

**SUMMARY OF MATERIAL MODIFICATIONS  
TO THE  
MEBCO HEALTH BENEFIT PLAN**

To: All Plan Participants and Beneficiaries

This notice, called a "Summary of Material Modifications," advises you of changes to your coverage under the Plan listed above. Please read this notice carefully, and if you have any questions, please contact the Plan Administrator.

Keep this notice with your Plan Document/Summary Plan Description and make a note in your PD/SPD as to what sections have been changed so that when you go to look up information you will be reminded that certain information has changed.

**Effective January 1, 2011**

**Amendment R.2008.004**

This Amendment:       1) Revises 2011 copayments, deductibles, and coinsurance limits;  
                                  2) Incorporates the provisions of the federal Affordable Care Act; and  
                                  3) Clarifies Plan coverage for certain healthcare facility employees.

**The Section entitled Immediate Reminders is amended to read as follows:**

**IMPORTANT REMINDERS**

**ENROLLMENT**

Failure to report enrollment changes could result in overpayment or denial of benefits. You will be required to reimburse the full amount of any benefit overpayment. Refer to Section II - Eligibility and Enrollment for details.

You must keep your enrollment information updated. It is important that you notify your Consortium Employer immediately for the following:

- Change in marital status
- Birth of a child or addition of a child
- Address change
- *Enrolled disabled child approaching the limiting age*
- *Marriage of your Dependent child*
- Any family member death
- Other group health plan information, including effective dates of coverage and name and address of the other group health plan(s)
- If you or your Dependent become eligible for Medicare due to disability, age or End Stage Renal Disease

**Section I – Summary of Benefits, subsections B., C., and D. are amended to read:**

**B. PREVENTIVE CARE EXPENSE BENEFITS**

<b>Preventive Covered Services</b>	<b>Network</b> <i>Unless otherwise specified below, the recommendations of the United States Preventive Services Task Force will apply.</i>	<b>Out-of-Network</b>
<b>Well Child Care</b>	Benefits provided for eligible children from birth to age 19 (under age 19). Includes age appropriate well child care, usual related tests and immunizations (including the HPV vaccine).	
<ul style="list-style-type: none"> <li>• Routine Physician Nursery Care</li> </ul>	Full Network Benefits for nursery care and circumcision.	Full Benefits for nursery care and/or circumcision.
<ul style="list-style-type: none"> <li>• Well Child Care</li> </ul>	Full Network Benefits	80%, after deductible
<p><b>Adult Routine or Well Care</b></p> <ul style="list-style-type: none"> <li>• <b>Adult Physical</b></li> </ul>	Benefits are provided for limited routine care services not due to illness or injury. Includes Physical exam and related screening tests, such as bone density testing, colorectal cancer screening, diabetes and cholesterol screening.	
	For all Covered Persons age 18 or older.	Out-of-Network benefits available only for active Employees, age 50 or older and/or for active Employee spouses, age 50 or older.
	<b>Full Network Benefits</b>	Benefit available only for the following: <b>Employee, age 50 or older: 80%, after Deductible once per Calendar Year.**</b> <b>Spouse, age 50 or older: 80%, after Deductible once per Calendar Year.**</b>  **Once per year limit is cumulative for Network or Out-of-Network exams. This benefit is not available for the same year eligible Employee or spouse had an exam under the Network Benefit.
<ul style="list-style-type: none"> <li>• <b>Adult Immunizations</b></li> </ul>	<b>Full Network Benefits</b>	<b>80%, after Deductible</b>
<ul style="list-style-type: none"> <li>• <b>Routine Mammography (age 18 or older)</b></li> </ul>	<b>Full Network Benefits in any setting</b>	
	<p>\$40.00 Copayment for Outpatient Hospital services. Other Providers in other settings covered are under Major Medical, subject to Deductible and Percentage Copayment.</p> <p>Frequency based on age and medical history:</p> <ul style="list-style-type: none"> <li>• With a Doctor's orders, Covered Persons, at any age, with a personal medical history of breast cancer, or whose mother or sister has a history of breast cancer;</li> <li>• A single baseline mammography for Covered Persons 35-39 years of age;</li> <li>• An annual mammography for persons age 40 or older.</li> <li>• In no event, will the Plan pay more than one routine mammography screening in any 12 consecutive months.</li> </ul>	

<b>Preventive Covered Services</b>	<b>Network</b> <i>Unless otherwise specified below, the recommendations of the United States Preventive Services Task Force will apply.</i>	<b>Out-of-Network</b>
<ul style="list-style-type: none"> <li><b>Routine Pap Smear and Pelvic Exam</b></li> </ul>	<b>Full Network Benefits</b> Exam includes related gynecological testing.	Benefit available only for the following: Employee, age 50 or older: <b>80%, after Deductible</b> once per Calendar Year.**  Spouse, age 50 or older: <b>80%, after Deductible</b> once per Calendar Year.** ----- **Once per year limit is cumulative for Network or Out-of-Network exams.
<ul style="list-style-type: none"> <li><b>Routine Prostate Cancer Screening (PSA test and related exam)</b></li> </ul>	\$20.00 Copayment per visit. Balance of Network Allowance paid in full.	Benefit available only for the following: Employee, age 50 or older: <b>80%, after Deductible</b> once per Calendar Year.**  Spouse, age 50 or older: <b>80%, after Deductible</b> once per Calendar Year.** ----- **Once per year limit is cumulative for Network or Out-of-Network screening.
<b>Nutritional/Dietary Counseling (for adults with risk factors and both adults and children with obesity)</b>	<b>Full Network Benefits</b> ----- Limited to four (4) visits per Covered Person per Calendar Year. Services must be rendered by a Physician, certified nutritionist or certified or registered dietician. Recommendations of the U.S. Preventive Service Task Force will apply.	<b>Not covered</b>
<b>Smoking/Tobacco Use Cessation Counseling</b>	<b>Full Network Benefits</b> Recommendations of the U.S. Preventive Service Task Force will apply.	<b>Not covered</b>

