



Benefit Summary for July 1, 2011 – June 30, 2012

Pacific Union College is proud to offer a wide range of benefits to meet the needs of you and your family. Enclosed in this summary are highlights of the following:

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Please note that this is a summary of the benefits as covered under the health care assistance plan are effective July 1, 2011 – June 30, 2012. This bulletin should answer most of your questions about the plan. However, this bulletin does not fully describe all of the benefits of the PUC health plan, limitations and exclusions. For more specific details or to obtain further information, contact your plan administrator – PUC Human Resources Ext. 6231 to examine the current Plan document or visit the PUC website at www.puc.edu to download a copy of the entire Health Care Assistance Plan Document.

HEALTH CARE REFORM

Effective **July 1, 2011**, the **Health Care Assistance Plan for Employees of Pacific Union College** has changed their benefit plan to comply with Patient Protection and Affordable Care Act and Health Care and Education Reconciliation Act of 2010. Below is an outline of the changes:

1. Coverage for children up to age 26, regardless of student status, marital status, financial dependency or residency. *Note: Coverage is not available for your adult child's spouse or children (i.e., grandchildren).*
2. There are no pre-existing conditions limitations for any individuals (employees or children) under age 19.
3. There is no longer lifetime limits on *Essential Benefits* (as defined in Section 1302(b) of the Affordable Care Act): ambulatory care, emergency care, hospitalization, maternity/newborn care, mental health and substance abuse use disorder services, prescription drugs, rehabilitation services, lab services, preventive/wellness care, chronic disease management, and pediatric care*, including oral and vision care. **Note: Awaiting regulatory guidance on what needs to be included for oral and vision care, as well as clarification on what the age limit is for pediatric care).* The plan has however, designated Non-Essential Health Benefits; based on a good faith effort to comply and a reasonable interpretation of the term "essential health benefits." These non-essential health benefits include infertility treatment, orthodontic treatment and refractive eye surgery.
4. Plan cover 100% of the cost of **in-network** preventive care; out-of-network providers may be used for this care, but a coinsurance amount and deductible will be applied
5. No recession of coverage unless a 30-day prior notice has been provided to participants (except in the case of fraud of misrepresentation). *Note: Termination of benefits due to non-payment of premiums is not considered to be rescission.*
6. Access to designate any PCP (including pediatrician and OB/GYN) without the need for a referral or prior authorization.
7. Requirements or limitations on benefits for out-of-network **emergency services** cannot be more restrictive than the requirements or limitations that apply to in-network emergency services.
8. An Independent Review Organization will review claims on a second appeal. *Note: This has been, and will continue to be, Delta Health Systems' practice.*
9. Under the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act, this non-grandfathered plan is required to provide a process for an external review of claims that have received an adverse benefit determination. The external review includes a process for a **standard** external review and a process for an **expedited** external review.

PUC is in the process of incorporating all of these changes into a new Summary Plan Description that will be available in the near future, in the meantime, attached is a summary for the upcoming benefit year.



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ELIGIBILITY

You are eligible to participate in the Health Care Assistance Plan if you are:

- currently employed on a full-time basis and
- have completed your benefits waiting period.

Your spouse and dependent children may be covered by the Plan if they meet the eligibility requirements. However, no one can be covered at the same time both as an employee and dependent.

MEDICAL PLAN BENEFITS

Preferred Provider Organization (PPO)

A PPO plan allows you to receive medical care and services from any physician or facility you choose. As a PPO plan participant, you do not need to select a primary care physician, nor do you need referrals for a specialist. There are two types of providers:

- **In-network Providers:** Including physicians and hospitals, which have agreed to become part of the organization and provide care to members at a lower negotiated rate. If you use in-network providers, benefit coverage will be greater and your out-of-pocket expenses will be lower.
- **Out-of-network Providers:** Any provider not affiliated with the network is out-of-network. If you reside in a PPO area, but you elect **not** to participate in the Participating Provider Program your covered benefits will be reduced in the following ways:
 - You will be reimbursed only 50% of the amounts listed in the charts, and
 - Any costs associated with out-of-network medical care do not apply towards reducing your out-of-pocket maximum.

