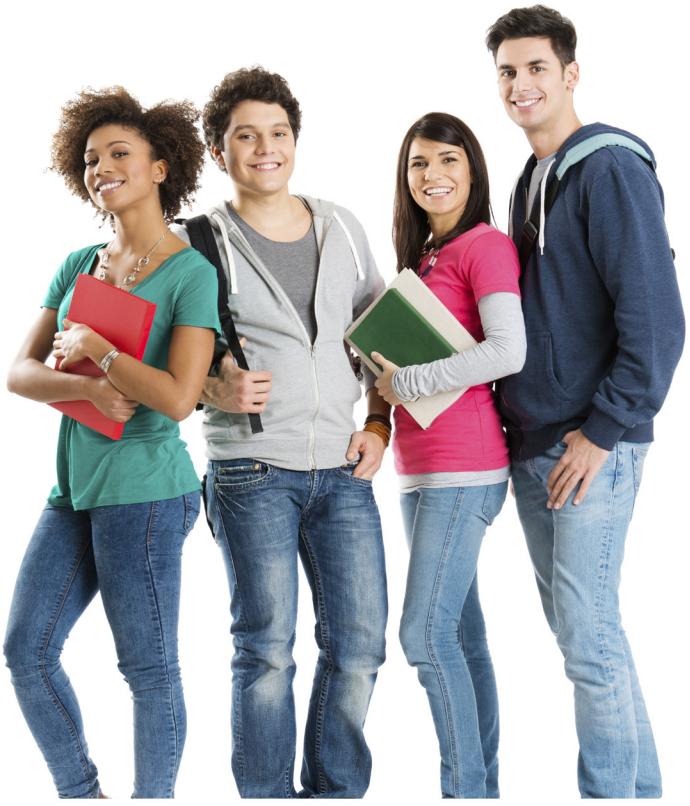
Pacific Union College

SHP Student Health Plan

Summary Description of Benefits 2015–2016



Inside you will find:

- Information on the EPO network
- Schedule of Benefits
- Exclusions
- Definitions of health plan terms
- Claim filing instructions

Pacific Union College ("PUC") offers this health benefits plan to its Students and their eligible Dependents ("Participants"). Enclosed in this summary are highlights of the following:

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GENERAL PLAN INFORMATION

The Plan name is the Student Health Plan of Pacific Union College ("Student Health Plan" or "Plan"), sponsored by Pacific Union College. The Plan effective date is September 1, 2015.

Please note that this is a summary of the benefits as covered under the Student Health Plan effective September 1, 2015, through August 31, 2016. This summary is intended to answer most of your questions about the Plan. However, this summary does not fully describe all of the benefits, limitations, and exclusions under the Plan. For more specific details or to obtain further information, contact your Plan Administrator, PUC Human Resources, Ext. 6231, or contact the Plan's Claims Administrator, Personal Insurance Administrators, Inc. (PIA).

PUC reserves the right, in its sole discretion at any time, to make any change, amendment, or modification to the Plan, or to terminate it. You will be notified in writing of any changes.

ELIGIBILITY

Any registered international and domestic Student enrolled in PUC for 6 or more credit hours or designated as a full-time Student is required to purchase and be covered under the Plan.

- Adventist Colleges Abroad Students, Student Missionaries, ECE and BSM Students, and off-campus nursing programs are not eligible for coverage under the Plan.
- Students must actively attend classes for at least the first 45 days after the date for which coverage under the Plan is purchased.
- Eligible Students who enroll in the Plan may also purchase Dependent coverage under the Plan. Eligible Dependents are defined as the spouse and dependent children under 26 years of age.

A spouse and/or Dependent children of an eligible Student may be eligible for coverage under the Plan if they meet the eligibility requirements for a Dependent as defined in the Definitions section. However, no Participant can be covered under the Plan at the same time as both a Student and a Dependent. Eligible Dependents are afforded 30 days from the date that they become eligible to enroll in the Plan.

Regular part-time and full-time employees of PUC are not eligible for and may not be covered under the Plan, including an individual who is an employee of PUC and also a Dependent as defined in the Plan.

When Coverage Begins
The Plan becomes effective at 12:01 a.m., September 1, 2015. The Participant's coverage under the Plan becomes effective at 12:01 a.m. on the later of:

- The first day of the Coverage Period for which premium was paid; or
- The date that the Participant's coverage is approved.

Coverage Periods

The Plan's Coverage Periods are as follows:

- Fall: September 1, 2015 – January 4, 2016
- Winter: January 5, 2016 – March 29, 2016
- Spring/Summer: March 30, 2016 – August 31, 2016

Dependent coverage will not be effective prior to that of the covered Student.

IMPORTANT NOTICE: Premiums will not be pro-rated if the Student enrolls past the first date of the Coverage Period for which he or she is applying.

Participants meeting certain conditions may be allowed a 30-day grace period from the date that they were eligible for coverage under the Plan to enroll in the Plan. In these instances, the coverage effective date will be retroactive for a maximum of 30 days to either the date that the Participant was originally eligible for coverage under the Plan, or the date coinciding with the 30th day prior to the late enrollment, whichever is later.

The following Students are eligible for the 30-day enrollment grace period:

- All registered international and domestic Students enrolled in 6 or more credit hours or designated as full-time required to purchase and be covered under the Plan; or
- All registered international and domestic Students enrolled in 6 or more credit hours or designated as full-time re-enrolling in the Plan if the re-enrollment occurs within 30 days of the prior Plan Year's termination date.

When Coverage Ends

The Plan terminates:

- At 11:59 p.m. on the Plan's termination date

The Participant's coverage will terminate on the earlier of:

- 11:59 p.m. on the last day of the Coverage Period for which premium is paid; or
- The date the Participant enters active duty military service.

Coverage for any Dependent shall terminate as indicated above or at the time that the Student's coverage under the Plan terminates, whichever is earlier.

Refund of premium will be made in the event the Participant enters active-duty military service. Refund of premium is not available under any other circumstances, and coverage will continue for the entire Coverage Period for which the Participant paid his/her premium.

HEALTH PLAN BENEFITS

SCHEDULE OF PLAN BENEFITS

Important Note: This is a basic summary description of benefits of your Pacific Union College ("PUC") Student Health Plan (the "Plan"). PUC reserves the right, in its sole discretion at any time, to make any change, amendment, or modification to the Plan, including this description, or to terminate it. You will be notified in writing of any changes or if the Plan is terminated. The Plan is a self-funded student health plan, and in the opinion of PUC is not governed by any of the following laws, among others:

- Employee Retirement Income Security Act (ERISA)
- Michelle's Law
- Family and Medical Leave Act (FMLA)
- Consolidated Omnibus Budget Reconciliation Act of 1984 (COBRA)
- Health Insurance Portability and Accountability Act (HIPAA)
- Health Information Technology for Economic and Clinical Health of 2009 (HITECH)
- California Insurance Code

Further, PUC is of the opinion that the Plan is not subject to federal laws concerning Qualified Medical Child Support Orders (QMCSOs).

In consideration of, and by enrolling for, seeking, or accepting benefits under the Plan, you and your covered Dependent(s) (any such person referred to herein as a "Participant") agree to be bound by all of the Plan's terms as set forth in this summary and the Plan document itself, as it may be amended from time to time. All Participants acknowledge and agree that all decisions of PUC and any administrator under the Plan are for the sole purpose of administering benefits under the Plan, and all decisions regarding any Participant's health care are solely a matter for decision by the Participant and the Participant's health care provider. To the maximum extent permitted by law, Participants agree that no legal action may be brought by any Participant for a claim for benefits under the Plan until all available appeals have been denied by the administrator, so long as the administrator adheres to the published appeals procedures. Failure to exhaust the Plan's available appeals procedures may be deemed an abandonment, waiver, and release of the underlying claim. Interest, if any, on any denied claim shall be 6% per annum beginning on the date the final appeal is denied. The sole purpose of the Plan is to provide benefits through the reimbursement, or payment on your behalf, of Eligible Expenses for Eligible Health Care Services that meet the requirements and limitations of the Plan. As such, to the maximum extent permitted by law, the Plan constitutes an obligation to pay money only. Neither the Plan, PUC, nor any administrator will, in connection with the administration of the Plan, provide any medical care, advice, consultation or treatment. PUC, the Plan, and its administrators assume no responsibility or liability for any medical decision made by Participant in consultation with the Participant's medical providers, or for any negative medical outcome. To the maximum extent permitted by law, any recovery under the Plan shall be limited to the benefits claimed, and interest, if applicable.

Exclusive Provider Organization (EPO)
This Student Health Plan is an Exclusive Provider Organization (EPO) Plan. An EPO plan allows the Participant to receive Eligible Health Care Services only from approved medical providers participating in the Plan's EPO. The Plan's EPO includes physicians, hospitals, and other medical providers, which have agreed to become part of the EPO and provide Eligible Health Care Services to Participants covered under the Plan at a lower negotiated rate. If the Participant uses approved EPO providers, coverage will be provided as listed in the Plan Benefits Section of this summary, and the Participant's out-of-pocket expenses will be lower. If the Participant does not use an approved EPO provider, they will not be eligible for benefits under the Plan. In other words, the Plan does not provide coverage for health care services received from a provider that is not a member of the Plan's EPO.

PUC's Student Health Plan EPO consists of:

- PUC Health Clinic: Students must use the resources of the PUC Health Clinic first when receiving Eligible Health Care Services under the Plan. The PUC Health Clinic will provide Eligible Health Care Services whenever possible. If the PUC Health Clinic is unable to provide Eligible Health Care Services under the Plan, it will issue a referral to an approved EPO provider and coordinate necessary follow-up care. Other Eligible Health Care Services under the Plan, such as care from a specialist, also require a referral from the PUC Health Clinic. Eligible Health Care Services requiring a PUC Health Clinic referral are identified in the Plan Benefits Section of this summary. Expenses incurred for Eligible Health Care Services received outside the PUC Health Clinic for which no PUC Health Clinic referral was obtained may be excluded from benefits and coverage under the Plan. Referrals issued by the PUC Health Clinic must be documented and on file with the PUC Health Clinic or accompany the Student's claim when submitted.

  A PUC Health Clinic referral for Eligible Health Care Services received outside of the PUC Health Clinic is not required under the following conditions:

  - Emergency. In the case of an Emergency, call 911 or go to the nearest emergency room. However, the Student must contact the PUC Health Clinic within 24 hours from the date of receiving Emergency Health Services and/or being discharged from a hospital emergency room or facility;
  - The Student may also be required to return to the PUC Health Clinic for necessary follow-up care within 72 hours from the date of receiving Emergency Health Services and/or being discharged from a hospital emergency room or facility;
  - When the PUC Health Clinic is closed. However, the Student must first contact the PUC Health Clinic on call nurse at (707) 965-6789 whenever reasonably possible before accessing Eligible Health Care Services outside the PUC Health Clinic's normal operating hours;
  - During scheduled school breaks. If the Student receives treatment during a school break and is outside a 50-mile radius of the PUC Health Clinic, he or she is not required to obtain a referral from the PUC Health Clinic for follow-up care upon returning from break;
  - Primary Care services for Student residing or traveling outside a 50-mile radius of the PUC Health Clinic;
  - Routine gynecological or obstetrical services (provided by EPO providers);
  - Maternity care;
  - Pharmacy services;
  - Preventive health services.

  Dependents are encouraged but not required to use the resources of the PUC Health Clinic first when receiving Primary Care services. Dependents can access Primary Care services through the Plan's other approved EPO providers on the First Health Network. However, in the event that a Dependent requires additional Eligible Health Care Services requiring a referral under the Plan, such as a specialist, they must first contact the PUC Student Health Clinic and obtain the necessary referral before receiving those services in order for benefits to be payable under the Plan.

