E-SYSTEMS

MELPARTICULARS

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Benefits Update: Issues and Answers

This is the second of a series of special issues of Melparticulars designed to communicate benefits changes currently underway.

Comparing In-Network and Out-of-Network Benefits

Many employees have asked how the in-network and out-of-network benefits compare. The following example illustrates costs and coverages incurred for treatment of a condition requiring hospital care.

Example of in-network benefits

This example assumes the employee lives in a network service area and receives the following medical services through the CIGNA network. This chart shows the cost to the employee and the amount paid by the network benefit.

In this example, the only out-of-pocket cost to the employee would be a co-payment for an initial office visit to the Primary Care Physician (PCP) and/or to the specialist to whom the employee was referred by the PCP.

Network benefits will apply for the services described in this example if:

- The hospital admission was arranged by the employee's PCP, or by a specialist to whom the PCP referred the employee for the condition.
- The diagnostic tests were ordered by the PCP or specialist to whom the PCP referred the employee for the condition.
- The surgical procedure was performed by the PCP or specialist to whom the PCP referred the employee for surgery.
- The physician/hospital visits were made by the PCP or specialist to whom the PCP referred the employee.

Example of out-of-network benefits

Out-of-network benefits apply to any covered services not provided or arranged by the PCP or the specialist to whom the PCP refers the employee. In this example, out-of-network benefits would apply:

- For the cost of hospital care if the employee's PCP or PCP-referred specialist did not arrange the hospital admission.
- For the cost of the diagnostic tests if the tests were not ordered by the employee's PCP or PCP-referred specialist.
- For the cost of the surgical procedure if the services were not provided or arranged by the PCP or PCP-referred specialist.
- For the physician hospital visits if the visits were not by the PCP or PCP-referred specialist.

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TYPE OF SERVICE	COST OF THE SERVICE	COST TO EMPLOYEE	AMOUNT PAID BY THE IN-NETWORK BENEFIT
Hospital Care	$1,179.00	$0.00	$1,179.00
Diagnostic Tests	$170.00	$0.00	$170.00
Physician Services for Surgery	$820.00	$0.00	$820.00
Physician Visits in the Hospital	$200.00	$0.00	$200.00
TOTAL	**$2,369.00**	**$0.00**	**$2,369.00**

An Overview of Your New Managed Care Plan Benefits

The table on page 2 compares your in-network and out-of-network benefits for the new Managed Care Health Plan, effective January 1, 1991. Updates on in-network benefits for vision and hearing care are included.

See Table on page 2

MANAGED CARE PLAN BENEFITS

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Primary Care Physician Required	Yes	No
Annual Deductible • Individual • Family	 None None	Must be satisfied annually before any benefits are payable $400 $1,000
Out-of-Pocket Maximum (does not include deductible and does not apply to mental health or substance abuse benefits) • Individual • Family	 N/A N/A	 $2,000 $4,000
Pre-existing Condition Limitation • Initial Group of Employees • New Hires	 None 10 months	 None 10 months
Maximum Benefit	Unlimited	$500,000 per lifetime, per person
Urgent Care Facility Co-payment	$25	$50, then subject to appropriate deductibles and co-insurance
Hospital Charges Benefit • Covered Services • Special Emergency Room co-payment (waived if admitted to the hospital)	100% $25	80% $50, then subject to appropriate deductibles and co-insurance
Mental Health & Substance Abuse Benefit	Only available through Employee Assistance Program. $50,000 lifetime maximum	Only available through Employee Assistance Program $50,000 lifetime maximum
Covered Physician Services • Surgery • Hospital Visits • Office Visits • Routine Physical • Well Baby Care	 100% 100% $10 co-payment $10 co-payment $10 co-payment	 80% 80% No coverage No coverage No coverage
Skilled Nursing Facility Benefit	100%: 365 days lifetime maximum	80%: 365 days lifetime maximum
Hospice-Type Care Benefit	100%: 180 days maximum	80%: 180 days maximum
Home Health Care Benefit	100%	80%
Private Duty Nursing Benefit	100% (as medically necessary)	80% (as medically necessary)
Diagnostic Fee Benefit (In conjunction with office visits)	100%	80%
Prescription Drug Benefit	$3 brand name co-payment for up to 30-day supply $0 mail co-payment for generic up to 30-day supply, $0 mail order co-payment for 90-day supply (oral contraceptives included)	80%
Preventive Care	$10 co-payment	No coverage
Annual Well Woman Care (Ob/Gyn Only)	$10 co-payment	No coverage
Vision Care Benefit	$5 co-payment (normal refraction and eyeglass fitting) by a network optometrist. One exam per year • Single lens annual benefit – $20 • Bifocal lens annual benefit –$30 • Trifocal lens annual benefit – $40 • Contact lens annual benefit (includes fitting) – $75 • Frames annual benefit – $30	No coverage
Hearing Care Benefit	Hearing aids/fittings $1,000 annual maximum: 100% benefit	Excluded
Durable Medical Equipment (DME)	100%	80% with $700 maximum per year
Prosthetics	100%	80% with $1,000 maximum per year
Preauthorization of Hospital	N/A	Minimum penalty $300 Maximum penalty – benefits reduced by 50%

Answers to Your Questions

What new benefits are provided under Managed Care?

