

## Health Plan Booklet Updates

---

*This notice summarizes the changes to the Health Plan since the January 1, 2010 booklet was released and supersedes the provisions described in that booklet.*

### APRIL 1, 2012

#### THERAPY BENEFITS (PAGES 72-73)

- The \$85 maximum allowable charge for therapy visits that was eliminated effective January 1, 2011 will be reinstated; and
- The annual 50-visit limit will be eliminated.

The changes made effective January 1, 2011 in the Health Plan Booklet update are revised as follows:

- Therapy must be performed by a licensed, certified physician or general practitioner up to a maximum Allowable Charge of \$85 per visit.
- The Plan will allow one office visit for the evaluation and management of a new patient and payment will be based on Reasonable and Customary Charges.

### JANUARY 1, 2012

#### MINIMUM EARNINGS THRESHOLDS (PAGES 11-12)

The minimum earnings thresholds to qualify for earned coverage for four-quarter earnings periods beginning January 1, 2012, are as follows:

- For the DGA Choice Plan, the minimum earnings threshold will be \$34,100; and
- For the DGA Premier Choice Plan, the minimum earnings threshold will be \$106,000.

#### NON-NETWORK OUT-OF-POCKET MAXIMUM (PAGES 55-56)

The following paragraphs and chart:

*The Out-of-Pocket Limit for non-network expenses for the DGA Premier Choice Plan is \$3,000.*

*The Out-of-Pocket Limit for non-network expenses for the DGA Choice Plan is \$7,500.*

Out-of-Pocket Limit		
	Network	Non-Network
DGA Premier Choice Plan	\$1,000	\$3,000
DGA Choice Plan	\$1,000	\$7,500

are replaced with:

*The Out-of-Pocket Limit for non-network expenses for the DGA Premier Choice Plan is \$3,550.*

*The Out-of-Pocket Limit for non-network expenses for the DGA Choice Plan is \$8,900.*

Out-of-Pocket Limit		
	Network	Non-Network
DGA Premier Choice Plan	\$1,000	\$3,550
DGA Choice Plan	\$1,000	\$8,900

## **MENTAL HEALTH AND CHEMICAL DEPENDENCY BENEFITS**

*Effective January 1, 2012, the Health Plan's mental health and chemical dependency benefits will be amended to comply with the Mental Health Parity Act. As a result, mental health and chemical dependency claims now have the same structure as Medical Benefits, with the exception of the Calendar Year Deductible, which does not apply to mental health and chemical dependency claims. Accordingly, the following changes were made to the Health Plan booklet:*

- On page xi, in the **Introduction**, the following paragraph:

*The nature and extent of benefits provided by the Health Plan and the rules governing eligibility are determined solely and exclusively by the Board of Trustees. Employees of the Health Plan office have no authority to alter those benefits and eligibility rules. Any interpretations or opinions given by employees of the Health Plan office are not binding upon the Board of Trustees and cannot enlarge or change such benefits and eligibility rules. The Board of Trustees is charged with the responsibility of interpreting the provisions of the Health Plan and establishing rules and regulations to assist in the administration of the Health Plan. They also determine the Health Plan's schedule of benefits and will rule on appeals of participants with respect to benefit denials regarding medical claims. Review of appeals regarding mental health, chemical dependency or vision claims will be ruled upon by providers of those services, as described in the Claims and Appeals Procedures section beginning on page 110.*

is replaced with:

*The nature and extent of benefits provided by the Health Plan and the rules governing eligibility are determined solely and exclusively by the Board of Trustees. Employees of the Health Plan office have no authority to alter those benefits and eligibility rules. Any interpretations or opinions given by employees of the Health Plan office are not binding upon the Board of Trustees and cannot enlarge or change such benefits and eligibility rules. The Board of Trustees is charged with the responsibility of interpreting the provisions of the Health Plan and establishing rules and regulations to assist in the administration of the Health Plan. They also determine the Health Plan's schedule of benefits and will rule on appeals of participants with respect to benefit denials regarding medical claims, including mental health and chemical dependency claims. Review of appeals regarding dental and vision claims will be ruled upon by providers of those services, as described in the Filing a Claim section beginning on page 105.*

- On page 1, in the **Calendar Year Deductible** section, the following paragraph:

*Emergency room co-payments, network outpatient psychiatric co-payments, non-network hospital co-payments, prescription drug co-payments, TIHN co-payments, inpatient psychiatric and chemical dependency claims and wellness benefits do not count towards your deductible.*

is replaced with:

*Emergency room co-payments, non-network hospital co-payments, prescription drug co-payments, TIHN co-payments, mental health and chemical dependency claims and wellness benefits do not count towards your deductible.*

- On page 2, in the **Lifetime Maximum Benefit** section, the following paragraph:

*Please refer to the What's Covered Under Medical Benefits section beginning on page 62 for specific information and benefit-specific visit limitations and co-insurance (e.g. psychiatric, chemical dependency, therapy, wellness benefits, etc.).*

is replaced with:

*Please refer to the What's Covered Under Medical Benefits section beginning on page 62 for specific information and benefit-specific visit limitations and co-insurance (e.g. therapy, wellness benefits, etc.).*

- The **Chemical Dependency Treatment and Mental Health Benefits** section that begins on page 3 is deleted in its entirety (as these benefits will be covered under the Medical Plan).
- On page 7, in the **Plan and Benefit Providers** section, OptumHealth is deleted.
- On page 32, in the **DGA Bronze Plan** section, delete the following lines:
  - *Inpatient psychiatric.*

And add under the **Deductible** section the following:

*With regards to mental health, the deductible only applies to inpatient mental health and is not applicable for outpatient mental health.*

- On page 54, in the **Deductibles** section, the following paragraph:

*Your deductible applies to both doctor and hospital expenses, as well as all other related expenses that are covered under the Health Plan. The Health Plan's dental benefit has a separate deductible. Prescription drug co-payments, emergency room co-payments, non-network hospital co-payments, TIHN co-payments, inpatient psychiatric and chemical dependency claims, network, outpatient psychiatric claims and wellness benefits do not count toward your deductible.*

is replaced with:

*Your deductible applies to both doctor and hospital expenses, as well as all other related expenses that are covered under the Health Plan. The Health Plan's dental benefit has a separate deductible. Prescription drug co-payments, emergency room co-payments, non-network hospital co-payments, TIHN co-payments, mental health and chemical dependency claims, and wellness benefits do not count toward your deductible.*

- On page 55, in the **Deductibles** section, delete the following sentence:

*There is a separate \$25 per person annual deductible for all outpatient, non-network mental health claims.*
- On page 56, in the **Out-of-Pocket Limit** section, delete the following lines:
  - ▶ *Inpatient psychiatric and chemical dependency expenses; and*
  - ▶ *Outpatient mental health claims (network and non-network).*
- On page 77, in the **What's Not Covered Under the Medical Plan** section, delete item #44.
- Pages 79-82, within the **Chemical Dependency Treatment and Mental Health Benefits** section, are replaced with the following:

#### **MENTAL HEALTH AND CHEMICAL DEPENDENCY BENEFITS**

- ▶ Effective January 1, 2012, mental health and chemical dependency benefits are covered under the medical plan, with the same benefit structure, with the exception of the calendar year deductible, which will not apply to mental health and chemical dependency claims.
- ▶ The Health Plan's mental health and chemical dependency benefit manager, effective January 1, 2012, will be Anthem Blue Cross. To determine if your current provider is part of Anthem's provider network or to find a network provider, visit [www.dgaplans.org](http://www.dgaplans.org) and click the **Find a Network Provider** quick link.
- ▶ Claims for visits that take place on or after January 1, 2012 will be processed by the Health Plan.

- ▶ Network and non-network mental health and chemical dependency claims will be covered as follows:

	Network	Non-Network***	
		Premier Choice	Choice
Deductible	None		
Co-insurance Inpatient	90%	70%	60%
Co-insurance intensive outpatient	90%	70%	60%
Co-insurance outpatient	90%	70%	60%
Out-of-pocket limit* (excluding deductibles)	\$1,000	\$3,550	\$8,900
Inpatient	Preauthorization required**		
Outpatient	No preauthorization required		
Visit Limits	None		
<p>*The out-of-pocket limit applies to the combined total for medical and mental health and chemical dependency benefits.</p> <p>**All inpatient admissions will need to be pre-authorized with Anthem Blue Cross under the same process that applies to medical admissions. For pre-authorization, contact Anthem Blue Cross at (800) 274-7767.</p> <p>***Non-network charges are paid at a percentage of the Reasonable and Customary charge.</p>			

For participants who are covered under the HealthNet HMO option, mental health and chemical dependency coverage will not feature any day and visit limits.

