

Summary Plan Description

***Grand Valley State University Early
Retiree Base Medical Plan***

Effective Date of Amended Plan: January 1, 2008

Claims Administrator

United Medical Resources, Inc.

P.O. Box 145804

Cincinnati, Ohio 45250-5804

513-619-3000

1-800-950-4867 Toll-Free

8:30 a.m. – 5:00 p.m. EST/EDT

<http://www.umar.com>

TABLE OF CONTENTS

<i>Table of Contents</i>	<i>i</i>
<i>Introduction</i>	<i>1</i>
Your Health Care Plan	1
Special Plan Features	1
Section 125	2
Rights and Limits	2
Medical Necessity of Services	2
Presumption of Exclusion	2
<i>Eligibility and Enrollment</i>	<i>3</i>
Eligible Employees and Effective Dates	3
Eligible Family Members and Effective Dates	3
Plan Enrollment	5
Changes in Plan Elections on a Pre-Tax Basis	5
<i>Continuation of Coverage</i>	<i>7</i>
COBRA	7
<i>Termination of Coverage</i>	<i>13</i>
<i>Coordination of Benefits and Subrogation</i>	<i>15</i>
Determining the Primary Payer	15
Coordination of Benefits and Other Plans	16
Coordination of Benefits and Medicare	17
Medicare and Limiting Charges	17
Recovery of Overpayments	18
Right to Receive and Release Necessary Information	18
Subrogation	18
Participant Agreement Obligation	20
<i>Plan Limitations and Provisions</i>	<i>23</i>
Pre-Existing Conditions	24
Detailed Description of Plan Limitations	24
Conditions for Providing Benefits	25
<i>Medical Benefits</i>	<i>27</i>
Overview of PPO/Non-PPO Option	27
Schedule of Benefits	27

Table of Contents

Detailed Description of Medical Benefits	34
Other Covered Medical Expenses	41
Care Outside the United States	43
Exclusions and Limitations — Medical	44
<i>Health Management Services and Special Provisions</i>	49
Case Management	49
Pre-Certification of Inpatient Services	49
Pre-Determination of Medical/Surgical Benefits	50
Pre-Certification of Outpatient Services	51
Employee Assistance Program	52
<i>How to File a Claim</i>	53
Timely Filing Provision	53
Hospital Claims	54
Physician Claims	54
Other Expenses	54
Submission of Claims	54
Release of Information	55
Effective Date	55
Questions	55
Claims Procedures	56
<i>Plan Administration</i>	63
Plan Administrator	63
Duties of the Plan Administrator	63
<i>Plan Information</i>	65
Plan Name	65
Plan Sponsor and Plan Administrator	65
Plan Type	65
Plan Effective Date	65
Eligible Participants	65
Claims Administrator	65
Plan Funding	65
Plan Service of Legal Process	65
Benefit Records — Calendar Year	66
Plan Records — Plan Year	66

Benefit Committee	66
Administration of Plan	66
Plan Modification, Amendment, and Termination	66
<i>HIPAA Privacy and Security</i>	<i>67</i>
Disclosure of Summary Health Information to the Plan Sponsor	67
Disclosure of Protected Health Information (PHI) to the Plan Sponsor for Plan Administration Purposes	67
Disclosure of Certain Enrollment Information to the Plan Sponsor	68
Disclosure of PHI to Obtain Stop Loss or Excess Loss Coverage	68
Disclosure of Electronic PHI to the Plan Sponsor for Plan Administration Functions	68
Other Disclosures and Uses of PHI	69
<i>Miscellaneous Information</i>	<i>71</i>
Conformity With Applicable Laws	71
Fraud	71
Headings	71
Gender and Number	71
No Waiver or Estoppel	71
Right to Receive and Release Information	71
Right of Recovery	72
<i>Plan Definitions</i>	<i>73</i>

INTRODUCTION

Your Health Care Plan

The amended *Plan* became effective January 1, 2008, and provides medical coverage for you and your eligible dependents. The *Plan*, as described in this Summary Plan Description (SPD), represents Grand Valley State University's continuing interest in helping you meet your financial responsibilities for your health care.

This SPD outlines eligibility requirements, services covered, and *Plan* limitations, as well as how to file a claim and how to find an answer when you have a question. We recommend that you read all of this SPD because many of the topics are interrelated; reading just one or two parts may result in a misunderstanding. As you review the material, please note that the words and phrases that you find in *italics* are further explained in the **PLAN DEFINITIONS** section. If you have any questions that do not appear to be covered in this SPD, please contact the *claims administrator*, United Medical Resources (*UMR*). *UMR* keeps the records of individual *Plan participants* and performs claims administration services for the *Plan*. *UMR's* address is listed at the end of this SPD.

Special Plan Features

Special features of this *Plan* are designed to help contain the ever-increasing costs of health care. These cost-effective features include:

Preferred Provider Organization (PPO)

A preferred *provider* organization, commonly known as a PPO, is a network of *hospitals* or *physicians* (or both) who have agreed to offer health care services at a reduced rate. In exchange, they receive marketing support from the PPO, generally resulting in a greater volume of patients.

The PPO plan option allows you to exercise control over the cost of your health care by choosing an in-network *provider*. For example:

- Benefits for *hospital* services, *physician* services, and other non-*hospital* services rendered by a member of the PPO are provided at a negotiated, discounted rate. These discounts translate into savings for you because your coinsurance is based on a lower dollar amount.
- Benefits for *hospital* services, *physician* services, and other non-*hospital* services rendered by a *provider* that is NOT a member of the PPO network are based on the *usual, customary, and reasonable charges*. You may receive services from an out-of-network *provider*; however, your claims will be reimbursed at a lower rate. You will be held responsible for your coinsurance **and** for any amounts over the *usual, customary, and reasonable charges*. Refer to the **MEDICAL BENEFITS** section of this SPD for specific details.

When you receive services from a PPO service *provider*, the *provider* will submit the claim to *UMR* on your behalf. Additional information about this option, as well as a list of participating *providers*, will be provided free of charge to covered *employees* and updated as needed.

Additional Features of This Plan

Additional services provided by this *Plan* include: Pre-Certification of Inpatient Services, Pre-Certification of Outpatient Services, and Pre-Determination of Benefits.

The above-referenced *Plan* features are designed to ensure that you receive the most appropriate and cost-effective treatment. These programs are described in detail in the **HEALTH MANAGEMENT SERVICES AND SPECIAL PROVISIONS** section of this Summary Plan Description.

Introduction

Section 125

This *Plan* is part of Grand Valley State University's Section 125 flexible benefits plan that allows you to elect health care coverage and pay your contributions on a pre-tax basis. This tax-saving advantage allows you to have a portion of your compensation deducted from your paycheck before your taxes are calculated. In this way, you pay for your health care coverage with pre-tax dollars, you pay less in taxes, and you take home more pay.

Rights and Limits

This SPD provides a general description of the *Plan* and your benefits. It is important to remember that:

- The description of benefits in this SPD replaces and supersedes any other SPD previously issued by Grand Valley State University for this *Plan*.
- No *Plan* provision is intended to provide *employees*, former *employees*, or *covered dependents* with a vested right to any benefits under the *Plan* or any rights for continued employment.
- Your rights, if any, to benefits of the *Plan* depend upon whether you satisfy the eligibility requirements of the *Plan* and whether your submitted claims are *covered charges* under the *Plan*.

Medical Necessity of Services

This *Plan* covers only those procedures, services, and supplies that are *medically necessary* unless otherwise specified. For a service to be *medically necessary* and covered by the *Plan*, it must be considered necessary for the diagnosis or treatment of an *illness* or *injury* and the care must be given at the appropriate level.

Presumption of Exclusion

This *Plan* provides for those expenses expressly described within, and any omission is presumed to be an exclusion.

ELIGIBILITY AND ENROLLMENT

Eligible Employees and Effective Dates

An individual must be an official retiree of Grand Valley State University to be eligible to participate in the Grand Valley State University Early Retiree Base Medical Plan. An official retiree for purposes of this *Plan* is defined as follows:

- Any regular University faculty or staff member who is or was employed by the University at the time of retirement or *disability*; and
- Who is or was vested in a University-sponsored retirement plan; and
- Whose years of service and age total a minimum of 75 at the time of his or her retirement or *disability*.

Coverage begins on the date of retirement, provided the *employee* has submitted a completed enrollment form to Human Resources within 31 days of that date.

Eligible Family Members and Effective Dates

Eligible *family* members may participate if you, the *employee*, elect *family* coverage as provided by this *Plan*.

Eligible *family* members are an *employee's* legally married *spouse* and each unmarried *dependent child* through the end of the day preceding each child's 19th birthday.

- If a *dependent child* is unmarried and is mentally or physically incapable of earning his or her own living due to permanent, chronic, and *total disability*, he or she may obtain continued coverage if, within 31 days after the date coverage would otherwise be canceled, you submit proof of your child's incapacity to *UMR*. See **ELIGIBILITY FOR DISABLED CHILDREN**.
- If a *dependent child* is an unmarried *full-time student*, he or she is eligible for *family* member benefits up to age 27. See **ELIGIBILITY OF FULL-TIME STUDENTS**.

Benefits for a *covered dependent* begin on the same date as the *employee's* benefits if the *covered dependent* is enrolled at the same time as the *employee*. See the **PLAN ENROLLMENT** section for further information.