**C. HOSPITAL EXPENSE BENEFITS (HEB)**

Maternity care is covered the same as any other Illness including, but not limited to, childbirth and other termination of Pregnancy. According to the Newborns' & Mothers' Health Protection Act, a federal law effective for this Plan as of January 1, 1998, a health Plan, or its managed care or benefits management program, that offers coverage for Hospital stays in connection with childbirth cannot limit that coverage to less than a 48-hour Hospital stay following an uncomplicated normal delivery; or less than a 96-hour Hospital stay following a Caesarean section delivery. In addition, the health Plan cannot restrict benefits for any portion of the required minimum stays in a manner that is less favorable than the benefits provided for any preceding portion of the stay. Additionally, this Plan will abide by a state law that provides more favorable maternity stays when such laws affect this Plan.

HEB Covered Services	Network and Out-of-Network Benefits/Limits
<p><b>Hospitals and other Facilities, Agencies</b></p> <p><b>Acute Care General Hospital</b></p>	<p>Most Inpatient admissions and home health care require a mandatory phone call to the Claims Administrator. See Section III - Benefits Management Program for details.</p> <p>Benefits are provided for services and supplies rendered and billed by a covered Hospital, facility or agency for the treatment of an Illness or injury. Inpatient private room will be allowed at the Average Semi-Private Room Rate. Benefit limits are per Covered Person. Benefit Limits are cumulative for In Network and Out-of-Network Providers. Note: If you use an Out-of-Network Provider you could be responsible for payment of charges that are more than the determined UCR allowance.</p> <p>Services and Supplies must be billed by the Hospital for its services or supplies. Physician charges are covered separately under Major Medical Expense Benefits subject to Copayments and Deductible.</p>
<p><b>Inpatient Care</b></p> <ul style="list-style-type: none"> <li>• Medical or Surgical Care, Maternity Care</li> </ul>	<p>Full Benefits for 365 benefit days per spell of Illness.</p>
<ul style="list-style-type: none"> <li>• Mental Health Disorder Care</li> </ul>	<p>See separate benefits shown under Mental Health Disorder Treatment, Hospital and Psychiatric Care Facility shown later in this schedule.</p>
<p><b>Hospital Outpatient</b></p>	<p>Services must be billed by the Hospital for its services or supplies. Major Medical Expense Benefits are available for charges by Physicians and other professional Providers. If criteria not met for Hospital Expense Benefits, then Hospital Outpatient Services are considered under Major Medical Expense Benefits. Enrollee Copayment shown below is paid per Covered Person for each Provider per service date. Copayments do not apply if the patient is admitted to the same Hospital from the Outpatient department.</p>
<ul style="list-style-type: none"> <li>• <b>Emergency Room</b> - Accidental Injury</li> <li>- Sudden and Serious Illness</li> </ul>	<p>Full Benefits after <b>\$70 copayment</b> when rendered within 72 hours after the accident.</p> <p>Full Benefits after <b>\$70 copayment</b> when rendered within 24 hours after the onset of acute symptoms.</p> <p>Please note - Conditions that do not meet the above criteria are Covered under Major Medical Expense Benefits.</p>
<ul style="list-style-type: none"> <li>• <b>Surgery</b></li> <li>• Preadmission Testing</li> </ul>	<p><b>\$40.00 Copayment</b> by Enrollee then balance of Allowable Fees paid in full.</p> <p>Full Benefits</p>
<ul style="list-style-type: none"> <li>• <b>Kidney Dialysis</b></li> <li>• <b>Diagnostic Tests (X-ray, Lab and Machine Tests when Covered Person present)</b></li> </ul>	<p>Full Benefits</p> <p><b>\$40.00 Copayment</b> by Enrollee then balance of Allowable Fees paid in full when patient (Covered Person) is present for tests. If not present, covered under Major Medical Expense Benefits, subject to Copayment or Deductible.</p>
<ul style="list-style-type: none"> <li>• <b>Radiation Therapy</b></li> </ul>	<p>Full Benefits.</p>