- The **Chemical Dependency Treatment Medication** section, beginning on page 87, is replaced in its entirety with the following:

**CHEMICAL DEPENDENCY TREATMENT MEDICATION**

*Participants receiving treatment under the Health Plan’s chemical dependency benefits can obtain prescribed chemical dependency treatment medication through a Medco network pharmacy.*

*In order to be covered under the Health Plan, chemical dependency medication must be prescribed by a physician during the course of your Anthem Blue Cross-approved chemical dependency treatment.*

*If, during your Anthem Blue Cross-approved chemical dependency treatment, you receive a prescription from your provider for chemical dependency treatment medication, you should contact the Health Plan prior to filling the initial prescription. The Health Plan will work with Medco and Anthem Blue Cross to implement the appropriate pre-authorization. This will allow you to pay only the applicable copayment at a network pharmacy.*

*If you do not contact the Health Plan for pre-authorization before filling a prescription for chemical dependency medication, you will pay 100% of the cost of the medication for the initial prescription. However, if you submit the claim to the Health Plan for reimbursement, and the prescription was part of an Anthem Blue Cross-approved course of chemical dependency treatment, the cost of the prescription will be refunded to you, less the applicable co-payment. For subsequent refills, the Health Plan will coordinate your pre-authorizations for these types of drugs with Medco and Anthem Blue Cross.*

*Once your prescription for chemical dependency medication has been established in Medco’s system and if the Anthem Blue Cross authorization for chemical dependency treatment has not expired, you will be able to obtain future prescriptions at a network pharmacy and will only have to pay the applicable co-payment. Once the Anthem Blue Cross authorization has expired, you will be required to obtain a new prescription from your provider.*

*For more information on the Health Plan’s chemical dependency benefit, please refer to the Chemical Dependency Treatment Benefits section beginning on page 79.*

- On page 89, in the **What’s Not Covered Under Prescription Drug Benefits** section, delete item #5.
- The **Mental Health and Chemical Dependency Claims** section that begins on page 108 is deleted in its entirety (these claims should be submitted according to the guidelines under the Medical Claims section that begins on page 105).

- On page 112, in the **Pre-Service Health Care Claims** section, the reference to “OptumHealth” should be replaced with “Anthem Blue Cross.”
- On page 125, in the **Identity of Providers of Benefits** section, the reference to “OptumHealth” should be replaced with “Anthem Blue Cross.”
- On page 136, in the **Biofeedback/Training** entry in the **Glossary**, the reference to “Optum Health” should be replaced with “Anthem Blue Cross.”

## **SEPTEMBER 16, 2011**

### **VERIFYING ELIGIBLE DEPENDENTS (PAGE 36)**

The section titled “Verifying Eligible Dependents” on page 36 before the heading “Marriage” is revised as follows:

*In order to verify if your dependent qualifies as an eligible dependent, you must promptly send the Health Plan office a copy of any document or information requested by the Health Plan that is necessary to establish initial qualification as a dependent or continued eligibility as a dependent. In addition to providing any such requested documentation or information, you are required to provide the following documents:*

[After list of documents, the following language is added:]

*By participating in the Health Plan, you are agreeing to cooperate with the Plan’s reasonable efforts to audit the status of any dependent. Timely providing information or documents that are required or requested is a condition of your dependent’s eligibility for benefits. Therefore, if the information or documents are not provided, the Health Plan in its sole discretion may determine that your dependent does not qualify as a dependent or loses continued eligibility as a dependent. You may be held responsible for any overpayments made as a result of the failure to provide such information or documentation.*

## **JULY 1, 2011**

### **CARRY-OVER COVERAGE (PAGE 14)**

- The amount of banked earnings that are needed for one year of carry-over coverage was increased to \$130,000, effective with benefit periods beginning on or after July 1, 2011.
- The carry-over threshold (the amount of earnings after which covered earnings will be credited to your carry-over account) was increased to \$130,000, effective with benefit periods beginning on or after July 1, 2011.

## **JUNE 24, 2011**

### **HEARING AID COVERAGE (PAGE 74)**

- Hearing aids were removed from the Wellness Benefit and a \$1,500 annual cap was put in place. The \$1,500 cap is applied per person, per year (not per device).

## **APRIL 1, 2011**

### **PRIVATE DUTY NURSING (PAGES 70 & 71)**

The \$25,000 annual limit on private duty nursing benefits was eliminated and replaced with an 860-hour annual limit.

**JANUARY 1, 2011****DEPENDENT PREMIUM (PAGES 1 & 37)**

The Health Plan's dependent premium for participants and dependents on earned coverage are structured as follows:

<b>Enrollment</b>	<b>Annual Premium</b>
Participant only	No premium
Participant +1 dependent	\$780 (\$65 per month)
Participant +2 or more dependents	\$1,200 (\$100 per month)

Premium payments must be paid on an annual or semi-annual basis, and cannot be paid monthly.

**PATIENT PROTECTION AND AFFORDABLE CARE ACT OF 2010 (PPACA) MANDATED HEALTH PLAN CHANGES (PAGE NUMBERS BELOW)**

1. The section titled "Lifetime Maximum Benefit" on page 2 under the heading "Medical "Benefits" is revised as follows:

**Visit Limitations and Co-Insurance**

Please refer to the What's Covered Under Medical Benefits section beginning on page 62 for specific information on benefit-specific visit limitations and co-insurance (e.g. psychiatric, chemical dependency, therapy, wellness benefits, etc.).