If both parents are *employees* and are enrolled separately in this *Plan*, then each unmarried, eligible, *dependent child* may be the *covered dependent* of only one parent.

An *employee* may enroll in the *Plan* either as an *employee* or as a *covered dependent* of his or her *spouse* who is enrolled in the *Plan* with *family* coverage, but not as both.

Eligibility for Disabled Children

In order for a *disabled dependent child* to be eligible for coverage under the *Plan* after his or her 19th birthday, he or she:

- must be incapable of self-support because of mental retardation or a permanent, chronic, and *total disability* that commenced prior to age 19 (or prior to age 27 if he or she is a *full-time student*),
- must be principally supported by the *employee*, and
- must be continuously *totally disabled* and covered thereafter.

If you believe a *covered dependent* of yours meets the *total disability* criteria above, obtain a statement from the attending *physician* indicating the complete diagnosis and prognosis of the *covered dependent*.

Eligibility and Enrollment

This information must be submitted to Human Resources within 31 days of the date the *covered dependent* attains age 19 (or prior to age 27 if he or she continues as a *full-time student*). This information will be reviewed by the *Plan* to determine eligibility for continued benefits under the *Plan*. You may be required to submit additional information in connection with the eligibility determination.

You will be notified if the *covered dependent* is eligible for benefits under the *Plan* as a *disabled dependent child*. If such eligibility is approved, you may be further required, usually not more frequently than once a year, to furnish satisfactory evidence to substantiate the continued eligibility of such a *covered dependent* for benefits under the *Plan*.

Eligibility of Full-Time Students

In order for a *dependent child* to be eligible for benefits under the *Plan* as a *full-time student* after attaining age 19 up to his or her 27th birthday, he or she:

- must not be employed on a regular, full-time basis;
- must not be covered under any employee group insurance or prepayment plan other than either parent's group coverage; and
- must be enrolled full-time in a recognized course of study or training at an accredited institution such as a:
 - ◆ high school or vocational school supported or operated by the local, state, or federal government;
 - ◆ state university, college, or community college; or
 - ◆ licensed private school, college, or university.

A *covered dependent* who is a *full-time student* must submit a copy of his or her current school schedule to *UMR* once per year. Failure to do so could result in a lapse in coverage.

Coverage of a dependent who qualifies as a *full-time student* continues during a regularly scheduled vacation period or between-term period as established by the institution. Work limited to such periods is not considered employment on a regular, full-time basis.

Coverage of a dependent who no longer qualifies as a *full-time student* ceases immediately (or at the end of the summer semester, if applicable).

A *covered dependent* who is a *full-time student* may continue coverage if the *full-time student* must take a leave of absence from school due to *illness* or *injury*. Coverage may continue until the dependent ceases to require a medical leave of absence, up to 12 months from the last day of attendance of school, or until the dependent reaches the age at which coverage would otherwise terminate, whichever occurs first. To qualify for continued coverage, the student dependent's *physician* must certify in writing to the *Plan* that it is *medically necessary* for the student dependent to take a leave of absence from school. A student *dependent child* must continue to meet all other eligibility requirements for dependent coverage in the *Plan* if the child takes a leave of absence from school due to *illness* or *injury*.

Qualified Medical Child Support Orders

This *Plan* complies with all *Qualified Medical Child Support Orders (QMCSOs)*.

The *QMCSO* will require that the *Plan* cover the children even if the *employee* does not want to enroll the children in the *Plan* or wishes to drop the children's medical coverage. The *employee* is required to pay for the cost of this coverage.

Plan participants and beneficiaries may obtain, without charge, a description of the procedures governing *QMCSO* determinations from the *Plan Administrator*.

Plan Enrollment

Human Resources provides you with information about your coverage prior to the date you become eligible for coverage. Carefully review the material and complete the electronic enrollment process as instructed by Human Resources as soon as possible.

- If you or an eligible dependent makes application for coverage within 31 days of eligibility, simply complete the electronic enrollment form as instructed.
- If you or an eligible dependent wants to make application for coverage more than 31 days from the date of eligibility, you must wait until the next annual enrollment period or until you incur a change in status. (See **CHANGES IN PLAN ELECTIONS ON A PRE-TAX BASIS.**)
- **If you or your *spouse* has a newborn, the child's coverage begins the day of birth, provided you enroll the child within 31 days of that event.**
- If you or any of your *covered dependents* become covered by *Medicare* or other group coverage, notify Human Resources.

Changes in Plan Elections on a Pre-Tax Basis

Generally, you may make a change in the *Plan* options you elected at your initial enrollment **only** at the next annual enrollment period. The annual enrollment period takes place prior to the beginning of each *Plan Year*.

However, you may change your level of coverage before the next annual enrollment period if you experience a change in status. The change in coverage must be on account of and consistent with a change in status event that affects coverage eligibility of the *employee*, a *spouse*, or a dependent under an employer's plan. A change in status includes:

- marriage.
- divorce, legal separation, or annulment.
- birth, adoption, or placement for adoption of a child.
- death of a *spouse* or *dependent child*.
- termination or commencement of employment by you, your *spouse*, or your *dependent child*.
- reduction or increase in hours of employment by you, your *spouse*, or your *dependent child* (including a switch from part-time to full-time employment status or vice versa, a strike, or a lockout).
- place of residence change by you, your *spouse*, or your *dependent child* that results in a change in eligibility.
- your *dependent child* satisfies or ceases to satisfy the requirements for coverage due to attainment of age, student status, or any similar circumstance as provided in the *Plan*.
- commencement or return from an unpaid leave of absence by you, your *spouse*, or your *dependent child*.
- a change in worksite of you, your *spouse*, or your *dependent child*.
- any other change in status that the *Plan Administrator* determines will permit a change or revocation of an election during a *Plan Year* under regulations and rulings by the Internal Revenue Service.

If you experience such a change in status and wish to change your level of coverage, you must submit written notification to Human Resources within 31 days of your change in status. The *Plan Administrator*

Eligibility and Enrollment

reserves the right to require the applicant to submit proof of any change in status at the applicant's expense. The change in coverage becomes effective the first day of the first pay period following the date the written notification is received by the *Plan Administrator*, except that coverage for birth, adoption, or placement for adoption becomes effective the date of the event.

If you declined coverage when first hired, you may enroll in this *Plan* during the annual enrollment period.

CONTINUATION OF COVERAGE

COBRA

Continuation of Coverage Under COBRA

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA). COBRA continuation coverage may become available to you when you otherwise would lose your group health coverage. It may also become available to other members of your *family* who are covered under the *Plan* when they otherwise would lose their group health insurance.

Qualifying Events for Covered Employees and Family Members

COBRA provides a continuation of *Plan* coverage when coverage otherwise would end because of a qualifying event. Specific qualifying events are listed below. When you experience a qualifying event, the *Plan* must offer COBRA continuation coverage to each person who is a *qualified beneficiary*. You, your *spouse*, and your *dependent children* may become *qualified beneficiaries* if coverage under the *Plan* is lost because of a qualifying event.

Your *spouse* will become a *qualified beneficiary* if your *spouse* loses coverage under the *Plan* due to either of the following qualifying events:

- You die.
- You become divorced or legally separated from your *spouse*.

Your *dependent children* will become *qualified beneficiaries* if they lose coverage under the *Plan* due to any of the following qualifying events:

- You die.
- You and your *spouse* become divorced or legally separated.
- A child ceases to be eligible for coverage under the *Plan* as a *dependent child*.

Sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code may be a qualifying event. If a proceeding in bankruptcy is filed with respect to Grand Valley State University, and that bankruptcy results in the loss of coverage of any retiree under the *Plan*, the retiree will become a *qualified beneficiary* with respect to the bankruptcy. The retiree's *spouse* and *dependent children* will also become *qualified beneficiaries* if bankruptcy results in the loss of their coverage under the *Plan*.

COBRA Continuation Coverage Notification and Election

COBRA continuation coverage procedures include specific notice requirements for the *employer*, Grand Valley State University, for the *qualified beneficiary*, and for the *Plan Administrator*. Complete instructions on how to elect COBRA continuation coverage will be provided by the *Plan Administrator* within 14 days of receiving the notice of your qualifying event. You will then have 60 days in which to elect COBRA continuation coverage. The 60-day period is measured from the later of the date coverage terminates or the date of the notice containing the instructions. If you do not elect COBRA continuation coverage within that 60-day period, then your right to elect COBRA continuation coverage ceases. Refer to the **PROVIDING NOTIFICATION AND ELECTION NOTICES** section of this SPD for the specific name and address of where to send the notices.

Each *qualified beneficiary* will have an independent right to elect COBRA continuation coverage. Covered *employees* may elect COBRA continuation coverage on behalf of their *spouses* and *dependent children*.

Continuation of Coverage

In the event that the *Plan Administrator* determines that the individual is not entitled to COBRA continuation coverage, the *Plan Administrator* will provide to the individual an explanation as to why he or she is not entitled to COBRA continuation coverage.

Notice from a Qualified Beneficiary

The *Plan* will offer COBRA continuation coverage to *qualified beneficiaries* only after the *Plan Administrator* has been notified that a qualifying event has occurred.