  Participants residing or traveling outside a 50-mile radius of the PUC Health Clinic are not required to use the resources of the PUC Health Clinic when receiving Primary Care services. In those instances, Participants can access Primary Care services through the Plan's other approved EPO providers on the First Health Network. However, in the event that the Participant requires additional Eligible Health Care Services requiring a referral under the Plan, such as a specialist, they must first contact the PUC Student Health Clinic and obtain the necessary referral before receiving those services in order for benefits to be payable under the Plan.

- St. Helena Hospital and California Medical Group (CMG): In the event that a Student requires Eligible Health Care Services from a specialist or a hospital, either on an inpatient or outpatient basis, the Student must use the resources of St. Helena Hospital or CMG first when receiving Eligible Health Care Services under the Plan. If St. Helena Hospital or CMG is unable to provide Eligible Health Care Services under the Plan, the Student may seek Eligible Health Care Services through the Plan's other approved EPO providers on the First Health Network.

Dependents are encouraged but not required to use the resources of the St. Helena Hospital and CMG first when receiving Eligible Health Care Services from a specialist or a hospital, either on an inpatient or outpatient basis. Dependents can access these Eligible Health Care Services through the Plan's other approved EPO providers on the First Health Network. However, in the event that a Dependent requires Eligible Health Care Services requiring a referral under this Plan, such as a specialist, they must first contact the PUC Student Health Clinic and obtain the necessary referral before receiving those services in order for benefits to be payable under the Plan.

- EPO Plan Providers: The Plan also provides coverage for Eligible Health Care Services received by other approved EPO providers outside the PUC Health Clinic, St. Helena Hospital, and CMG. The Plan's EPO includes physicians, hospitals, and other medical facilities. In the event that a Participant requires Eligible Health Care Services outside the PUC Student Health Clinic, St. Helena Hospital, or CMG, the Participant is required to use an approved EPO provider on the First Health Network. An approved EPO provider under the Plan is defined as any provider that is contracted as a preferred provider on the First Health Network at the time that Eligible Health Care Services are received. For a list of approved EPO providers, please visit www.myfirsthealth.com or contact the PUC Health Clinic.

Please Note: The Plan defines approved EPO providers as providers contracted as preferred providers with the First Health Network. However, it is important to note that the Plan is not a PPO Plan nor does it provide benefits or coverage for health care services received from providers that are not members of the Plan's approved EPO network. The EPO consists of the PUC Student Health Clinic, St. Helena Hospital, CMG, and the First Health Network. The Plan is an EPO plan, which means benefits and coverage are available only for Eligible Health Care Services received from approved EPO providers.

Plan Features: Exclusive Provider Organization (EPO)

IMPORTANT: The following benefits levels, coverage amounts and benefit limitations are based on a SEPTEMBER 1, 2015 – AUGUST 31, 2016 Plan Year	
Aggregate Maximum Benefit *Important: The Plan provides benefits for Eligible Expenses incurred by a Participant for Eligible Health Care Services due to a covered Injury or Sickness up to the Maximum Benefit.* Student: Dependent:	 Unlimited, except as noted below Unlimited, except as noted below
Deductible *Important: Routine Preventive Services, Physician Office Visits, and certain Mental Health Services are not subject to the Plan Year Deductible. All other Eligible Health Care Services are subject to the Plan Year Deductible unless otherwise noted.* Student Only: Family:	 $250 $1,000 *Note: Copays do not count towards Deductible amounts*
Plan Year Out-of-Pocket Maximum Individual: Family:	$6,600 $13,200 *Note: There is no Out-Of-Pocket Maximum for non-EPO services*
Plan Year Student Premium Contribution (Annual) <u>Domestic</u> Student Only: Student + one Dependent: Student + two or three Dependents (maximum of three): <u>International</u> Student Only: Student + one Dependent: Student + two or three Dependents (maximum of three):	 $750 $750/Student + $2,400/Dependent $750/Student + $7,200/Dependents $1,200 $1,200/Student + $2,400/Dependent $1,200/Student + $7,200/Dependents

Plan Benefits: Exclusive Provider Organization (EPO)

Plan Benefits *NOTE: Except where listed otherwise (e.g., Deductible waived), all benefits are subject to the Plan Year Deductible; the Deductible must be satisfied before benefits are paid*	
Type of Benefit	Eligible Expenses Payable by the Plan and Additional Coverage Explanations
Preventive Health Services	Students Only: Paid at 100% of Eligible Expenses when Preventive Health Services are received at the PUC Health Clinic. Deductible waived. Copay waived. Preventive Health Services received by Students outside PUC Health Clinic at EPO providers are paid at 100% of Eligible Expenses. Deductible waived. Copay waived. Dependents: Preventive Health Services received outside PUC Health Clinic at EPO providers are paid at 100% of Eligible Expenses Deductible waived. Copay waived. *Important: Preventive Health Services include services that meet the guidelines established by the U.S. Preventive Services Task Force (USPSTF) grade A & B, select immunizations, and additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration covered under the Plan.*
Physician Office Visits (Office Visits, Consultations, and Physician's Referral Services) Primary Care Physician Office Visit – PUC Health Clinic	Plan pays 100% of Eligible Expenses after you pay a $5 Copay per office visit when services are received at the PUC Health Clinic. Deductible waived.

Plan Benefits *NOTE: Except where listed otherwise (e.g., Deductible waived), all benefits are subject to the Plan Year Deductible; the Deductible must be satisfied before benefits are paid*	
Type of Benefit	Eligible Expenses Payable by the Plan and Additional Coverage Explanations
Primary Care Physician Office Visit – EPO Providers *PUC Health Clinic referral required (except as noted)*	Plan pays 100% of Eligible Expenses after you pay a $50 Copay per office visit. Deductible waived. Students: Primary Care Services received from approved EPO providers not affiliated with the PUC Health Clinic are only permitted if the Student receives a referral from the PUC Health Clinic or if the Student resides or is traveling outside a 50-mile radius of PUC Health Clinic. Dependents: Primary Care Services received from approved EPO providers not affiliated with the PUC Health Clinic are permitted without a referral. However, in the event that a Dependent requires additional Eligible Health Care Services requiring a referral under the Plan, they must first contact the PUC Student Health Clinic and obtain the necessary referral before receiving those services in order for benefits to be payable under the Plan. *Important: Plan pays 80% of Eligible Expenses after Plan Year Deductible for additional Eligible Health Care Services that are billed separately from the physician's office visit charges, including but not limited to tests, labs, X-rays, and in-office procedures.*
Specialist Visits (Office Visits, Consultations and Physician's Referral Services) Specialist Office Visit – EPO Providers *PUC Health Clinic referral required*	Plan pays 100% of Eligible Expenses after you pay a $50 Copay per office visit. Deductible waived. *Important:* ▪ *Eligible Health Care Services received from a Specialist require a referral from the PUC Health Clinic in order for benefits to be payable under the Plan.* ▪ *Participants residing or traveling outside a 50-mile radius of the PUC Health Clinic requiring Eligible Health Care Services from a Specialist must first contact the PUC Health Clinic and obtain a referral before receiving those services in order for benefits to be payable under the Plan.* *Note: Physician office visits to an approved EPO obstetrician or gynecologist do not require a referral from the PUC Health Clinic.*

Plan Benefits *NOTE: Except where listed otherwise (e.g., Deductible waived), all benefits are subject to the Plan Year Deductible; the Deductible must be satisfied before benefits are paid*	
Type of Benefit	Eligible Expenses Payable by the Plan and Additional Coverage Explanations
Specialist Office Visit – Allergy Testing, Treatment, and Injections *PUC Health Clinic referral required*	Plan pays 80% of Eligible Expenses after Plan Year Deductible.
Inpatient Services Inpatient Hospital – Facility Services Hospital Confinement/Room and Board and Hospital Miscellaneous (daily average semi-private room rate and general nursing care provided by a hospital; hospital miscellaneous expenses, such as the cost of the operating room, laboratory tests, X-rays, anesthesia supplies, physical therapy, drugs (excluding take-home drugs) or medicines, therapeutic devices and supplies. Includes intensive care) *Prior Authorization Required*	Plan pays 80% of Eligible Expenses after Plan Year Deductible.
Inpatient Hospital Physician's Visits/Consultations *Prior Authorization Required*	Plan pays 80% of Eligible Expenses after Plan Year Deductible.
Inpatient Hospital Professional Services (Including but not limited to: Surgeon, Radiologist, Pathologist, and/or Anesthesiologist fees in connection with inpatient surgery or procedure) *Prior Authorization Required*	Plan pays 80% of Eligible Expenses after Plan Year Deductible. *Assistant Surgeon Eligible Expenses are limited to 20% of primary Surgeon Eligible Expenses.* *Important:* *If two or more surgical procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid for the additional procedures will be limited to:* ▪ *50% of the second procedure; and* ▪ *50% of all subsequent procedures.*
Inpatient Services at Other Health Care Facilities (Including but not limited to: Skilled Nursing Facility, Rehabilitation Hospital, and Sub-Acute Facilities) *Prior Authorization Required*	Plan pays 80% of Eligible Expenses after Plan Year Deductible.

Plan Benefits *NOTE: Except where listed otherwise (e.g., Deductible waived), all benefits are subject to the Plan Year Deductible; the Deductible must be satisfied before benefits are paid*	
Type of Benefit	Eligible Expenses Payable by the Plan and Additional Coverage Explanations
Outpatient Services	
Outpatient Facility Services (Including but not limited to: Operating Room, Recovery Room, Procedure Room, Treatment Room, and Observation Room) *Prior Authorization Required*	Plan pays 80% of Eligible Expenses after Plan Year Deductible.
Outpatient Professional Services (Including but not limited to: Surgeon, Radiologist, Pathologist and/or Anesthesiologist fees in connection with outpatient surgery or procedure) *Prior Authorization Required*	Plan pays 80% of Eligible Expenses after Plan Year Deductible. *Assistant Surgeon Eligible Expenses are limited to 20% of primary Surgeon Eligible Expenses.* *Important:* *If two or more surgical procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid for the additional procedures will be limited to:* ▪ *50% of the second procedure; and* ▪ *50% of all subsequent procedures.*
Outpatient Laboratory and Radiology Services *Prior Authorization Required*	Plan pays 80% of Eligible Expenses after Plan Year Deductible.
Outpatient Advanced Radiological Imaging (Including but not limited to: MRIs, MRAs, CAT Scans, PET Scans) *Prior Authorization Required*	Plan pays 80% of Eligible Expenses after Plan Year Deductible.
Outpatient Rehabilitative and Habilitative Therapy, including Physical Therapy *Prior Authorization Required*	Plan pays 80% of Eligible Expenses after Plan Year Deductible.
Outpatient Rehabilitative and Habilitative Chiropractic Care *Prior Authorization Required*	Plan pays 80% of Eligible Expenses after Plan Year Deductible *Limited to 15 visits per Plan Year*
Acupuncture Treatment *Prior Authorization Required*	Plan pays 80% of Eligible Expenses after Plan Year Deductible.
Pain Management Injections (including epidural and facet injections) *Prior Authorization Required*	Plan pays 80% of Eligible Expenses after Plan Year Deductible.
Maternity Care Services	
Initial visit to confirm pregnancy	Plan pays 100% of Eligible Expenses after Plan Year Deductible after you pay a $50 Copay per office visit.
All subsequent Prenatal Visits, Postnatal Visits, and Physician's Delivery Charges	Plan pays 80% of Eligible Expenses after Plan Year Deductible.