2. The section titled "Maximum Lifetime Benefits" on page 3 under the heading "Chemical Dependency Treatment Benefits" is deleted in its entirety.
3. The section titled "Maximum Lifetime Benefits" on page 4 under the heading "Mental Health Benefits" is deleted in its entirety.
4. The section titled "Calendar Year Maximum" on page 5 under the heading "Dental Benefits" is revised as follows:

**Calendar Year Maximum**

\$2,500 per person. This limit does not apply to children under age 19.

5. The second and third paragraphs in the section titled "Adjustments to Reported Contributions" on page 10 under the heading "Qualifying for Health Coverage" are revised as follows:

We strongly urge you to keep detailed records of your DGA-covered earnings and to re-report any discrepancies to the Plan. If contributions are overreported on your behalf, your coverage could be cancelled immediately. Also, to the extent permitted by law, you may be held responsible for overpaid benefits. On the other hand, if contributions are under-reported on your behalf, you might not receive all of the benefits for which you should have been eligible.

If there is an adjustment that reduces the amount of your acceptable contributions (as a result of an audit or otherwise), you may be held responsible for any benefits that were paid on your behalf that would not have been paid had the contributions been properly reported. This can include both the loss of coverage or coverage that switches from one plan of benefits to another (i.e. from the DGA Premier Choice Plan to the DGA Choice Plan).

6. The references to age 19 in the 11th and 12th paragraphs of the section titled "Retiree Carry-Over Coverage" on page 27 under the heading "Retiree Self-Pay Coverage" are revised to age 26.
7. The references to age 19 in the 9th and 10th paragraphs of the section titled "Certified Retiree Coverage" on page 29 under the heading "Retiree Self-Pay Coverage" are revised to age 26.
8. The section titled "Your Unmarried Children Under Age 19" on page 34 under the heading "Eligible Dependents" is revised as follows:

### **Your Children Under Age 26**

Your children under age 26 are:

- Your natural children and those of your spouse or your same-sex spouse;
- Adopted or biological children of your same-sex domestic partner who you have adopted;
- Biological children of your same-sex domestic partner where you are listed as a parent on the child's birth certificate;
- Your adopted children, beginning on the date of the placement for adoption; or
- Any other children dependent upon you for the majority of their financial support and living with you in a normal parent-child relationship, provided proof of these conditions can be verified.

Notwithstanding the above, for Plan Years prior to January 1, 2014, children age 19 to 26 are not eligible dependents under this Plan if they are eligible to enroll in an employer-sponsored health plan other than a group health plan of a parent. For this purpose, an employer-sponsored health plan is a group health plan or group health insurance coverage offered by an employer to an employee, including a governmental plan.

9. The section titled "Your Unmarried Children Ages 19-22" on page 35 under the heading "Eligible Dependents" is deleted in its entirety.
10. The section titled "Your Disabled Children Ages 19 and Older" on page 35 under the heading "Eligible Dependents" is amended as follows:

#### **Your Disabled Children Age 26 and Older**

Your children age 26 and older are eligible dependents if they are not capable of self-sustaining employment because of a mental or physical handicap and are considered medically to have incurred a total disability, provided that this disability existed immediately prior to the maximum age and provided that the child was covered by the Health Plan immediately prior to turning age 26. In addition, the child must be primarily dependent upon you for support and maintenance.

11. The section titled "Student Status" on page 36 under the heading "Verifying Eligible Dependents" is deleted in its entirety.
12. The references to age 19 in the first and second paragraphs of the section titled "Dependent Children of Retirees" on page 40 under the heading "Covering Your Dependents" are revised to age 26.
13. The reference to "or student" in the fourth paragraph of the section titled "Dropping Your Dependents Coverage" on page 42 under the heading "Covering Your Dependents" is deleted.
14. The section titled "Lifetime Maximum Benefit" on pages 56 through 57 is deleted in its entirety.
15. The third paragraph of the section titled "Nursing Care" on pages 70 through 71 under the heading "What's Covered Under Medical Benefits" is revised as follows:

The maximum benefit payable for private duty nursing care is \$25,000 per calendar year. Note that this maximum benefit limit does not apply to any services relating to private duty nursing care that are considered "essential health benefits" under the Patient Protection and Affordable Care Act. If you need assistance in determining whether any private nursing care provided to you is considered to be an "essential health benefit" under the Patient Protection and Affordable Care Act, please contact the Health Plan Office.

16. The section titled "Therapy Benefit" on pages 72 through 73 under the heading "What's Covered Under Medical Benefits" is revised as follows:

### **Therapy Benefit**

Therapy benefits (in-hospital or out-of-hospital) are only covered when prescribed by a physician.