The *qualified beneficiary* must notify the *Plan Administrator* when any of these qualifying events occurs:

- Divorce.
- Legal separation.
- Child's loss of dependent status.
- A second qualifying event after an individual has become entitled to COBRA continuation coverage with a maximum duration of 18 (or 29) months.

The *qualified beneficiary* must notify the *Plan Administrator* in writing by the date that is 60 days after the latest of:

- The date of the qualifying event.
- The date coverage would be lost under the *Plan*.
- The date on which the *qualified beneficiary* is informed through the SPD or general notice of his or her responsibility to provide the notice and the *Plan's* procedures for providing the notice to the *Plan Administrator*.

The following actions must then be taken:

- ◆ The *Plan Administrator* must notify the *qualified beneficiary* within 14 days after such preceding notice of his or her election rights for COBRA continuation coverage.
- ◆ The *qualified beneficiary* must then notify the *Plan* in writing within 60 days after such preceding notice if he or she wants COBRA continuation coverage. Waiver of coverage is automatic if no election is received within 60 days.

Each *qualified beneficiary* making notice to the *Plan* may obtain a qualifying event notice, free of charge, from the *Plan Administrator*, or provide his or her own notice that contains all of the required information as outlined under the **REQUIRED CONTENTS OF THE NOTICE** section of this SPD.

If you have already begun receiving COBRA continuation coverage and one of these events occurs:

- Death of covered *employee*.
- Divorce.
- Legal separation.
- Child's loss of dependent status.

The following action must be taken:

- ◆ The *qualified beneficiary* must notify the *Plan* in writing within 60 days of whether or not he or she wants COBRA continuation coverage.

In these situations, COBRA continuation coverage may be extended up to 36 months from the date of the original qualifying event.

If you have already begun receiving COBRA continuation coverage and one of these events occurs:

- Former covered *employee* gives birth.
- Former covered *employee* adopts a child.

The following action must be taken:

- ◆ The *qualified beneficiary* must notify the *Plan Administrator* of the birth or adoption within 30 days of the event.

In these situations, the former covered *employee* is entitled to add the newborn or newly adopted child to the *Plan* as a *qualified beneficiary*.

Notice from an Employer

The *Plan* will offer COBRA continuation coverage to *qualified beneficiaries* only after the *Plan Administrator* has been notified that a qualifying event has occurred.

The employer must notify the Plan Administrator when either of these qualifying events occurs:

- Death of covered *employee*.
- Commencement of *employer's* bankruptcy proceedings.

The following actions must then be taken:

- ◆ The *Plan Administrator* must notify the *qualified beneficiary* within 14 days of his or her election rights for COBRA continuation coverage. In certain cases, the preceding notice requirement may be extended to 44 days.
- ◆ The *qualified beneficiary* must respond in writing within 60 days, notifying the *Plan* if he or she wants COBRA continuation coverage. Waiver of coverage is automatic if no election is received within 60 days.

Providing Notification and Election Notices

The *qualified beneficiary* is responsible for providing the *Plan Administrator* with the qualifying event notice and election notice, in writing, either by U.S. First Class mail or hand delivery. The notice must be postmarked (if mailed) or received by the *Plan Administrator* (if hand delivered) by the deadline set forth above. If the notice is late, the opportunity to elect or extend COBRA continuation coverage will be lost. If you are electing COBRA continuation coverage, your coverage under the *Plan* will terminate on the last date for which you are eligible under the terms of the *Plan*, or if you are extending COBRA continuation coverage, such coverage will end on the last day of the initial 18-month COBRA continuation coverage period.

All qualifying event and election notices should be directed to:

Grand Valley State University
Plan Administrator
140 Lake Michigan Hall, 1 Campus Drive
Allendale, Michigan 49401-9403

Any individual who is a *qualified beneficiary* with respect to the qualifying event, or any representative acting on behalf of the *qualified beneficiary*, may provide the notice, and the provision of notice by one individual will satisfy any responsibility to provide notice on behalf of all related *qualified beneficiaries* with respect to the qualifying event.

Required Contents of the Notice

The notice must contain the following information:

Continuation of Coverage

- Name and address of the covered *employee*.
- If you are already receiving COBRA continuation coverage and wish to extend the maximum coverage period, identification of the initial qualifying event and its date of occurrence.
- A description of the qualifying event (for example, divorce, legal separation, or a *dependent child's* loss of dependent status).
- In the case of divorce or legal separation, the name(s) and address(es) of the *spouse* and *dependent child(ren)* covered under the *Plan*, the date of divorce or legal separation, and a copy of the decree of divorce or legal separation.
- In the case of a *dependent child's* cessation of dependent status under the *Plan*, the name and address of the child and the reason the child ceased to be an eligible dependent (for example, attainment of limiting age, loss of student status, or marriage).
- In the case of the death of a covered *employee*, the date of death and the name(s) and address(es) of the *spouse* and *dependent child(ren)* covered under the *Plan*.
- A certification that the information is true and correct, a signature, and the date of the signature.

If you cannot provide a copy of the decree of divorce or legal separation by the deadline for providing the notice, complete and provide the notice, as instructed, by the deadline and submit the copy of the decree of divorce or legal separation within 30 days after the deadline. The notice will be considered timely if you do so. However, no COBRA continuation coverage, or extension of such coverage, will be available until you provide the copy of the decree of divorce or legal separation.

If the notice does not contain all of the required information, the *Plan Administrator* may request additional information. The *Plan Administrator* may reject the notice if the individual fails to provide such information within the time period specified by the *Plan Administrator* in the request, or if it does not contain enough information for the *Plan Administrator* to identify the *Plan*, the covered *employee*, the *qualified beneficiaries*, the qualifying event, and the date on which the qualifying event occurred.

COBRA Continuation Coverage and Cost

COBRA continuation coverage is identical to the coverage provided to similarly situated beneficiaries who are covered under the *Plan*. In addition, the *Plan* requires the *qualified beneficiary* to pay the full cost of COBRA continuation coverage and an administrative fee. The total charge may not exceed 102% of the cost of the *Plan* for similarly situated *Plan participants* for whom such a qualifying event has not occurred. The monthly payments are due the first day of each month that COBRA continuation coverage is available and requested. Payments are to be made to Grand Valley State University and forwarded to *UMR*.

COBRA Continuation Coverage and Timely Payment

Timely payment is payment that is made to the *Plan* by the date that is 30 days after the first day of that period. Payment that is made to the *Plan* by a later date is also considered timely payment if either under the terms of the *Plan*, covered *employees* or *qualified beneficiaries* are allowed until that later date to pay for their coverage for the period, or under the terms of an arrangement between the *employer* and the entity that provides *Plan* benefits on the *employer's* behalf, the *employer* is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Once you elect COBRA continuation coverage, you must pay for the cost of the initial period of coverage within 45 days. Payments are then due on the first day of each month in order to continue coverage for that month. If a payment is not received within 30 days of the due date, COBRA continuation coverage

will be canceled and will not be reinstated. Payment is considered made on the date on which it is sent to the *Plan*.

If timely payment is made to the *Plan* in an amount that is not significantly less than the amount the *Plan* requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the *Plan*'s requirement for the amount to be paid, unless the *Plan* notifies the *qualified beneficiary* of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a timely payment is not significant if it is no greater than the lesser of \$50 or 10% of the required amount.

COBRA Continuation Coverage Period

COBRA continuation coverage will be available up to the maximum time period shown in the following table. Generally, multiple qualifying events that may be combined under COBRA will not result in continuation coverage for more than 36 months beyond the date of the original qualifying event.

Qualifying Event	Continuation Coverage Period
Covered <i>employee's</i> death Divorce Legal separation	up to 36 months, for the <i>spouse</i> and <i>dependent child(ren)</i>
Child's loss of dependent status	up to 36 months, for the <i>dependent child</i>
Special note: In the event of multiple qualifying events, in some cases continuation coverage may be extended up to 36 months measured from the date of the first qualifying event.	

Extended COBRA Continuation Coverage

There are two ways in which the 18-month period of COBRA continuation coverage may be extended.

Disability Extension

If you or any covered *family* member is determined by the Social Security Administration to be *disabled* and you notify the *Plan Administrator* as set forth above, you and your entire *family* may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The *disability* must begin before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. An extra fee will be charged for this extended COBRA continuation coverage.

Second Qualifying Event Extension

If your *family* experiences another qualifying event while receiving 18 months of COBRA continuation coverage, your *spouse* and *dependent child(ren)* may receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months. Proper notice of the second qualifying event must be given to the *Plan* as set forth above. This extension may be available to the *spouse* and any *dependent child(ren)* receiving COBRA continuation coverage if the covered *employee* dies or gets divorced or legally separated, or if a *dependent child* loses eligibility under the *Plan* as a *dependent child*, but only if the event would have caused the *spouse* or *dependent child* to lose coverage under the *Plan* had the first qualifying event not occurred.

Termination of Continuation Coverage Under COBRA

The *Plan* is not required to provide continuation coverage if:

- The *Plan Sponsor* ceases to provide any group health plan to its *employees*.