Plan Benefits *NOTE: Except where listed otherwise (e.g., Deductible waived), all benefits are subject to the Plan Year Deductible; the Deductible must be satisfied before benefits are paid*	
Type of Benefit	Eligible Expenses Payable by the Plan and Additional Coverage Explanations
Office Visits in addition to the global maternity fee when performed by an OB or Specialist	Plan pays 100% of Eligible Expenses after Plan Year Deductible after you pay a $50 Copay per office visit.
Delivery-Facility (Inpatient Hospital, Birthing Center)	Plan pays 80% of Eligible Expenses after Plan Year Deductible.
Emergency Health Services (Emergency Room) Student must contact the PUC Health Clinic within 24 hours from the date of receiving emergency medical care services and/or being discharged from a hospital emergency room or facility. The Student may also be required to return to the PUC Health Clinic for necessary follow-up care within 72 hours from the date of receiving emergency medical care services and/or being discharged from a hospital emergency room or facility. Treatment must be received within 72 hours from time of Injury or first onset of Sickness.	Plan pays 80% of Eligible Expenses after Plan Year Deductible and $100 Copay per emergency room visit. *Note:* ▪ *$100 Copay per emergency room visit is waived if the Participant is directed by the PUC Health Clinic to obtain Emergency Health Services from an emergency room facility or other health care facility.* ▪ *Benefits payable for Emergency Health Services, including the services of St. Helena Hospital or CMG, an approved EPO emergency room facility as well as any non-EPO emergency room facility and/or physicians, are always paid at the same level as EPO benefits under the Plan.* ▪ *Coverage and benefits for Emergency Health Services are subject to review for Medical Necessity and appropriateness. Eligible Health Care Services obtained from an emergency room facility or providers not meeting the definition of Medical Necessity are not covered under the Plan.*
Emergency Room Physician and/or Anesthesiologist	Plan pays 80% of Eligible Expenses after Plan Year Deductible. ▪ *Non-EPO physicians are always paid at the same level as EPO benefits under the Plan.*
Urgent Care Services Student must contact the PUC Health Clinic within 24 hours from the date of receiving urgent care services	Plan pays 80% of Eligible Expenses after Plan Year Deductible.
Ambulance (Ground Only)	Plan pays 80% of Eligible Expenses after Plan Year Deductible.
Durable Medical Equipment *Prior Authorization Required*	Plan pays 80% of Eligible Expenses after Plan Year Deductible.
Mental Health and Substance Abuse Outpatient Mental Health Counseling Services PUC Career and Counseling Center	Plan pays 100% of Eligible Expenses when services are received at the PUC Career and Counseling Center. Deductible and Copay waived.

Plan Benefits *NOTE: Except where listed otherwise (e.g., Deductible waived), all benefits are subject to the Plan Year Deductible; the Deductible must be satisfied before benefits are paid*	
Type of Benefit	Eligible Expenses Payable by the Plan and Additional Coverage Explanations
Outpatient Mental Health Counseling Services EPO Provider *PUC Health Clinic referral or PUC Career and Counseling Center referral required*	Plan pays 80% of Eligible Expenses — Deductible and Copay waived.
Outpatient Mental Health Facility Services (including Physician's Office Visits at Outpatient Facility) *PUC Health Clinic or PUC Career and Counseling Center referral required* *Prior Authorization Required*	Plan pays 80% of Eligible Expenses after Plan Year Deductible.
Outpatient Mental Health Facility Services—Severe Mental Illness (including Physician's Office Visits at Outpatient Facility) *PUC Health Clinic or PUC Career and Counseling Center referral required* *Prior Authorization Required*	Plan pays 100% of Eligible Expenses after you pay a $50 copay per office visit for diagnosis and Medically Necessary treatment of Severe Mental Illness of a Covered Individual of any age and of Serious Emotional Disturbances of a Covered Child. Deductible waived. Severe mental illness includes: ▪ Schizophrenia ▪ Schizoaffective Disorder ▪ Bipolar Disorder ▪ Major Depression ▪ Obsessive-Compulsive Disorder ▪ Panic Disorder ▪ Eating Disorders (Anorexia Nervosa and Bulimia Nervosa) ▪ Autism or Pervasive Developmental Disorder ▪ Serious Emotional Disturbance in Children and Adolescents
Inpatient Mental Health Services *Prior Authorization Required*	Plan pays 80% of Eligible Expenses after Plan Year Deductible.

Plan Benefits *NOTE: Except where listed otherwise (e.g., Deductible waived), all benefits are subject to the Plan Year Deductible; the Deductible must be satisfied before benefits are paid*	
Type of Benefit	Eligible Expenses Payable by the Plan and Additional Coverage Explanations
Inpatient Mental Health Services — Severe Mental Illness *Prior Authorization Required*	Plan pays 80% of Eligible Expenses after Plan Year Deductible for diagnosis and Medically Necessary Inpatient Mental Health Treatment of Severe Mental Illness of a Participant of any age and of Serious Emotional Disturbances of a Covered Child. Severe mental illness includes: ▪ Schizophrenia ▪ Schizoaffective Disorder ▪ Bipolar Disorder ▪ Major Depression ▪ Obsessive-Compulsive Disorder ▪ Panic Disorder ▪ Eating Disorders (Anorexia Nervosa and Bulimia Nervosa) ▪ Autism or Pervasive Developmental Disorder ▪ Serious Emotional Disturbance in Children and Adolescents
Mental Health Acute Partial Hospitalization *Prior Authorization Required*	Plan pays 80% of Eligible Expenses after Plan Year Deductible.
Mental Health Acute Partial Hospitalization— Severe Mental Illness *Prior Authorization Required*	Plan pays 80% of Eligible Expenses after Plan Year Deductible for diagnosis and Medically Necessary treatment of Severe Mental Illness of a Participant of any age and of Serious Emotional Disturbances of a Covered Child. Severe mental illness includes: ▪ Schizophrenia ▪ Schizoaffective Disorder ▪ Bipolar Disorder ▪ Major Depression ▪ Obsessive-Compulsive Disorder ▪ Panic Disorder ▪ Eating Disorders (Anorexia Nervosa and Bulimia Nervosa) ▪ Autism or Pervasive Developmental Disorder ▪ Serious Emotional Disturbance in Children and Adolescents
Substance Abuse/Chemical Dependency Inpatient Treatment *Prior Authorization Required*	Plan pays 80% of Eligible Expenses after Plan Year Deductible.
Substance Abuse/Chemical Dependency Partial Hospitalization *Prior Authorization Required*	Plan pays 80% of Eligible Expenses after Plan Year Deductible.

Plan Benefits *NOTE: Except where listed otherwise (e.g., Deductible waived), all benefits are subject to the Plan Year Deductible; the Deductible must be satisfied before benefits are paid*	
Type of Benefit	Eligible Expenses Payable by the Plan and Additional Coverage Explanations
Substance Abuse/Chemical Dependency Outpatient Treatment *PUC Health Clinic referral or PUC Career and Counseling Center referral required*	Plan pays 80% of Eligible Expenses after Plan Year Deductible.
Other Benefits	
Pediatric Dental Care *Limited to Covered Persons under the age of 19; includes coverage for preventive and diagnostic, basic restorative, major, medically necessary orthodontia services; waiting periods and other limitations may apply; benefits are subject to the medical Deductible and Out-of-Pocket Maximum;* *Prior Authorization Required for Major Services and Orthodontia*	100% of Eligible Expenses for preventive & diagnostic services 70% of Eligible Expenses for restorative services 50% of Eligible Expenses for major services and Medically Necessary orthodontia.
Pediatric Vision Care *Limited to Covered Persons under the age of 19; includes one exam/fitting per policy year, including prescription eyeglasses (lens and frames, limited to one per year) or contact lenses (in lieu of eyeglasses)*	100% of Eligible Expenses up to $150; 50% thereafter
Hospice *Prior Authorization Required*	Plan pays 80% of Eligible Expenses after Plan Year Deductible.
Home Health Care *Prior Authorization Required*	Plan pays 80% of Eligible Expenses after Plan Year Deductible.
Approved Clinical Trials *Prior Authorization Required*	Plan pays 80% of Eligible Expenses after Plan Year Deductible.

PRESCRIPTION DRUG PLAN

Prescription Drug Plan Benefits: Exclusive Provider Organization (EPO)

Prescription Drug Benefit*	Approved Retail Pharmacy 30-day Supply	Home Delivery Program 90-day Supply
Tier 1: Generic Drugs (including generic insulin)	Plan pays 100% of Eligible Expenses after the Participant pays a $10 Copay per prescription	Plan pays 100% of Eligible Expenses after the Participant pays a $20 Copay per prescription
Tier 2: Preferred Brand Name drugs (including Preferred Brand Name insulin) where no Generic Alternative exists	If no Generic Alternative exists, plan Pays 100% of Eligible Expenses after the Participant pays a $30 Copay per prescription	If no Generic Alternative exists, plan Pays 100% of Eligible Expenses after the Participant pays a $60 Copay per prescription
Tier 3: Preferred Brand Name drugs (including Preferred Brand Name insulin) where a Generic Alternative exists	If Generic Alternative exists, plan pays 0% of Eligible Expenses –the Participant pays 100% of Eligible Expenses	If Generic Alternative exists, plan pays 0% of Eligible Expenses –the Participant pays 100% of Eligible Expenses
Diabetic Supplies, including: ▪ insulin syringes with needles; ▪ blood testing strips - glucose; ▪ urine testing strips - glucose; ▪ ketone testing strips and tablets; ▪ lancets and lancet devices; and ▪ insulin pump supplies, including infusion sets, reservoirs, glass cartridges, and insertion sets.	Plan Pays 100% of Eligible Expenses after the Participant pays a $30 Copay	Plan Pays 100% of Eligible Expenses after the Participant pays a $60 Copay
Specialty Drugs	Plan pays 80% of Eligible Expenses after Plan Year Deductible	Plan pays 80% of Eligible Expenses after Plan Year Deductible

**The Plan requires mandatory use of Generic prescription drugs whenever possible. The Plan also uses a process called Step Therapy, requiring participants to try approved Generic prescription drugs first, before coverage for certain Brand Name prescription drugs is allowed.*

Benefits for Preferred Brand Name prescription drugs will only be paid in cases where no Generic Alternative exists on the Formulary/Prescription Drug List. If the participant chooses to fill a Preferred Brand Name prescription drug and a Generic alternative is available, the participant will be responsible for 100% of the cost of the Preferred Brand Name prescription drug.

Prescription drugs not listed on the Plan's Formulary/Prescription Drug List are not covered under the Plan.

Important: A copy of the Plan's Formulary/Prescription Drug List including approved Generic drugs and Preferred Brand Name drugs is available upon request. A copy of the Plan's Approved Retail Pharmacy List is also available upon request.

Important: Certain classes of prescription drugs also require Prior Authorization in order for benefits to be payable under the Plan. Your prescribing physician and/or retail pharmacy of choice may be required to obtain Prior Authorization from the Plan's Prescription Benefit Manager (PBM) first before you fill the prescription under the Plan. See Prior Authorization Section for a detailed list of classes of prescription drugs requiring Prior authorization.

Copay waived for generic contraceptives. Oral anticancer medications limited to cost sharing of $200 per prescription, up to a 30-day supply.

PRIOR AUTHORIZATION

IMPORTANT: Certain Eligible Health Care Services and Prescription Drugs covered under the Plan require Prior Authorization in order for benefits to be payable.