Therapy includes:

- Physical Therapy administered by a registered physical therapist;
- Speech therapy (see requirements in this section);
- Biofeedback for covered non-psychiatric diagnoses;
- Vision therapy (excluding refractions – see requirements in the following section);
- Osteopathic adjustments or manipulations by a Doctor of Osteopathy;
- Occupational Therapy (OT); and
- Continuously monitored cardiac rehabilitation (a phase II program).

Therapy must be performed by a licensed, certified physician or general practitioner and is covered up to 50 visits per individual per calendar year.

The Plan will allow one office visit for the evaluation and management of a new patient, which will not be included in the 50 visit limit, and payment will be based on Reasonable and Customary Charges.

Multiple therapy treatments in one day by the same provider are treated as one visit.

Speech therapy and Occupational Therapy expenses will not be covered when they are part of educational therapy for a child with a learning delay or when necessary treatment is provided or reimbursed by a school system or other governmental agency.

Whether a therapy treatment is covered is determined by the terms of the Health Plan. If you have any questions about the coverage of the Health Plan, you may contact the Health Plan office.

17. The second sentence in the first paragraph of the section titled “Wellness Benefits” on page 73 under the heading “What’s Covered Under Medical Benefits” is deleted.
18. The second paragraph of the introductory language of the “Chemical Dependency Treatment and Mental Health Benefits” section on page 79 is deleted.
19. The penultimate paragraph of the section titled “Chemical Dependency Treatment Benefits” on page 80 is deleted.
20. The third paragraph of the introductory language of the “Prescription Drug Benefits” section on page 83 is deleted.
21. The section titled “Network Co-Insurance” on page 92 under the heading “Network Dentists” is revised as follows:

### **Network Co-Insurance**

For network dentists, the Health Plan pays a percentage of charges based upon one of four categories of service:

- 100% for Category I procedures;
- 80% for Category II procedures;
- 70% for Category III procedures; and
- 50% for orthodontia for dependent children under 19.

You are responsible for the remaining percentage of charges.

The maximum amount payable for covered dental expenses during a calendar year is \$2,500 per individual. This limit does not apply to children under age 19.

Orthodontia is limited to a lifetime maximum of \$1,500 per dependent child under 19.

22. The section titled “Non-Network Co-Insurance” on page 93 under the heading “Non-Network Dentists” is revised as follows:

**Non-Network Co-Insurance**

Once you satisfy the deductible, the Health Plan pays a percentage of Reasonable and Customary Charges based upon one of four categories of service:

- 85% for Category I procedures;
- 60% for Category II procedures;
- 50% for Category III procedures; and
- 50% for orthodontia for dependent children under 19.

You are responsible for the remaining percentage of charges and any amounts above Reasonable and Customary Charges.

The maximum amount payable for covered dental expenses during a calendar year is \$2,500 per individual. This limit does not apply to children under age 19.

Orthodontia is limited to a lifetime maximum of \$1,500 per dependent child under 19.

23. The section titled “Special Provisions for Orthodontic Treatments” on page 96 under the heading “Dental Benefits” is revised as follows:

**Special Provisions for Orthodontic Treatments**

A separate benefit for orthodontic treatment is provided only for your dependent children under age 19.

Benefits are paid at 50% of Reasonable and Customary Charges and are paid on a pro-rated basis throughout the course of treatment. Covered expenses are not subject to the dental deductible.

The lifetime maximum for all orthodontic treatment is \$1,500 per dependent child whether or not there has been an interruption in dental coverage.

24. The section titled “Overpayments” on page 119 under the heading “General Provisions” is revised as follows:

**Overpayments**

The Health Plan has the right to recover any mistaken payment, overpayment, or any payment made to any individual who was not eligible for that payment. All together, these overpayments are referred to in this Booklet as an “overpayment.” You will receive written notification if a refund is required.

You can be held individually liable for reimbursing the Health Plan for the amount of the overpayment if your eligibility was established because of fraud or intentional misrepresentation of material fact or to the extent permitted by law. In addition, the Health Plan has the right to collect the over-payment from you, your eligible dependents, or your employer, or to pursue each or all of you for reimbursement. The Board of Trustees can take all actions as it determines appropriate, in its sole discretion, to recover the overpayment. Such actions may include:

- Reducing the amount owed to the Health Plan by applying the amount of contributions made by your employer during the relevant period;

- Entering into written agreements for the repayment of overpaid benefits, with interest if applicable; and
- Requiring that the amount of overpayment be deducted from all future benefit payments for participants and participant's eligible dependents until a full refund is paid.