Continuation of Coverage

- The *qualified beneficiary* with COBRA continuation coverage fails to make timely payment of any contributions due.
- The *qualified beneficiary* with COBRA continuation coverage reaches the maximum time period for his or her qualifying event.
- The *qualified beneficiary* with COBRA continuation coverage becomes covered under another group health plan, except as stated under COBRA's special bankruptcy rules.
 - ◆ However, continuation coverage terminates only if the *Plan participant's* amount of creditable coverage meets the pre-existing conditions limitation of the new plan. You may be able to maintain your continuation coverage, at your expense, for benefits related to a pre-existing condition, as excluded by the new group health plan.

If a *disabled qualified beneficiary* recovers from his or her *disability* before the end of the 29-month period, COBRA that has been extended due to the special *disability* extension may be terminated. COBRA coverage may be terminated as of the month that begins more than 30 days after a final determination under the Social Security Administration that the individual is no longer *disabled*. This will terminate not only the *disabled* individual's COBRA continuation coverage, but also that of all non-*disabled qualified beneficiaries* who are entitled to a *disability* extension due to that *disabled* individual's status.

Trade Act of 2002

Two provisions under the Trade Act of 2002 may affect benefits under COBRA. First, certain eligible individuals who lose their jobs due to international trade agreements may receive a 65% tax credit for premiums paid for certain types of health insurance, including COBRA continuation coverage premiums. Second, eligible individuals under the Trade Act who do not elect COBRA continuation coverage within the election period will be allowed an additional 60-day period to elect COBRA continuation coverage. If a *qualified beneficiary* elects COBRA continuation coverage during this second election period, the coverage period will run from the beginning date of the second election period. Consult the *Plan Administrator* if you believe the Trade Act applies to you.

Current Addresses

In order to protect your *family's* rights, keep the *Plan Administrator* informed of any changes to the addresses of *family* members.

Additional Information

Additional information about the *Plan* and COBRA continuation coverage is available from the *Plan Administrator*.

TERMINATION OF COVERAGE

You and your *covered dependents* are no longer eligible for coverage effective the day any one of the following events occurs:

- You become eligible for *Medicare*.
- Your status as an eligible retiree changes.
- The *Plan* is amended to make your classification ineligible.
- The *Plan* terminates.
- You cease making the required contributions for the *employee* and/or *covered dependent* and the last period for which you made a required contribution has expired.
- You join any *military service* covered by USERRA.
- You or your *covered dependents* defraud or attempt to defraud the *Plan*.

In addition, *covered dependents* are no longer eligible for coverage effective the day any one of the following events occurs:

- Your *covered dependent* other than your *spouse* becomes eligible for benefits as an eligible *employee* of Grand Valley State University.
- Your benefits discontinue.
- Your *covered dependent* no longer meets conditions for eligibility (e.g., ceases to be dependent upon you for principal support, reaches the age limit, etc.). See **ELIGIBILITY AND ENROLLMENT**.
- You get divorced or legally separated such that your *covered spouse* is no longer eligible for coverage.
- The *Plan* is amended to make the dependent classification ineligible.
- You cease making the required contributions for the *employee* and/or *covered dependent* and the last period for which you made a required contribution has expired.
- Your *covered dependent* joins the military.
- You die.
- You become eligible for *Medicare*.

Continuation of benefits may be available. See **CONTINUATION OF COVERAGE**.

COORDINATION OF BENEFITS AND SUBROGATION

Coordination of benefits (COB) is a feature of this *Plan* that prevents duplicate payment of *covered charges* if a *Plan participant* is covered under more than one benefits program. In order to ensure that you receive the maximum benefits if you have duplicate coverage, always present both ID cards and take the claim forms (if required) from both benefits programs when you receive a service.

COB determines which benefit plan is the primary payer (which plan pays first), and specifies how much is paid.

Determining the Primary Payer

Several rules are used to determine which benefit plan is the primary payer (or primary carrier) if a person is covered by more than one plan. The rules for primary payer are applied in the following order:

- A benefits plan that does not have a COB feature is always the primary payer.
- In the event of a motor vehicle accident, this *Plan* is not primary. The other plan may include, but may not be limited to, auto medical insurance coverage, no-fault coverage, casualty coverage, or liability insurance.
- A benefits plan that covers the patient as an employee is the primary payer and pays before a plan that covers the patient as a dependent.
- A benefits plan that covers the patient as an active employee is the primary payer and pays before a plan that covers the patient as an inactive employee.
- If a child is covered under both parents' plans, the plan covering the parent whose **birthday** occurs earlier in the year pays before the plan covering the other parent.
- If the child's parents are divorced, separated, or not married, the primary payer is determined in the following order:
 - ◆ The plan of the parent who by court order or agency ruling is responsible for the child's health care expenses is the primary payer.
 - ◆ If there is no decree, the plan that covers the child as a dependent of the custodial parent is the primary payer. The plan of the non-custodial parent is secondary.
 - ◆ If there is no decree, the custodial parent's plan is the primary payer, and if the custodial parent remarries, the plan of the custodial parent's *spouse* is secondary. The plan of the non-custodial parent is tertiary.
 - ◆ If the parents have joint custody of the child, the plan covering the parent whose **birthday** occurs earlier in the year pays before the plan covering the other parent.
 - ◆ For purposes of this COB provision, if there is no decree, "custody" will be determined based upon which parent may claim the child as an IRS dependent.
- If none of the above rules apply, the plan covering the *Plan participant* for the longer period of time pays before the plan covering the *Plan participant* for the shorter period of time.

If this *Plan* is secondary and you receive duplicate payment from the *Plan* and another health benefits plan, the *Plan* will collect that duplicate payment from you.

When This Plan Is Secondary

The following may help you understand how COB works.

Coordination of Benefits and Subrogation

- As secondary payer, this *Plan* pays benefits after your primary plan has paid.
- This *Plan* will never pay more as the secondary plan than it would have paid if it had been the primary plan.
- You will never be reimbursed more than the allowable charges of this *Plan*. (Allowable charges exclude such items as services not covered by this *Plan*, charges over *UCR*, and the discounts that are obtained through a PPO.)

With COB, this *Plan*'s benefits are paid up to the **allowable level of this *Plan***. This means that when you submit a claim for a charge for which this *Plan* is determined to be the secondary payer, this *Plan* pays the lesser of either the *Plan*'s allowable benefit or the *Plan*'s allowable charges less any amount the primary plan or carrier paid.

In the following example, this *Plan* pays the benefit of this *Plan* because the allowable charges less the amount paid by the primary plan (\$950) are greater than the benefit of this *Plan* (90% of the allowable charges or \$900).

Example 1 <i>(assumes deductibles have been met)</i>	
Amount Billed by Hospital	\$1200
Less PPO Discount	-200
Allowable Charges Under This Plan	\$1000
Less Amount Paid by Primary Plan	-50
Amount Submitted to This Plan	\$ 950
This Plan Pays the maximum benefit of this Plan, which is \$900.	\$ 900

In the following example, this *Plan* pays the allowable charges less any amount the primary carrier paid. This amount is less than the benefit of this *Plan*, and therefore your *hospital* bill will be paid in full.

Example 2 <i>(assumes deductibles have been met)</i>	
Amount Billed by Hospital	\$1200
Less PPO Discount	-200
Allowable Charges Under This Plan	\$1000
Less Amount Paid by Primary Plan	-720
Amount Submitted to This Plan	\$ 280
This Plan Pays the difference between the allowable charges and the amount paid by the primary plan.	\$ 280

Coordination of Benefits and Other Plans

The COB provision applies to other benefit plans. These plans include:

- group, blanket, or franchise insurance coverage;
- BlueCross, BlueShield, or other prepayment coverage;
- coverage under a labor-management trusted plan;

- any union welfare plan;
- an employer organization plan or employee benefit organization plan;
- coverage under any law, including any federal, state, or other governmental plan or law, toward the cost of which any employer has made payroll deductions; and
- coverage under any plan solely or largely tax-supported or otherwise provided for, by, or through action of any government.

The *Plan* provides benefits related to health care services *incurred* as a result of an automobile accident on a secondary basis only. Benefits payable under the *Plan* will be coordinated with and secondary to benefits provided or required by any automobile insurance statute (whether or not a no-fault policy is in effect) and/or other automobile insurance.

Injuries Resulting from a Motor Vehicle Accident

Michigan Residents: This *Plan* excludes charges *incurred* for medical costs with respect to any accidental bodily *injury* that arises out of the ownership, operation, maintenance, or use of a motor vehicle as a motor vehicle within the meaning of Section 3105 of the Michigan No-Fault Statute. This exclusion applies regardless of where no-fault benefits are actually paid to the eligible member.

Michigan no-fault insurance provides medical coverage for *injuries* as a result of a motor vehicle accident.

In Michigan it is illegal to operate a motor vehicle without no-fault insurance.

Residents in All Other States: This *Plan* excludes charges *incurred* for medical costs with respect to accidental bodily *injury* involving an automobile to the extent of personal *injury* protection coverage applicable to you for those *injuries*. If auto insurance coverage is in effect, the auto coverage will be primary. This *Plan* will pay after all other available medical coverage has been exhausted.

Coordination of Benefits and Medicare

Plan Participants with Permanent Kidney Failure

Medicare is a secondary payer to an *employer's* group health plan for up to 30 months for beneficiaries who have *Medicare* solely because of permanent kidney failure. At the end of the 30-month period, *Medicare* becomes the primary payer until your *Medicare* coverage for permanent kidney failure ends. For further information check with your nearest Social Security office or the *Medicare* insurance carrier in your area.

