

2011

Employee Benefits Outline

Prepared for the employees of:



Effective June 1, 2011

IMPORTANT:

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, Federal law gives you more choices about your prescription drug coverage. Please see page 12 for more details.

PLEASE NOTE:

This overview has been prepared to briefly highlight key features of your plan and is not to replace your insurance contract or booklet. We have compiled information into summary form to answer questions we most commonly receive. Please refer to the insurance carriers' contracts and booklets for more detailed information and plan limitations. Actual claims paid are subject to the terms and conditions of the individual carriers' contracts.

2011 BENEFIT HIGHLIGHTS

Dependent Eligibility

(Medical/Dental/Vision): Married/unmarried children are now eligible to age 26, if they are not eligible for health coverage under their employer's plan

Medical

- Preventive care is now covered in full, copay & coinsurance waived, with Preferred & Participating providers
- Lifetime maximum has been removed and replaced by an \$2,000,000 Annual maximum
- Pre-existing condition waiting period has been removed for members under age 19
- Organ transplant lifetime maximum has been removed
- Annual dollar limits on Rehabilitation have been replaced by visit limits

YOUR BENEFIT COSTS

		Medical/Vision	Dental
Employee only	Total Monthly Cost	\$537.24	\$41.60
	PNWU Monthly Cost	\$537.24	\$41.60
	Employee Monthly Cost	\$0	\$0
Employee & Spouse	Total Monthly Cost	\$1,205.33	\$82.91
	PNWU Monthly Cost	\$537.24	\$41.60
	Employee Monthly Cost	\$668.09	\$41.31
Employee & Child/ren	Total Monthly Cost	\$1,013.91	\$75.00
	PNWU Monthly Cost	\$537.24	\$41.60
	Employee Monthly Cost	\$476.67	\$33.40
Employee, Spouse & Child/ren	Total Monthly Cost	\$1,682.00	\$126.19
	PNWU Monthly Cost	\$537.24	\$41.60
	Employee Monthly Cost	\$1,144.76	\$84.59

On March 23, 2010, the Affordable Care Act was signed into law. The Act puts in place comprehensive health insurance reform over the next four years and beyond. Please see Page 9 for important changes that have already begun for dependents and those who have previously exhausted any lifetime limits on benefits.

MEDICAL BENEFITS – REGENCE BLUESHIELD

Regence Innova Unlimited

	Category 1 Preferred Provider	Category 2 Participating Provider	Category 3* Non- Contracted Provider
PCY = Per Calendar Year			
Annual Deductible			
Individual	\$500		
Family	\$1,500		
Out of Pocket Maximum (plus deductible)			
Individual	\$2,000		
Family	\$6,000		
Outpatient Professional Services office visits	\$20 co-pay (deductible waived)	\$35 co-pay (deductible waived)	60%
Preventive Care	100% (deductible waived)	100% (deductible waived)	60%
Spinal Manipulations - up to 10 visits PCY	80%	60%	60%
Acupuncture - up to 12 visits PCY	80%	60%	60%
Rehabilitation			
Inpatient - up to 30 days PCY	80%	60%	60%
Outpatient - up to 25 visits PCY	80%	60%	60%
Inpatient Facility Services semi-private room/board, ICU, CCU, ancillary charges, maternity	80%	60%	60%
Prescription Drugs	<i>At Preferred Pharmacies</i>		
Generic	<i>Per 30-day supply, \$3,000 Out of Pocket maximum</i>		
Brand Name, Formulary	<i>\$5 co-pay</i>		
Brand Name, Non-Formulary	<i>\$25 co-pay (plus 100% of Generic equivalent)</i>		
Mail Order	<i>\$50 co-pay (plus 100% of Generic equivalent)</i>		
	<i>3x co-pay for up to a 90-day supply</i>		
Emergency Room Services <i>co-pay waived if admitted</i>	\$100 co-pay per visit then 80%		
Outpatient Diagnostic Lab & X-ray <i>First \$400 PCY</i>	100% (deductible waived)	100% (deductible waived)	100% (deductible waived)
<i>Thereafter</i>	80% (deductible applies)	60% (deductible applies)	60% (deductible applies)
	<i>Preventive Diagnostic Lab & X-ray covered in full</i>		
Mental Health & Chemical Dependency Services			
Inpatient	80%	60%	60%
Outpatient	80%	60%	60%
TMJ	\$1,000 PCY		
Lifetime Maximum	Unlimited; \$2,000,000 Annual Maximum		
Dependent Daughter Maternity	not covered		
4th Quarter Deductible Carryover	not included		

