the emergency condition up to the point where the condition is no longer immediately life threatening. If you require additional non-emergency care and you are ambulatory, the EPO plan will pay to transport you to a networked facility.

Q What is considered emergency treatment?

A Emergency care is considered care to prevent or treat an immediate, life-threatening illness or injury. Once the condition giving rise to the immediate emergency is stabilized, treatment is no longer considered emergency care.

Q How do I know if the new EPO plan is right for me?

A If you are non-Medicare, already utilizing in-network providers and do not have a concern about CHOMP or SVMH being non-network facilities...and...you are looking for a plan with lower premiums, this plan may be for you!

!!! TURN THE PAGE OVER FOR MORE INFORMATION !!!

EPO PLAN BENEFIT SUMMARY COMPARISON

2010

<u>Benefit</u>	<u>PPO Option III In-Network</u>	<u>PPO Option III Out-Of-Network</u>	<u>EPO In-Network</u>	<u>EPO Out-of-Network</u>
Single Rate	\$ 503.78		\$ 440.29	
Double Rate	\$1,007.56		\$ 880.58	
Family Rate	\$1,309.83		\$ 1,144.75	
Annual Deductible	\$650/person \$1,300/family	\$650/person \$1,300/family	\$650/person \$1,300/family	\$650/person \$1,300/family
Annual Out-of-Pocket Maximum	\$4,000/person \$8,000/family	\$7,000/person \$14,000/family	\$4,000/person \$8,000/family	Unlimited
Co-Insurance	80% of most expenses	60% of most expenses	80% of most expenses	No coverage
ER Co-pay	\$250 per visit	\$250 per visit	\$250 per visit	\$250 per visit
Inpatient & Outpatient Surgery & Anesthesia	80% @ 2-bed rate after deductible	60% @ 2-bed rate after deductible	80% @ 2-bed rate after deductible	Not covered except emergency
Hospital stays (inpatient or outpatient)	80% @ 2-bed rate after deductible	60% @ 2-bed rate after deductible	80% @ 2-bed rate after deductible	Not covered except emergency
Office Visits	Primary Care: 100% after \$25 co-pay, no deductible; Specialist: 100% after \$35 co-pay, no deductible	60% after you meet deductible	Primary Care: 100% after \$25 co-pay, no deductible; Specialist: 100% after \$35 co-pay, no deductible	Not covered
Physical Exam (per age schedule)	100% up to \$250 per calendar year; no deductible (employee & spouse only)	100% of UCR, up to \$250 per calendar year; no deductible (employee & spouse only)	100% up to \$250 per calendar year; no deductible (employee & spouse only)	Not covered
Well Child -includes immunizations	100% to age 16; no deductible	60% to age 16, after deductible	100% to age 16; no deductible	Not covered
Chiropractic benefits only through Chiropractic Network of California	100% after \$10 co-pay, no deductible	Not covered	100% after \$10 co-pay, no deductible	Not covered
Behavioral Health benefits only through OptumHealth	\$15 co-pay	40% of UCR	\$15 co-pay	40% of UCR
Network	Anthem Prudent Buyer	60% of UCR	Anthem Prudent Buyer—CHOMP & SVMH non-networked	Not covered
Prescription Drugs (all self-funded Plans)	RETAIL: \$7/\$20/\$35 Up to 30 day supply	RETAIL MTCE: \$9.50/\$29/\$44 Up to 30 day supply	MAIL ORDER: \$0/\$40/\$70 Up to 90 day supply	SPECIALTY: \$21/\$60/\$100 Up to 30 day supply

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HOSPITAL PER ADMISSION CO-PAY PPO OPTIONS I & II ONLY

Effective July 1, 2010, a hospital per-admission co-pay is added to PPO Options I and II as follows:

A new section is added to the **SCHEDULE OF BENEFITS** section of your PPO **Option I or Option II** medical plan booklet as follows:

	Options I & II Participating Providers	Options I & II Non-Participating Providers
	YOU PAY	YOU PAY
Per hospital admission co-pay (does not apply to annual deductible or accrue towards annual out-of-pocket maximum)	<u>Hospital Tier</u>	<u>Per-Admission Inpatient Co-pay</u> <u>Per Episode Outpatient Co-pay</u>
	Tier I	No co-pay No co-pay
	Tier II	\$500 \$250
	Tier III	\$1,000 \$500