HEB Covered Services	Network and Out-of-Network Benefits/Limits
<ul style="list-style-type: none"> <li>Chemotherapy</li> </ul>	Full Benefits for services, supplies and medications used for non-Experimental chemotherapy.
<ul style="list-style-type: none"> <li>Physical Therapy</li> </ul>	Full Benefits after \$20 copayment for physical therapy that starts within six months and is rendered within 365 days after related surgery or after discharge from related Hospitalization. Major Medical Expense Benefits available for other covered physical therapy.
<ul style="list-style-type: none"> <li>Diagnostic Tests (Patient not present)/Other Outpatient Hospital Expenses</li> </ul>	For Outpatient Services not listed above, coverage is available under Major Medical Expense Benefits. *
<b>Mental Health Disorder Treatment - Hospital and Psychiatric Facility</b>	
Inpatient	Full Benefits for 365 benefit days per spell of Illness. Benefit days count toward the Hospital 365-day per spell of Illness limit.
Day/Night Care	Full Benefits for an Approved Plan of Care. Benefit days count toward the 365 benefit day per spell of Illness limits.
<b>Certified Birth Center</b>	Full Benefits. Covered the same as Acute Care General Hospital for services and supplies related to maternity care.
<b>Skilled Nursing Facility Inpatient</b>	Full Benefits up to 365 benefit days per spell of Illness. Each room and board day is equal to ½ benefit day. Benefit days count toward the acute care Hospital 365 benefit day limit. Additional coverage is not available under Major Medical Expense Benefits.  If Medicare is primary, inpatient care is not covered.
<b>Ambulatory Surgical Facility</b>	Covered under Major Medical Expense Benefits
<b>Medicare-Certified Free Standing Kidney Dialysis</b>	Full Benefits for services and supplies related to kidney dialysis.
<b>Home Health Agency</b>	Full Benefits up to 365 benefit days per spell of Illness. Three visits by members of home care team equals one benefit day. Benefit days count toward the Hospital 365 day per spell of Illness.
<b>Hospice Care Agency</b>	Full Benefits for an Approved Plan of Care.
<b>Substance Use Disorder Treatment - Facility or Agency</b>	
Inpatient	Full Benefits for 365 benefit days per spell of Illness. Benefit days count toward the Hospital 365-day per spell of Illness limit.
Day/Night Care Center	Full Benefits for an Approved Plan of Care. Benefit days count toward the 365 benefit day per spell of Illness limits.
Outpatient	Covered under Major Medical Expense Benefits
<b>Ambulance</b>	Hospital Owned: Full Benefits when billed by the owner admitting Hospital. Other Ambulance Services: Coverage available under Major Medical Expense Benefits.

**D. MAJOR MEDICAL EXPENSE BENEFITS**

<b>Deductibles, Copayments and Benefit Maximums</b>
<i>Unless shown otherwise, the Plan Deductibles and Percentage Copayments apply to Out-of-Network Allowable Fees. The Network Copayments apply only when shown for covered Network services. The Deductible and Percentage Copayments may be automatically increased annually as indexed to the medical component of the Consumer Price Index (CPI).</i>
<p><b>Calendar Year Deductible:</b> The part of the Allowable Fees that the participant must pay each Calendar Year. Benefits are based on the balance.</p> <p><b>Percentage Copayment:</b> The portion of Allowable Fees paid by the Plan (usually after Deductible is taken).</p> <p><b>Network Copayment:</b> The portion of the Network allowable fee paid by the Employee. This Copayment does not count toward Major Medical Deductibles or Percentage Copayments.</p> <p><b>Per Event:</b> Means all services rendered by the same Provider on the same day.</p> <p><b>Calendar Year/Lifetime Benefit Maximum:</b> The most the Plan pays per Covered Person for Major Medical Expense Benefits.</p>

<b>Major Medical Expenses</b>	<b>Network</b>	<b>Out-of-Network</b>
<b>Calendar Year Deductible</b>	Does not apply.	Employee/Retiree: <b>\$375.00</b> per person Spouse: <b>\$375.00</b> per person Children: <b>\$375.00</b> per person Cumulative maximum for two or more children is <b>\$375.00</b> .
<b>Common Accident Deductible</b>	Does not apply.	Cumulative for two or more covered Family Members injured in the same accident. Only expenses due to that accident and applied against the Plan Deductible count toward this limit. Expenses also count toward the Calendar Year Deductible. <b>\$375.00</b> per accident
<b>Percentage Copayment and Percentage Copayment Limit (Maximum)</b> <ul style="list-style-type: none"> <li>• Individual – Enrollee</li> </ul>	Does not apply.	After Calendar Year Deductible, Plan pays 80% of the first <b>\$5,165.00</b> of Allowable Fees, then 100% of Allowable Fees Incurred during the remainder of the Calendar Year. Enrollee pays 20% or a maximum of <b>\$1,033.00</b> .
	Does not apply.	After Calendar Year Deductible, Plan pays 80% of the first <b>\$5,165.00</b> of Allowable Fees, then 100% of Allowable Fees Incurred during the remainder of the Calendar Year. Enrolled Spouse pays 20% or a maximum of <b>\$1,033.00</b> .
	Does not apply.	After Calendar Year Deductible, Plan pays 80% of the first <b>\$5,165.00</b> of Allowable Fees, then 100% of Allowable Fees Incurred during the remainder of the Calendar Year. Enrolled Child/Children pays 20% or a maximum of <b>\$1,033.00</b> .
<ul style="list-style-type: none"> <li>• Individual – Spouse</li> </ul>		
<ul style="list-style-type: none"> <li>• All Dependent Children <u>combined</u></li> </ul>		

Major Medical Expenses	Network	Out-of-Network
<b>Network Copayment</b> Does not apply when Medicare or another health plan is primary payer.	\$20.00 per Provider per type of Service  Copayment Limit: \$40.00 per Covered Person each event (all services by the same Provider on the same day). After Network Copayments, Plan usually pays balance of Network allowance in full. If the Plan limits network benefit to a maximum number of visits, per visit or per year maximum benefit, Providers may balance bill up to the Network allowance for covered service.	Does not apply.
<i>Calendar Year/Lifetime Benefit Maximum</i>	Does not apply.	<i>Does not apply.</i>
<i>Chiropractic Services Calendar Year Maximum</i>	Does not apply.	\$1,500.00 per each Covered Person.