Deductible applies unless otherwise noted.

*Member may be responsible for any provider costs above the Category 3 allowed amount.

COVERAGE ON Preventive Services.

Regence has a long history of supporting and providing preventive services for our members. In fact, we believe that prevention is the key to detecting many serious and costly conditions, and ultimately benefiting the long-term health of our members.

The new health care reform law requires us to offer additional preventive coverage on many of our benefit plans. Regence supports this, and as a result, we would like to share some additional details regarding preventive care coverage many of our members will receive as part of their benefit plans.

Newly added preventive services

Regence will now cover the services listed here at 100% (no deductibles, coinsurance or copayments) for many of our members, including routine visits for preventive care (including, but not limited to, routine well-baby and well-child exams, and physical exams for adults).

Covered Preventive Services for Adults

Screenings, tests and counseling:

- Adult aortic aneurysm screening – covered once per lifetime for men age 65 and over if ever smoked
- Alcohol misuse screening and behavioral counseling intervention – age 19 and older
- Anemia (iron deficiency) screening – up to age 21
- Aspirin use for the prevention of cardiovascular disease – for men age 45-79 and women age 55-79 – requires a prescription
- Blood pressure screening – age 18 and older
- Cholesterol screening – all men at age 35 and older and men ages 20-35 who are at increased risk for cardiovascular disease. Women at age 45 and older and those 20-45 who are at increased risk.
- Colorectal cancer screening – age 50 and older, once every 5 years for a sigmoidoscopy and every 10 years for a colonoscopy, fecal occult blood testing annually
- Depression screening
- (Type 2) Diabetes screening for adults with sustained high blood pressure
- Diet behavioral counseling for adults with high cholesterol and other risk factors
- Gonorrhea screening – males up to age 21 and all females
- HIV screening – for those at increased risk and those up to age 21
- Lead screening – up to age 21
- Obesity screening and counseling
- Sexually transmitted infection (STI) prevention counseling for those at increased risk
- Tobacco use counseling – does not include programs or classes
- Syphilis screening for those at increased risk and those up to age 21

Immunization vaccines for adults – consult your physician for frequency:

- Diphtheria, pertussis, tetanus (DPT)
- Hepatitis A
- Hepatitis B
- Herpes zoster – age 60 and older
- Human papillomavirus (HPV) – females up to age 27
- Influenza
- Measles, mumps, rubella (MMR)
- Meningococcal
- Pneumococcal
- Travel immunizations – yellow fever, typhoid and Japanese encephalitis
- Varicella

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Covered Preventive Services for Adults *(continued)*

Additional covered preventive services for women, including pregnant women:

- Anemia (iron deficiency) screening for pregnant women
- Bacteriuria (urinary tract infection) screening for asymptomatic women
- Breast cancer screenings for women – age 40 and older and those at increased risk. Mammograms only.
- Breast cancer chemoprevention counseling – for women at increased risk
- Breast feeding interventions to support and promote breast feeding – does not include lactation classes
- Cervical cancer screening for sexually active women
- Chlamydia infection screening
- Folic acid supplements – requires a prescription
- Genetic risk assessment and BRCA (breast cancer susceptibility) mutation testing – for women with family risk of breast and ovarian cancer
- Hepatitis B screening for pregnant women
- Osteoporosis screening – age 60 and older and those at increased risk
- Rh(D) incompatibility screening for pregnant women
- Syphilis screening for those at increased risk and those up to age 21, also includes pregnant women
- Tobacco use counseling for pregnant women – does not include programs or classes