Prior Authorization is a process the Plan uses to determine if a requested health care service, prescription drugs or supply is an Eligible Health Care Service and that the individual's care is provided in the most medically appropriate setting. The Prior Authorization process may set limits on the Eligible Health Care Services to be given. Prior Authorization is required prior to all inpatient hospital admissions and before receiving certain outpatient procedures or services. Some prescription drugs also require Prior Authorization. Services that require Prior Authorization include but are not limited to:

- Inpatient hospital services
- Inpatient services at other health care facilities (hospice, skilled nursing facility, etc.)
- Outpatient facility services
- Surgeries
- Outpatient rehabilitation
- Outpatient laboratory, pathology, and radiology services
- Advanced radiological imaging services
- Non-emergency ambulance
- Inpatient mental health
- Inpatient substance abuse
- Certain prescription drugs
- Specialty prescription drugs
- Home health care

The Prior Authorization process is managed by the Plan's Utilization Review Administrator for Eligible Health Care Services and by the Plan's Prescription Benefit Manager for prescription drugs. The Participant's physician or health care provider must contact the Plan's Utilization Review Administrator and/or Prescription Benefit Manager for Prior Authorization to determine which inpatient admission and outpatient procedures and/or prescription drugs require Prior Authorization, and/or to be sure that Prior Authorization has been obtained. Participants may also contact the Plan's Utilization Review Administrator and/or Prescription Benefit Manager at the customer service number listed in this summary or on the Participant's health plan ID card. If Prior Authorization is not obtained for a scheduled inpatient admission or for an outpatient procedure and/or for prescription drugs requiring prior authorization, benefits may not be payable for those services under the Plan.

If a requested health care service or prescription drug is approved for Prior Authorization by the Plan's Utilization Review Administrator, it does not guarantee that benefits will be paid under the Plan. Benefit payment is subject to all other terms and conditions under the Plan without regard to Prior Authorization.

QUICK REFERENCE GUIDE TO PRIOR AUTHORIZATION REQUIREMENTS

The following list can be used as a guide to those Eligible Health Care Services and Prescription Drugs requiring Prior Authorization from the Plan's Utilization Review Administrator. Please keep in mind that you and your health care provider are responsible for Prior Authorization in the following situations:

Type of Eligible Health Care Services	Requirements and Timeframe
Inpatient Services Scheduled Services: ▪ Scheduled or non-emergency inpatient hospitalizations ▪ Scheduled inpatient hospital services ▪ Scheduled inpatient services at other health care facilities ▪ Scheduled inpatient surgeries ▪ Scheduled inpatient mental health ▪ Scheduled inpatient substance abuse	▪ For all scheduled inpatient hospitalizations and inpatient hospital services, you or your physician must initiate the Prior Authorization process at least three business days prior to the date you are scheduled to receive those services. ▪ The Plan's Utilization Review Administrator will send written confirmation of the Prior Authorization decision within two business days of receipt of all necessary information. ▪ For inpatient hospitalizations and inpatient hospital services, the Plan's Utilization Review Administrator will, if appropriate, specify a specific length of stay for services.
Unscheduled (Emergency) Services: ▪ Unscheduled (emergency) inpatient hospitalizations ▪ Unscheduled (emergency) inpatient hospital services	▪ For all unscheduled (emergency) inpatient hospitalizations and inpatient hospital services, you or your physician are required to notify the Plan's Utilization Review Company within one business day of the hospital admission. ▪ When it is determined that the service is Medically Necessary and appropriate, the Plan's Utilization Review Administrator will, if appropriate, specify a specific length of stay for services. ▪ If it is determined that the service is not Medically Necessary and appropriate, your physician will be notified by telephone no later than 24 hours following the Plan's decision. You and your physician will also receive a written notice within two business days of the decision. However, care will not be discontinued until your physician has been notified and a plan of care that is appropriate has been agreed upon.
Outpatient Services ▪ Outpatient facility services ▪ Outpatient surgeries and procedures ▪ Outpatient rehabilitation ▪ Outpatient laboratory, pathology, and radiology services ▪ Advanced radiological imaging services ▪ Non-emergency ambulance ▪ Home health care	For all scheduled outpatient procedures and services, you or your physician must initiate the Prior Authorization process at least three business days prior to the date that you are scheduled to receive those services. The Plan's Utilization Review Administrator will send written confirmation of the Prior Authorization decision within two business days of receipt of all necessary information.

Type of Eligible Health Care Services	Requirements and Timeframe
Other Services Prior Authorization is required for the following classes of prescription drugs covered under the Plan: Actemra®, Adcirca®, Amevive®, Ampyra®, Aralast®, Aranesp®, Arcalyst®, Avonex®, Berinert®, Betaseron®, Boniva IV®, Botox®, Carimune® NF Nanofiltered, Chenodal®, Cimzia®, Cinryze®, Copaxone®, Dysport®, Egrifta™, Eligard®, Enbrel®, Epogen®, Erbitux®, Euflexxa®, Extavia®, Firazyr®, Flebogamma®, Flolan®, Forteo®, Gammagard® Liquid, Gammagard® S/D, Gammaked®, Gamunex®, Gamunex-C®, Genotropin®, Gleevec®, Herceptin®, Humatrope®, Humira®, Hyalgan®, Illaris®, Incivek™, Increlex®, Iveegam® EN, Kalbitor®, Kalydeco®, Kineret®, Korlym®, Krystexxa®, Kuvan®, Letairis®, Lupron®, Makena®, Myobloc®, Neulasta®, Neupogen®, Norditropin®, Nplate®, Nutropin®, Nutropin® AQ, Octagam®, Omnitrope™, Onsolis®, Orencia®, Orthovisc®, Pegasys®, PEG-Intron®, Polygam®, Procrit®, Prolastin®, Prolia®, Promacta®, Rebif®, Reclast®, Remicade®, Remodulin®, Revatio®, Rituxan®, Saizen®, Samsca®, Selzentry®, Serostim®, Simponi®, Somavert®, Sprycel®, Stelara®, Supartz®, Synagis®, Synvisc®, Tasigna®, Tev-Tropin®, Tracleer®, Tykerb®, Tysabri®, Tyvaso, Vectibix®, Ventavis, Victrelis™, Vivaglobin®, Xalkori®, Xenazine®, Xeomin®, Xolair®, Zelboraf®, Zemaira®, Zorbtive®	The retail pharmacy being used by the Participant will be notified by the Prescription Benefit Manager at the point of sale when a prescription drug requires Prior Authorization. If so, the retail pharmacy contacts the Prescription Benefit Manager to request authorization for the prescription drug to be filled. The Prescription Benefit Manager reviews the prescription for Medical Necessity, appropriateness, and eligible services. If the pharmacist does not have the needed information to authorize the prescription drug to be filled, the pharmacist notifies the prescribing physician, who then calls the Prescription Benefit Manager's Prior Authorization services for approval. The prescriber can also mail or fax a letter of request. The Prescription Benefit Manager typically provides a resolution within a few moments. However, some inquiries require a return call if the Prescription Benefit Manager needs to perform additional research or consult with a clinical pharmacist. The Prescription Benefit Manager reviews written and faxed requests within two business days of receipt and communicates responses to the physician or the dispensing pharmacist.

IMPORTANT NUMBERS AND WEBSITE ADDRESSES

Contact and Hours	Contact Information and Toll-free Telephone Number	Website
PUC Health Clinic Hours of Operation: Monday-Thursday 9:00 a.m. - 1:00 p.m. and 2:00 p.m. - 4:00 p.m. Friday 9:00 a.m. - 12:00 p.m. Saturday/Sunday: Contact the On Call Nurse Line	PUC Health Clinic Pacific Union College One Angwin Avenue Angwin, CA 94508-9646 Phone: (707) 965-6339	www.puc.edu/campus-services/health-services/home
PUC Career and Counseling Center Hours of Operation: Monday-Thursday 9:00 a.m. - 12:00 p.m. and 1:00 p.m. - 5:00 p.m. Friday 9:00 a.m. - 12:00 p.m. Saturday/Sunday: Contact the On Call Nurse Line	PUC Career and Counseling Center Pacific Union College One Angwin Avenue Angwin, CA 94508-9646 Phone: (707) 965-7080	www.puc.edu/campus-services/counseling-center/home
PUC Health Clinic – On Call Nurse Line Hours of Operation: Monday-Thursday 4:00 p.m. - 9:00 a.m. Friday-Sunday 12:00 p.m. Friday - 9:00 a.m. Monday	Phone: (707) 965-6789	Not applicable
EPO Providers – First Health Network Hours of Operation: 24 Hours a Day	First Health Phone: (800) 226-5116	www.myfirsthealth.com
Plan Sponsor The Plan is administered on behalf of Pacific Union College and the Human Resources Department. The Plan Sponsor is responsible for the proper administration of the plan according to the terms of the summary plan description.	PUC HR Office Pacific Union College One Angwin Avenue Angwin, CA 94508-9646 Phone: (707) 965-6231, Ext. 6231 Email: hr@puc.edu	www.puc.edu/campus-services/human-resources/home

Contact and Hours	Contact Information and Toll-free Telephone Number	Website
Claims Administrator A company that performs all functions reasonably related to the general management, supervision, and administration of the Plan in accordance with the terms and conditions of an administration agreement between the Claims Administrator and the Plan Sponsor. The Claims Administrator is not a fiduciary of the Plan and does not exercise any discretionary authority with regard to the Plan. The Claims Administrator is not an insurer of the Plan Hours of Operation: Monday-Thursday 8:00 a.m. - 5:00 p.m. PT Friday 8:00 a.m. – 4:00 p.m. PT	Personal Insurance Administrators, Inc. (PIA) P.O. Box 6040 Agoura Hills, CA 91376-6040 Phone: (800) 468-4343 Fax: (818) 735-3567 Email: piainfo@ascensionins.com	www.piaclaims.com
Utilization Review Administrator ("Prior Authorization") Hours of Operation: Monday-Friday 6:00 a.m. – 6:00 p.m. CT	American Health Holding Phone: (888) 638-5706 (press 2)	
Prescription Benefit Manager (PBM) Hours of Operation: 24 Hours a Day	Express Scripts, Inc. P.O. Box 66773 St. Louis, MO 63166 Customer Service Phone: (800) 451-6245 Prior Authorization: (800) 889-0376	www.express-scripts.com
Privacy Notice	PUC HR Office Pacific Union College One Angwin Avenue Angwin, CA 94508-9646 Phone: (707) 965-6231, Ext. 6231 Email: hr@puc.edu	www.puc.edu/campus-services/human-resources/home

CHANGING COVERAGE DURING THE YEAR

It is your responsibility to report changes in eligibility or general family status to the College (not the Plan Administrator) within 30 days, due to the fact that the College may be unaware of changes in family status that might affect your or your family members' ability to fully participate in the Plan. If you do not enroll within 30 days, your next opportunity to make a change will be during the next open enrollment period.

Examples of the type of changes that you must report are:

- Change in marital status (including marriage, divorce, or legal separation);
- Attainment of new health coverage under a Dependent spouse's employer group plan;
- Address and telephone changes;
- New children;
- Dependent child becoming no longer eligible due to age; and
- Child custody changes.

EXCESS PROVISION

No benefit is payable for any expense incurred for Injury or Sickness that is paid or payable by other valid and collectible insurance, except for Automobile Medical Payments Insurance.

However, this Excess Provision will not be applied to the first $100 of Eligible Expenses incurred.

Eligible Expenses excludes amounts not covered by the primary carrier due to penalties imposed on the Insured for failing to comply with Plan provisions or requirements.

Important: The Excess Provision has no practical application if you do not have other medical insurance or if your other insurance does not cover the loss.

RECOVERY RIGHTS

Right of Recovery: If the amount of the payment made by the Plan is more than the Plan should have paid under this Policy, the Plan Sponsor may recover the excess from one or more of: (a) The person we have paid; (b) The person for whom we have paid; (c) Insurance companies or any other plan; or (d) other organization. The amount of the payments made includes the reasonable cash value of any benefit provided in the form of services.