In addition, the Board of Trustees shall assess interest on the amount due to the Health Plan at the rate in effect at the time of the overpayment, as periodically set by the Trustees and may, in their discretion, seek payment of such amounts through filing a lawsuit or taking any other measure they deem necessary and appropriate. You, your eligible dependent, and your employer are also responsible for paying the Health Plan all expenses incurred collecting the overpayment, audit fees, attorneys' fees and interest calculated from the date of the initial overpayment.

25. The following section shall be added after the section titled "Plan Year" on page 125 under the heading "ERISA Required Information:"

**Grandfathered Plan Status**

This group health plan believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Health Plan at (323) 866-2200 or toll-free at (877) 866-2200.

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). This website has a table summarizing which protections do and do not apply to grandfathered health plans.

26. The section titled "False or Fraudulent Claims" on pages 131 through 132 under the heading "A Final Word" is revised as follows:

**False or Fraudulent Claims**

Anyone who submits any false or fraudulent claim or information to the Health Plan may be subject to criminal penalties including a fine or imprisonment or both as well as damages in a civil action under California or federal law. Furthermore, the Board of Trustees reserves the right to impose such restrictions upon the payment of further benefits to any such participant or dependent as may be necessary to protect the Health Plan, including the deduction from such future benefits of amounts owed to the Health Plan because of the payment of any false or fraudulent claim. The participant or dependent must pay the Health Plan for all its legal and collection costs as well as benefit payments made (with interest).

If it is determined that a participant became eligible for Health Plan benefits as a result of earnings which are determined to be non-covered earnings, the participant's coverage could be cancelled immediately. Also, to the extent permitted by law, the participant may be obligated to refund all benefits received in excess of contributions by the participant's employer to the Health Plan on the participant's behalf. If the participant also loses pension credit as a result, improper pension contributions may be utilized as an offset against benefits paid to the participant.

27. The reference to age 19 in the definition of the word "Kids COBRA" on page 142 in the Glossary section is revised to age 26.

### **SURVIVING SPOUSES AND SAME-SEX DOMESTIC PARTNERS OF PARTICIPANTS ON EARNED OR SELF-PAY COVERAGE (PAGE 42)**

Surviving spouses and same-sex domestic partners of participants on earned or self-pay coverage will inherit such coverage provided that they had been married to the participant or in a same-sex domestic partnership with the participant for a minimum of two years prior to the participant's death.

The inherited coverage will terminate upon the earlier of:

- The date the remaining earned coverage/self-pay expires;
- The date the surviving spouse/same-sex domestic partner marries or enters into same-sex domestic partner relationship or fails to timely provide to the Plan (upon the Plan's request) an affidavit attesting to their marital status or same-sex domestic partnership status or any other documentation requested by the Plan needed to confirm the status. It is the spouse/same-sex domestic partner's responsibility to notify the Health Plan of a new marriage or same-sex domestic partner relationship. If a spouse/same sex domestic partner fails to do so, or fails to provide the affidavit referred to above, or other information requested by the Plan to confirm that status, he or she will be held liable for any claims overpayments made as a result of their failure to notify the Health Plan.

### **SURVIVING SPOUSES AND SAME-SEX DOMESTIC PARTNERS OF PARTICIPANTS QUALIFIED FOR CERTIFIED RETIREE COVERAGE (PAGE 44)**

Surviving spouses and same-sex domestic partners of participants that are eligible for Certified Retiree coverage will inherit the Certified Retiree coverage even if the participant never began such coverage, provided that the marriage or same-sex domestic partner relationship was in existence for a minimum of two years immediately prior to the participant's death. They will be eligible to begin this coverage when the participant would have been eligible for Certified Retiree status. If the participant was eligible for Certified Retiree status at the time of death, coverage will begin immediately.

In conjunction with this change, the rules for the inheritance of Certified Retiree coverage have been changed. A surviving spouse/same-sex domestic partner that inherits Certified Retiree coverage will inherit such coverage, but the coverage will terminate upon the earlier of:

- The date on which the spouse/same-sex domestic partner marries or enters into a same-sex domestic partner relationship or fails to timely provide the Plan (upon the Plan's request) an affidavit attesting to their marital status or same-sex domestic partnership status or any other documentation requested by the Plan needed to confirm that status.
- The date on which the spouse/same-sex domestic partner fails to pay the required premium for Certified Retiree coverage; or
- The date on which the spouse/same-sex domestic partner dies.

It is the spouse/same-sex domestic partner's responsibility to notify the Health Plan of a new marriage or same-sex domestic partner relationship. They will be held liable for any claims overpayments made as a result of their failure to notify the Health Plan.