Covered Preventive Services for Infants and Children

Screenings, tests and counseling:

- Anemia (iron deficiency) screening
- Congenital hypothyroidism screening for newborns
- (Major) depression disorders screening – part of routine physical
- Fluoride supplements for children without sufficient fluoride in their water source – requires a prescription
- Gonorrhea preventive medication for the eyes of all newborns
- Gonorrhea screening
- Hearing screening for newborns – one screening in the first year of life
- HIV screening – for those at increased risk
- Iron supplements for children age 6-12 months at increased risk – requires a prescription (drops only)
- Lead screening
- Metabolic screening – up to age 2 months
- Obesity screening and counseling – age 6 and older
- Oral health risk assessment for preschool children
- Phenylketonuria (PKU) screening for genetic disorder in newborns
- Sexually transmitted infection (STI) prevention counseling for those at increased risk
- Sickle cell screening – up to 12 months
- Tuberculosis skin test
- Vision screening – up to age 5

Immunizations for children – consult your physician for frequency:

- Diphtheria, pertussis, tetanus (DPT)
- Haemophilus influenzae type b (Hib)
- Hepatitis A
- Hepatitis B
- Human papillomavirus (HPV) - females
- Inactivated poliovirus
- Influenza
- Measles, mumps, rubella (MMR)
- Meningococcal
- Pneumococcal
- Rotavirus
- Travel immunizations – yellow fever, typhoid and Japanese encephalitis
- Varicella

Are you eligible for this new coverage?

There are some criteria you must meet in order to take advantage of this new preventive coverage:

- You must have a new Regence policy that becomes effective on or after Sept. 23, 2010, or your existing policy must renew on or after that date.
- These additions to covered preventive services: (1) are not required in “grandfathered” policies, which are essentially policies in effect on March 23, 2010, as long as few or no changes are made to them (please note that Regence has chosen to retain grandfathered status for a very limited number of policies);¹ (2) may apply to grandfathered plans that have added these preventive care services; (3) may apply to retiree-only plans and; (4) apply to Association plans at the Association’s plan renewal date.
- For many plans, we will cover the preventive services at 100% (no deductibles, coinsurance or copayments) only when you see preferred or participating providers (Category 1 or Category 2).

Check your policy benefit booklet or contract for details.

What preventive services are covered?

We follow government guidelines to determine which preventive services we cover.² These guidelines are updated periodically to reflect new scientific and medical advances. New services will be covered within one year of being approved. Additionally, current services could be revised and subject to different limitations; thus benefits are subject to change. You’ll find more detailed information on these preventive services, including recommended timelines for child and adolescent immunizations, at healthcare.gov.

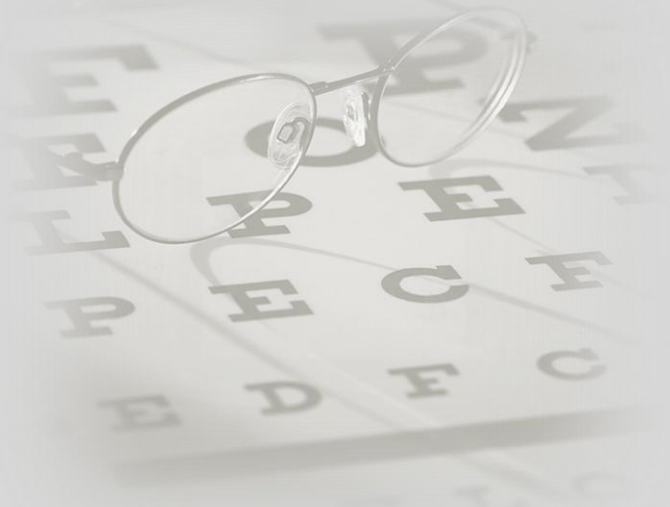
Find out if you are eligible for coverage. To learn more, call the Customer Service number on the back of your member card, or see the Contact Us link at regence.com.