Plan Participants Under Age 65 with Disabilities

Medicare may be a secondary payer for people under age 65 who are entitled to *Medicare* based on *disability* and who have large group health plan coverage. For further information check with your nearest Social Security office or the *Medicare* insurance carrier in your area.

Medicare and Limiting Charges

When *Medicare* is the primary or secondary payer for a *Plan participant*, the *Plan* specifically limits coverage of *Medicare* balance bills to the limiting charge amounts. Generally, a *provider* who has not accepted assignment may not charge more than 115% of the *Medicare*-approved amount. This is considered the limiting charge.

Coordination of Benefits and Subrogation

Recovery of Overpayments

Occasionally, health care benefits are paid more than once, are paid based on improper billing, or are not paid according to the *Plan's* terms, conditions, limitations, or exclusions. Whenever the *Plan* pays health care benefits exceeding the amount of benefits payable under the terms of the *Plan*, the *Plan Administrator* has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from the *Plan participant* on whose behalf such payment was made.

A *Plan participant*, a health care service *provider*, another health benefit plan, an insurer, or any other person or entity who receives a payment for health care expenses exceeding the amount of benefits payable under the terms of the *Plan* or on whose behalf such payment was made, must return the amount of such erroneous payment to the *Plan* within 30 days of discovery or demand. The *Plan Administrator* will have no obligation to secure payment for the health care expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another health care expense. The *Plan Administrator* will have the sole discretion to choose who will repay the *Plan* for an erroneous payment and such payment will be reimbursed in a lump sum or deducted from future claims presented for processing.

Health care service *providers* and any other person or entity accepting payment from the *Plan*, in consideration of such payments, agree to be bound by the terms of this *Plan* and agree to submit claims for reimbursement in strict accordance with their states' health care practice acts, ICD-9 or CPT standards, *Medicare* guidelines, HCPCS standards, or other standards approved by the *Plan Administrator* or insurer. Any payments made on claims for reimbursement not in accordance with the above provisions must be repaid to the *Plan* within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If court action is necessary to recover any erroneous payment, the *Plan* will be entitled to recover its litigation costs and actual attorneys' fees incurred.

Right to Receive and Release Necessary Information

For the purpose of determining the applicability of, and implementing the terms of, this COB provision or any provision of similar purpose of any other plan, this *Plan* may, without the consent of or notice to any person, release to or obtain from any insurance company, or other organization or individual, any information with respect to any person that the *Plan* deems to be necessary for such purposes. Any person claiming benefits under this *Plan* must furnish to the *Plan* such information as may be necessary to implement this provision.

Subrogation

This *Plan* reserves all rights of subrogation. This means that the *Plan* has the right to recover its previously paid benefit payments from any award, settlement, or damages that you or your *covered dependents* may receive or to which you may become entitled. It also means that the *Plan* has the right to assert your rights (take action on your behalf) to obtain an award, settlement, or damages. The most common situations involving subrogation are auto accidents, but others include medical malpractice, *accidental injuries*, negligence, defective products, etc.

IMPORTANT NOTE: You must immediately notify the *Plan Administrator* whenever an *injury* or *illness* arises as a result of an accident, a person's negligence, or any other circumstance that may entitle you or your *covered dependent* to an award, settlement, or damages.

Right to Recover Benefit Payments

The *Plan* will have the first lien upon all awards, settlements, or damages subject to its subrogation or reimbursement rights listed below. This lien will be in the amount of benefits provided or the amount of

benefits that will be provided under the *Plan*, plus the reasonable expenses, including attorneys' fees, to enforce the *Plan's* rights.

- The *Plan* has the right to recover payments it has made for benefits.
- The *Plan* has the right to recover payments it has made for benefits to or on behalf of you or your *covered dependents* from any award, settlement, or damages to which you or your *covered dependents* may become entitled or that you may receive as a result of an accident, a person's fault or negligence, or any other circumstance under which you or your *covered dependent* has the right to recover from any other party.
- The *Plan* may recover its benefit payments for any type of benefit that may be paid by the *Plan*, such as medical, dental, vision, mental, *disability*, supplemental accident, or accidental death or dismemberment benefits.
- An "award, settlement, or damages" includes any award, settlement, damages (whether equitable, legal, compensatory, etc.), compensation, benefits, or any other payment of any kind. The amount may be paid by formal court award, informal compromise, redemption agreement, application for benefits, or otherwise. The amount also may be paid in a lump sum, installment, or annuity payments (such as income replacement). The *Plan* has the right to recover from all of these amounts.
- An "award, settlement, or damages" includes amounts of any type, kind, nature, or character, regardless of whether the amount identifies or covers the *Plan's* benefit payments, otherwise relates to medical benefits, or is specifically limited to certain kinds of damages or payments. For example, if you receive an award, settlement, or damages solely for pain and suffering, the *Plan* is still entitled to recover its benefit payments from such amount. In addition, attorneys' fees or any other costs associated with the amount will not reduce the amount of the *Plan's* reimbursement. **This *Plan* has the first priority to recover from your award, settlement, or damages.** The *Plan's* first priority lien also will apply regardless of whether you or your *covered dependent* is or was made whole from the award, settlement, or damages, whether before or after the *Plan's* subrogation recovery. This *Plan* precludes the operation of the "made-whole" and "common fund" doctrines.
- Your "right to recover" from any other party means that you or your *covered dependent* has the right to recover damages or expenses from another party, such as an individual, partnership, corporation, government, or other entity, as well as against that party's respective insurance carriers or governmental fund, for causing an *injury* or *illness* to you or your *covered dependent* or otherwise with respect to any *injury* or *illness incurred* by you or your *covered dependents*. This right to recover from any other party also includes your own insurance carrier, such as your automobile insurance, automobile no-fault coverage, homeowners insurance, personal accident coverage, general liability insurance, or life insurance carrier. It also includes a second medical insurance or other non-insured medical or other coverage. It also includes uninsured and underinsured motorist coverage or programs. The *Plan* has the right to recover from any of these parties, or any other parties, in connection with your *illness* or *injury*.

In the event you or your *covered dependent* is entitled to or receives an award, settlement, or damages from any party (including the other party's or your own insurance carrier or coverage), the *Plan* has the first lien upon the award, settlement, or damages and must be reimbursed for its benefit payments made to you or your *covered dependent*, or on your behalf. The *Plan's* first lien supersedes any right that the *Plan participant* may have to be "made whole." In other words, the *Plan* is entitled to the right of first reimbursement out of any award, settlement, or damages the *Plan participant* procures or may be entitled to procure regardless of whether the *Plan participant* has received compensation for any of his or her damages or expenses, including any of his or her attorneys' fees or costs. The *Plan* has a right to any full or partial recovery of any and all amounts paid by it on the *Plan participant's* behalf. The *Plan* will be accorded priority over the *Plan participant* as to any funds recovered. Additionally, the *Plan's* right of

Coordination of Benefits and Subrogation

first reimbursement will not be reduced for any reason, including attorneys' fees, costs, comparative negligence, limits of collectibility or responsibility, or otherwise. As a condition to receiving benefits under the *Plan*, the *Plan participant* agrees that acceptance of benefits is constructive notice of this provision.

Reimbursement to the *Plan* must be made immediately upon entitlement or receipt of any award, settlement, or damages. The *Plan* will charge interest at a reasonable rate for any delay in reimbursement.

Right to Assert Claims on Your Behalf

The *Plan* has the right, if it so chooses, to assert rights on your behalf to obtain an award, settlement, or damages. Specifically, through subrogation, the *Plan* is entitled to all claims, demands, actions, and rights of recovery that you or your *covered dependent* may have against or from any party (including the other party's or your own insurance carriers) to the extent of the *Plan's* benefit payments. In addition, this *Plan* is entitled to attorneys' fees incurred in asserting rights on your behalf.

The *Plan* does not require you or your *covered dependents* to pursue a claim against another party. However, as stated above, the *Plan* reserves the right to directly pursue recovery against another party on your behalf, should you or your *covered dependent* elect not to pursue an award, settlement, or damages against or from a party.

Miscellaneous Subrogation

You, your *covered dependents*, your attorneys, or anyone acting on your behalf legally cannot do anything to prejudice the rights of the *Plan* in the exercise of its subrogation rights to recover from, or assert your rights to obtain, an award, settlement, or damages.

The *Plan's* subrogation rights also extend to the guardian or estate of you and your *covered dependents*. The *Plan's* subrogation provisions will apply without limitation by the *Plan's* coordination of benefits provisions, unless the COB provisions would result in a greater recovery for the *Plan*.

Participant Agreement Obligation

As a condition to participating in the *Plan* and receiving benefits under the *Plan*, you and your *covered dependents* agree to be bound by all of the *Plan's* provisions, including, but not limited to, the *Plan's* subrogation provisions. The *Plan* will make benefit payments on a claim on the condition that you or your *covered dependent*, upon entitlement or receipt of any award, settlement, or damages, will fully reimburse the *Plan* for the *Plan's* benefit payments and for expenses (including attorneys' fees and costs of suit, regardless of an action's outcome) incurred by the *Plan* in collecting this amount.