### **SURVIVING SPOUSES AND SAME SEX DOMESTIC PARTNERS OF PARTICIPANTS ON CERTIFIED RETIREE OR RETIREE CARRY-OVER COVERAGE (PAGE 44)**

Surviving spouses and same-sex domestic partners of participants on Certified Retiree or Retiree Carry-Over coverage will inherit such coverage; however, the inherited coverage will terminate upon the earlier of:

- The date coverage for any remaining RCO credits expire, if not otherwise eligible for Certified Retiree coverage;
- The date the surviving spouse/same-sex domestic partner marries or enters into same-sex domestic partner relationship or fails to timely provide to the Plan (upon the Plan's request) an affidavit attesting to their marital status or same-sex domestic partnership status, or other information requested by the Plan to confirm that status;
- The date the surviving spouse/same-sex domestic partner fails to pay the required premium; or

- The date the surviving spouse/same-sex domestic partner dies.

It is the spouse/same sex domestic partner’s responsibility to notify the Health Plan of a new marriage or same-sex domestic relationship. If a spouse/same sex domestic partner fails to do so, or fails to provide the affidavit referred to above, or other information requested by the Plan to confirm that status, he or she will be held liable for any claims overpayments made as a result of their failure to notify the Health Plans.

**VERIFYING ELIGIBLE DEPENDENTS (PAGE 37)**

Same Sex Domestic Partnership:

A domestic partner enrollment packet that is available from the Plan office must be completed and the enrollment must be approved in order to establish initial eligibility. After eligibility is established, the Plan office must be notified immediately of any change in the status of a same-sex domestic partnership. Please refer to sections “Dropping Your Dependents’ Coverage” and “Dependent Coverage Extensions Upon a Participant’s Death” (as amended July 1, 2010) of this Summary Plan Description for further information regarding obligations to notify the Plan office of a change of status.

**MINIMUM EARNINGS THRESHOLDS (PAGE 11)**

The minimum earnings thresholds to qualify for earned coverage for four-quarter earnings periods beginning January 1, 2011, are as follows:

- For the DGA Choice Plan, the minimum earnings threshold will remain at \$33,400; and
- For the DGA Premier Choice Plan, the new minimum earnings threshold will be \$103,900.

**OCTOBER 1, 2010**

**MEDCO PRIOR-AUTHORIZATION FOR SPECIALTY DRUGS (PAGE 71)**

The DGA-Producer Health Plan began instituting new prior-authorization rules for specialty medication to help prevent off-label drug use. This means that a small subset of certain highly specialized medications must be authorized by Medco, the Health Plan's pharmacy benefit manager, before they can be covered under Health Plan benefits. If a participant submits a prescription for a specialty medication to be filled, Medco will automatically begin the drug approval process by contacting the prescribing physician. The specialty drug approval process typically takes one to three days, depending on the prescribing physician’s response time.

**THE INDUSTRY HEALTH NETWORK FACILITY CO-PAYMENTS CHART (PAGE 53)**

The following chart details the co-payment for benefits received through The Industry Health Network (TIHN) facility and primary care physician (PCP). This chart should have been included on page 53 of the January 2010 Health Plan Booklet.

Benefits Through a TIHN Facility and PCP	Co-Payment
Primary Care Visits	\$10
Specialist Visits, referred by your PCP	\$10
Well Child Care	\$10
Pediatric Visits	\$10
Physical Therapy	\$10
Surgery, including Assistant Surgeon* (inpatient and hospital-based outpatient)	\$100

\*Does not include hospitalization fees.

**JULY 1, 2010**

**CERTIFIED RETIREE COVERAGE (PAGE 28)**

Participants who retired from either the Basic or Supplemental Pension Plans on or after July 1, 2006 will be able to continue accruing earned coverage years toward Certified Retiree coverage. You will still be required to take a benefit from the Basic or

Supplemental Pension Plan to qualify. Previously, if you retired with less than the minimum 20 years of earned coverage, you would never be able to qualify for Certified Retiree coverage.

#### **CARRY-OVER COVERAGE (PAGE 14)**

- Dependent children of retirees on carry-over coverage will be considered eligible dependents. This change will allow all participants to cover their eligible dependent children under their carry-over coverage, regardless of whether or not they had taken a pension benefit and provided the applicable dependent premium is paid. Previously, if a participant had taken a benefit from the Basic or Supplemental Pension Plan, their dependent children were not considered eligible dependents under their carry-over coverage.
- The carry-over bank maximum (the maximum balance permitted in an individual's carry-over account) was increased to \$450,000, effective retroactively to benefit periods beginning on or after July 1, 2010.

#### **RETIREE CARRY-OVER COVERAGE (PAGE 25)**

Participants who have at least 10 years of earned coverage and have retired from the Basic or Supplemental Pension Plan will be eligible to begin Retiree Carry-Over coverage at age 65. Previously, the age requirement for participants to be eligible to begin Retiree Carry-Over coverage was age 60. Participants that have previously begun Retiree Carry-Over coverage who do not meet the new criteria will be allowed to continue such coverage under the prior eligibility rules.