Right to Reimbursement: If benefits are paid under this Plan and any person recovers from a third party by settlement, judgment or by operation of primary coverage, the Plan Sponsor has a right to recover from that person an amount equal to the amount the Plan paid. However, the Plan Sponsor will reimburse the Participant for any charges on a pro-rata basis for any expense incurred in securing the settlement, judgment or otherwise.

EXCLUSIONS AND LIMITATIONS

No benefits will be paid under the Plan for: a) loss or expense caused by, contributed to, or resulting from; or b) treatment, services or supplies for, at, related to:

1. College entrance physicals;
2. Acne;
3. Addiction, such as caffeine addiction; non-chemical addiction, such as gambling, sexual, spending, shopping, working and religious;
4. Biofeedback;
5. Circumcision;
6. Congenital conditions, except as specifically provided in benefits for reconstructive surgery or for newborn or adopted infants;
7. Cosmetic procedures, except cosmetic surgery required to correct an Injury for which benefits are otherwise payable under the Plan or for newborn or adopted children; removal of warts, non-malignant moles and lesions;
8. Custodial care; care provided in: rest homes, health resorts, homes for the aged, halfway houses, college infirmaries or places mainly for domiciliary or custodial care; extended care in treatment or substance abuse facilities for domiciliary or custodial care;
9. Dental treatment, except for accidental Injury to natural teeth; except as required under the Affordable Care Act.
10. Deviated nasal septum, including submucous resection and/or other surgical correction thereof; nasal and sinus surgery;
11. Elective surgery or elective treatment;
12. Eye examinations, eye refractions, eyeglasses, contact lenses, prescriptions or fitting of eyeglasses or contact lenses, vision correction surgery, or other treatment for visual defects and problems, except when due to a disease process; except as required under the Affordable Care Act.
13. Foot care including: flat foot conditions, supportive devices for the foot, care of corns, bunions (except capsular or bone surgery), calluses, toenails, fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet;
14. Health spa or similar facilities; strengthening programs;
15. Hearing examinations or hearing aids; or other treatment for hearing defects and problems. “Hearing defects” means any physical defect of the ear which does or can impair normal hearing, apart from the disease process; except as required under the Affordable Care Act.
16. Hirsutism; alopecia;
17. Hypnosis;
18. Immunizations; except as specifically provided for in the Plan;
19. Injuries due to skydiving, parachuting, hang gliding, glider flying, parasailing, sail planing, bungee jumping, or flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline;
20. Preventive medicines or vaccines; except as specifically provided for in the Plan; or where required for treatment of a covered Injury;
21. Injury or Sickness for which benefits are paid or payable under any Workers’ Compensation or Occupational Disease Law or Act, or similar legislation;
22. Injury sustained while (a) participating in any interscholastic, intercollegiate, or professional sport, contest, or competition; (b) traveling to or from such sport, contest, or competition as a participant; or (c) while participating in any practice or conditioning program for such sport, contest, or competition;
23. Investigational services;
24. Lipectomy;
25. Naturopathic services;
26. Participation in a riot or civil disorder; commission of or attempt to commit a felony;
27. Prescription Drug Services – no benefits will be payable for:
    a. Therapeutic devices or appliances, including hypodermic needles, syringes, support garments and other non-medical substances, regardless of intended use, except as specifically provided in the Benefits for Diabetes;
    b. Immunization agents, biological sera, blood or blood products administered on an outpatient basis;
    c. Drugs labeled, “Caution – limited by federal law to investigational use” or experimental drugs;
    d. Products used for unapproved cosmetic indications;
    e. Drugs used to treat or cure baldness, and anabolic steroids used for bodybuilding;
    f. Anorectics – drugs used for the purpose of weight control;
    g. Fertility agents, such as Parlodel, Pergonal, Clomid, Profasi, Metrodin, or Serophene;
    h. Growth hormones; or
    i. Refills in excess of the number of specified or dispensed after one (1) year of date of the prescription;

28. Reproductive/Infertility services including but not limited to: family planning; fertility tests; infertility (male or female), including any services or supplies received for the purpose or with the intent of inducing conception; premarital examinations; impotence, organic or otherwise; vasectomy; vasectomy reversal; reversal of sterilization procedures;
29. Research or examinations relating to research studies, or any treatment for which the Participant or the Participant's representative must sign an informed consent document identifying the treatment in which the Participant is to participate as a research study or clinical research study; except in the case of cancer clinical trial or Approved Clinical Trial;
30. Routine Newborn Infant Care, well-baby nursery and related Physician charges in excess of 48 hours for vaginal delivery or 96 hours for cesarean delivery;
31. Services provided normally without charge by the Health Service of the Policyholder; or services covered or provided by the Student health fee;
32. Sexual/gender reassignment surgery except as provided when determined to be Medically Necessary or when treatment is otherwise covered under the Plan in the absence of a diagnosis of gender dysphoria. This exclusion does not include related mental health counseling or hormone therapy.
33. Sleep disorders;
34. Supplies, except as specifically provided in the Plan;
35. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia; except as specifically provided in the Plan;
36. Travel in or upon sitting in or upon, alighting to or from, or working on or around any motorcycle or recreational vehicle including but not limited to: two- or three-wheeled motor vehicle; four-wheeled all-terrain vehicle (ATV); jet ski; ski cycle; or snowmobile, scuba diving, surfing, roller skating;
37. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment;
38. War or any act of war, declared or undeclared; or while in the armed forces of any country (a pro-rata premium will be refunded upon request for such period not covered);
39. Weight management, weight reduction, nutrition programs, surgery for removal of excess skin or fat;

MISCELLANEOUS PROVISIONS

Plan Administrator

PUC is the administrator of the Plan. PUC may appoint one (1) or more persons to act as Plan Administrator, or may delegate administrative duties to one (1) or more persons, who will act as the Plan Administrator to that extent. The Plan Administrator has overall responsibility for the administration of the Plan. All decisions made by the Plan Administrator are final and conclusive on all Participants and all other persons. PUC may pay all usual and reasonable expenses of administering the Plan, in whole or in part, and any expenses not paid by PUC are not the responsibility of the Plan Administrator (unless PUC is the Plan Administrator). Neither the Plan Administrator nor any other designated representative of PUC who is an Employee may receive any compensation with respect to services as Plan Administrator. However, a Student who is also a participant in the Plan and acts as an administrator may be eligible for benefits under the Plan.

Administrator's Powers and Duties

The Plan Administrator has all the duties and powers necessary to discharge its duties under the Plan, including the following:

- To have complete and final sole discretionary authority to administer, enforce, construe and interpret the Plan, including interpretation of all Plan documents, decisions relating to all questions of eligibility to participate and determination of the amount, manner and time of payment of any benefits or Eligible Expenses (including questions of whether or not a claim is a reimbursable claim or otherwise covered under the Plan) including the determination of all related or non-related questions and matters that arise under the Plan. All decisions, interpretations and determinations by the Plan Administrator under the Plan shall be final and conclusive, and there shall be no de novo review of any such decision by any court except as required by law. Any review of such decision shall, to the maximum extent permitted by law, be limited to determining whether the decision was so arbitrary and capricious as to be an abuse of discretion;
- To prescribe procedures to be followed by Participants filing application for benefits, and procedures for appeals of denied claims;
- To prepare and distribute, in such manner as the Plan Administrator determines to be appropriate, information explaining the Plan;
- To receive from PUC and from Participants such information as shall be necessary for the proper administration of the Plan;
- To receive, review and keep on file (as it deems necessary) appropriate records of the operation of the Plan;
- To appoint individuals to assist in the administration of the Plan and any other agents it deems advisable. The Plan Administrator may delegate to such individual any power or duty imposed upon or granted to it by the Plan.
- The Plan Administrator may rely upon the reasonable direction or information from a Participant relating to such Participant's entitlement to benefits hereunder as being proper under the Plan and shall not be responsible for any act or failure to act by PUC. Neither the Plan Administrator nor PUC makes any guarantee to any individual in any manner for any loss or other event because of the individual's participation in the Plan.

If the Plan Administrator fails to strictly enforce any provision of the Plan in a given instance, it will not be construed as a waiver of that provision in any later case. The Plan Administrator reserves the right to strictly enforce each and every Plan provision at any time without regard to its prior actions and decisions, the similarity of the circumstances, or the number of occurrences. Coverage under the Plan will be determined solely according to the terms of the Plan and the applicable facts. Only the duly authorized acts of the Plan Administrator are valid under the Plan. Participants under the Plan may not rely on any oral statement of any person regarding the Plan, and may not rely on any written statement of any person unless that person is authorized to provide the statement by the Plan Administrator, and one of the following applies:

- The statement is an official decision of the Plan Administrator to an individual whose eligibility for enrollment, participation or payment of benefits under the Plan is in dispute,
- The statement constitutes a duly authorized interpretation of an ambiguous or doubtful term of the Plan Name,
- The statement constitutes the issuance of a rule, regulation or policy under the Plan and applies to all Participants, or
- The statement communicates an amendment to the Plan, and applies to all Participants.

Source of Funding

This is a self-funded Student health plan. That means that all obligations to pay benefits under the Plan constitute an unsecured obligation of PUC. Benefits are not funded, that is, they are not provided through a trust, policy of insurance or other funding source other than the general assets of PUC.

Amendment or Termination of the Plan

PUC intends to continue the Plan described within this summary, but reserves the right to amend or terminate the Plan at any time.

CLAIMS AND APPEAL PROCEDURES

You are entitled to full and fair review of any claim for benefits made under the Plan. The procedures described here describe how benefit claims and appeals are made and decided.

How to File a Claim Under the Plan

Ordinarily, when you seek medical care, the Plan's EPO provider will submit a claim for coverage on your behalf. However, it is in all cases your responsibility to make sure that your claim for coverage of any medical care, service, supply or medication is filed with the Plan Administrator. The Plan Administrator can provide you with a copy of the appropriate form for making claims under the Plan. The Plan Administrator may appoint a Claims Administrator under the Plan. If no Claims Administrator is appointed, the Plan Administrator will be the Claims Administrator.

For the purposes of the Plan, Personal Insurance Administrators, Inc. (PIA) shall be the Claims Administrator as appointed by PUC.

Time Limit: You must file a Completed Claim for benefits as to any Eligible Expense not later than 90 days or the expense will not be covered under the Plan.

A Completed Claim means a claim for benefits as to an Eligible Expense on a form satisfactory to the Claims Administrator, accompanied by proof of payment and the provider's description of services received, supplies or medications as appropriate, plus any additional documentation requested by the Plan Administrator to substantiate that coverage is appropriate under the Plan.

Authorized Representative

An authorized representative may act on your behalf with respect to a benefit claim or appeal under these claims procedures. You must submit a signed Plan-approved form designating your authorized representative before the Plan will recognize your authorized representative.

However, the Plan will recognize a health care professional with knowledge of your medical condition as your authorized representative if your claim is for urgent care.

An authorized representative form may be obtained from and completed forms must be submitted to:

Personal Insurance Administrators, Inc. (PIA)
P.O. Box 6040
Agoura Hills, CA 91376-6040

Phone: (800) 468-4343
Fax: (818) 735-3567
Email: piainfo@ascensionins.com

Once an authorized representative is appointed, the Plan will direct all information, notification, etc. regarding the claim to the authorized representative. You will be copied on all correspondence.

TYPES OF GROUP HEALTH CLAIMS

Pre-Service Claims

Pre-Service claims are claims that condition receipt of the benefit, in whole or in part, on *approval before obtaining the medical care.* Note that claims involving urgent care are defined below and treated differently.