As a precondition to receiving benefits under the *Plan*, you and your *covered dependents* must enter into agreement with the *Plan* to reimburse the *Plan* for its benefit payments from any award, settlement, or damages pursuant to the *Plan's* subrogation provisions. In this agreement, you also must agree to assign direct payment to the *Plan* from any award, settlement, or damages to the extent of the *Plan's* benefit payments. You and your *covered dependents* also otherwise must sign and deliver any and all instruments, papers, and reimbursement agreements required by the *Plan* necessary for the *Plan's* reimbursement right. You and your *covered dependents* also are required to do whatever is requested or necessary in order to fully execute and to fully protect all the *Plan's* rights and to do nothing that would interfere with or diminish those rights. Further, you and your *covered dependents* must notify the *Plan* in writing of any proposed settlement and obtain the *Plan's* written consent before signing any release or agreeing to any settlement. In any event, the *Plan's* benefit payments for any current or historical claims under the *Plan* on your behalf will be deemed to be the equivalent of you or your *covered dependent* entering into an agreement to reimburse the *Plan* and otherwise signing and delivering any instruments and papers as required by the *Plan*.

In the event that you or your *covered dependents* fail to enter into the foregoing agreement, or otherwise to comply with such requests, the *Plan* is entitled to withhold or deny benefits otherwise due under the *Plan* until you do so.

When a Plan Participant Retains an Attorney

A *Plan participant* or his or her attorney who receives any recovery (whether by award, settlement, damages, compromise, or otherwise) has an absolute obligation to immediately tender the recovery to the *Plan* under the terms of this provision. A *Plan participant* or his or her attorney who receives any such recovery and does not immediately tender the recovery to the *Plan* will be deemed to hold the recovery in constructive trust for the *Plan*, because the *Plan participant* or his or her attorney is not the rightful owner of the recovery and should not be in possession of the recovery until the *Plan* has been fully reimbursed.

When a Plan Participant Does Not Comply

When a *Plan participant* does not comply with the provisions of this section, the *Plan Administrator* will have the authority, at its sole discretion, to deny payment of any claims for benefits by the *Plan participant* and to deny or reduce future benefits payable (including payment of future benefits for other *injuries* or *illnesses*) under the *Plan* by the amount due as reimbursement to the *Plan*. The *Plan Administrator* may also, at its sole discretion, deny or reduce future benefits (including future benefits for other *injuries* or *illnesses*) under any other group benefits plan maintained by the *Plan Sponsor*. The reductions will equal the amount of the required reimbursement. If the *Plan* must bring an action against a *Plan participant* to enforce this provision, then that *Plan participant* agrees to pay the *Plan's* attorneys' fees and costs, regardless of the action's outcome.

PLAN LIMITATIONS AND PROVISIONS

Deductibles		
	PPO	Non-PPO
Per Individual	\$250 per calendar year	\$500 per calendar year
Per Family	\$500 per calendar year	\$1000 per calendar year

Out-of-Pocket Maximums		
	PPO	Non-PPO
Per Individual	\$1000 per calendar year	\$2500 per calendar year
Per Family	\$2000 per calendar year	\$5000 per calendar year

Excludes:

- Deductibles
- Amounts over the usual, customary, and reasonable charges (UCR)
- Penalties incurred for non-compliance with the Pre-Certification of Inpatient Services Program
- Penalties incurred for non-compliance with the Pre-Certification of Outpatient Services Program
- Coinsurance for inpatient and/or outpatient mental health care and/or substance abuse care
- Co-payments for prescription drugs
- Flat dollar co-payments
- Exclusions and Limitations — Medical

Remember, to obtain specific benefits you must comply with the Pre-Certification Programs as outlined in the HEALTH MANAGEMENT SERVICES AND SPECIAL PROVISIONS section.

Lifetime Maximums	
Per Individual	\$1,000,000 per Plan Participant All Services, While Enrolled in the Plan
	365 days for Inpatient Mental Health Care and Inpatient Substance Abuse Care combined
	\$1000 for Non-Surgical Services Related to Temporomandibular Joint Syndrome

Annual Maximums (Per Calendar Year)	
Per Individual	60 days for Inpatient Mental Health Care and Inpatient Substance Abuse Care combined
	20 visits for Outpatient Mental Health Care
	State of Michigan mandated amount for Outpatient Substance Abuse Care
	\$600 for Chiropractic Care and Osteopathic Manipulation Therapy
	120 days of Extended Skilled Nursing Facility Care

Plan Limitations and Provisions

Annual Maximums (Per Calendar Year)	
	Routine Preventative Care or Well Baby Care (including nutritional counseling and health education counseling such as diabetic education, wellness, office visits, and all routine laboratory and X-ray charges)
	PPO
	<ul style="list-style-type: none"> • \$1500 Birth to 2 years • \$400 Age 2 through 39 years • \$800 Age 40 and over
	Non-PPO
	<ul style="list-style-type: none"> • \$400
	3 Surgical Brassieres following Mastectomy
	3 Pairs of Compression Stockings prescribed for Vascular Conditions

Other Maximums	
Per Individual	60 visits per period for Home Health Care Nursing Visits (a period begins the day following discharge from the hospital)
	60 visits per period of Private Duty Nursing – inpatient or home (a period begins the day following discharge from the hospital)
	1 Routine Ultrasound Test associated with Pregnancy (unless additional are required due to medical necessity)

Pre-Existing Conditions

This *Plan* does not limit benefits relative to a *Plan participant's* pre-existing condition.

Detailed Description of Plan Limitations

Deductibles

The medical deductibles are the amounts you must pay first each calendar year before this *Plan* pays benefits. The deductibles apply to each *Plan participant* and are listed at the beginning of this section.

The deductible applies to each covered member of a *family*. However, when *family* members *incur* any combination of *covered charges* totaling the *family* deductible in any calendar year (as long as no one person contributes more than his or her individual amount), then the deductible amount is considered satisfied for your entire *family*.

Any payments for *covered charges* that are used to help satisfy the deductible under the PPO portion of the *Plan* are also used to satisfy the deductible under the non-PPO portion of the *Plan*, and vice versa.

Coinsurance

Coinsurance is the amount you must pay for each service before the *Plan* pays benefits. This is a percentage of the eligible benefit that is not covered by the *Plan*. For example, for those benefits for which the *Plan* pays 90%, you are responsible for the 10% coinsurance.

Co-Payments

A co-payment is a flat dollar amount you must pay for certain services before the *Plan* pays benefits. For example, for some services, you must first make a \$20 co-payment, and the *Plan* then covers the

remainder of your eligible expenses for those services at 100% of the PPO rate or the *UCR*. You must make a \$20 co-payment each time you receive those services.

Out-of-Pocket Maximum

This *Plan* has an out-of-pocket maximum feature that helps limit the amount of money you must pay for *covered charges* in any one calendar year. This means that once you have reached the out-of-pocket maximum, this *Plan* covers subsequent eligible charges at 100% of the PPO negotiated rate or the *UCR* for the remainder of the calendar year. This feature helps ensure that the amount you must pay out-of-pocket for eligible benefits remains a manageable amount. The out-of-pocket maximums apply to each *Plan participant* and are listed at the beginning of this section.

The out-of-pocket maximum applies to each covered member of a *family*. However, when *family* members *incur* any combination of *covered charges* totaling the *family* out-of-pocket maximum in any calendar year (as long as no one person contributes more than his or her individual amount), then the out-of-pocket maximum is considered satisfied for your entire *family*.

Any payments for *covered charges* that are used to help satisfy the out-of-pocket maximum under the PPO portion of the *Plan* are also used to help satisfy the out-of-pocket maximum under the non-PPO portion of the *Plan*, and vice versa.

The out-of-pocket maximum does not include items listed in the **OUT-OF-POCKET MAXIMUMS** table at the beginning of this section.

Lifetime and Annual Maximums

The *Plan* provides a cumulative maximum of \$1 million for each person covered by the *Plan* while he or she is enrolled in the *Plan*. After the lifetime maximum has been reached for any *Plan participant*, no additional benefits will be paid by this *Plan* for that *Plan participant*.

Once the lifetime maximum for a specific, listed service has been reached, no additional benefits will be paid for that service for that *Plan participant*.

Annual maximums are calculated on a calendar year basis as listed at the beginning of this section. Once the annual maximum for a listed service has been reached, no additional benefits will be paid during the remainder of the calendar year for that service for that *Plan participant*.

Conditions for Providing Benefits

Medical benefits are provided at the PPO negotiated rate when you use a PPO *provider*, or on the basis of *usual, customary, and reasonable (UCR) charges* when you use a non-PPO *provider*, based on what is usually and customarily accepted as payment for the same service within a geographic area, as determined by the *Plan*.

Benefits are provided only for covered services recommended by a *physician* who is a member of the medical staff or acceptable to the *hospital* or *ambulatory care center* selected by the *Plan participant*.

The *Plan participant* may select any *hospital* or *ambulatory care center* that meets the criteria described in the definition of that type of facility. All services furnished are subject to the rules and regulations of the facility.

Usually, benefits under this *Plan* are paid directly to the *provider* rendering the service, unless you provide itemized bills indicating that the charges have been paid in full. In that case, allowable benefits are paid to the *Plan participant*.

In making a decision on claims involving services, supplies, or days of care that are determined by the *Plan* to be medically unnecessary, the *Plan* reserves the right to obtain advisory opinions from consultant(s) of its choice. On reconsideration of denied claims for this reason, the *Plan* further reserves the right to refer such cases to the appropriate peer review committee.