¹ For group size 1-99, grandfathering does not apply.

² Evidence-based preventive guidelines are developed and validated by the following government entities: United States Preventive Services Task Force (USPSTF), Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC), and Health Resources and Services Administration (HRSA).

VISION BENEFITS – REGENCE BLUESHIELD

	<i>Preferred Provider</i>	<i>Participating Provider</i>	<i>Non-Participating Provider</i>
Basic Examination <i>-once every 12 months-</i>	100%		
Lens Allowance <i>-once every 12 months-</i> ➤ Single Vision ➤ Bifocals ➤ Trifocals	Up to \$150 PCY, Shared with Contacts and Frames		
Contact Lenses (in lieu of eyeglasses) <i>-once every 12 months-</i> ➤ Medically Necessary ➤ Elective	Up to \$150 PCY, Shared with Lenses and Frames		
Frames <i>-once every 12 months-</i>	Up to \$150 PCY, Shared with Contacts and Lenses		



DENTAL BENEFITS – UNITED CONCORDIA

	Advantage Plus Provider	Out-of-Network Provider
Calendar Year Deductible		
➤ Per Person		\$50
➤ Per Family		\$150
Calendar Year Maximum Benefit		
➤ Per Person		\$1,000

After the deductible is satisfied, benefits will be paid as follows:

	Advantage Plus Provider	Out-of-Network Provider
Diagnostic and Preventive exams, x-rays, cleanings, topical fluoride application, sealants	100% (deductible waived)	100% (deductible waived)
Basic Services fillings, extractions, oral surgery, periodontics, endodontics, space maintainers	80% (deductible applies)	80% (deductible applies)
Major Services crowns, bridges, dentures, inlays, onlays	50% (deductible applies)	50% (deductible applies)

Pre-determination Limit: A predetermination is a review in advance of treatment by Us to determine patient eligibility and coverage for planned services. Predetermination is not required to receive a benefit for any service under the Plan. However, it is recommended for extensive, more costly treatment such as crowns and bridges.

Late Enrollment Penalty: If an employee or dependent does not enroll onto the dental plan within 31 days of initially becoming eligible for coverage, late entrants will not be able to enroll onto the dental plan until the next open enrollment period.

Limitations: This benefit outline is for illustrative purposes only. Actual claims paid are subject to maximum allowable charge, frequencies, age limitations, terms and conditions of the contract.

Important Notes:

1. You may seek care from a participating dentist or any licensed; however, if you use a United Concordia dentist, there are no claim forms necessary and dentists cannot charge you for any charges above maximum allowable charges.
2. Some benefits are subject to age and/or frequency limitations. Please refer to your benefits booklet.
3. Dental enrollment is required to match medical enrollment.
4. Plan includes Preventive Incentive benefit feature - covered Class I services do not count toward the plan maximum.
5. Out-of-Network claims are reimbursed at the 99th percentile.

Dental Plan includes Davis Vision Discount program– please see flyer for more details.

LIFE & DISABILITY INSURANCE BENEFITS – UNUM



	LIFE/AD&D
Benefit Amount – All Eligible Employees	
➤ Life Insurance	1 X Base Annual Earnings
➤ Accidental Death & Dismemberment	1 X Base Annual Earnings
Benefit Maximum	\$100,000
Guarantee Issue	\$100,000
Benefits Reduce	35% at age 70; 50% at age 75; terminates at retirement
Accelerated Benefit Provision	Included

	LONG TERM DISABILITY
Monthly Benefit Amount	60% of Basic Monthly Earnings
Maximum Monthly Benefit	\$6,000
Minimum Monthly Benefit	Greater of \$100 or 10%
Elimination Period	90 days
Benefit Duration	To age 65 SSNRA
Definition of Disability	80/80% Earnings Test, own occupation to age 65 SSNRA/ADEA
Definition of Earnings	Base Salary
Pre-Existing Condition Limitation	3 month look back/12 month wait
24-Month Benefit Limitations	Applies to mental illness and self-reported conditions
Partial Disability	Included

Long Term Disability Plan includes Work-Life Assistance Program – please see flyer for more details.