E-Teamers will have coverage for:

- Periodic physical examinations (frequency depending on age, sex, family history, etc.)
- Vaccinations as necessary
- Routine office visits
- Well baby care
- Vision
- Hearing

For physical examinations, office visits, and well baby care, there is a small co-payment of $10.

If glasses or contacts are needed, you can refer yourself to a Managed Care optometrist who will give you a prescription for glasses or contacts for a $5 co-payment. You do not need to go through your PCP.

The benefit for glasses or contacts is covered according to the schedule shown on page 2.

If you have a hearing problem and are referred to a specialist by your PCP, and it is determined that you need a hearing aid, the plan pays up to $1,000 per year for this benefit.

How does Managed Care work in emergency or urgent care situations?

You should get medical attention immediately at the nearest hospital and doctor. You must inform CIGNA of your medical emergency within 48 hours of any emergency admission or treatment.

Emergency care is medical, surgical, hospital, and related health care services and testing, including ambulance transport required to treat a sudden, unexpected onset of injury or serious illness which, if not treated immediately, may result in serious medical complications, loss of life, or permanent impairment to bodily functions. Included are conditions that produce loss of consciousness or excessive bleeding.

For other non-life-threatening emergencies, you must call your PCP for assistance.

Urgent care is a non-emergency, unforeseen illness or injury that requires prompt medical attention but is neither life-threatening nor a serious medical emergency. This situation can be for:

- Injuries or illness in which onset is unexpected
- Symptoms that are sufficiently severe
- Treatment that may not be unduly delayed without incurring the risk of serious impairment.

Preventive, routine care and follow-up is not urgent care.

In all emergencies, you are encouraged to seek the nearest medical care. You should contact your PCP or CIGNA as soon as possible (generally within 48 hours) to make them aware of your emergency situation. The doctors will determine when and if you should be moved from the non-network hospital to a network hospital

How are doctors credentialed?

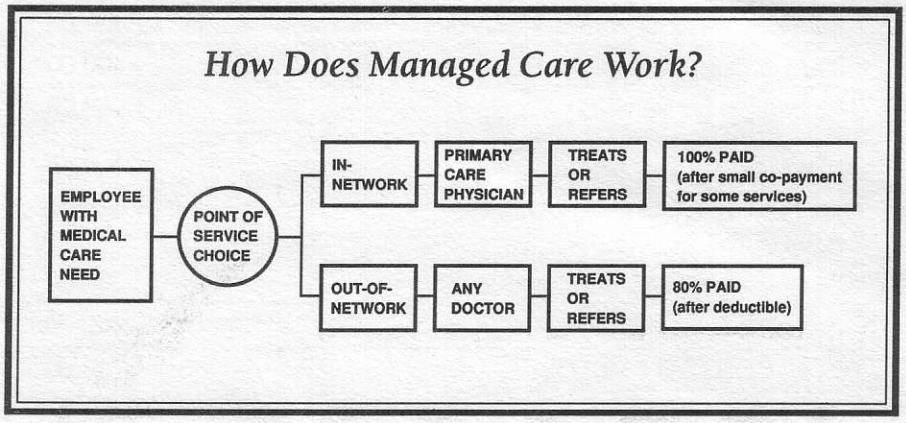
The term "credentialing of doctors" generally means that the doctors' qualifications and standing in the community have been reviewed and that they meet a set of necessary criteria. This includes the training and education essential to providing quality medical care in compliance with CIGNA's standards. The doctor who wishes to become a PCP or a network specialist is required to complete an application. The written application is only the first step of the credentialing process. There are many questions that must be answered, and responses are checked by visiting the doctors' offices and contacting state medical agencies, insurance companies, other doctors in the community, medical schools, and hospitals where the doctor practices. The following is a partial list of the actions involved in credentialing network providers:

- Verify and obtain current copies of the state medical and drug enforcement agency licenses.
- Check all degrees and confirm accuracy with each institution.
- Review the employment history since graduation from medical school, looking for any missing dates and researching any "gaps."
- Check with the local network hospital in which the doctor practices and verify that he/she is in good standing with the hospital.
- Review the board certification.
- Check for any malpractice suits that may be pending against him/her or that have been settled in the past.
- Review liability insurance coverage to ensure that he/she has sufficient coverage.
- Check his/her reputation within the medical community and within his/her peer group (through personal references, etc.).
- Make an on-site visit to the physician's office to check medical records for clarity and completeness, handling of patients, capacity to accept new patients, and availability and adequacy of parking, waiting room, examination room and equipment.