MEDICAL BENEFITS

Overview of PPO/Non-PPO Option

If you use a *provider* who is a member of the PPO network, most benefits are paid at 90% of the PPO negotiated rate, subject to the deductible. You are responsible for the deductible and for the 10% coinsurance. In the case of some services provided by a PPO network *provider*, you are responsible for the applicable co-payment. Benefits are then paid at 100% of the PPO negotiated rate.

If you use a *provider* who is **not** a member of the PPO network, most benefits are paid at 70% of *UCR*, subject to the deductible. You are responsible for the deductible, for the 30% coinsurance, **and** for any amount in excess of the *UCR*.

Services that are covered by this *Plan* and are not available through a network *provider* are paid at the PPO benefit percentage of *UCR*, subject to the in-network deductible, even when the service is provided by an out-of-network *provider*.

Services provided at a network *hospital* either on an inpatient or outpatient basis, by an out-of-network *provider*, are paid according to the PPO/Non-PPO option, if the patient has a choice of *providers*. If the patient has no choice of *providers*, benefits are paid at the PPO benefit percentage of *UCR*, subject to the in-network deductible.

Some PPO *hospitals* have arrangements through which the patient is billed more than the actual charges, e.g., per diem or diagnosis-related group (DRG) charges. When this occurs, the *Plan* pays 100% of these excess charges.

You may obtain information regarding participating PPO *providers*, without charge, through the *claims administrator's* Website at <http://www.umn.com>. If you have any questions, contact Human Resources.

Each *Plan participant* has a free choice of any *physician* or surgeon, and the *physician-patient* relationship will be maintained. The *Plan participant*, together with his or her *physician*, is ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the *Plan* will pay for all or a portion of the cost of such care. The PPO *providers* are independent contractors; neither the *Plan* nor the *Plan Administrator* makes any warranty as to the quality of care that may be rendered by any PPO *provider*.

Depending on the geographic area in which you reside and the service you receive, you may have access through the *claims administrator's* Shared Savings Program to non-PPO *providers* who have agreed to discount their charges for covered health services. If you receive covered health services from these *providers*, benefits will be payable at the non-PPO benefit percentage, but the total you owe may be less because the eligible expenses may be a lower amount. However, you will always experience the greatest savings when you receive services from a PPO *provider*.

<p>Note: In order to receive your maximum allowable benefits, you must comply with the Pre-Certification Programs as outlined in the HEALTH MANAGEMENT SERVICES AND SPECIAL PROVISIONS section.</p>
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Schedule of Benefits

The following tables outline your percentage of coverage as provided by this *Plan*. The tables are followed by a more detailed description of specific benefits.

Urgent Care or Emergency Services: It is important to remember that, if a *Plan participant* needs medical care for a condition that could seriously jeopardize his or her life, there is no need to contact the *Plan* for prior approval. The *Plan participant* should obtain such care without delay and

Medical Benefits

follow the rules described in **HEALTH MANAGEMENT SERVICES AND SPECIAL PROVISIONS.**

Hospital Inpatient Services		
	PPO	Non-PPO
Standard Room and Board and Ancillary	90% of PPO rate for Semi-Private Room, subject to deductible	70% of UCR for Semi-Private Room, subject to deductible
Extended Skilled Nursing Facility, Room and Board and Ancillary	90% of PPO rate, subject to deductible and maximum	70% of UCR, subject to deductible and maximum
	Confinement must begin after a hospital confinement for the same or related cause and within 14 days after discharge from the hospital.	
Intensive Care Room and Board	90% of PPO Intensive Care Rate, subject to deductible	70% of UCR of Intensive Care Rate, subject to deductible
Rehabilitation Room and Board	90% of PPO rate for Semi-Private Room, subject to deductible	70% of UCR for Semi-Private Room, subject to deductible
Personal Items	Not Covered	Not Covered

Hospital Newborn Care		
	PPO	Non-PPO
Newborn Nursery and Ancillary	90% of PPO rate, subject to deductible	70% of UCR, subject to deductible
Neo-Natal Room and Board and Ancillary	90% of PPO rate, subject to deductible	70% of UCR, subject to deductible

Mental Health and Substance Abuse Inpatient, Partial Hospitalization, and Intensive Outpatient Services		
	PPO	Non-PPO
Mental Health Care — Room and Board and Ancillary	90% of PPO rate for Semi-Private Room, subject to deductible and maximums	70% of UCR for Semi-Private Room, subject to deductible and maximums
Substance Abuse Care — Room and Board and Ancillary	90% of PPO rate for Semi-Private Room, subject to deductible and maximums	70% of UCR for Semi-Private Room, subject to deductible and maximums
Mental Health Care — Partial Hospitalization and Intensive Outpatient Services	90% of PPO rate for Semi-Private Room, subject to deductible and maximums	70% of UCR for Semi-Private Room, subject to deductible and maximums
	2 days equal to 1 inpatient day.	
Substance Abuse Care — Partial Hospitalization and Intensive Outpatient Services	90% of PPO rate for Semi-Private Room, subject to deductible and maximums	70% of UCR for Semi-Private Room, subject to deductible and maximums
	2 days equal to 1 inpatient day.	

Providers' In-Hospital Services		
	PPO	Non-PPO
Provider Hospital Visit	90% of PPO rate, subject to deductible	70% of UCR, subject to deductible
Mental Health Hospital Visit	90% of PPO rate, subject to deductible and maximums	70% of UCR, subject to deductible and maximums

Providers' In-Hospital Services		
	PPO	Non-PPO
Substance Abuse Hospital Visit	90% of PPO rate, subject to deductible and maximums	70% of UCR, subject to deductible and maximums
Newborn Visit	90% of PPO rate, subject to deductible	70% of UCR, subject to deductible

Surgical Inpatient Services		
	PPO	Non-PPO
Primary Surgeon	90% of PPO rate, subject to deductible	70% of UCR, subject to deductible
Prenatal and Postnatal Care Visits Global Fee	100% of PPO rate after \$200 co-payment	70% of UCR, subject to deductible
Colonoscopy	100% of PPO rate For Plan participants age 50 and above.	70% of UCR, subject to deductible
Pain Management	90% of PPO rate, subject to deductible	70% of UCR, subject to deductible
Assistant Surgeon	90% of PPO rate, subject to deductible	70% of UCR, subject to deductible
Anesthesia	90% of PPO rate, subject to deductible	70% of UCR, subject to deductible
TMJ Surgery	90% of PPO rate, subject to deductible	70% of UCR, subject to deductible
Dental Surgery — Non-Accident	Not Covered	Not Covered

Surgical Outpatient Services		
	PPO	Non-PPO
Primary Surgeon	90% of PPO rate, subject to deductible	70% of UCR, subject to deductible
Colonoscopy	100% of PPO rate For Plan participants age 50 and above.	70% of UCR, subject to deductible
Pain Management	90% of PPO rate, subject to deductible	70% of UCR, subject to deductible
Assistant Surgeon	90% of PPO rate, subject to deductible	70% of UCR, subject to deductible
Anesthesia	90% of PPO rate, subject to deductible	70% of UCR, subject to deductible
TMJ Surgery	90% of PPO rate, subject to deductible	70% of UCR, subject to deductible
Dental Surgery — Non-Accident	Not Covered	Not Covered

Professional Interpretation Services Inpatient and Outpatient		
	PPO	Non-PPO
Pathologist Fee	90% of PPO rate, subject to deductible	70% of UCR, subject to deductible

Medical Benefits

Professional Interpretation Services Inpatient and Outpatient		
	PPO	Non-PPO
Radiologist Fee	90% of PPO rate, subject to deductible	70% of UCR, subject to deductible
Diagnostic Testing — Interpretation Fee	90% of PPO rate, subject to deductible	70% of UCR, subject to deductible

Emergency Room Services		
	PPO	Non-PPO
Emergency Room — Accident — Facility	100% of PPO rate after \$50 co-payment (co-payment waived if admitted)	100% of billed charges after \$50 co-payment (co-payment waived if admitted)
Emergency Room — Illness — Facility	100% of PPO rate after \$50 co-payment (co-payment waived if admitted)	100% of billed charges after \$50 co-payment (co-payment waived if admitted)
Emergency Room — Accident — Physician or Other Provider	100% of PPO rate	100% of billed charges
Emergency Room — Illness — Physician or Other Provider	100% of PPO rate	100% of billed charges
Urgent Care	100% of PPO rate after \$20 co-payment	70% of UCR, subject to deductible

Outpatient Facility Fees		
	PPO	Non-PPO
Outpatient Surgery or Surgery Center — Facility Fee only	90% of PPO rate, subject to deductible	70% of UCR, subject to deductible
Clinic Visit — Facility Fee only	90% of PPO rate, subject to deductible	70% of UCR, subject to deductible
Outpatient Hospital Services or Ambulatory Care Center	90% of PPO rate, subject to deductible	70% of UCR, subject to deductible
Pre-Admission Testing	90% of PPO rate, subject to deductible	70% of UCR, subject to deductible
	Within 7 days of admission.	