Employers who pay for employees’ group life insurance must tax them on the cost of insurance for amounts exceeding \$50,000. Internal Revenue Code Section 79 requires the taxable amount to be calculated using “uniform premium” rates commonly referred to as “Table I Rates”. The Table I rates effective July 1, 1999 to current are as follows:

Cost per \$1,000 of coverage per month:

Employee’s age	Monthly Cost (per \$1,000 of benefits)
Under 25	\$0.05
25-29	0.06
30-34	0.08
35-39	0.09
40-44	0.10
45-49	0.15
50-54	0.23
55-59	0.43
60-64	0.66
65-69	1.27
70 and older	2.06





IMPORTANT INFORMATION REGARDING YOUR MEDICAL BENEFIT PLAN

PRE-EXISTING CONDITION LIMITATIONS

This health plan contains a pre-existing condition clause which excludes coverage for three (3) months from the date an individual age 19 and over enrolls on the plan or the start of an eligibility waiting period, if earlier. A pre-existing condition is a condition for which medical advice, diagnosis; care or treatment was recommended or received within the three (3) months ending on your enrollment date (which is normally your date of hire). The pre-existing condition exclusion period will be shortened one day for each day that you had creditable coverage under another health plan, provided you had no more than a three (3) month lapse in coverage immediately prior to your date of hire.

For this exclusion period to be shortened as described above, you must show proof of prior creditable coverage. You should provide your current employer with a certificate of creditable coverage from your prior plan. All plans, health insurers and health maintenance organizations are required to provide these certificates to individuals upon request. This certificate will tell your employer how long you had coverage under your prior plan and when it ended. If you have difficulty getting a certificate of coverage from your prior plan, please contact your current employer and they will attempt to assist you.

Effective for June 1, 2011 under the Affordable Care Act pre-existing condition limitations cannot be applied to any enrollee under the age of 19.

ORGAN TRANSPLANT

Benefits will be provided to an organ transplant recipient who is covered under this plan for medically necessary services related to a human organ transplant. Transplants must be pre-authorized and performed by a facility designated by Regence BlueShield. Transplants are now limited to the annual maximum with a 6-month waiting period. Members may receive credit from prior medical coverage.

WOMEN'S HEALTH AND CANCER RIGHTS ACT

The Women's Health and Cancer Rights Act of 1998 requires group health plans that provide medical and surgical coverage for mastectomies also provide coverage for reconstructive surgery following such mastectomies, in a manner determined in consultation with the attending physician and the patient.

Coverage must include:

- All stages of reconstruction of the breast on which the mastectomy has been performed,
- Surgery and reconstruction of the other breast to produce a symmetrical appearance, and
- Prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.

Benefits for the above coverage are payable on the same basis as any other physical condition covered under the plan, including any applicable deductible and/or co-pays and co-insurance amounts.

OUT-OF-AREA BENEFITS

The BlueCard Program is a unique program that enables you to access hospitals and physicians when traveling outside the four-state area Regence serves (Idaho, Oregon, Utah and Washington), as well as receive care in 200 countries around the world. Find a provider near you at www.bcbs.com or call 1 (800) 810-BLUE (2583).

SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

You may also be able to enroll yourself or your dependents in the future if you or your dependents lose health coverage under Medicaid or your state Children's Health Insurance Program, or become eligible for state premium assistance for purchasing coverage under a group health plan, provided that you request enrollment within 60 days after that coverage ends or after you become eligible for premium assistance.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, 60 days after the birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact your Human Resources Department. Refer to your benefit booklet for details.

