Summary of Material Modification
4/1/2013

Atlantic Dialysis Management Services
Welfare Benefit Plan

Applies to: Atlantic Dialysis Management Services Employees and Dependents

The following document provides a summary of 2013 changes to the Atlantic Dialysis Management Services benefits booklets.

This Summary of Material Modifications should be retained with your other benefits information.

This summary of material modification ("**SMM**") describes changes to the Atlantic Dialysis Management Services Welfare Plan ("**Plan**") and supplements the Summary Plan Description ("**SPD**") for the Plan. The effective date of each of these changes is indicated above.

Summary of Changes:

Section: BENEFIT PLANS CUSTOMER SERVICE DIRECTORY

Replace: TPA Exchange Written Inquiries address with:

PO Box 1043 Matthews, NC 28106

Section: COVERAGE EXCLUSIONS AND LIMITATIONS

Added:

- Care and treatment of an injury and/or illness that results from engaging in a hazardous hobby or activity. A hobby or activity is considered hazardous if it is an activity which is characterized by a constant threat of danger or risk of bodily harm, or maybe competitive in nature, but does not include certain activities which are considered recreational (as determined by the Plan Administrator).

- Charges for services received as a result of injury or sickness occurring directly or indirectly, as a result of a serious illegal act, or a riot or public disturbance. This exclusion does not apply if the injury or sickness resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

- Services, supplies, care or treatment to a Covered Person for injury or sickness resulting from that Covered Person's voluntary taking of or being under the influence of any

controlled substance, drug, hallucinogen or narcotic not administered on the advice of a physician. This exclusion does not apply if the injury or sickness resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

Add Section: **PRECERTIFICATION / COST MANAGEMENT SERVICES**

Precertification / Cost Management Services Phone Number

Please refer to the Employee ID card for the Precertification / Cost Management Services phone number.

The patient or family member must call this number to receive certification of certain Cost Management Services. This call must be made at least 7 days in advance of services being rendered or within 48 hours after an emergency.

Any reduced reimbursement due to failure to follow cost management procedures will not accrue toward the 100% maximum out-of-pocket payment.

UTILIZATION REVIEW

Utilization review is a program designed to help insure that all Covered Persons receive necessary and appropriate health care while avoiding unnecessary expenses.

The program consists of:

(a) Precertification of the Medical Necessity for the following non-emergency services before Medical and/or Surgical services are provided:

Inpatient Hospitalizations
Outpatient Surgery
MRIs/MRAs
PET/CAT scans
DME over $1,000.00
Botox injections
All Infused Prescription Drugs

(b) Retrospective review of the Medical Necessity of the listed services provided on an emergency basis;

(c) Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending Physician; and

(d) Certification of services and planning for discharge from a Medical Care Facility or cessation of medical treatment.

The purpose of the program is to determine what charges may be eligible for payment by the Plan. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care provider.

If a particular course of treatment or medical service is not certified, it means that either the Plan will not pay for the charges or the Plan will not consider that course of treatment as appropriate for the maximum reimbursement under the Plan. The patient is urged to find out why there is a discrepancy between what was requested and what was certified before incurring charges.

The attending Physician does not have to obtain precertification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

In order to maximize Plan reimbursements, please read the following provisions carefully.

Here's how the program works.

Precertification. Before a Covered Person enters a Medical Care Facility on a non-emergency basis, the utilization review administrator will, in conjunction with the attending Physician, certify the care as appropriate for Plan reimbursement. A non-emergency stay in a Medical Care Facility is one that can be scheduled in advance.

The utilization review program is set in motion by a telephone call from the Covered Person. Contact the utilization review administrator at the telephone number on your ID card **at least 7 days before** services are scheduled to be rendered with the following information:

- The name of the patient and relationship to the covered Employee
- The name, Member ID number and address of the covered Employee
- The name of the Employer
- The name and telephone number of the attending Physician
- The name of the Medical Care Facility, proposed date of admission, and proposed length of stay
- The diagnosis and/or type of surgery
- Planned procedure codes

If there is an **emergency** admission to the Medical Care Facility, the patient, patient's family member, Medical Care Facility or attending Physician must contact the utilization review administrator **within 48 hours** of the first business day after the admission.

The utilization review administrator will determine the number of days of Medical Care Facility confinement authorized for payment. **Failure to follow this procedure may reduce reimbursement received from the Plan.**

If the Covered Person does not receive authorization as explained in this section, the benefit payment will be reduced by 50%.