Initial decision timeframe	No later than 15 days after receipt of the claim
Incorrectly filed claims	If you file a claim incorrectly: • The Plan will notify you within 5 days. • The notice will explain that the request for benefit is not a claim until it is filed correctly. • The notice will explain how to file the request properly. • Notice from the Plan may be made orally or in writing.
Incompletely filed claims	If you file an incomplete claim, the Plan may deny it or request more information from you and suspend and extend the claim decision time while you provide that information. If the Plan takes an extension of time, the extension notice will explain what information the Plan needs in order to make a decision on the claim and will give you no less than 45 days to provide the information. If you do not provide the information, your claim may be denied. The decision will be suspended until you provide the information or the extension expires. Once the information is received, the Plan will make a decision on your claim within the time remaining on the original 15-day time period.
Extension of decision deadline	You may agree to an extension of time for a decision on a claim at any time. If the Plan, for reasons beyond its control, cannot make a decision within the claim deadline, then the Plan may extend the time for a decision on your claim by 15 days. If an extension is needed, the Plan will notify you before the end of the original decision deadline and let you know when you can expect a decision.
Where to send your claim	Personal Insurance Administrators, Inc. (PIA) P.O. Box 6040 Agoura Hills, CA 91376-6040 Phone: (800) 468-4343 Fax: (818) 735-3567 Email: piainfo@ascensionins.com

When the Plan receives a pre-service claim, it will first determine if it is an urgent care claim. If it is, it will be treated as follows:

Urgent Care Claim
An urgent care claim is a special type of pre-service claim. An urgent care claim is a pre-service claim for medical care or treatment that could seriously jeopardize your life or health or ability to regain maximum function or would—in the opinion of a physician with knowledge of your medical condition—subject you to severe pain that could not be adequately managed without the care or treatment.

Initial decision timeframe	No later than 72 hours after receipt of the claim.
Incompletely filed claims	If you file an incomplete claim, the Plan can deny it or request more information from you and suspend and extend the claim decision time while you provide that information. If the Plan takes an extension of time, the extension notice will explain what information the Plan needs in order to make a decision on the claim, and will give you no less than 48 hours to provide the information. If you do not provide the information, your claim may be denied. The decision will be suspended until you provide the information or the extension expires. Once the information is received, the Plan will make a decision on your claim as soon as possible but no later than 48 hours after the earlier of: (a) receipt of the specified information or (b) the end of the 48-hour period.
Extension of decision deadline	The Plan may not extend the decision time for an urgent care claim unless you agree.
Where to send your claim	Personal Insurance Administrators, Inc. (PIA) P.O. Box 6040 Agoura Hills, CA 91376-6040 Phone: (800) 468-4343 Fax: (818) 735-3567 Email: piainfo@ascensionins.com

Post-Service Claims
Post-service claims are claims for a benefit under the Plan that are not a pre-service claim or an urgent care claim.

Initial decision timeframe	No later than 30 days after receipt of the claim.
Incorrectly filed claims	If you file a claim incorrectly: • The Plan will notify you within 5 days. • The notice will explain that the request for benefits is not a claim until it is filed correctly. • The notice will explain how to file the request properly. Notice from the Plan may be made orally or in writing.
Incompletely filed claims	If you file an incomplete claim, the Plan can deny it or request more information from you and suspend and extend the claim decision time while you provide that information. If the Plan takes an extension of time, the extension notice will explain what information the Plan needs in order to make a decision on the claim and will give you no less than 45 days to provide the information. If you do not provide the information, your claim may be denied. The decision will be suspended until you provide the information or the extension expires. Once the information is received, the Plan will make a decision on your claim within the time remaining on the original 15-day time period.
Extension of decision deadline	You may agree to an extension of time for a decision on a claim at any time. If the Plan, for reasons beyond its control, cannot make a decision within the claim deadline, then the Plan may extend the time for a decision on your claim by 15 days. If an extension is needed, the Plan will notify you before the end of the original decision deadline and let you know when you can expect a decision.
Where to send your claim	Personal Insurance Administrators, Inc. (PIA) P.O. Box 6040 Agoura Hills, CA 91376-6040 Phone: (800) 468-4343 Fax: (818) 735-3567 Email: piainfo@ascensionins.com

Concurrent Care Claims

Concurrent care involves situations where the Plan approves an ongoing course of treatment to be provided over a period of time, or for a specified number of treatments. There are two types of concurrent care claims:

(a) a claim that results in a reduction or termination of the initially approved period of time or number of treatments; and
(b) a claim that requests an extension of treatment beyond the initially approved period of time or number of treatments.

Concurrent care extension request	If the claim is for urgent care and is made at least 24 hours before the end of the approved treatment, a decision will be made within 24 hours of the end of the approved treatment. Any other request to extend a concurrent care claim will be classified as a pre-service, urgent care, or post-service claim, and a decision will be made based on the procedures stated above.
Concurrent care early termination	If the claim is made as a result of the Plan's decision to reduce or terminate an initially approved course of treatment, the Plan will notify you of its decision to reduce or terminate the treatment before the benefit is actually terminated or reduced. Your concurrent care claim will be classified as a pre-service, urgent care, or post-service claim and a decision will be made based on the procedures stated above.
Where to send your claim	Personal Insurance Administrators, Inc. (PIA) P.O. Box 6040 Agoura Hills, CA 91376-6040 Phone: (800) 468-4343 Fax: (818) 735-3567 Email: piainfo@ascensionins.com

Change in Classification of Your Claim

The claim type is determined initially when the claim is filed, but it could change during the claim procedures. If so, it may be re-classified. For example, if the urgency subsides, it may be re-characterized as a pre-service claim.

Notification of Initial Claim Decision

You will receive written notice of the decision on an urgent care or pre-service claim, whether the decision is denied or not.
If your claim was a post-service claim, you will receive notice only if your claim is denied.
If your claim is denied, your written notice of denial will include:

- A statement of the specific reason(s) for the decision;
- Reference(s) to the specific Plan provision(s) on which the decision is based;
- A description of any additional material or information necessary to perfect the claim and why such information is necessary;
- A description of the Plan procedures and time limits for appeal of the decision, and the right to obtain information about those procedures;
- A statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse decision (or a statement that such information will be provided free of charge upon request);
- If the decision involves scientific or clinical judgment, either (a) an explanation of the scientific or clinical judgment applying the terms of the Plan to the claimant's medical circumstances, or (b) a statement that such explanation will be provided at no charge upon request; and
- In the case of an urgent care claim, an explanation of the expedited review methods available for such claims.

INTERNAL APPEALS PROCEDURES

Your Right to Internal Appeals

- You have the right to appeal an adverse decision twice, internally, under these claims procedures. These appeals are known as the "First Level of Appeals" and the "Second Level of Appeals," respectively.
- The First Level of Appeal will be decided by the Plan's Claims Administrator.
- The Second Level of Appeal will be decided by the Plan Sponsor.
- During each level of appeal, the individual who decides your appeal will be different from, and not a subordinate of, the person who made the initial benefit decision or any earlier level of appeal.
- During each level of appeal, you have the right to submit documents, written comments, or other information in support your appeal.
- During each level of appeal, you may receive, on request, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits, including the names of any experts consulted in connection with the claim. This information is free of charge.
- During each level of appeal, the Plan will take into account all information you have submitted, even if it was not presented or available at the initial benefit decision. During your appeal, the Plan will not defer to the initial benefit decision.
- If your claim was denied on the grounds of a medical judgment, during each level of appeal, the Plan will consult with a health professional with appropriate training and experience to decide the claim. The individual consulted on appeal will not be the same individual who was consulted regarding the initial benefit decision, nor a subordinate of that individual.

Timely Appealed Claims

During each level of appeal, a claim appeal form will be treated as received by the Plan:

(a) on the date it is hand-delivered to the above address; or

(b) on the date that it is deposited in the U.S. Mail for first-class delivery in a properly stamped envelope containing the above name and address. The postmark on any such envelope will be proof of the date of mailing.

Deadlines for filing appeals and for decisions on each level of appeal are set forth below based on the type of claim:

	First Level of Appeal, filing deadline	Second Level of Appeal, filing deadline	Appeal Decision deadlines
Pre-Service Claims	180 days following notice of denial of initial claim	60 days following notice of decision on your First Level of Appeal	For each level of appeal, respectively, not later than 30 days after the Plan receives your appeal
Urgent Care Claims	180 days following notice of denial of initial claim	60 days following notice of decision on your First Level of Appeal	Not later than 72 hours after the Plan receives your initial claim
Post-Service Claims	180 days following notice of denial of initial claim	60 days following notice of decision on your First Level of Appeal	For each level of appeal, respectively, not later than 60 days after the Plan receives your appeal
Concurrent Care Claims	180 days following notice of denial of initial claim	60 days following notice of decision on your First Level of Appeal	Your claim will be treated as it is classified, as a pre-service, urgent care, or post-service claim, according to this table

Notification of Appeal Decision

At each level of appeal, if your appeal is denied in whole or in part, you will receive the information provided above under the Notification of Benefit Decision. Your written notice may also include the following information:

- A statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse decision (or a statement that such information will be provided free of charge upon request); and
- A statement indicating entitlement to receive on request, and without charge, reasonable access to or copies of all documents, records or other information relevant to the determination.

Urgent care claim denials may be communicated orally. If so, written notice will follow no later than 3 days following the oral notice.

EXTERNAL APPEALS PROCEDURES

You may file a request for external review provided that the First and Second Level of Appeal have been exhausted. You must exhaust all internal and external claims and appeal procedures prior to filing any lawsuit for benefits denied.

There are two types of external review: standard external review and expedited external review. External review of denied claims under the Plan is available under these procedures if the denial was based on:

- *A decision requiring medical judgment* (such as medical necessity, appropriateness of care, health care setting, level of care, whether care is experimental or investigational, or effective) or
- *A rescission of coverage* (rescission is when benefits are retroactively terminated by the Plan).

Filing Fees

A $25.00 filing fee will be imposed on each request for external review, but will not exceed a maximum of $75.00 each Plan Year. The filing fee will be refunded if the claim denial is reversed on external review or if the filing fee itself is an undue financial hardship for you. If you do not pay the filing fee (and the fee is neither waived nor paid by the Plan), your request for external review will not be considered filed and no action will be taken on your claim until it is properly filed.

Independent Review Organization (IRO)

The Plan will engage an independent review organization (IRO) that is accredited by the Utilization Review Accreditation Commission (URAC) or by a similar nationally recognized accrediting organization, to conduct external reviews under these claim procedures.

The Plan will take actions to guard against bias in favor of denial of external review claims and to ensure independence. Therefore the Plan will contract with at least two IROs for external review of claims under this procedure.

When there are at least two IROs appointed under this procedure, the Plan will rotate external claim assignments among them (or incorporate other independent, unbiased methods for selection of IROs, such as random selection). Any IRO will not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

A contract between the Plan and an IRO will include the following provisions in the contract for services (in one form or another):

- The IRO will use legal experts where appropriate to make coverage determinations under the Plan.
- The assigned IRO will notify you in writing informing you about the eligibility and acceptance for external review of your denied claim. This notice will include a statement that you may submit additional information that the IRO must consider when conducting the external review. The additional information must be submitted within 10 business days of receipt of the notice. The IRO is not required to, but may, accept and consider additional information submitted after 10 business days. The IRO will forward any information submitted by you to the Plan within 1 day of receiving it.
- Within 5 business days after the date the claim has been assigned to the IRO, the Plan must provide to the IRO the documents and any information considered in making the denial. If the Plan fails to provide the documents and information on time, it will not delay the external review. If the Plan fails to provide the documents and information on time, the IRO may terminate the external review and reverse the denial. Within 1 business day after making the decision, the IRO must notify you and the Plan.
- The Plan may reconsider its denial that is under external review. Reconsideration by the Plan must not delay the external review. The external review may be terminated as a result of the reconsideration only if the Plan decides to reverse its denial and provide coverage or payment of the denied claim. Within 1 business day after reversing its decision, the Plan must provide written notice of its decision to you and the IRO. The IRO must terminate the external review upon receipt of the notice from the Plan.