Below is a listing of hospital tiers for hospitals located in and near Monterey County. Contact MCSIG customer service for network hospitals not listed below. All network hospitals outside California are Tier I. **All independent networked outpatient surgery centers are in Tier I. Hospital based outpatient surgery centers are tiered.**

<u>Monterey County</u>	<u>San Mateo County</u>	<u>Alameda</u>
CHOMP Tier 3	Menlo Park Tier 2	Alameda County Med Cntr Tier 1
Mee Memorial Tier 3	Peninsula Tier 2	Alameda Hospital Tier 1
Natividad Medical Center Tier 1	San Mateo Regional Tier 1	Alta Bates Alta Campus Tier 2
SVMH Tier 3	Sequoia Tier 1	Alta Bates Summit Tier 2
	Seton Medical Cntr Tier 2	Eden Med Cntr Tier 1
<u>Santa Clara County</u>	<u>San Francisco</u>	
O'Connor Tier 1		St. Rose Tier 1
Regional Medical Cntr San Jose Tier 1	CalPacific (St Luke's) Tier 2	Valleycare Med Cntr Tier 2
Saint Louise Tier 1	CalPacific (Pacific Camp) Tier 2	Washington Hospital Tier 3
Community Hosp of Los Gatos Tier 1	Chinese Tier 1	
El Camino Tier 1		<u>Fresno</u>
Good_Samaritan Tier 1	Saint Francis Memorial Tier 1	Clovis Community Tier 1
Santa Clara Valley Tier 1	San Franciscoc General Tier 1	Coalinga Regional Med Cntr Tier 1
Stanford University Tier 2	Saint Mary's Med Cntr Tier 2	Community Regional Med Cntr Tier 1
<u>Santa Cruz County</u>	UCSF Med Cntr Tier 1	Fresno Heart & Surgical Tier 1
Dominican Tier 2	<u>Santa Barbara</u>	Fresno Surgical Hosp Tier 1
Sutter Maternity & Surgery Cntr Tier 2		
Watsonville Community Tier 1	Goleta Valley Cottage Tier 1	Saint Agnes Med Cntr Tier 1
	Lompoc Valley Med Tier 1	Sierra Kings District Tier 1
<u>San Benito County</u>		
	Santa Barbara Cottage Tier 2	<u>San Luis Obispo</u>
Hazel Hawkins Tier 1	Santa Ynez Valey Cottage Tier 1	
<u>Merced</u>		Arroyo Grande Tier 1
		French Tier 1
Memorial—Los Banos Tier 2		Sierra Vista Med Cntr Tier 1
Mercy Med Cntr—Merced Tier 1		Tw i n Cities Community Tier 1

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PHARMACY BENEFIT CHANGES FOR *SPECIALTY* DRUGS ONLY

What are *specialty* drugs?

Specialty drugs are injectable or noninjectable drugs having one or more of several key characteristics, including:

- Requirement for frequent dosing adjustments and intensive clinical monitoring to decrease the potential for drug toxicity, and increase the probability for beneficial treatment outcomes
- Need for intensive patient training and compliance assistance to facilitate therapeutic goals
- Limited or exclusive product availability, and distribution
- Specialized product handling and / or administrative requirements
- Cost in excess of \$500 for a 30-day supply

Examples of the cost of specialty drugs: A drug to treat a rare form of blood disease costs \$200,000 per patient annually; the use of oral cancer drugs, which cost \$40,000 to \$75,000 per patient, grew 24 percent from 2006 to 2007; a drug that treats hemophilia costs \$100,000 a year per patient.

Why is MCSIG changing the *specialty* drug co-pays?

MCSIG's specialty drug spend trended upward 25.6% between August 2008 and August 2009. Specialty drug growth is projected to outpace the traditional drug market moving from 21% of the total Rx spend to 25% of the total Rx spend by 2012. This trend will be driven by the nearly 400 new specialty drugs in the FDA approval pipeline due to hit the market over the next five years coupled with aggressive direct-to-consumer advertising and direct-to-physician marketing.