Major Medical Covered Services	Network Benefits/ Limits	Out-of-Network Benefits/ Limits
<b>Acute Care General Hospital</b>  Inpatient/Outpatient - after Hospital Expense Benefits exhausted.	80%, after Deductible, for Covered Services after Hospital Expense Benefits are exhausted. In Network and Out-of-Network expenses count toward the Percentage Copayment Limit. Note: Network Providers can balance bill up to negotiated allowance.	
<b>Mental Health Disorder - Inpatient Care and Day/Night Care</b>  <ul style="list-style-type: none"> <li>• Hospital and Private Facility</li> <li>• Physician and Therapist Visits</li> </ul>	80%, after Deductible, for Covered Services after Hospital Expense Benefits are exhausted. In Network and Out-of-Network expenses count toward the Percentage Copayment Limit. Note: Network Providers can balance bill up to the negotiated allowance.	
	Full Network Benefits	80%, after Deductible, for Covered Services.
<b>Mental Health Disorder - Outpatient Care</b>	\$20.00 Copayment  A treatment plan will be required. The Plan of care requires coverage approval by the Claims Administrator.	80%, after Deductible Percentage Copayment limit applies.
<b>Substance Use Disorder (alcohol and drug abuse) - Inpatient Treatment and Day/Night Care</b>	80%, after Deductible, for Covered Services after Hospital Expense Benefits are exhausted. In Network and Out-of-Network expenses count toward the Percentage Copayment Limit. Note: Network Providers can balance bill up to the negotiated allowance.	
<b>Substance Use Disorder - Outpatient Care</b>	\$20.00 Copayment	80%, after Deductible
	Plan of care requires coverage approval by the Claims Administrator. Note: Network Providers can balance bill up to Network Allowance.	
<b>Ambulatory Care Facility</b>	\$30.00 Copayment	80%, after Deductible.

Major Medical Expenses	Network	Out-of-Network
<b>Hospital Outpatient</b>	<i>Includes covered Hospital Outpatient Services or Supplies that do not meet criteria for Hospital Expense Benefits.</i>	
<ul style="list-style-type: none"> <li>• Clinic Services (facility charge for physician care only)</li> </ul>	Full Network Benefits	80%, after Deductible
<ul style="list-style-type: none"> <li>• Diagnostic Lab (Patient not present)</li> </ul>	\$20.00 Copayment	80%, after Deductible
<ul style="list-style-type: none"> <li>• Other Diagnostic Tests (Patient not present)</li> <li>• Non-emergency use of an emergency room</li> <li>• Other Hospital Outpatient Services</li> </ul>	80%, after Deductible	
<b>Physical Therapy/Chiropractic Services</b>	Physical Therapy in Outpatient Hospital covered separately under Hospital Outpatient Services.	
	\$20.00 Copayment per visit. Separate Copayment applies to Diagnostic X-ray and Lab. <b>Calendar Year Chiropractic Maximum does not apply.</b>	Allowable Fees based on Network Allowance. 50% of Network Allowance, after \$250 Physical Therapy/Chiropractic Deductible per Calendar Year (This is separate from other Plan Deductibles and does not count toward any family limits). Enrollee is responsible for payment of remaining balance.  <b>Out-of-Network: \$1,500 Calendar Year Maximum for chiropractic care per each Covered Person.</b>

Major Medical Expenses	Network	Out-of-Network
<b>Other Medical/Surgical Office Services</b>	Office visits include medical management, therapy and surgical services rendered in any Provider's office (or outpatient/office clinic). For example: by Physicians, chiropractors, podiatrists, physical therapists, et. al.  *Diagnostic Tests rendered during an office visit are covered separately; an additional copayment is required.	
Office Visits	\$20.00 Copayment per visit*	80%, after Deductible.
<b>Emergency Room Physician</b>	<b>\$20.00 Copayment</b>	<b>\$20.00 Copayment</b> <i>Providers may balance bill up to the amount of the charge.</i>

<b>Major Medical Expenses</b>	<b>Network</b>	<b>Out-of-Network</b>
<b>Specialist Consultations</b> Outpatient	Office: \$20.00 Copayment. Other Outpatient: Full Network Benefits. Limit: one consultation per specialty for each Calendar Year.	80%, after Deductible.
Inpatient	Full Network Benefits. Limit: one consultation per specialty for each Hospital confinement.	80%, after Deductible.
<b>Second Opinion Consultations (SOC)</b> Mandatory Second Opinion (Benefit Management Program)	Full Network Benefits.	Full Benefits. Deductible and Percentage Copayment do not apply.
Voluntary Second Opinion (Benefit Management Program)	Full Network Benefits.	Full Benefits when obtained through Benefit Management Program. Deductible and Percentage Copayment do not apply.
Second Surgical Opinion	\$20.00 Copayment when not obtained through the Benefits Management Program. Limit: Initial and one additional second opinion if the first opinion does not agree surgery is necessary.	80%, after Deductible when not obtained through Benefit Management Program.
<b>Diagnostic Tests</b> (X-rays, Labs and machine tests)	\$20.00 Copayment per visit for each series of x-rays, each series of lab and each series of machine tests	80%, after Deductible.
<b>Ambulance</b>	See Hospital Expense Benefits for Hospital-owned ambulance to owner Hospital when patient admitted.	
Professional or Hospital-Owned Ambulance	Deductible and Percentage Copayment do not apply to the first \$35.00 per trip, then Plan pays balance of Allowable Fees at 80%, after Deductible.	
Volunteer Ambulance	Full Benefits up to maximum of \$50.00 per trip under 50 miles and maximum of \$75.00 for 50 miles or more. Deductible and Percentage Copayment do not apply.	
<b>Professional Nursing</b>	The first 48 hours of covered care per Calendar Year is excluded for Private Duty Nursing.	
Private Duty Nursing	Full Network Benefits for care following 48 hour exclusion.	50%, after Deductible for care following 48 hour exclusion.
Visiting Nurse	Full Network Benefits	80%, after Deductible
Nurse Midwife	Same as Physician and other Providers. For example, \$20.00 Copayment for office visit. Full Network Benefits for Inpatient services. Paid on same basis as Physician for office visits and surgery.	80%, after Deductible