- The IRO will review all of the information and documents that are received on time. When making a decision, the IRO will review the claim and not be bound by any previous decisions or conclusions made by the Plan. In addition to the documents and information provided, the IRO may consider the following information when making a decision:
    - Your medical records;
    - Your attending health care professional's recommendation;
    - Reports from appropriate health care professionals and other documents submitted by the Plan or issuer, you or your treating provider;
    - The terms of the Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;
    - Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
    - Any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or applicable law; and
    - The opinion of the IRO's clinical reviewer or reviewers after considering the information described above, to the extent the information or documents are available and the clinical reviewer or reviewers consider such information or documents appropriate.
- The IRO must provide written notice of the final external review decision within 45 days after the IRO receives the request for the external review. The IRO must deliver the notice of final external review decision to you and the Plan.
- The IRO's decision notice will contain:
    - A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount -if applicable, the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);
    - The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
    - References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
    - A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
    - A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Plan or to you;
    - A statement that judicial review may be available to you; and
    - Contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under applicable law.

After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for 6 years. An IRO must make such records available for examination by you, the Plan, or any applicable State or Federal oversight agency upon request, except where such disclosure would violate applicable privacy laws.

Standard External Review

Standard external review is external review that is not considered expedited.

Request for Standard External Review

The Plan will allow you to file a request for an external review with the Plan if the request is filed within 4 months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination.

However, if the date that your claim would be due has passed, but you have not been notified about the external review procedure, you will have 4 months from the date the Plan gives you notice of the external claim review procedures. If that date does not correspond with the same date in four months (for example, a leap year or a month that does not have 31 days), then your deadline to request external review would be the first day of the 5th month following the date you received notice from the Plan.

If your deadline to file falls on a weekend or a federal holiday, then you must file your request for external review on the next business day following the last filing date.

Preliminary Review

Within 5 business days following the date of receipt of the external review request, the Plan must complete a preliminary review of your request to determine whether:

- You are or were covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;
- The denial does not relate to your failure to meet the requirements for eligibility under the terms of the Plan (e.g., worker classification or similar determination);
- Determinations of eligibility for participation (other than rescissions) are not available for external review;
- You have exhausted the Plan's internal appeal process (unless you are not required to exhaust the internal appeals process); and
- You have provided all the information and forms required to process an external review.

Notification Following Preliminary Review

Within 1 business day after completion of the preliminary review, the Plan must notify you of its determinations from the preliminary review.

If the request is complete but not eligible for external review, the notice will tell you why it is ineligible.

If the request is not complete, the notice will tell you what information or materials are needed to make the request complete. You may provide the missing information within the 4-month filing period or within the 48-hour period following the receipt of the notice, whichever is later.

Referral to IRO

If your request passes preliminary review, the Plan will assign the external review to an IRO.

Notice of Standard Review Decision

If the Plan's denial is reversed by the IRO on final external review and the Plan is notified of that reversal, the Plan will immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the Claim, even if the Plan seeks judicial review of the reversal.

EXPEDITED EXTERNAL REVIEW

Request for Expedited External Review

You may request an expedited external review with the Plan when you receive:

- A claim denial if the denial involves an urgent medical condition and the timeframe for an expedited internal appeal would seriously jeopardize your life or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or
- A denial of a final internal appeal, if you have a medical condition where the timeframe for a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the final internal denial concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.

Preliminary Review of Expedited External Review

When the Plan receives your request for expedited external review, the Plan must determine whether the request meets the reviewability requirements above. The Plan will notify you if your request meets the requirements and will proceed with the expedited external review.

Referral to IRO

If your request passes preliminary review, the Plan will assign the external review to an IRO. The Plan must provide or transmit all necessary documents and information considered in making the denial to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The IRO will review all of the information and documents that are received on time. When making a decision, the IRO will review the claim and not be bound by any previous decisions or conclusions made by the Plan.

Notice of Expedited External Review Decision

The Plan's contract with the IRO must require the IRO to provide notice of the final external review decision, as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice of final review decision is not in writing, within 48 hours after the date of providing that notice, the IRO must provide written confirmation of the decision to you and the Plan.

Privacy of Medical Information

The Plan is not subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) or the Health Information Technology for Economic and Clinical Health of 2009 (HITECH). However, the Plan Administrator is committed to complying with all other laws and rules affecting the privacy of your health information and to protecting the privacy and security of that information.

Therefore, the Plan Administrator and all of the service providers to the Plan will be subject to the Plan's policies safeguarding all protected health information (PHI) as defined in the HIPAA Privacy Rule, and electronic protected health information (EPHI) as defined in the HIPAA Security Rule, by the terms of the Plan and by written, effective, binding contractual obligation, shall comply with the HIPAA Privacy Rule as if the Plan were subject to HIPAA and HITECH.

No service provider will be permitted to access PHI or EPHI unless and until such service provider has, through an effective, written, enforceable and binding contractual obligation, satisfactory to the Plan Administrator, agreed to observe all the provisions of the HIPAA Privacy Rule pertaining to the privacy of PHI, and further agreed that all subcontractors of such person, and their subcontractors, shall be similarly bound, together with appropriate enforcement provisions, including but not limited to, immediate termination of such relationship and indemnities from such person for any violation which harms the Participant, Plan or any Plan Entity or which is in violation of the HIPAA Privacy Rule. The Plan Administrator and all other Plan Entities shall take all reasonable steps in good faith to comply with the provisions of the HIPAA Privacy Rule as if it were fully applicable to the Plan, and, through the use of written, enforceable, binding contractual relationships, assure such compliance with respect to PHI on the part of all service providers and business associates (as defined in the HIPAA Privacy Rule).

Further, any service provider or business associate to the Plan, and any other person who comes into contact with EPHI, by the terms of the Plan and by written, effective, binding contractual obligation, shall comply with the HIPAA Security Rule to (i) ensure the confidentiality, integrity, and availability of all EPHI and (ii) protect against any reasonably anticipated threats or hazards to the security of EPHI, as if the HIPAA Security Rule were fully applicable to the Plan. The Plan Administrator and all other administrators agree to permit no person to enter into a contractual relationship with the Plan or the Plan Administrator as a service provider, business associate or in any other capacity, unless and until such person has, through an effective, written, enforceable and binding contractual obligation, satisfactory to the Plan Administrator, agreed to observe all the provisions of the HIPAA Security Rule pertaining to the security of EPHI, and further agreed that all subcontractors of such person, and their subcontractors, shall be similarly bound, together with appropriate enforcement provisions, including but not limited to, immediate termination of such relationship and indemnities from such person for any violation which harms the Participant, Plan, PUC or which would be in violation of the HIPAA Security Rule. The Plan Administrator and all other Plan Entities shall take all reasonable steps to comply with the provisions of the HIPAA Security Rule as if they were fully applicable to the Plan, and, through the use of written, enforceable, binding contractual relationships, assure such compliance with respect to EPHI on the part of all service providers and business associates.

DEFINITIONS

Aggregate Maximum Benefit is the maximum amount in aggregate the Plan will pay per Participant every Plan Year in benefits for Eligible Health Care Services covered under the Plan. The Plan will not reimburse or pay out benefits for Eligible Health Care Services and/or other health care services beyond this amount.

Approved Clinical Trials means a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is one of the following:

1. A federally funded or approved trial;
2. A clinical trial conducted under an FDA investigational new drug application; or
3. A drug trial that is exempt from the requirement of an FDA investigational new drug application.

Brand Name Drug is a Prescription Drug that has been patented and is only produced by one manufacturer.

Claims Administrator is Personal Insurance Administrators, Inc. (PIA). PIA is a third-party administrator specializing in the administration of Student health programs. The Claims Administrator is responsible for adjudicating claims for health benefits under the Plan.

Copay is the set dollar amount you are required to pay for certain Eligible Healthcare Services.

Coverage Period is a period for which a participant pays a premium in exchange for coverage under the Plan; in the case of this Plan the coverage terms are: Fall term, Winter term, and Spring/Summer term.

Dependent is the spouse and dependent children under 26 years of age of a Student who is eligible and enrolled in the Plan.

Durable Medical Equipment is medical equipment that is all of the following:

- Used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms;
- Not disposable
- Not of use to a person in the absence of a Sickness, Injury or their symptoms;
- Durable enough to withstand repeated use;
- Not implantable within the body; and
- Appropriate for use, and primarily used, within the home.

Eligible Expenses are the amounts approved EPO providers agree to accept as payment in full for Eligible Health Care Services covered under the Plan. It is usually lower than their normal charge for services. Eligible Expenses are rates determined by First Health Provider Agreements and other Provider Agreements established under the Plan.

Eligible Health Care Services are health care services covered under the Plan for which benefits are payable in the event that all terms, conditions and/or requirements for benefits under the Plan have been satisfied.

Emergency means a Sickness or Injury for which immediate medical treatment is sought at the nearest available facility. The condition must be one which manifests itself by acute symptoms which are sufficiently severe (including severe pain) that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention would result in any the following: 1) placing the health of the individual or, with respect to a pregnant woman, the health of a woman or her unborn child, in serious jeopardy; 2) serious impairment to bodily functions; or 3) serious dysfunction of any bodily organ or part.

Emergency Health Services are medical, psychiatric, surgical, Hospital and related health care services and testing, including ambulance service, which are required to treat a sudden, unexpected onset of a bodily Injury or serious Sickness which could reasonably be expected by a prudent layperson to result in serious medical complications, loss of life, or permanent impairment to bodily functions in the absence of immediate medical attention. Examples of emergency situations include uncontrolled bleeding, seizures or loss of consciousness, shortness of breath, chest pains or severe squeezing sensations in the chest, suspected overdose of medication or poisoning, sudden paralysis or slurred speech, burns, cuts, and broken bones. The symptoms that led you to believe you needed emergency care, as coded by the provider and recorded by the Hospital on the

UB92 claim form, or its successor, or the final diagnosis, whichever reasonably indicated an emergency medical condition, will be the basis for the determination of coverage, provided such symptoms reasonably indicate an emergency.

EPO Provider is one of the following providers which have a Provider Agreement in effect with the Plan at the time services are received:

- PUC Health Clinic;
- St. Helena Hospital or CMG;
- Other approved EPO providers contracted with the First Health Network, including but not limited to:
    - A hospital;
    - A physician;
    - An ambulatory surgical center;
    - A home health agency;
    - A facility which provides diagnostic imaging services;
    - A durable medical equipment outlet;
    - A skilled nursing facility;
    - Hospice;
    - A clinical laboratory; or
    - A home infusion therapy provider.

EPO Providers agree to accept the negotiated rate as payment for Eligible Health Care Services.

A directory of other approved EPO Providers is available at: http://www.myfirsthealth.com.

Important: The Plan's EPO requires Participants to use the resources of the PUC Health Clinic and St. Helena Hospital and CMG first in certain circumstances. Please see the Plan Benefits Section of this summary for a detailed explanation.

Essential Health Benefits has the meaning found in section 1302(b) of the Patient Protection and Affordable Care Act, and is further defined by the Secretary of the United States Department of Health and Human Services, and includes the following categories of Covered Services: ambulatory patient services; Emergency services; Hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; Rehabilitative and Habilitative services and devices; laboratory services; Preventive and Wellness services and chronic disease management; and pediatric services, including oral and vision care (in accordance with the applicable state or federal benchmark plan).

