

**EMPLOYEE NOTIFICATION NUMBER 6
TO
PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION
FOR**

DANVILLE AREA COMMUNITY COLLEGE

BY THIS AGREEMENT, Danville Area Community College – Plan Three Group Medical Benefit Plan (hereinafter referred to as the “Plan”) is hereby amended to reflect the following, effective July 1, 2010:

In accordance with The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, the Plan has been amended to remove all references to treatment limitations for Psychiatric and Substance Abuse Care. Psychiatric and Substance Abuse Care will be covered the same as any other illness, subject to all Plan provisions.

The **SCHEDULE OF BENEFITS** has been deleted and replaced with the following:

DEDUCTIBLE/OUT-OF-POCKET/PENALTIES		
SUMMARY OF SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Mandatory Hospital Pre-Admission And Pre-Surgical Review Refer To The Section Entitled “Utilization Review Program”		
Non-Compliance Penalty		
All Surgeries		\$400
Hospital Admissions		\$400
Lifetime Maximum Benefit		\$2,000,000
Per Confinement Deductible	None	None
Plan Year Deductible		
Individual	\$500	\$1,000
Family	\$1,000	\$2,000
<i>Note: The Family Deductible Maximum includes covered expenses which are used to satisfy Deductibles for all family members combined. Network/Non-Network expenses will be applied equally toward the satisfaction of both the Network and Non-Network Deductible amounts.</i>		
Out-of-Pocket Maximum – In Excess of Deductible		
Individual	\$2,000	\$4,000
Family	\$4,000	\$8,000
<i>Note: The Family Out-of-Pocket Maximum includes Out-of-Pocket expenses for all family members combined. Network/Non-Network expenses will be applied equally toward the satisfaction of both the Network and Non-Network Out-of-Pocket Maximums. Co-payments continue to be the responsibility of the Covered Person.</i>		

SPECIAL COVERAGES		
<i>Refer to Specific Section for Details</i>		
SUMMARY OF SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Second Surgical Opinion	80% Deductible Applies	60% Deductible Applies
Preventive Care		
Well Child Care, <i>through age 6</i>		
Office Visits	100% After a \$20 Co-pay	60% Deductible Applies
Immunizations and lab/x-ray	100% After a \$20 Co-pay	60% Deductible Applies
School Health Exams - <i>Excluding Sports Physicals (Grades 5 and 8)</i>		
Office Visits	100% After a \$20 Co-pay	60% Deductible Applies
Immunizations and lab/x-ray	100% After a \$20 Co-pay	60% Deductible Applies
Adult Physicals <i>age 19 and older</i>		
Office Visits	100% After a \$20 Co-pay	60% Deductible Applies
Immunizations and related professional charges.	100% No Deductible	60% Deductible Applies
Lab/X-ray	100% No Deductible	60% Deductible Applies
Pap Smear	100% No Deductible	60% Deductible Applies
Related Exam	100% No Deductible	60% Deductible Applies
Related Professional charges	100% No Deductible	60% Deductible Applies
Mammograms	100% No Deductible	60% Deductible Applies
Related Professional charges	100% No Deductible	60% Deductible Applies
Sigmoidoscopy	100% No Deductible	60% Deductible Applies
Fecal Occult Blood Testing	100% No Deductible	60% Deductible Applies
Related Professional charges	100% No Deductible	60% Deductible Applies
PSA	100% No Deductible	60% Deductible Applies
Related Exam	100% No Deductible	60% Deductible Applies
Related Professional charges	100% No Deductible	60% Deductible Applies
Smoking Cessation Program	80% Up to \$150, No Deductible	60% Up to \$150, No Deductible
	Limited to One Program per Plan Year	
Charges for the diagnosis and treatment of Autism Spectrum Disorder	Benefits are based on place/type of service	Benefits are based on place/type of service
	Calendar Year Maximum - \$36,000 per person	
LabOne	100% No Deductible	
PHYSICIAN AND OFFICE SERVICES		
<i>Including Psychiatric and Substance Abuse Care</i>		
SUMMARY OF SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Office Visits	100% After a \$20 Co-pay	60% Deductible Applies
Emergency Illness/Accident Office Visit	100% After a \$20 Co-pay	60% Deductible Applies
Surgeon	80% Deductible Applies	60% Deductible Applies
Diagnostic X-Ray & Lab	80% Deductible Applies	60% Deductible Applies
Independent Lab, Radiologist & Pathologist	80% Deductible Applies	*60% Deductible Applies
	*Services Performed by a Non-Network Provider Which The Patient Did Not Have The Option To Choose will be payable at the Network rate.	
Allergy Injections	80% Deductible Applies	60% Deductible Applies
Allergy Testing	80% Deductible Applies	60% Deductible Applies
Acupuncture, <i>for treatment of chronic pain</i>	80% Deductible Applies	60% Deductible Applies
Christian Science Practitioner	80% Deductible Applies	60% Deductible Applies
Nurse Practitioner	80% Deductible Applies	60% Deductible Applies
Dietician Services and Consultation	80% Deductible Applies	60% Deductible Applies
Chemotherapy	80% Deductible Applies	60% Deductible Applies
Physical, Occupational & Speech Therapy	80% Deductible Applies	60% Deductible Applies
Chiropractic Services	50% Deductible Applies	50% Deductible Applies
	Plan Year Maximum - \$500	
Podiatric Services – NO ROUTINE FOOT CARE	80% Deductible Applies	60% Deductible Applies
Orthotics	80% Deductible Applies	60% Deductible Applies
Infertility Services	80% Deductible Applies	60% Deductible Applies
Other Covered Services	80% Deductible Applies	60% Deductible Applies