Major Medical Expenses	Network	Out-of-Network
Hearing Aids	Full Benefits up to \$1500.00 per ear in any 4-year period for adults and in any 2-year period for children age 12 and under. Includes costs for hearing aid, exam and fitting. Deductible and Percentage Copayment do not apply.	
Hairpiece	\$20 copayment	80%, after Deductible.
	Benefit limit \$1,500.00 for one hairpiece per Lifetime when ordered by Physician for hair loss due to chemotherapy treatment.	
Diabetic Shoes (specially designed shoes for diabetic patients)	Full Network Benefits	75% of network allowance
	Benefit limit \$500 per calendar year	
Other Services and Supplies Inpatient Care including Hospital visits, surgery, anesthesia, maternity, professional interpretations of diagnostic tests, Durable Medical Equipment, prosthetics, home care and supplies, et al.	Full Network Benefits for Covered Services.	80%, after Deductible, for Covered Services.

**3. Section II – Eligibility and Enrollment, subsection A. Eligibility for Plan Enrollment, paragraph 2. c. and d. Dependents is amended to read:**

**2. Dependents.**

The following Dependents are eligible to be enrolled in the program:

**c. Your Children who are:**

- 1) your biological child, legally adopted child (including a preadoptive newborn and a child placed for adoption), foster child, or stepchild who is under 26 years of age, regardless of marital status, financial dependence, residence, or student status. Your newborn child is eligible from the moment of birth if enrolled in family coverage within 30 days after date of birth.

Time spent in the U.S. Military service, not to exceed four years, may be deducted from the Dependent's age for the purposes of establishing eligibility.

*Your Dependent child under age 26 who previously was not eligible for benefits or had benefits ended may be reinstated to family coverage.*

*Dependent children who terminated from the Plan prior to January 1, 2011 (including those who elected COBRA continuation coverage) may re-enroll as dependents during the Plan's annual Open Enrollment period or during a minimum 30-day special open enrollment period which occurs on or after September 23, 2010.*

- 2) Any other unmarried child (a) under age 19 or (b) over 19 years of age but under 25 who receives more than half their support from the Employee and is a full-time matriculating student at an accredited secondary school, College or University. Time spent in the U.S. Military service, not to exceed four years, may be deducted from the Dependent's age for the purposes of establishing eligibility.

In the event your Dependent child, who is a full-time student, is disabled and is granted a medical leave by the school he or she is attending, benefits will continue for a maximum of 12 calendar months following the month in which the child withdraws from school. If the end of the 12 calendar months occurs during a vacation period, benefits will be extended to the beginning of the next regular semester.

In the event your unmarried Dependent child between the ages of 19 and 25 who previously was not eligible for benefits or had benefits ended and returns to a full-time student status, may be reinstated to family coverage effective the actual date the student commenced full-time attendance at the high school or an accredited institute of higher learning.

Effective January 1, 2010, federal law (Michelle's Law) mandates that coverage will not terminate if the covered dependent child's failure to maintain full-time status at a postsecondary educational institution is due to a Medically Necessary leave of absence or other change in enrollment (such as reduction of hours). If the child's treating Physician certifies in writing that the child is suffering from a serious illness or injury, and that the leave of absence or other change in enrollment is Medically Necessary, coverage may continue for up to a year after the date the Medically Necessary leave of absence or other change in enrollment begins. To be eligible for the extension, the child must be enrolled in the Plan as a full-time student immediately before the first day of the Medically Necessary leave of absence. However, this extension does not extend coverage beyond the date that a child fails to meet the dependent eligibility requirements other than the requirement to be a full-time student.

- 3) *Any child who has reached at least the limiting age as described in 1) and 2) above and is incapable of self-support because of mental or physical disability and became so disabled before reaching the limiting age. The eligibility of such a Dependent should be established as early as possible. This should be done at the time of your initial enrollment if the child has attained his or her limiting age at that time. If the child has not yet attained his or her limiting age at the time you first enroll in the program, eligibility for continued benefits should be established at the time of his or her birthday on which he or she reached the limiting age.*

To obtain Plan coverage for incapacitated Dependents or full-time students, you may be required to document, at least annually, appropriate certification of this fact to your Consortium employer. Failure to provide the required information when requested will result in that child being removed from enrollment and eligibility for benefits until proof is provided which supports continued eligibility for Plan enrollment.

d. Child Definition -Child or children mean:

- 1) *The Employee's biological child, legally adopted child or foster child,*
- 2) *Any stepchild of the Employee.*
- 3) *Any other child supported by the Employee or the spouse of the Employee and permanently residing in the Employee's home, provided the support and residence commenced before the child reached age 19; or*
- 4) *Any child placed for adoption before the child reaches age 18. The term placed for adoption means a child placed in the Employee's home and the employee's assumption and retention of a legal obligation for total or partial support of a*

child in anticipation of adoption of the child. This eligibility ends when such legal obligation terminates. Proof of pre-adoption status will be required by your Participating Consortium Employer to establish eligibility. Once the child is legally adopted, he or she retains eligibility as a legally adopted child as shown above.