Formulary/Prescription Drug List means a list of approved Prescription Drugs and related supplies covered under the Plan. The Prescription Drugs and related supplies on the list have been approved by the Plan's Prescription Benefit Manager (PBM) Pharmacy and Therapeutics (P&T) Committee based on safety and efficacy. The list is regularly reviewed and updated by the PBM's P&T Committee.

Generic Prescription Drug is a pharmaceutical equivalent of one or more brand name drugs and must be approved by the Food and Drug Administration as meeting the same standards of safety, purity, strength, and effectiveness as the brand name drug.

Habilitative Treatment or Therapy means treatment or therapy that develops or attempts to develop a function that did not previously exist, but would normally be expected to exist. Treatment or therapy is considered habilitative if the function has achieved maximal or optimal improvement or is static, showing no progressive improvement with additional treatment.

Injury means bodily injury which is: 1) directly and independently caused by specific accidental contact with another body or object; 2) unrelated to any pathological, functional, or structural disorder; 3) a source of loss; 4) treated by a Physician within 30 days after the date of accident; and 5) sustained while the Participant is covered under the Plan. All injuries sustained in one accident, including all related conditions and recurrent symptoms of these, will be considered one injury. Injury does not include loss which results wholly or in part, directly or indirectly, from disease or other bodily infirmity. Eligible Expenses incurred as a result of an injury that occurred prior to the Plan's effective date will be considered a Sickness under the Plan.

Inpatient Hospital Services is an uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility, which includes health services, on an inpatient basis, for the acute care and treatment of sick or injured individuals. Care is provided through medical, mental health, substance use disorders, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians and has 24-hour nursing services.

Maternity Care Services are services required by a Participant for the diagnosis and care of a pregnancy and for delivery services. Delivery Services include:

- Normal vaginal delivery
- Caesarean section delivery
- Spontaneous termination of pregnancy prior to full term
- Complications of pregnancy

Medical Necessity is a service or supply determined by the Plan's Utilization Review Administration to be:

- Required to diagnose or treat an illness, Injury, disease or its symptoms;
- In accordance with generally accepted standards of medical practice;
- Clinically appropriate in terms of type, frequency, extent, site and duration;
- Not primarily for the convenience of the patient, Physician or other health care provider; and
- Rendered in the least intensive setting that is appropriate for the delivery of the services and supplies. Where applicable, the Utilization Review Administration may compare the cost-effectiveness of alternative services, settings or supplies when determining least intensive setting.

The fact that your medical provider recommends or approves the service or supply is not relevant in determining whether the service or supply is Medically Necessary.

Mental Health relates to an emotional, psychological or psychiatric condition not resulting from a physical Injury.

Outpatient Services means any medical care or treatment that does not involve a hospital admission or overnight stay in a medical facility.

Out-of-Pocket Maximum is when a Participant has incurred $6,600 of out-of-pocket expenses ($13,200 per family) for Eligible Expenses (EPO only) during a policy year, after which the Company payment for Eligible Expenses incurred will increase to 100% when treated by EPO providers for the remainder of the Plan year, up to the Maximum Benefit. This provision does not apply to non-EPO providers. Out-of-pocket expenses include Copays, as well as any Deductible and Coinsurance amounts paid, but exclude non-covered medical expenses and elective services.

Participant is either the Student or an enrolled Dependent only while enrolled and eligible for Benefits under the Plan. References to "you" and "your" throughout this Summary are references to a Participant, except where the context indicates otherwise.

Pediatric Dental Care means:

1. Preventive and diagnostic services, including X-rays (bitewing, full-mouth, and panoramic) and sealants (for permanent first and second molars only, as needed);
2. Basic restorative services, including Emergency palliative treatment of pain, fillings (amalgam, resin-based composite), and simple extractions;
3. Major services, including prosthodontics, crowns, bridges, and dentures (one per tooth/arch every 60 months); endodontics, (root canals), periodontics, oral surgery, and general anesthesia in conjunction with complex oral surgery; (note: all major services require pre-authorization); and
4. Medically Necessary orthodontia services. Medically Necessary Orthodontia services means the patient must have a severe and handicapping malocclusion, and the child's condition must be severe enough to impact their ability to function such as having trouble eating and/or speaking.

Physical Therapy is Eligible Health Care Services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Physician Office Visits (as opposed to other physician professional services) refers strictly to the evaluation and management component of any physician's office visit. The evaluation and management component is associated only with the physician's time spent with the Participant to evaluate and plan for treatment of an Injury or Sickness. It does not include additional Eligible Health Care Services that are billed separately from the evaluation and management component of the physician's office visit, including tests, labs, X-rays and in-office procedures.

Plan is this Pacific Union College Student Health Plan offered to its Students and eligible dependents (Participants).

Plan Sponsor is Pacific Union College.

Plan Year Deductible is the amount you owe for the Eligible Health Care Services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is $250, your plan won't pay anything until you've met your $250 deductible for covered Eligible Health Care Services subject to the deductible. The deductible may not apply to all services.

Prescription Drug is a medication, product or device that has been approved by the Food and Drug Administration and that can, under federal and state law, only be dispensed using prescription order or refill. A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For purposes of the Plan, Prescription Drugs include:

- Insulin;
- The following diabetic supplies:
  - Insulin syringes with needles;
  - Blood testing strips-glucose;
  - Urine testing strips-glucose;
  - Ketone testing strips and tablets;
  - Lancets and lancet devices; and
  - Insulin pump supplies, including infusion sets, reservoirs, glass cartridges, and insertion sets.

Preventive Health Services include routine examinations, screenings, tests, education and immunizations administered with the intent of preventing future disease, illness or Injury. Services are considered preventive if you have no current symptoms or prior history of a medical condition associated with that screening or service. These services shall meet requirements as determined by federal and state law. Sources for determining which services are recommended include the following:

- Services with "A" or "B" rating from the United States Preventive Services Task Force of the Centers for Disease Control and Prevention;
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- Preventive care and screenings for infants, children, and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
- Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration, except contraceptives.

You may also refer to the following website that is maintained by the U.S. Department of Health & Human Services:
http://www.hhs.gov/healthcare/prevention

Primary Care Physician is a Physician who qualifies as an EPO Provider in general practice, internal medicine, family practice or pediatrics; as authorized by the EPO to provide or arrange for medical care for Participants.

Prior Authorization is a process the Plan uses to determine if a requested health care service or supply is a covered benefit and that the individual's care is provided in the most medically appropriate setting. The Prior Authorization process may set limits on the Eligible Health Care Services to be given. Prior Authorization is required prior to all inpatient hospital admissions and before receiving certain outpatient procedures or services. Some prescription drugs also require Prior Authorization. Services that require Prior Authorization include but are not limited to:

- Inpatient hospital services;
- Inpatient services at other health care facilities;

- Outpatient facility services;
- Surgeries;
- Outpatient short-term rehabilitation;
- Outpatient laboratory, pathology and radiology services;
- Advanced radiological imaging services;
- Non-emergency ambulance;
- Inpatient mental health;
- Inpatient substance abuse;
- Certain classes of prescription drugs; and
- Specialty prescription drugs.

Rehabilitative Therapy means the process of restoring a person's ability to live and work after a disabling Condition by: 1) helping the person achieve the maximum possible physical and psychological fitness; 2) helping the person regain the ability to care for himself or herself; 3) offering assistance with relearning skills needed in everyday activities, with occupational training and guidance and with psychological readjustment.

Scheduled Services vs. Unscheduled (Emergency) Services means services that are not Emergency Services and are scheduled with the provider in advance of the care being provided.

Sickness means a physical or mental illness. It also includes pregnancy. Expenses incurred for routine Hospital and pediatric care of a newborn child prior to discharge from the Hospital nursery will be considered to be incurred as a result of Sickness.

Specialist Physician is a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Specialty Prescription Drug is a Prescription Drug that is generally a high-cost, self-injectable, oral or inhaled biotechnology drug used to treat patients with certain illnesses.

Step Therapy is a program administered by your Plan's Prescription Benefit Manager designed to ensure you get the right drug to treat your condition, at the lowest cost to you and Pacific Union College. Through the program drugs are put into groups based on Copayment amount.

- Generic drugs - the first option - are generic drugs proven to be safe, effective and affordable. For many patients, these drugs should be tried because they can provide the same health benefit as more expensive drugs, at a lower cost. Only your doctor can say if one is appropriate for you.
- Brand Name drugs - the second option - are brand-name drugs that generally are necessary for only a small number of patients. Brand Name drugs typically cost more than Generic drugs.

Generic drugs are covered at a lower cost to the Participant, whereas Brand Name drugs may require higher cost-sharing from the Participant or be excluded as a covered benefit.

Student is the person who, by meeting the plan's eligibility requirements, is allowed to choose membership under the Plan for himself or herself and his or her eligible Dependents. Such requirements are outlined in the Eligibility Section of this Summary. A Student may enroll as a Participant under only one health plan provided by the Plan Sponsor, or any of its affiliates.

Student Premium Contribution is the premium amount that a Student pays for coverage under the plan for a specified coverage period.

Substance Abuse means chemical dependency or substance abuse disorder of such a degree as to result in interference with your daily activities or disrupting normal interaction with those around you.

Urgent Care Services are medical, surgical, Hospital or related Eligible Health Care Services and testing which are not Emergency Services, but which are determined by the Plan, in accordance with generally accepted medical standards, to have been necessary to treat a condition requiring prompt medical attention. This does not include care that could have been foreseen before leaving the immediate area where you ordinarily receive and/or were scheduled to receive services. Such care includes, but is not limited to, dialysis, scheduled medical treatments or therapy, or care received after a Physician's recommendation that the insured should not travel due to any medical condition.

Utilization Review Administrator (URA) is an organization with a staff of clinicians which may include Physicians, Registered Graduate Nurses, licensed mental health and substance abuse professionals, and other trained staff members who perform utilization review services under the Plan.

IRS REPORTING REQUIREMENTS

The ACA created new reporting requirements under Internal Revenue Service Code Section 6055 for student health plans. Under these new reporting rules, information must be provided to the IRS about health plan coverage for individuals. This information must also be sent to the covered individual. The additional reporting is intended to provide the government with data to administer certain ACA requirements, such as the individual mandate (that is, the requirement that individuals obtain acceptable health coverage for themselves and their family members or pay a penalty).

Effective Date

Reporting requirements will become effective for the 2015 tax year. The first returns will be due in 2016 for coverage provided during the 2015 *calendar* year. Although students may be enrolled for all or part of the 2014–2015 or 2015–2016 Plan years, only the coverage information for 2015 is included in the 2015 reporting.

Reporting Responsibility for the Student

The responsible individual (in this case, the student) will be required to provide evidence of health coverage that meets Minimum Essential Coverage requirements on their federal tax return, whether they are filing individually, jointly with a spouse, or as a tax dependent on a parent's plan. If an individual cannot provide evidence of Minimum Essential Coverage, they (or their family member who is the primary taxpayer) will be charged a tax penalty. Each family member must provide evidence of this coverage to avoid a tax penalty.

Because IRS will be matching the data submitted from the issuer to each individual's federal tax return, the social security number is the primary identifier, and will therefore be requested at the time of enrollment into the Plan.

Reporting Responsibility for Issuer

The issuer for this Plan is Pacific Union College. All issuers that provide Minimum Essential Coverage will be required to file an annual return with the IRS to report information for each individual who is provided with this coverage. Related statements will also be sent to the covered student. *Note: This Plan meets Minimum Essential Coverage requirements.*

Form 1095-B, also known as the *Responsible Individual Statement*, is the proof of coverage information sent to the student to be filed with their tax return. Students and their covered dependents will be listed on the same form. Employer group plans and coverage through the Exchange have different forms but the same requirements, so a family could have different forms from their different insurance providers.

Social security numbers and current addresses will be necessary for the issuer to fulfill this requirement.