HIPAA PRIVACY NOTICE UPDATE

The HIPAA law requires PNWU to notify its employees that a privacy notice is available from the Human Resources Department. To request a copy of PNWU's Privacy Notice or for additional information, please contact Human Resources.



IMPORTANT INFORMATION REGARDING YOUR MEDICAL BENEFIT PLAN, CONTINUED...

GRANDFATHERED STATUS

Pacific Northwest University of Health Sciences believes this plan or coverage is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan or policy may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits effective on June 1, 2011.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Human Resources. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

EXTENSION OF DEPENDENT COVERAGE TO AGE 26

Effective June 1, 2011 under the Affordable Care Act, coverage for dependent children is extended to the dependent’s 26th birthday.

Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in the Regence BlueShield plan. Individuals may request enrollment for such children for 30 days from the date of notice. Enrollment will be effective retroactively to June 1, 2011. For more information contact the Regence BlueShield listed under “Your Benefits Contacts” on the last page of this guide.

SPECIAL ENROLLMENT FOR MEMBERS WHO HAVE EXCEEDED THE PLAN LIFETIME MAXIMUM

The lifetime limit on the dollar value of benefits under the Regence BlueShield plan no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to enroll in the plan. Individuals have 30 days from the date of this notice to request enrollment. For more information contact Regence BlueShield, listed under “Your Benefits Contacts” on the last page of this guide.

PATIENT PROTECTION DISCLOSURE NOTICE

Regence BlueShield generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Regence BlueShield, listed under “Your Benefits Contacts” on the last page of this guide.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Regence BlueShield or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Regence BlueShield listed under “Your Benefits Contacts” on the last page of this guide.

MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

Offer Free or Low-Cost Health Coverage to Children and Families

If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.**

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of January 31, 2011. You should contact your State for further information on eligibility.

ALABAMA – MEDICAID

Website: <http://www.medicaid.alabama.gov>
Phone: 1-800-362-1504

ALASKA – MEDICAID

Website: <http://health.hss.state.ak.us/dpa/programs/medicaid/>
Phone (Outside of Anchorage): 1-888-318-8890
Phone (Anchorage): 1-907-269-6529

ARIZONA – CHIP

Website: <http://www.azahcccs.gov/applicants/default.aspx>
Phone: 1-877-764-5437

ARKANSAS – CHIP

Website: <http://www.arkidsfirst.com/>
Phone: 1-888-474-8275

CALIFORNIA – MEDICAID

Website:
http://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx
Phone: 1-866-298-8443

COLORADO – MEDICAID AND CHIP

Medicaid Website: <http://www.colorado.gov/>
Medicaid Phone: 1-800-866-3513
CHIP Website: <http://www.CHPplus.org>
CHIP Phone: 1-303-866-3243

GEORGIA – MEDICAID

Website: <http://dch.georgia.gov/>
Click on Programs, then Medicaid
Phone: 1-800-869-1150

IDAHO – MEDICAID AND CHIP

Medicaid Website: www.accesstohealthinsurance.idaho.gov
Medicaid Phone: 1-800-926-2588
CHIP Website: www.medicaid.idaho.gov
CHIP Phone: 1-800-926-2588

INDIANA – MEDICAID

Website: <http://www.in.gov/fssa/2408.htm>
Phone: 1-877-438-4479

IOWA – MEDICAID

Website: www.dhs.state.ia.us/hipp/
Phone: 1-888-346-9562

KANSAS – MEDICAID

Website: <https://www.khpa.ks.gov>
Phone: 1-800-766-9012

KENTUCKY – MEDICAID

Website: <http://chfs.ky.gov/dms/default.htm>
Phone: 1-800-635-2570

LOUISIANA – MEDICAID

Website: <http://www.lahipp.dhh.louisiana.gov>
Phone: 1-888-342-6207

MAINE – MEDICAID

Website: <http://www.maine.gov/dhhs/oms/>
Phone: 1-800-321-5557

MASSACHUSETTS – MEDICAID AND CHIP

Medicaid & CHIP Website: <http://www.mass.gov/MassHealth>
Medicaid & CHIP Phone: 1-800-462-1120