Concurrent review, discharge planning. Concurrent review of a course of treatment and discharge planning from a Medical Care Facility are parts of the utilization review program. The utilization review administrator will monitor the Covered Person's Medical Care Facility stay or use of other medical services and coordinate with the attending Physician, Medical Care Facilities and Covered Person either the scheduled release or an extension of the Medical Care Facility stay or extension or cessation of the use of other medical services.

If the attending Physician feels that it is Medically Necessary for a Covered Person to receive additional services or to stay in the Medical Care Facility for a greater length of time than has been precertified, the attending Physician must request the additional services or days.

Add Section: **CASE MANAGEMENT**

Case Management. The Plan may elect, in its sole discretion, when acting on a basis that precludes individual selection, to provide alternative benefits that are otherwise excluded under the Plan. The alternative benefits, called "Case Management," shall be determined on a case-by-case basis, and the Plan's determination to provide the benefits in one instance shall not obligate the Plan to provide the same or similar alternative benefits for the same or any other Covered Person, nor shall it be deemed to waive the right of the Plan to strictly enforce the provisions of the Plan.

A case manager consults with the patient, the family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient. This plan of care may include some or all of the following:

-- personal support to the patient;

-- contacting the family to offer assistance and support;

-- monitoring Hospital or Skilled Nursing Facility;

-- determining alternative care options; and

-- assisting in obtaining any necessary equipment and services.

Case Management occurs when this alternate benefit will be beneficial to both the patient and the Plan.

The case manager will coordinate and implement the Case Management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The Plan Administrator, attending Physician, patient and patient's family must all agree to the alternate treatment plan.

Once agreement has been reached, the Plan Administrator will direct the Plan to reimburse for Medically Necessary expenses as stated in the treatment plan, even if these expenses normally would not be paid by the Plan.

Note: Case Management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate.

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

Update Section 4: **YOUR MAGNACARE MEDICAL BENEFITS**
PREVENTIVE SERVICES and/or MATERNITY CARE

All members

- Yearly preventive care visits for adults (male and female)
- All standard immunizations recommended by the American Committee on Immunization Practices

All members at an appropriate age or risk status

- Colorectal cancer screening (including CT colonography, fecal occult blood testing, screening sigmoidoscopy, and screening colonoscopy)
- Cholesterol and lipid disorders
- Certain sexually transmitted diseases screening including HIV
- High blood pressure, diabetes and depression screening
- Screening and counseling in a primary care setting for alcohol or substance abuse, tobacco use, obesity, diet and nutrition

Women's health

- Mammography screening (film and digital) for all adult women
- Genetic screening and evaluation for the BRCA breast cancer gene
- Cervical cancer screening including Pap smears
- Sexually transmitted diseases screening including gonorrhea, Chlamydia, syphilis and HIV
- Iron-deficiency anemia, bacteriuria, hepatitis B virus and Rh incompatibility screening in pregnant women
- Breast-feeding counseling and promotion
- Osteoporosis screening (age 60 and older)
- Counseling women at high risk of breast cancer for chemoprevention
- Breast-feeding support, supplies, and counseling, including costs for renting or purchasing specified breast-feeding equipment from a network provider or national durable medical equipment supplier
- Domestic violence screening and counseling

- FDA-approved contraception methods, sterilization procedures and contraceptive counseling
- Gestational diabetes screening for all pregnant women
- HIV counseling and screening for all sexually active women
- Human papillomavirus DNA testing for all women 30 years and older
- Sexually transmitted infection counseling for all sexually active women annually
- Well-woman visits including preconception counseling and routine, low-risk prenatal care

Men's health

- Prostate cancer screening for men (age 40 and older)
- Abdominal aortic aneurysm screening in men (age 65-75) who ever smoked
- Human papillomavirus (HPV) vaccine for males age 9-26

Children

- Newborn screening for hearing, thyroid disease, phenylketonuria and sickle cell anemia and standard metabolic screening panel for inherited enzyme deficiency diseases
- Counseling for fluoride use
- Major depressive disorders screening
- Vision screening
- Developmental/autism screening
- Lead and tuberculosis screening
- Obesity counseling

The Department of Health and Human Services has defined the preventive services to be covered with no cost-share as those services described in the U.S. Preventive Services Task Force A and B recommendations, the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC), and certain guidelines for infants, children, adolescents and women supported by the Health Resources and Services Administration (HRSA) Guidelines including the American Academy of Pediatrics Bright Futures periodicity guidelines.

All other terms and conditions remain unchanged.