- 5) Pre-adoptive newborn from the moment of birth under a family Plan when all of the following conditions are met:
  - a) You enroll the child, you intend to adopt, in a family Plan within 30 days of the birth and applicable family Contribution is made;
  - b) You take physical custody of the child upon discharge from the Hospital or Birth Center; and
  - c) Within 30 days of the child's birth, you file a petition to adopt or for temporary legal guardianship under New York State Domestic Relations Law.

Coverage will not be provided for initial Inpatient treatment of a pre-adoptive newborn, if the child's biological parent has health coverage for that care. Also, if a notice of revocation of the adoption has been filed, or a biological parent revokes consent to the adoption, coverage will not be provided. If Plan benefits were paid for a pre-adoptive newborn whose adoption was revoked, the Employee may be requested to reimburse those Plan payments.

#### Please Note

Documentation of the Dependent status with your Consortium Employer's Personnel Office will be required. Criteria of support, *if required*, will be deemed to have been met if the Employee contributes at least 50 percent to the support of the Dependent and that Dependent qualifies as an exemption on the most recent federal income tax return filed by the Employee.

#### **Section II – Eligibility and Enrollment, subsection E. End of Coverage, paragraph 4. is amended to read**

4. Dependent Child coverage ends at 12:01 a. m. due to reasons such as:
  - a. *The date your child (your biological child, legally adopted child, a child placed for adoption, foster child or stepchild reaches age 26).*
  - b. *The date your child (other than your biological child, legally adopted child, a child placed for adoption, foster child or stepchild):*
    - 1) *marries,*
    - 2) *is no longer living in your home,*
    - 3) *and/or is no longer dependent on you for most of his or her support or maintenance, or.*
    - 4) *reaches age 19 and is not a full-time student or is not eligible as a disabled/handicapped child dependent on the Employee for support.,*
    - 5) *between ages 19 and 25 is no longer eligible as a full-time student, or*
    - 6) *is a full-time student who reaches age 25.*
  - c. The date an eligible disabled/handicapped child is no longer disabled and/or dependent on the Employee for support.
  - d. The date a pre-adoptive child is removed from placement for adoption.

**Section II – Eligibility and Enrollment, subsection E. End of Coverage, last paragraph is amended to read:**

*Coverage may be stopped if you or your Dependents knowingly submit a claim, or allow a claim to be submitted with false information, or conceal any facts that could affect the outcome of a claim determination. In this case, you or your Dependents cannot continue coverage under COBRA.*

*The Consortium Employer or Plan has the right to rescind any coverage of the Employee and/or dependents for cause, making a fraudulent claim or an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan. The Consortium Employer or Plan may either void coverage for the Employee and/or covered dependents for the period of time coverage was in effect or may terminate coverage as of a date to be determined at the Plan's discretion; 30 calendar days advance notice will be provided. The Consortium Employer will refund all contributions paid for any coverage rescinded; however, claims paid will be offset from this amount. The Consortium Employer reserves the right to collect additional monies if claims are paid in excess of the Employee's and/or dependent's paid contributions.*

**Section IV – Covered Services, subsection B. is amended as follows:**

**B. PREVENTIVE CARE EXPENSE BENEFITS (WELLNESS OR ROUTINE CARE)**

Coverage is available for limited routine screening exams for preventive care. Preventive care is wellness or routine care unrelated to the diagnosis or treatment of specific symptoms or specific illness or injury. Coverage is available under Medical Expense Benefits for diagnostic testing and exams related to specific symptoms or treatment of an illness or injury. If care or management of an illness or injury requiring minimal time or minimal professional expertise is done during a visit that is primarily for preventive care, the visit will be considered as preventive care, subject to Plan limitations. Only the following routine services are covered for preventive or wellness care. Refer to **Section I - Summary of Benefits** under **Preventive Care Benefits** for benefit limits.

*Among the provisions of the Affordable Care Act is expanded coverage for preventive care services. These new standards will apply to in-network services only unless otherwise specified in the Schedule of Benefits. POMCO's medical criteria may apply to frequency limitations.*

*The following is a listing of the most common services. This listing is subject to change based on evidence-based items or services with an "A" or "B" rating from the United States Preventive Services Task Force (USPSTF); evidence-informed preventive care and screenings for infants, children, adolescents and women provided in guidelines supported by the Health Resources and Services Administration (HRSA); and immunizations for routine use in children, adolescents and adults with a recommendation in effect from the Advisory Committee on Immunization Practices (ACIP).*

*See <http://www.healthcare.gov/center/regulations/prevention/recommendations.html>.*

*If these standards change, the Plan will automatically cover the new recommended standards. The Plan will comply within one year of the effective date of all new recommendations or guideline changes; the Plan will not cover any item or service that is no longer a recommended preventive service.*

- 1. Well Child Care.** Benefits are available for routine well child care rendered for eligible and enrolled Dependent children from birth to age 19 (until but not including 19th birthday). Routine well child care rendered in a Physician's office, Hospital or clinics licensed to render such care, includes the following services only:

- a. **Newborn Nursery Care.** Benefits are available for initial routine newborn exam or nursery care rendered and billed by Physicians while newborn is confined in the Hospital nursery. Routine newborn nursery care is limited to four days of Inpatient Care. Payment will not be made for routine care after four days. For example, extra nursery days due to the mother's extended Hospital stay will not be covered. However, if child is ill, usual Plan benefits will apply. Plan includes coverage for routine circumcisions. Routine newborn care billed by an anesthesiologist or the delivering Physician is not covered.