MINNESOTA – MEDICAID

Website: <http://www.dhs.state.mn.us/>
Click on Health Care, then Medical Assistance
Phone (Outside of Twin City Area): 1-800-657-3739
Phone (Twin City Area): 1-651-431-2670

MISSOURI – MEDICAID

Website: <http://www.dss.mo.gov/mhd/index.htm>
Phone: 1-573-751-6944

MONTANA – MEDICAID

Website:
<http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml>
Telephone: 1-800-694-3084

NEBRASKA – MEDICAID

Website: <http://www.dhhs.ne.gov/med/medindex.htm>
Phone: 1-877-255-3092

MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) (CONTINUED)

NEVADA – MEDICAID AND CHIP

Medicaid Website: <http://dwss.nv.gov/>
Medicaid Phone: 1-800-992-0900
CHIP Website: <http://www.nevadacheckup.nv.org/>
CHIP Phone: 1-877-543-7669

NEW HAMPSHIRE – MEDICAID

Website:
<http://www.dhhs.state.nh.us/DHHS/MEDICAIDPROGRAM/default.htm>
Phone: 1-800-852-3345 x 5254

NEW JERSEY – MEDICAID AND CHIP

Medicaid Website:
<http://www.state.nj.us/humanservices/dmahs/clients/medicaid/>
Medicaid Phone: 1-800-356-1561
CHIP Website: <http://www.njfamilycare.org/index.html>
CHIP Phone: 1-800-701-0710

NEW MEXICO – MEDICAID AND CHIP

Medicaid Website: <http://www.hsd.state.nm.us/mad/index.html>
Medicaid Phone: 1-888-997-2583
CHIP Website: <http://www.hsd.state.nm.us/mad/index.html>
Click on Insure New Mexico
CHIP Phone: 1-888-997-2583

NEW YORK – MEDICAID

Website: http://www.nyhealth.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – MEDICAID

Website: <http://www.nc.gov>
Phone: 1-919-855-4100

NORTH DAKOTA – MEDICAID

Website: <http://www.nd.gov/dhs/services/medicalserv/medicaid/>
Phone: 1-800-755-2604

OKLAHOMA – MEDICAID

Website: <http://www.insureoklahoma.org>
Phone: 1-888-365-3742

OREGON – MEDICAID AND CHIP

Medicaid & CHIP Website: <http://www.oregonhealthykids.gov>
Medicaid & CHIP Phone: 1-877-314-5678

PENNSYLVANIA – MEDICAID

Website: <http://www.dpw.state.pa.us/partnersproviders/medicalassistance/doingbusiness/003670053.htm>
Phone: 1-800-644-7730

RHODE ISLAND – MEDICAID

Website: www.dhs.ri.gov
Phone: 1-401-462-5300

SOUTH CAROLINA – MEDICAID

Website: <http://www.scdhhs.gov>
Phone: 1-888-549-0820

TEXAS – MEDICAID

Website: <https://www.gethipptexas.com/>
Phone: 1-800-440-0493

UTAH – MEDICAID

Website: <http://health.utah.gov/medicaid/>
Phone: 1-866-435-7414

VERMONT – MEDICAID

Website: <http://ovha.vermont.gov/>
Telephone: 1-800-250-8427

VIRGINIA – MEDICAID AND CHIP

Medicaid Website: <http://www.dmas.virginia.gov/rcp-HIPP.htm>
Medicaid Phone: 1-800-432-5924
CHIP Website: <http://www.famis.org/>
CHIP Phone: 1-866-873-2647

WASHINGTON – MEDICAID

Website: <http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm>
Phone: 1-877-543-7669

WEST VIRGINIA – MEDICAID

Website: <http://www.wvrecovery.com/hipp.htm>
Phone: 1-304-342-1604

WISCONSIN – MEDICAID

Website: <http://dhs.wisconsin.gov/medicaid/publications/p-10095.htm>
Phone: 1-800-362-3002

