

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

DANVILLE AREA COMMUNITY COLLEGE

BY THIS AGREEMENT, Danville Area Community College – Plan Two 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 <i>Refer To The Section Entitled “Utilization Review Program”</i>		
Non-Compliance Penalty		
All Surgeries		\$400
Hospital Admissions		\$400
Lifetime Maximum Benefit		Unlimited
Per Confinement Deductible	None	\$200
Plan Year Deductible		
Individual		\$200
Out-of-Pocket Maximum (INCLUDES THE PLAN YEAR DEDUCTIBLE, EMERGENCY ROOM DEDUCTIBLES AND NON-NETWORK PER ADMISSION DEDUCTIBLES)		
Individual	\$800	\$3,000
Family	\$2,000	\$7,000
Note: The Family Out-of-Pocket Maximum includes Out-of-Pocket expenses for all family members combined.		
The Non-Network Out-of-Pocket Maximums apply to Non-Network Hospital Expenses Only.		
SPECIAL COVERAGES		
<i>Refer to Specific Section for Details</i>		
SUMMARY OF SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Second Surgical Opinion		
Voluntary		80% No Deductible
Required		100% No Deductible
Well Child Care <i>through age 6</i>		
Office Visits		80% No Deductible
Immunizations/Routine Lab Work		100% No Deductible
School Health Exams (<i>grades 5 and 8</i>)		
Office Visits		80% No Deductible
Immunizations/Routine Lab Work		100% No Deductible
Adult Physicals, <i>age 19 and over</i>		
Office Visits, Immunizations and related professional charges.		80% No Deductible
Routine Lab Work		100% No Deductible
		<i>Maximum benefit per exam \$175, Age 19-49 one exam every 3 plan years, age 50 and over one exam every plan year</i>
Pap Smear		100% No Deductible
Related Exam and Professional charges		80% No Deductible <i>Once per plan year</i>

SPECIAL COVERAGES - Continued

Refer to Specific Section for Details

SUMMARY OF SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Mammograms		100% No Deductible
Related Professional charges		100% No Deductible
	<p align="center"><i>A baseline mammogram for women age 35-39 years of age; An annual mammogram for women age 40 and older;</i></p> <p align="center"><i>A mammogram at the age and intervals considered Medically Necessary by the woman's health care provider for women under age 40 and having a family history of breast cancer, prior personal history of breast cancer or other risk factors.</i></p>	
Sigmoidoscopy		80% No Deductible
Fecal Occult Blood Testing		100% No Deductible
Related Professional charges		80% No Deductible
	<p align="center"><i>Once every three (3) years for persons age fifty (50) and older or for persons who are at least age thirty (30) with a family history of colorectal cancer.</i></p>	
PSA Test		100% No Deductible
Related Exam and Professional charges		80% No Deductible
	<p align="center"><i>Age 40 and older, once per plan year</i></p>	
Charges for the diagnosis and treatment of Autism Spectrum Disorder		Benefits are based on place/type of service <i>Calendar Year Maximum - \$36,000 per person</i>
LabOne		100% No Deductible

PHYSICIAN AND OFFICE SERVICES

Including Psychiatric and Substance Abuse Care

SUMMARY OF SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Office Visits		80% Deductible Applies
Surgeon		80% Deductible Applies
Diagnostic X-Ray & Lab		100% Deductible Applies
Independent Lab, Radiologist & Pathologist		100% Deductible Applies
Allergy Injections		80% Deductible Applies
Allergy Testing		100% Deductible Applies
Acupuncture, <i>for treatment of chronic pain</i>		80% Deductible Applies
Christian Science Practitioner		80% Deductible Applies
Nurse Practitioner		80% Deductible Applies
Dietician Services/Consultation		80% Deductible Applies
Chemotherapy		80% Deductible Applies
Physical, Occupational & Speech Therapy		80% Deductible Applies
Chiropractic Services		80% Deductible Applies
Podiatric Services		
Office Visits		80% Deductible Applies
Surgery		80% Deductible Applies
X-Ray & Lab		80% Deductible Applies
Orthotics		80% Deductible Applies
Infertility Services		
Physician Charges		80% Deductible Applies
Lab/X-ray		100% Deductible Applies
Other Covered Services		80% Deductible Applies