OUTPATIENT HOSPITAL & AMBULATORY SURGICAL CENTER

SUMMARY OF SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Facility	80% Deductible Applies	60% Deductible Applies
Urgent Care Facility	100% After a \$150 Co-pay, Deductible Applies	100% After a \$150 Co-pay, Deductible Applies
Emergency Room	100% After a \$150 Co-pay, Deductible Applies <i>Co-pay waived if admitted to a Network Hospital</i>	
Non-Emergency	80% Deductible Applies	60% Deductible Applies
Diagnostic X-Ray & Lab	80% Deductible Applies	60% Deductible Applies
Pre-Admission Testing	80% Deductible Applies	60% Deductible Applies
Surgeon	80% Deductible Applies	60% Deductible Applies
Physical, Occupational & Speech Therapy	80% Deductible Applies	60% Deductible Applies
Chemotherapy & Radiation Therapy	80% Deductible Applies	60% Deductible Applies
Assistant Surgeon, Anesthesiologist, Pathologist, Radiologist & Consulting Physician	80% Deductible Applies	*60% Deductible Applies
	<i>*Services Performed by a Non-Network Provider Which The Patient Did Not Have The Option To Choose will be payable at the Network rate.</i>	
Other Covered Services	80% Deductible Applies	60% Deductible Applies

INPATIENT HOSPITAL

Including Psychiatric & Substance Abuse Care

SUMMARY OF SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Facility	80% After a \$150 Co-pay, Deductible Applies	60% After a \$150 Co-pay, Deductible Applies
Room, Board & Miscellaneous	80% After a \$150 Co-pay, Deductible Applies	60% After a \$150 Co-pay, Deductible Applies
Nursery	80% After a \$150 Co-pay, Deductible Applies	60% After a \$150 Co-pay, Deductible Applies
	<i>Baby & Mother's Charges Will Be Combined</i>	
Surgeon	80% Deductible Applies	60% Deductible Applies
Physician Visits	80% Deductible Applies	60% Deductible Applies
Private Duty Nursing	80% Deductible Applies	60% Deductible Applies
Assistant Surgeon, Anesthesiologist, Radiologist, Pathologist & Consulting Physician	80% Deductible Applies	*60% Deductible Applies
	<i>*Services Performed by a Non-Network Provider Which The Patient Did Not Have The Option To Choose will be payable at the Network rate.</i>	
Other Covered Services	80% Deductible Applies	60% Deductible Applies