PLAN BENEFITS: DESIGNATED PROVIDER PROGRAM	
IMPORTANT: The following limits are based on a JULY 1 – JUNE 30 Plan Year.	
Lifetime Maximum	No lifetime maximum
Plan Year Deductible	<ul style="list-style-type: none"> • \$350/Employee Only • \$700/Family Important: Only Office Visits are exempt from the Deductible
Plan Year Out-of-Pocket Maximum (OOP)	<ul style="list-style-type: none"> • \$3,000/Employee Only • \$6,000/Family Important: Out-of-Pocket Maximum (OOP) applies to all medical claims except where noted
Plan Year Cost Contribution	<ul style="list-style-type: none"> • \$50.00/Employee Only • \$80.00/Employee + 1 Dependent • \$110.00 Employee + 2 or More Dependents

Benefit information is provided on the following pages.



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Note: Except where listed otherwise (e.g., Deductible Waived), all benefits are applied to the plan year deductible; the deductible must be satisfied before benefits are paid.

Type of Benefit	Additional Limits and Explanations
<ul style="list-style-type: none"> • Primary Care • Specialist 	<ul style="list-style-type: none"> • Office visit \$25 co-pay, then Plan pays 100% only on office visit charge • Office visit \$40 co-pay, then Plan pays 100% only on office visit charge <p>Notes:</p> <ul style="list-style-type: none"> • <i>Deductible Waived</i> • Office visit co-pays are not included in the OOP • All other charges on the same bill are paid at 80%, including labs, x-rays, in-office procedures
<p>Outpatient Services</p>	<p>Paid at 80% of Provider's charges</p> <p>Notes: Services must be received at St. Helena Hospital, unless St. Helena Hospital is unable to provide the service.</p>
<p>Inpatient/Outpatient Hospital Stays & Office/Ambulatory Surgical Procedures <i>Prior Authorization Required for Inpatient</i></p>	<p>Paid at 80% of Provider's charges</p> <p>Notes: Services must be received at St. Helena Hospital. Unless St. Helena Hospital is unable to provide the service.</p>
<p>Hospital Emergency & Urgent Care Center <i>Prior Authorization Required for Inpatient</i></p>	<ul style="list-style-type: none"> • Paid at 80% of Provider's charges: <ul style="list-style-type: none"> ○ Level 1 ER services: \$105/visit (includes room and ER Physician fee) ○ Level 2 ER services: \$165/visit (includes room and ER Physician fee) ○ Levels 1 and 2 exclude lab and x-ray services; these are reimbursed at 33% of billed charges ○ Level 3 and up: 33% of charges <p>Notes:</p> <ul style="list-style-type: none"> • <i>Deductible Waived</i> • Services must be received at St. Helena Hospital, unless St. Helena Hospital is unable to provide the service. • Plus \$50 deductible per Hospital Emergency Room visit.
<p>Ambulance</p>	<p>Paid at 80% of Provider's charges.</p>
<p>Preventive Health Examinations</p> <p>Non-screening procedures covered under the standard Health Plan. See Human Resources regarding refund of contributions bi-yearly for wellness participation.</p>	<p>Covered at 100% in-network; guidelines provided by the US Preventive Services Task Force. <i>Deductible Waived</i></p> <p>Notes: PUC Healthcare Services for your Wellness needs is also covered at 100%, plus:</p> <ul style="list-style-type: none"> • It's right here on campus! • Less paperwork! <p>See the <i>Wellness Plan Document</i> for full details.</p>
<p>Physical, Occupational and Speech Therapy Services <i>Prior Authorization Required</i></p>	<p>Services paid at 80%. Benefit Maximum: 30 visits per Plan year for each category of therapy.</p> <p>Notes: Appropriate billing codes (CPT) must be included for each charge. No prescription required for service.</p>
<p>Massage Therapy</p>	<p>Services paid at 80%. Benefit Maximum: : 30 visits per Plan year for Massage Therapy</p> <p>Notes: Appropriate billing codes (CPT) must be included for each charge.</p>
<p>Vision Therapy <i>Prior Authorization Required</i></p>	<p>Services paid at 80%</p> <p>Notes: Appropriate billing codes (CPT) must be included for each charge.</p>
<p>Chiropractic Treatment</p>	<p>Services paid at 80%. Benefit Maximum: 30 visits per Plan year for Chiropractic Treatment</p> <p>Notes: Limited to spinal manipulation only. Appropriate billing codes (CPT) must be included for each charge.</p>



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Note: Except where listed otherwise (e.g., Deductible Waived), all benefits are applied to the plan year deductible; the deductible must be satisfied before benefits are paid.