**Please Note**

To be eligible for benefits from the moment of birth, your child must be enrolled in family coverage within 30 days from the date of birth. If you are not enrolled in family coverage at the time of your newborn's birth, you may be required to pay family coverage participation for the month of birth and thereafter to maintain coverage. If you fail to enroll the newborn within 30 days from the date of birth, coverage cannot begin until after the date of enrollment according to Plan provisions.

- b. **Well Child Care/Immunizations for Dependent children up to age 19:**
- *The recommendations of the U.S. Preventive Services Task Force apply to In-Network services, which include ACIP for immunizations and Bright Futures for well child exams. POMCO's medical criteria may also apply to frequency limitations.*
  - **The following applies to Out-of-Network Services:**
    - 1) Usual well child laboratory screening and testing.
    - 2) Usual routine well child physical exams.
    - 3) Developmental assessments.
    - 4) Age appropriate immunizations for diphtheria, tetanus, pertussis, polio, measles, mumps, rubella, hepatitis b, haemophilus influenza type b, varicella (chicken pox), and HPV, based on immunization guidelines recommended by the American Academy of Pediatrics and as designated by New York State Superintendent of Insurance. Immunizations given later than the recommended age level will still be covered if administered to the child before age 19. Immunizations for other diseases may be covered when required by New York State Law or designated by the New York State Superintendent of Insurance.
    - 5) Well child care coverage is available for usual visit frequency as follows:
      - a) At birth, for Newborn Routine Nursery Care and one pediatric evaluation 48-72 hours after discharge for breastfeeding infants or for those discharged from the Hospital in less than 48 hours after delivery.
      - b) In addition to "a)" above, Plan covers once during the first month following birth, then up to 5 visits to age 12 months; then
      - c) Up to 4 visits to age 24 months; then
      - d) Once per year to age 19.
2. **Mammography Screening.** Benefits are available for Allowable Fees billed by a Hospital, clinic, or Doctor for routine mammography screening

**3. Adult Routine Care.**

- a. **Out-of-Network Coverage.** Benefits are available for annual routine health exams or general physicals rendered by Out-of-Network Providers for active Employees, age 50 or older, or for active Employee's spouse age 50 or older. Coverage includes related routine tests and is limited to once per Calendar Year.

Charges for routine gynecological exams and the Pap smear are Covered.

Benefits are not payable for retiree or retiree Dependents or for Covered Persons under age 50. This benefit is not available if a Covered Person was already reimbursed for a routine health exam during the same Calendar Year under the Network benefit shown below.

- b. **In-Network Coverage.** Benefits are available for routine adult physical exams and usual related tests for Covered Persons, age 18 or older. Covered Persons include Employees, retirees and Eligible Dependents.

Charges for routine gynecological exams and routine cervical cancer screening tests to include the Pap smear and the HPV screening test (for women age 30 years and older in conjunction with the Pap smear) are Covered.

- c. **Routine Adult Immunizations:**

- **In-Network:** *The recommendations of the U.S. Preventive Services Task Force apply to In-Network services, which include the ACIP for immunizations.*
- **Out-of-Network for age 50 and above:** influenza including seasonal and H1N1 (swine), pneumonia, measles, mumps, rubella, varicella, tetanus, meningitis, herpes zoster/shingles (from age 55).

3. **Routine Prostate Cancer Screening (PSA test and related exam).** Coverage for the diagnostic screening for prostate cancer including: standard diagnostic testing including, but not limited to, a digital rectal examination and a prostate-specific antigen test at any age for men having a prior history of prostate cancer; and an annual standard diagnostic examination for men age 50 and over who are asymptomatic and for men age 40 or older with a family history of prostate cancer or other prostate cancer risk factors.
4. **Nutritional Counseling.** *The Plan will cover wellness nutritional counseling (no underlying chronic condition required) up to the benefit maximum shown in the Schedule of Benefits. Services must be rendered by a Physician, certified nutritionist or certified and registered dietician.*
5. **Smoking/Tobacco Use Cessation Counseling.** *The Plan covers charges related to tobacco use or smoking cessation counseling that is rendered by or prescribed by a Physician.*

**Section VII – Plan Exclusions, subsections 19 and 29. are amended to read:**

19. **Weight Reduction/Diet Management /Exercise.** Services or supplies related to weight reduction or diet management for treatment of obesity no matter what age, condition, diagnosis or prognosis of the patient. Diet management, exercise programs or general

conditioning programs even when ordered by a Physician. Exceptions: Limited coverage for certain Medically Necessary treatments, such as bariatric surgery for Morbid Obesity, and Physician medical management services for certain medical conditions when the treatment plan is approved by the Claims Administrator. *Charges for nutritional counseling as covered as a Preventive Care Expense Benefit when rendered by participating providers.*