OUTPATIENT HOSPITAL & AMBULATORY SURGICAL CENTER

SUMMARY OF SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
	*80% benefit will apply if a Network Hospital is not within 25 miles of where you reside	
Facility *	90% Deductible Applies	65% Deductible Applies
Surgi-Center/Ambulatory Surgicenter (Facility Fee Only)	90% Deductible and Network OOP Applies	
Emergency Room	80% After a \$200 Per Visit Co-Pay, in addition to Plan Year Deductible, <i>Co-pay waived if admitted to a Network Hospital</i>	
Urgent Care Facility		
Non-Emergency Care	80% Deductible Applies	
Emergency Care	100% Deductible Applies	
Lab/X-ray	100% Deductible Applies	
Diagnostic X-Ray & Lab	100% Deductible Applies	
Pre-Admission Testing	90% Deductible Applies	65% Deductible Applies
Surgeon	80% Deductible Applies	
Physical, Occupational & Speech Therapy	90% Deductible Applies	65% Deductible Applies
Chemotherapy & Radiation Therapy	90% Deductible Applies	65% Deductible Applies
Assistant Surgeon, Anesthesiologist, & Consulting Physician	80% Deductible Applies	
Pathologist, Radiologist	100% Deductible Applies	
Other Covered Services	90% Deductible Applies	65% Deductible Applies

INPATIENT HOSPITAL

Including Psychiatric & Substance Abuse Care

SUMMARY OF SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
	*80% benefit will apply if a Network Hospital is not within 25 miles of where you reside	
Room, Board & Miscellaneous*	90% Deductible Applies	65% Deductible Applies
Nursery*	90% Deductible Applies	65% Deductible Applies
	<i>Baby & Mother's Charges Will Be Separate</i>	
Diagnostic X-Ray & Lab*	90% Deductible Applies	65% Deductible Applies
Surgeon	80% Deductible Applies	
Physician Visits	80% Deductible Applies	
Private Duty Nursing	80% Deductible Applies	
Assistant Surgeon, Anesthesiologist, Radiologist, Pathologist & Consulting Physician	80% Deductible Applies	
Other Covered Services	90% Deductible Applies	65% Deductible Applies

OTHER COVERED SERVICES

SUMMARY OF SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Extended Care Facility	80% Deductible Applies	
Home Health Care	80% Deductible Applies	
Hospice Care	80% Deductible Applies	
Bereavement Counseling	80% Deductible Applies	
Ambulance	80% Deductible Applies	
Durable Medical Equipment	80% Deductible Applies	
	<i>Limited to the lesser of the purchase price or the total anticipated rental charges.</i>	
Prosthetic Appliances	80% Deductible Applies	
	<i>Includes replacements which are medically necessary or required by pathological change or normal growth</i>	
Smoking Cessation Program	100% Up to \$50	
	<i>Limited to One Program per Plan Year</i>	

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	\$6
Preferred	\$12
Brand	\$24
If a generic is available and you choose to purchase the brand-name, you will be responsible for the \$6 co-payment plus the difference in cost between the brand-name and generic prescription	
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	\$12
Preferred	\$24
Brand	\$48
If a generic is available and you choose to purchase the brand-name, you will be responsible for the \$12 co-payment plus the difference in cost between the brand-name and generic prescription	
PURCHASED OUTSIDE OF THE RETAIL OR MAIL ORDER PRESCRIPTION PLANS	100% OF THE DISCOUNTED AMOUNT MINUS THE APPROPRIATE CO-PAY
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 & auto injector (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 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 Maximums Under Either The Network or Non-Network Level Of Benefits.

INSERT THIS NOTIFICATION IN YOUR BENEFIT BOOKLET