A full re-credentialing process is performed every year.

A board-certified physician is one who has been certified by the state medical board as having passed written/oral examinations in his/her field of specialization. To maintain certification, the physician must satisfy continuing medical education requirements as mandated by his/her board specialty. **M**

This information only highlights some of the new E-Systems programs and is not intended to be construed as a legal document. In all cases, official plan documents will govern.



Point-of-Service Choice: It's Yours to Manage

Point-of-service means that if you live in a network area and have a health care need, *you* decide where to receive that care–in the CIGNA Managed Care network or outside the network. For you and any covered dependents, point-of-service means you always have a choice. At any time during the year, you can use any health care provider or facility you choose. Your dependents can do the same.

You will generally save money by using in-network benefits . . .

During the annual Flexcomp enrollment (November 26–December 14), you will choose an in-network Primary Care Provider, or PCP, for yourself and each eligible dependent you choose to cover. This doctor can be a family practitioner, an internist, a general practitioner or a pediatrician. You may choose the same PCP for everyone or a different one for each family member. You and your family may also change any PCP as often as once a month.

When you want to use in-network benefits, your PCP's role will be similar to that of a family doctor. The PCP either treats you or recommends a specialist to treat you. The specialist is usually a member of the network too. The PCP *could* recommend a specialist outside the network, however, and you can still count on receiving the higher in-network benefits when that happens.

You will generally save money by using in-network benefits because the in-network coverage approaches 100 percent. There's no deductible or out-of-pocket maximum, just small co-payments for office visits and prescriptions. That's a benefit level almost unheard of in today's health care environment. But the important point of the point-of-service concept is that you are not locked in to using either the network or your PCP.

Suppose a doctor you want to use is not in the network, and you are unwilling to see a new doctor for health care service. Point-of-service choice means you can see the doctor you choose. You don't see your PCP at all in that case. Your benefits will be similar to the current E-Systems Plan B, except the deductibles and out-of-pocket maximums are higher. (You should know that covered services are also much broader in the network. For example, routine physical checkups are covered.)

Point-of-service choice means you can see the doctor you choose.

Suppose you have been using a doctor who is not in the network, and he/she says you now need more extensive treatment or even surgery. You face the prospect of increased cost due to the deductibles and out-of-pocket expenses in the out-of-network plan. Now what do you do? The answer is that you can "cross over" into the network–use your PCP and a specialist to whom you are referred and receive in-network benefits at or near the 100 percent level. All of this applies even if you received some treatment outside the network.

Suppose you see your PCP for some services during the year, but you come down with an illness you want to have treated by an out-of-network doctor. The plan allows you to "cross over" to the doctor of your choice and receive out-of-network benefits. However, you get the higher benefits and more extensive coverage when you use your PCP than you would get with the out-of-network benefits when you use the out-of-network doctor.

You can use the new Managed Health Care Plan any way that suits you . . .

You can use the new Managed Health Care Plan any way that suits you or your family. One family member could have an ongoing condition that you feel requires the special ongoing services of an out-of-network doctor or hospital. That family member could choose to use only out-of-network services while the rest of the family uses only in-network services or a mixture of in- and out-of-network services. With point-of-service choice, any combination works. Choice–that's the key point of the new Managed Health Care Plan. **M**

COMPARISON continued from page 1

Assuming all services provided are eligible and with the reasonable and customary guidelines, the out-of-network benefits would be payable as follows:

Total Cost of Out-of-Network Services	$2,369.00
MINUS Annual Deductible (Employee Cost)	– 400.00
Cost Eligible for Benefits	1,969.00
	X 0.80
Total Paid by the Out-of-Network Benefit (80%)	$1,575.20
20% of Cost Paid by Employee	393.80
PLUS Annual Deductible	+ 400.00
TOTAL COST TO EMPLOYEE	$793.80

In this example, the total cost to the employee would be $400 (deductible) + $393.80 (20 percent of remaining cost), or $793.80. Two items are important to note in this example. First, once the employee's 20 percent share of expenses reaches $2,000 in a year, the employee's benefit percentage increases from 80 percent to 100 percent for covered reasonable and customary expenses for the rest of the year. Also, if the employee used out-of-network benefits and failed to precertify the hospital admission, the benefit in this example would be reduced by a minimum of $300 to a maximum of 50 percent of the total eligible expenses. **M**