Type of Benefit	Additional Limits and Explanations
Acupuncture Therapy	Services paid at 80%. Benefit Maximum: 18 visits per Plan year for Acupuncture Therapy <i>Notes: Appropriate billing codes (CPT) must be included for each charge.</i>
Hearing Care	Paid at 80% of charges. Benefit Maximum: \$3,200 payment limit per Plan year
Durable Medical Equipment <i>Prior Authorization Required for Equipment over \$10000</i>	Paid at 80% of charges. Benefit Maximum: \$8,000 payment limit per Plan year
Home Health Care <i>Prior Authorization Required for Inpatient</i>	Paid at 80% of charges <i>Notes:</i> <ul style="list-style-type: none"> • Maximum of 52 Visits per Plan year • 0-4 Hours = 1 Visit • Service must be provided by Adventist Health-Home Care Service unless Adventist Health-Home Care Service is not available
Hospice Care <i>Prior Authorization Required for Inpatient</i>	Paid at 100% of charges
Counseling Services	Paid at 80% of charges <i>Notes:</i> <ul style="list-style-type: none"> • Counselor must be on PUC HRD approved list or belong to Blue Cross network
Outpatient Mental Health Services	Paid at 80% of charges.
Inpatient Mental Health Services <i>Prior Authorization Required for Inpatient</i>	Paid at 80% of charges
Mental Health Acute Partial Hospitalization <i>Prior Authorization Required for Inpatient</i>	Paid at 80% of charges
Substance Abuse/Chemical Dependency Outpatient Treatment	Paid at 80% of charges
Substance Abuse/Chemical Dependency Inpatient Treatment <i>Prior Authorization Required for Inpatient</i>	Paid at 80% of charges
Substance Abuse Chemical Dependency Partial Hospitalization <i>Prior Authorization Required for Inpatient</i>	Paid at 80% of charges
Organ /Tissue Transplants <i>Prior Authorization Required</i>	Covered at 80% <i>Notes: Organ donor charges are only covered if the donor is a plan participant.</i>
Infertility Treatments <i>Prior Authorization Required</i>	Covered at 80% of Provider's charges. Lifetime Maximum: \$16,000 <i>Notes: Services do not apply to the OOP maximum</i>
Refractive Eye Surgery	Paid at 80% of Provider's charges. Lifetime Maximum: \$2,400 <i>Notes: Services do not apply to the OOP maximum</i>
Vision Care	Paid at 80% of Provider's charges. Benefit Maximum: \$560 per Plan year. <i>Notes: The Plan year deductible and the OOP do not apply. Refer to Vision Care Provider list.</i>



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PRESCRIPTION DRUG PLAN

Prescription Drug Benefit	Retail 30-Day Supply	Home Delivery 90-Day Supply
Plan Year Out-of-Pocket Maximum	\$1,500	
Prescription Drug		
<ul style="list-style-type: none"> • Formulary <ul style="list-style-type: none"> ○ Generic ○ Brand • Non-Formulary • Special Medications 	\$10 \$30 \$45 \$75	\$15 \$40 \$50 \$50
<p>Important: This prescription plan is mandatory Generic. If the employee requests Brand name, the employee will have to pay the difference between brand and generic.</p>		

Prior Authorization for Certain Prescription Drugs

When obtaining prescription medication through your retail pharmacist or home delivery program, the following categories of medications are a sampling subject to review and/or restrictions. For further information, call **HealthTrans at (1-877-839-8119)**.

- Anti-Emetics
- Erythroid Stimulants
- Growth Hormones
- Fertility Agents
- Biotechnological Agents
- Dermatologicals
- Anti-Narcoleptic Agents
- COX 2 Inhibitors
- Migraine Therapy
- Immunomodulatory Agents
- Erectile Dysfunction

VISION CARE PROVIDERS

Recommended Provider Organizations	Recommended Doctors		
<ul style="list-style-type: none"> • Lens Crafters • Costco • Sears Optical • JC Penney Optical • Pearl Vision • Other Chain Group Facilities 	<ul style="list-style-type: none"> • Charles H. Bailey, O.D. • Matthew R. Hileman, O.D. • Julie M. Perry, M.D. • Delmar D. Fjarli, M.D. • Jean A. Nelley, O.D. • Bicais Optical • Site for Sore Eyes 	St.Helena St.Helena St.Helena Deer Park Calistoga Napa Napa	963-7923 963-7923 963-1775 963-6333 942-4674 224-9444 224-7483

Note: If your vision provider is a Blue Cross PPO Participant, the Vision payable is based on the Blue Cross contract which overrides the PUC maximum payable per plan year.