#### **SELF-PAY COVERAGE (PAGE 24)**

Self-pay coverage will no longer terminate when a participant retires from either of the pension plans.

#### **RETIREE SELF-PAY EXTENSION COVERAGE (PAGE 25)**

Retiree Self-Pay Extension Coverage will be eliminated. However, participants with at least 10 years of earned coverage will be eligible to self-pay for up to five years and will no longer have their self-pay coverage terminated due to retirement. Any participants that are on Retiree Self-Pay Extension Coverage on July 1 will be allowed to continue coverage under the prior eligibility rules.

#### **SURVIVING SPOUSES AND SAME-SEX DOMESTIC PARTNERS OF PARTICIPANTS ON EARNED OR SELF-PAY COVERAGE (PAGE 42)**

Surviving spouses and same-sex domestic partners of participants on earned or self-pay coverage will inherit such coverage provided that they had been married to the participant or in a same-sex domestic partnership with the participant for a minimum of two years prior to the participant's death.

The inherited coverage will terminate upon the earlier of:

- The date the remaining earned coverage/self-pay expires;
- The date the surviving spouse/same-sex domestic partner marries or enters into same-sex domestic partner relationship. It is the spouse/same-sex domestic partner's responsibility to notify the Health Plan of a new marriage or same-sex domestic partner relationship. They will be held liable for any claims overpayments made as a result of their failure to notify the Health Plan.

#### **SURVIVING SPOUSES AND SAME-SEX DOMESTIC PARTNERS OF PARTICIPANTS QUALIFIED FOR CERTIFIED RETIREE COVERAGE (PAGE 44)**

Surviving spouses and same-sex domestic partners of participants that are eligible for Certified Retiree coverage will inherit the Certified Retiree coverage even if the participant never began such coverage, provided that the marriage or same-sex domestic partner relationship was in existence for a minimum of two years immediately prior to the participant's death. They will be eligible to begin this coverage when the participant would have turned age 60. If the participant was at least 60 at the time of death, coverage will begin immediately.

In conjunction with this change, the rules for the inheritance of Certified Retiree coverage have been changed. A surviving spouse/same-sex domestic partner that inherits Certified Retiree coverage will inherit such coverage, but the coverage will terminate upon the earlier of:

- The date on which the spouse/same-sex domestic partner marries or enters into a same-sex domestic partner relationship. It is the spouse/same-sex domestic partner's responsibility to notify the Health Plan of a new marriage or same-sex domestic partner relationship. They will be held liable for any claims overpayments made as a result of their failure to notify the Health Plan;
- The date on which the spouse/same-sex domestic partner fails to pay the required premium for Certified Retiree coverage; or
- The date on which the spouse/same-sex domestic partner dies.

**SURVIVING SPOUSES AND SAME-SEX DOMESTIC PARTNERS OF PARTICIPANTS ON CERTIFIED RETIREE OR RETIREE CARRY-OVER COVERAGE (PAGE 44)**

Surviving spouses and same-sex domestic partners of participants on Certified Retiree or Retiree Carry-Over coverage will inherit such coverage; however, the inherited coverage will terminate upon the earlier of:

- The date coverage for any remaining RCO credits expire, if not otherwise eligible for Certified Retiree coverage;
- The date the surviving spouse/same-sex domestic partner marries or enters into same-sex domestic partner relationship. It is the spouse/ same-sex domestic partner's responsibility to notify the Health Plan of a new marriage or same-sex domestic partner relationship. They will be held liable for any claims overpayments made as a result of their failure to notify the Plan;
- The date the surviving spouse/same-sex domestic partner fails to pay the required premium; or
- The date the surviving spouse/same-sex domestic partner dies.

**JANUARY 1, 2010**

**AMBULANCE SERVICE (PAGE 63)**

The Ambulance Service section of the Health Plan Booklet was amended to read as follows:

Licensed ambulance company service is covered for:

- Emergency transportation to a local hospital; or
- Local ambulance transport from a hospital to home at discharge when transport by non-ambulance is impossible or the patient's health would be seriously jeopardized if an ambulance was not used; or
- Local ambulance transport to and from a separate facility for Medically Necessary diagnostic/treatment services during inpatient hospital confinement.

In the event that specialized treatment is needed at a specially-equipped hospital, and a ground ambulance is not available or practical, or if you should have an Accident or medical emergency in an area not easily accessible by conventional transportation, coverage is provided for air transportation to the nearest facility equipped to provide the necessary services.

For any air ambulance service provided after January 1, 2010, coverage is limited to three times in the lifetime of each participant or eligible dependent. In determining the number of times air ambulance service is utilized, service utilized both before and after January 1, 2010 is counted.

Transportation for patient/doctor convenience is not covered.