29. **Smoking/Tobacco Use Cessation.** Services, supplies, or drugs related to therapy for cessation of smoking or other use of tobacco products whether or not recommended, ordered or prescribed by a Physician. *Exception: Screening and counseling related to tobacco use that is Covered as a Preventive Care Expense Benefit when rendered by participating providers.*

**Section VII – Plan Exclusions, subsection 33, is amended as follows; this is not a change in benefits:**

33. **Facility Employees.** Separate charges for services by members of the staff employed by a Hospital, skilled nursing facility, Convalescent Care Facility, rehabilitation facility, or by any Inpatient facility where care is received. *Exception: Hospitalists and Physician Extenders who have contracts for payment with the Claims Administrator.*

**Section X – Definitions is amended to add Hospitalist and Physician Extender to read:**

**Advanced Physician Care Extender or Physician Extender** includes physician assistants (PAs), nurse midwives, nurse practitioners (NPs) and advanced practice nurses (APNs). These Providers are generally overseen by Physicians and must be licensed and regulated by a state or federal agency and acting within the scope of his or her license.

**Hospitalist** is a Physician that assumes the care of a Hospitalized patient and acts as a primary doctor while a patient is in a Hospital.



CANCER SUPPORT SYSTEM

## Programs and services for those living with cancer.

As the second most common cause of death in the United States, cancer touches nearly all of our lives. That's why POMCO Group, in collaboration with OptumHealth, created the Cancer Support Program (CSP) for MEBCO enrollees. If you are a POMCO Group member, and you, or your dependent have been diagnosed with cancer, you will find the CSP a valuable source of cancer-related information and support services.

In addition to providing up-to-date, well-researched data on all types of cancers, the CSP can assist you in identifying quality health care providers and connect you to a Nurse Advocate. These Advocates will work directly with you to coordinate your medical services as well as determine the need for consultation for any additional plan-covered services within the community.

**MEBCO**

**POMCO**  
GROUP

EXPERIENCE. EXCELLENCE.



**"...the Cancer Support Program helps you realize improved quality of life through proactive, targeted interventions and support from your experienced Nurse Advocate..."**

## Helping you make informed decisions about cancer care

Utilizing an integrated approach that delivers both clinical and economic support, the CSP helps you realize improved quality of life through proactive, targeted interventions and support from your experienced Nurse Advocate who:

- Helps manage symptoms and prevent some side effects, leading to fewer inpatient admissions and emergency room visits.
- Collaborates with treating physicians to fill gaps in knowledge, support and management of patients.
- Helps manage pharmacy costs by reviewing and comparing medications.
- Helps you make informed decisions about treatment.
- Educates you on hospice services and palliative care.
- Helps you navigate the health care system and refers you to specialists as needed.

## Quality in Transplant Programs

If your physician has determined that you are in need of a cancer-related transplant, POMCO Group's Transplant Program provides you with a tremendous clinical and economical value.

Offered in partnership with premier transplant networks such as OptumHealth Care Solutions and Interlink, the program provides access to our Transplant Centers of Excellence network, which delivers exceptional outcomes.

Each transplant program within the Centers of Excellence network is evaluated annually to help ensure it meets stringent standards for quality of care.

The transplant programs within the Centers of Excellence network generally boast higher survival rates than non-network programs. In addition, they help minimize length of stay, complications, and re-transplantation procedures, resulting in a lower overall cost of care.

### *POMCO Group's Transplant Program Service provides:*

- **A Transplant Centers of Excellence network**
- **Ongoing clinical consulting from qualified nurses**
- **A collective commitment to high-quality, cost-effective care**
- **Solutions to minimize overall transplant-related costs**
- **Reduced reinsurance costs and future trend increases**
- **Best-case outcomes for the plan and its members**

## Quality in Service

The transplant program and partnership network contracts are structured to cover all transplant-related charges, including evaluation, transplant (hospital, physician, organ acquisition) and 90 days of follow-up care.

These services are managed by your Nurse Advocate and include (where applicable):

**Precertification/Prior Authorization** – a review of your medical records to determine if the services are appropriate and necessary.

**Concurrent Review** – a review of your treatment in preparation of your discharge.

**Discharge Planning** – a review of your treatment program to determine if your release from the hospital is safe and appropriate.

**Requests for Extension of Care** – a review of your progress to determine if there is a need and opportunity to extend the necessary benefit(s).

**Retrospective Review** – completed at the end of your treatment to review the services used and the frequency of the usage.

**Pharmacy Benefit Management** – coordination of any necessary specialty drugs and treatments.

All reviews are completed in collaboration with a treatment team which may include your physician, hospital, pharmacy and pharmacy benefit manager where appropriate.

## POMCO Group Partners in Care

POMCO Group provides opportunities for its members to receive health care management through services administered by POMCO Group's Medical Services department and in partnership with premier vendors such as CORAM Health-care, OptumHealth, Interlink and ByramHealth.

Our premier vendors work together to create a suite of services that best match your cancer program needs: from equipment and nutrition to identifying transplant health care providers and alternate sites of care.

**If you are undergoing cancer treatment or if you have been recently diagnosed with cancer, please contact POMCO Group's Medical Services department to enroll in the Cancer Support Program - 800.695.5170.**

*This program is voluntary and enrollment in the program is at no cost to you. Copayments will be waived for services provided by in-network providers.*

**POMCO  
GROUP**

EXPERIENCE. EXCELLENCE.