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DENTAL CARE PLAN

Important: All payments are based on usual and customary charges. If the billed amount is greater than the usual and customary, then the difference is the responsibility of the insured. *Note: Oral Surgery is covered under the Medical Plan and should not be billed as Dental*

Type of Limit	Amount
Plan Year Deductible (July 1 – June 30) <ul style="list-style-type: none"> • Employee Only • Employee + 1 or More Dependents 	<ul style="list-style-type: none"> • \$75 • \$150
Plan Year Maximum <ul style="list-style-type: none"> • Employee Only • Employee + 1 or More Dependents 	<ul style="list-style-type: none"> • \$2,500 • \$5,520

Type of Benefit	Additional Limits and Explanations
Type A: Preventive Care	Covered at 100% of Provider's charges. Deductible Waived
Type B: Basic Restorative	80% of Provider's charges
Type C: Major Restorative	80% of Provider's charges

Prior Authorization for Certain Dental Services

The following procedures require a written proposal from dental providers for review and approval by Delta Health Systems:

- Temporomandibular Disorders
- Jaw Surgery
- Dental Implants
- Orthodontic Procedures

Please forward all dental proposals to:

Delta Health Systems
P.O. Box 80
Stockton, CA 95201



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QUICK REFERENCE GUIDE TO PRIOR AUTHORIZATION REQUIREMENTS

Certain health care services require prior authorization before services will be covered. The following list can be used as a guide to those services that require prior approval. Please keep in mind that **you** are responsible for preauthorization in the following situations,

Care or Services	Timeframe
Anthem Blue Cross Preauthorization	
Inpatient Hospital Stays Including inpatient care for mental health or chemical dependency treatment: <ul style="list-style-type: none"> • Scheduled or Non-emergency Admissions • Non-scheduled, Emergency Admission <p><i>Note: Outpatient hospital stays do not require pre-certification.</i></p>	<ul style="list-style-type: none"> • At least 48 hours prior to the admission • Within 48 hours of an admission
Additional Services <ul style="list-style-type: none"> • Organ and Tissue transplant procedures • Skilled Nursing Facility Admissions • Gastric By-pass surgery 	48 hours prior to care, treatment or admission
Pacific Union College Preauthorization	
Additional Services <ul style="list-style-type: none"> • Home Health Care Services • Hospice Care • Occupational and Speech Therapy Benefits • High Cost Durable Medical Equipment (\$1,000 or more) • C-PAP Machine • Infertility treatment programs • Cosmetic, Plastic or Reconstructive procedures i.e., eye, nasal, and venous • Surgically placed devices such as cochlear implants • Cardiac Rehabilitation treatment programs • Vocal Nodule Treatment • Non-Emergency Ambulance / Air Ambulance 	48 hours prior to care, treatment or admission

For contact information, see **Important Numbers and Website Addresses** on the following page.



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IMPORTANT NUMBERS AND WEBSITE ADDRESSES

For case management, pre-authorization, forms, claims, questions or provider directories, refer to the information below.

Benefit Plan	Contact Information and Toll-free Telephone Number	Website
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 descriptions and insurance contracts.	PUC HR Office Pacific Union College One Angwin Avenue Angwin, CA 94508-9646 1-707-965-6231 x. 6231	www.puc.edu/campus-services/human-resources/home <i>Email: hr@puc.edu</i>
Claims Administrator A company which 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.	Delta Health Systems Customer Service P.O. Box 80 Stockton, CA 95201 1-800-556-7830	www.deltahealthsystems.com
Medical: Prior Authorization	Anthem Blue Cross 1-800-274-7767	www.anthem.com
Dental: Prior Authorization	Delta Health Systems 1-800-556-7830	N/A
Prescription Drug	HealthTrans <i>Help Desk: 1-877-839-8119</i> <i>Prior Authorization: 1-866-805-1690</i>	N/A
Privacy Notice	PUC HR Office 1-707-965-6231 x. 6231	<i>Email: hr@puc.edu</i>

CHANGING COVERAGE DURING THE YEAR

It is **your** responsibility to report changes in eligibility, or general family status to your *employer*, (not the Plan Administrator), **within 30 days**, since your employer may be unaware of family changes that might affect you or your family member's 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 open enrollment period.**

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

- a 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, and
- child custody changes.