Currently, the MCSIG specialty drug co-pays provide for less than an average 1% member share-of-cost. MCSIG is adjusting the specialty drug co-pays to provide for an average 3.5% member share-of-cost. An average 3.5% member share-of-cost for specialty drugs is consistent with market prevalence.

MCSIG is making the following changes to the *specialty* drug pharmacy program effective July 1, 2010*

1. The *specialty* drug co-pays for 30-day fills will be \$21.00 for generic, \$60 for brand and \$100 for non-formulary.
2. Only specified specialty drugs will be available at retail—limited to 3 fills— before requiring fills through CuraScript, our current specialty drug mail-order pharmacy.
3. All new specialty prescriptions will be subject to prior authorization. Prior authorization assures that specialty drugs are dispensed according to clinical guidelines.

*Effective date for Medicare participants is January 1, 2011.

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PPO OPTION I & II ANNUAL DEDUCTIBLE CHANGES

Effective **January 1, 2011**, the annual deductible for PPO Options I and II will change as follows:

The Annual Deductible section of the **SCHEDULE OF BENEFITS** section of your PPO Option I medical plan booklet is amended to read:

	Option I Participating Providers	Option I Non-Participating Providers
	YOU PAY	YOU PAY
Annual Deductible (Applies to all ex- penses unless other- wise noted. Does not include Office Visit and Prescription Drug or Hospital Admission Co-payments)	You pay \$400 per person or You pay two deductibles per family (two individuals must meet their \$400 deductibles to satisfy the family deductible of \$800)	

The Annual Deductible section of the **SCHEDULE OF BENEFITS** section of your PPO Option II medical plan booklet is amended to read:

	Option II Participating Providers	Option II Non-Participating Providers
	YOU PAY	YOU PAY
Annual Deductible (Applies to all ex- penses unless other- wise noted. Does not include Office Visit and Prescription Drug or Hospital Admission Co-payments)	You pay \$500 per person or You pay two deductibles per family (two individuals must meet their \$1,000 deductibles to satisfy the family deductible of \$1,000)	

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PPO OPTIONS I & II MAXIMUM OUT-OF-POCKET CHANGES

Effective **January 1, 2011**, the maximum out-of-pocket amounts for PPO Options I and II will change as follows:

The Annual Out-of-Pocket Maximum in the **SCHEDULE OF BENEFITS** section of your PPO **Option I** medical plan booklet is amended to read:

	Option I Participating Providers	Option I Non-Participating Providers
	YOU PAY	YOU PAY
Annual Out-of-Pocket Maximum (Includes deductible, excludes Office Visit and Prescription Drug and Hospital Admission Co-payments)	You pay \$2,000 per person or \$4,000 per family	You pay \$4,000 per person or \$8,000 per family

The Annual Out-of-Pocket Maximum in the **SCHEDULE OF BENEFITS** section of your PPO

	Option II Participating Providers	Option II Non-Participating Providers
	YOU PAY	YOU PAY
Annual Out-of-Pocket Maximum (Includes deductible, excludes Office Visit and Prescription Drug and Hospital Admission Co-payments)	You pay \$3,000 per person or \$6,000 per family	You pay \$6,000 per person or \$12,000 per family

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PPO OPTION I IN-NETWORK SURGERY BENEFIT CHANGE

Effective **January 1, 2011**, the in-network surgery benefit for PPO Option I will change as follows:

The Surgery/Anesthesia and Ambulatory Surgical Center sections of the **SCHEDULE OF BENEFITS** section of your PPO Option I medical plan booklet are amended to read:

	Option I Participating Providers	Option I Non-Participating Providers
	YOU PAY	YOU PAY
Surgery/Anesthesia	10% after deductible	40% of customary and reasonable charge PLUS charges in excess of covered expense

	Option I Participating Providers	Option I Non-Participating Providers
	YOU PAY	YOU PAY
Ambulatory Surgical Center	10% after deductible	40% of customary and reasonable charge PLUS charges in excess of covered expense

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