

**EMPLOYEE NOTIFICATION NUMBER 7
TO
PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION
FOR**

DANVILLE AREA COMMUNITY COLLEGE

BY THIS AGREEMENT, Danville Area Community College – Plan One 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
Lifetime Maximum Benefit	Unlimited	No Coverage
Per Confinement Deductible	None	No Coverage
Plan Year Deductible		
Individual	None	No Coverage
Family	None	No Coverage
Out-of-Pocket Maximum		
Individual	None	No Coverage
Family	None	No Coverage
<i>Co-payments are 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	100% After a \$10 Co-pay	No Coverage
Well Child Care		
Office Visits	100% After a \$10 Co-pay	No Coverage
Immunizations/Routine Lab Work	100%	No Coverage
School Health Exams – Excluding Sports Physicals		
Office Visits	100% After a \$10 Co-pay	No Coverage
Immunizations/Routine Lab Work	100%	No Coverage
Adult Physicals		
Office Visits	100% After a \$10 Co-pay	No Coverage
Immunizations and related professional charges.	100%	No Coverage
Routine Lab Work	100%	No Coverage
Pap Smear	100%	No Coverage
Related Exam	100% After a \$10 Co-pay	No Coverage
Related Professional charges	100%	No Coverage
Mammograms	100%	No Coverage
Related Professional charges	100%	No Coverage
Sigmoidoscopy	100%	No Coverage
Fecal Occult Blood Testing	100%	No Coverage
Related Professional charges	100%	No Coverage
PSA Test	100%	No Coverage
Related Exam	100% After a \$10 Co-pay	No Coverage
Related Professional charges	100%	No Coverage
Charges for the diagnosis and treatment of Autism Spectrum Disorder	Benefits are based on place/type of service	No Coverage
<i>Calendar Year Maximum - \$36,000 per person</i>		
Lab One	100%	

PHYSICIAN AND OFFICE SERVICES

Including Psychiatric and Substance Abuse Care

SUMMARY OF SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Office Visits	100% After a \$10 Co-pay	No Coverage
Surgeon	100%	No Coverage
Diagnostic X-Ray & Lab	100%	No Coverage
Independent Lab, Radiologist & Pathologist	100%	*No Coverage
	<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>	
Allergy Injections	100%	No Coverage
Allergy Testing	100%	No Coverage
Acupuncture, <i>for treatment of chronic pain</i>	100% After a \$10 Co-pay	No Coverage
Christian Science Practitioner	100% After a \$10 Co-pay	No Coverage
Nurse Practitioner	100% After a \$10 Co-pay	No Coverage
Dietician Services/Consultation	100%	No Coverage
Chemotherapy	100%	No Coverage
Physical, Occupational & Speech Therapy	100%	No Coverage
Chiropractic Services	100% After a \$10 Co-pay	No Coverage
Podiatric Services		
Office Visits	100% After a \$10 Co-pay	No Coverage
Surgery	100%	No Coverage
X-Ray & Lab	100%	No Coverage
Orthotics	100%	No Coverage
Infertility Services		
Physician Charges	100% After a \$10 Co-pay	No Coverage
Lab/X-ray	100%	No Coverage
Other Covered Services	100%	No Coverage

OUTPATIENT HOSPITAL & AMBULATORY SURGICAL CENTER

SUMMARY OF SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Facility	100%	No Coverage
Emergency Room	100% After a \$150 Co-pay or 50% Co-pay whichever is less, <i>Co-pay waived if admitted to a Network Hospital</i>	
Urgent Care Facility	100% After a \$10 Co-pay	No Coverage
Diagnostic X-Ray & Lab	100%	No Coverage
Pre-Admission Testing	100%	No Coverage
Surgeon	100%	No Coverage
Physical, Occupational & Speech Therapy	100%	No Coverage
Chemotherapy & Radiation Therapy	100%	No Coverage
Assistant Surgeon, Anesthesiologist, Consulting Physician, Pathologist, and Radiologist	100%	*No Coverage
	<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	100%	No Coverage

INPATIENT HOSPITAL

Including Psychiatric & Substance Abuse Care

SUMMARY OF SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Room, Board & Miscellaneous	100% After a \$150 Co-pay	No Coverage
Nursery	100% After a \$150 Co-pay	No Coverage
	<i>Baby's/Mother's Charges Will Be Combined</i>	
Surgeon	100% After a \$10 Co-pay	No Coverage
Physician Visits	100% After a \$10 Co-pay	No Coverage
Private Duty Nursing	100%	No Coverage
Assistant Surgeon, Anesthesiologist, Radiologist, Pathologist & Consulting Physician	100%	*No Coverage
	<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	100%	No Coverage

OTHER COVERED SERVICES		
SUMMARY OF SERVICES	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Extended Care Facility	100% After a \$150 Co-pay	No Coverage
Home Health Care	100%	No Coverage
Hospice Care	100%	No Coverage
Bereavement Counseling	100%	No Coverage
Ambulance	100%	No Coverage
Durable Medical Equipment	80%	No Coverage
	<i>Limited to the lesser of the purchase price or the total anticipated rental charges.</i>	
Prosthetic Appliances	80%	No Coverage
	<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	\$5	
Brand	\$10	
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	\$10	
Brand	\$20	
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 & auto injector (48 kits per year)		◆ Vaccinations
◆ Dexedrine to age 25		◆ RhoGAM
◆ Prenatal Vitamins		◆ Anorexiants, 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.

INSERT THIS NOTIFICATION IN YOUR BENEFIT BOOKLET