OTHER COVERED SERVICES

SUMMARY OF SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Extended Care Facility	80% After a \$150 Co-pay, Deductible Applies	60% After a \$150 Co-pay, Deductible Applies
Home Health Care	80% Deductible Applies	60% Deductible Applies
Home Infusion Therapy	80% Deductible Applies	60% Deductible Applies
Hospice Care	80% Deductible Applies	60% Deductible Applies
Bereavement Counseling	80% Deductible Applies	60% Deductible Applies
Ambulance*	80% Deductible Applies	60% Deductible Applies
Durable Medical Equipment*	80% Deductible Applies	60% Deductible Applies
	<i>Limited to the lesser of the purchase price or the total anticipated rental charges</i>	
Prosthetic Appliances*	80% Deductible Applies	60% Deductible Applies
	<i>Includes replacements which are medically necessary or required by pathological change or normal growth</i>	

**If there is no network availability, the network benefit will apply.*

PRESCRIPTION DRUG PLAN

RETAIL PRESCRIPTION PLAN

If obtained through the Prescription Drug Plan – 100% after satisfaction of applicable co-payment: - **Per 34 day supply**

Generic	\$10
Formulary Brand	\$20
Non-Formulary Brand	\$40

If a generic is available and you choose to purchase the brand-name, you will be responsible for the Applicable co-payment.

MAIL ORDER PRESCRIPTION PLAN

If obtained through the Mail Order Prescription Drug Plan – 100% after satisfaction of applicable co-payment: - **Per 90 day supply**

Generic	\$20
Formulary Brand	\$40
Non-Formulary Brand	\$80

If a generic is available and you choose to purchase the brand-name, you will be responsible for the Applicable co-payment.

PURCHASED OUTSIDE OF THE RETAIL OR MAIL ORDER PRESCRIPTION PLANS

NO COVERAGE

COVERAGE INCLUDES

COVERAGE EXCLUDES

♦ Federal Legend Drugs	♦ Growth Hormone
♦ AIDS Medications	♦ Diagnostic Agents
♦ Insulin	♦ Rogaine
♦ Diabetic Supplies	♦ Devices
♦ Needles & Syringes	♦ Smoking Cessation Products
♦ Imitrex, vial & autoinjector (48 kits per year)	♦ Vaccinations
♦ Dexedrine to age 25	♦ RhoGAM
♦ Prenatal Vitamins	♦ Anorexiant, Diet Drugs
♦ Retin-A to age 25	♦ Life Style Drugs
♦ Accutane to age 25	♦ OTC Counterparts*
♦ Injectables	♦ Cosmetic Drugs
♦ Bee Sting Kits	♦ Vitamins
♦ Genetically Engineered Drugs	♦ Children's Vitamins
♦ Injectable Fertility, Fertility Drugs	
♦ Viagra – only if medically necessary	
♦ Contraceptives	

Acute Medications - those drugs used primarily for short-term use such as antibiotics, pain relievers, etc. Maximum thirty-four (34) days supply with one (1) refill at the local pharmacy.

Maintenance Medications – those drugs used primarily to treat chronic conditions such as heart medications, high blood pressure medications, etc. Maximum ninety (90) day supply with three (3) refills.

Expenses Related To Satisfaction Of The Individual Or Family Deductibles, Per Visit Co-payments, Prescription Drug Co-payments, Charges In Excess Of Benefit Maximums, Charges In Excess Of Reasonable And Customary Fees And Non-Compliance Penalties Do Not Accumulate Toward The Out-of-Pocket Maximum.

Any Maximums Which Are Stated In Dollar Amounts, Number Of Days Or Number Of Treatments And Which Limit Either The Maximum Benefits Payable Or The Maximum Allowable Covered Expense Are The Combined Maximums Under The Network and Non-Network Level Of Benefits.

INSERT THIS NOTIFICATION IN YOUR BENEFIT BOOKLET