WYOMING – MEDICAID

Website: <http://www.health.wyo.gov/healthcarefin/index.html>
Telephone: 1-307-777-7531

To see if any more States have added a premium assistance program since January 31, 2011, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor Employee Benefits
Security Administration

www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health
and Human Services

Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Ext. 61565

CERTIFICATE OF CREDITABLE PRESCRIPTION DRUG COVERAGE

IMPORTANT NOTICE FROM PNWU ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with PNWU and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. PNWU has determined that the prescription drug coverage offered by Regence BlueShield is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from November 15th through December 31st.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

WHAT HAPPENS TO YOUR CURRENT COVERAGE IF YOU DECIDE TO JOIN A MEDICARE DRUG PLAN?

If you decide to join a Medicare drug plan, your current PNWU coverage may be affected. Your current coverage pays for other health expenses in addition to prescription drugs. If you enroll in a Medicare prescription drug plan, you and your eligible dependents may still be eligible to receive all of your current health and prescription drug benefits.

If you do decide to join a Medicare drug plan and drop your current PNWU coverage, be aware that you and your dependents may be able to get this coverage back by enrolling back into the PNWU benefit plan during the open enrollment period under the Client Name benefit plan.

WHEN WILL YOU PAY A HIGHER PREMIUM (PENALTY) TO JOIN A MEDICARE DRUG PLAN?

You should also know that if you drop or lose your current coverage with Client Name and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

FOR MORE INFORMATION ABOUT THIS NOTICE OR YOUR CURRENT PRESCRIPTION DRUG COVERAGE...

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through PNWU changes. You also may request a copy of this notice at any time.

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

FOR MORE INFORMATION ABOUT MEDICARE PRESCRIPTION DRUG COVERAGE:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Date: June 1, 2011
Name of Entity/Sender: Pacific Northwest University of Health Sciences
Contact--Position/Office: Stefanie Durand
Address: 111 University Parkway, #202 Yakima, WA 98901
Phone Number: (509) 452-5100

REMEMBER:

Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

STATEMENT OF ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, the documents governing the plan, including the insurance contract and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report, if any. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report, if any.

You have a right to continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

You have rights regarding reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for operation of the Plan. These people, called "fiduciaries" of the Plan, have a duty to operate the Plan prudently and in the interest of you and other Plan participants and beneficiaries. Fiduciaries who violate ERISA may be removed and required to make good any losses they have caused the Plan.

No one, including the Company or any other person, may fire you or discriminate against you in any way to prevent you from obtaining welfare benefits or exercising your rights under ERISA.

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan Administrator and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement, or your rights under ERISA, or if you need assistance or information regarding your rights under HIPAA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

YOUR BENEFITS CONTACTS

General Support

If you have any questions regarding your insurance plans, we suggest you first call the Customer Service numbers listed below. In the event you are unable to have your questions answered to your satisfaction, please contact a Benefits Specialist at Gallagher Benefit Services:

Benefit Specialist, All Areas	800-542-3737	
Benefit Specialist, e-mail	Askgbs-wa@ajg.com	www.gbswa.com

Medical and Vision Coverage – Regence BlueShield – Group #60004642

All Areas	888-367-2112	www.wa.regence.com
Blue Card	800-810-2583	www.bcbs.com

Dental Coverage – United Concordia – Group #8882744000

All Areas	800-332-0366	www.ucci.com
Davis Vision	877-923-2847	www.davisvision.com
		Control Code: 7602

Life/AD&D & Long Term Disability Insurance – UNUM – Group #R0094920

All Areas	800-421-0344	www.unum.com
Work-Life Assistance Program	800-854-1446	www.lifebalance.net
		User ID & Password: lifebalance

Prepared by:



Gallagher Benefit Services, Inc.

Your Benefits People

Contact us by phone: (509) 965-6000

Visit us online: www.GBSWA.com