Outpatient Diagnostic Services		
	PPO	Non-PPO
Diagnostic Laboratory	90% of PPO rate, subject to deductible	70% of UCR, subject to deductible
Diagnostic Testing	90% of PPO rate, subject to deductible	70% of UCR, subject to deductible
Diagnostic X-ray	90% of PPO rate, subject to deductible	70% of UCR, subject to deductible
PET Scan	90% of PPO rate, subject to deductible	70% of UCR, subject to deductible
CAT Scan	90% of PPO rate, subject to deductible	70% of UCR, subject to deductible

Outpatient Diagnostic Services		
	PPO	Non-PPO
Magnetic Resonance Imaging	90% of PPO rate, subject to deductible	70% of UCR, subject to deductible

Outpatient Therapy Services		
	PPO	Non-PPO
Biofeedback — Medical	Not Covered	Not Covered
Cardiac Rehabilitation	90% of PPO rate, subject to deductible	70% of UCR, subject to deductible
Chemotherapy	90% of PPO rate, subject to deductible	70% of UCR, subject to deductible
Dialysis	90% of PPO rate, subject to deductible	70% of UCR, subject to deductible
Intravenous Therapy	90% of PPO rate, subject to deductible	70% of UCR, subject to deductible
Occupational Therapy	90% of PPO rate, subject to deductible	70% of UCR, subject to deductible
Osteopathic Manipulation Therapy	100% of PPO rate after \$20 co-payment, subject to maximum	70% of UCR, subject to deductible and maximum
Physical Therapy	90% of PPO rate, subject to deductible	70% of UCR, subject to deductible
Radiation Therapy	90% of PPO rate, subject to deductible	70% of UCR, subject to deductible
Speech Therapy	90% of PPO rate, subject to deductible	70% of UCR, subject to deductible
Vision Therapy	Not Covered	Not Covered

Doctor's Office Services		
	PPO	Non-PPO
Allergy Care (extracts, serums, injections)	90% of PPO rate, subject to deductible	70% of UCR, subject to deductible
Injections	90% of PPO rate, subject to deductible	70% of UCR, subject to deductible
Office Extras	90% of PPO rate, subject to deductible	70% of UCR, subject to deductible
Office Visit	100% of PPO rate after \$20 co-payment	70% of UCR, subject to deductible
	Includes urgent care visits billed by a physician.	
TMJ-Related Services	90% of PPO rate, subject to deductible and maximum	70% of UCR, subject to deductible and maximum

Medical Benefits

Chiropractic Services		
	PPO	Non-PPO
Chiropractic Visit	100% of PPO rate after \$20 co-payment, subject to maximum	70% of UCR, subject to deductible and maximum
Chiropractic X-ray	100% of PPO rate after \$20 co-payment, subject to maximum; 100% of PPO rate after office visit co-payment, subject to maximum, if billed with office visit, on or for same date of service	70% of UCR, subject to deductible and maximum

Outpatient Mental Health and Substance Abuse Services		
	PPO	Non-PPO
Biofeedback — Mental Health	Not Covered	Not Covered
Mental Health Office Visit — Outpatient	100% of PPO rate after \$20 co-payment, subject to maximum	70% of UCR, subject to deductible and maximum
Mental Health Testing and Evaluation	100% of PPO rate after \$20 co-payment, subject to maximum; 100% of PPO rate after office visit co-payment, subject to maximum, if billed with office visit, on or for same date of service	70% of UCR, subject to deductible and maximum
Social Worker Visit	100% of PPO rate after \$20 co-payment, subject to maximum	70% of UCR, subject to deductible and maximum
Substance Abuse Visit — Outpatient	100% of PPO rate after \$20 co-payment, subject to maximum	70% of UCR, subject to deductible and maximum

Preventative Care Services		
	PPO	Non-PPO
Immunizations	100% of PPO rate, subject to maximum	70% of UCR, subject to deductible and maximum
Well Child Care	100% of PPO rate after \$20 co-payment, subject to maximum	70% of UCR, subject to deductible and maximum
Preventative Exam	100% of PPO rate after \$20 co-payment, subject to maximum	70% of UCR, subject to deductible and maximum
Prostate Exam	100% of PPO rate after \$20 co-payment, subject to maximum	70% of UCR, subject to deductible and maximum
GYN Exam	100% of PPO rate after \$20 co-payment, subject to maximum	70% of UCR, subject to deductible and maximum
Mammogram	100% of PPO rate, subject to maximum	70% of UCR, subject to deductible and maximum
Pap Test	100% of PPO rate, subject to maximum	70% of UCR, subject to deductible and maximum
Eye Exam	Not Covered	Not Covered
Hearing Exam	Not Covered	Not Covered
Preventative Lab	100% of PPO rate, subject to maximum	70% of UCR, subject to deductible and maximum
Lab — Lipid Profile	100% of PPO rate, subject to maximum	70% of UCR, subject to deductible and maximum

Preventative Care Services		
	PPO	Non-PPO
Lab — Hemocult	100% of PPO rate, subject to maximum	70% of UCR, subject to deductible and maximum
Lab — PSA	100% of PPO rate, subject to maximum	70% of UCR, subject to deductible and maximum
Preventative Lab — Pathologist Fee	100% of PPO rate, subject to maximum	70% of UCR, subject to deductible and maximum
Lab — Lipid Profile Pathology	100% of PPO rate, subject to maximum	70% of UCR, subject to deductible and maximum
Lab — Hemocult Pathology	100% of PPO rate, subject to maximum	70% of UCR, subject to deductible and maximum
Lab — PSA Pathology	100% of PPO rate, subject to maximum	70% of UCR, subject to deductible and maximum
Lab — Pap Pathology	100% of PPO rate, subject to maximum	70% of UCR, subject to deductible and maximum
Preventative X-ray	100% of PPO rate, subject to maximum	70% of UCR, subject to deductible and maximum
Preventative X-ray — Radiologist Fee	100% of PPO rate, subject to maximum	70% of UCR, subject to deductible and maximum
X-ray — Mammogram Radiologist Fee	100% of PPO rate, subject to maximum	70% of UCR, subject to deductible and maximum
Preventative Testing	100% of PPO rate, subject to maximum	70% of UCR, subject to deductible and maximum
Preventative Testing — Interpretation Fee	100% of PPO rate, subject to maximum	70% of UCR, subject to deductible and maximum

Other Services		
	PPO	Non-PPO
Ambulance — Air Transportation	90% of PPO rate, subject to deductible	90% of UCR, subject to PPO deductible
Ambulance — Ground Transportation	90% of PPO rate, subject to deductible	90% of UCR, subject to PPO deductible
Durable Medical Equipment	90% of PPO rate, subject to deductible	70% of UCR, subject to deductible
Orthotics	90% of PPO rate, subject to deductible	70% of UCR, subject to deductible
Prosthetics	90% of PPO rate, subject to deductible	70% of UCR, subject to deductible
RN and LPN Services — Outpatient	100% of PPO rate after \$20 co-payment, subject to maximum	100% of UCR after \$20 co-payment, subject to maximum
	A visit is considered 8 hours or more.	
Home Health Care Services	100% of PPO rate after \$20 co-payment, subject to maximum	100% of UCR after \$20 co-payment, subject to maximum
Hospice	90% of PPO rate	90% of UCR

Medical Benefits

Second Surgical Opinion Services		
	PPO	Non-PPO
Office Visit For Second Surgical Opinion — Confirmed	90% of PPO rate, subject to deductible	70% of UCR, subject to deductible
Office Visit For Second Surgical Opinion — Non-Confirmed	90% of PPO rate, subject to deductible	70% of UCR, subject to deductible

Other Miscellaneous Services		
	PPO	Non-PPO
Miscellaneous Covered Expenses	90% of PPO rate, subject to deductible	70% of UCR, subject to deductible
Behavioral Modification Programs	Not Covered	Not Covered
Dental Service — Accidental Injury	90% of PPO rate, subject to deductible	70% of UCR, subject to deductible
Medical Records Reimbursement	100% of charges	100% of charges
Sleep Disorder Clinic	90% of PPO rate, subject to deductible	70% of UCR, subject to deductible

Prescription Drugs	
Specialty Drugs	<p>PPO: 100% of PPO rate Non-PPO: 100% of UCR</p> <p>Specialty drugs, including, but not limited to, Multiple Sclerosis injectables such as Avonex and Beta Seron, growth hormones, and hemophilia treatment such as Recombinate, Kogenate, and Rhogram are covered under the medical portion of this Plan.</p>

Detailed Description of Medical Benefits

Hospital Inpatient Benefits

Inpatient Care: A *Plan participant* who is admitted to a *hospital* as an inpatient is entitled to benefits for *hospital* services. Benefits are paid according to the **SCHEDULE OF BENEFITS**, to include all types of room and board per *confinement*, unless otherwise excluded by the *Plan*.

In order for inpatient care (including partial hospitalization programs) to be covered as a benefit of this *Plan*, the service must be consistent with and *medically necessary* in the diagnosis and treatment of the patient's condition. Also, in order to receive the maximum benefits allowed, the hospitalization must be determined to be necessary and certified by *UMR* through Pre-Certification of Inpatient Services. Failure to follow the Pre-Certification of Inpatient Services steps may result in your claims being paid at a reduced amount.

The following **inpatient care** charges are covered:

- Charges for *semi-private room* and board, including bed, meals, special diets, and general nursing services. If the *Plan participant* receives room and board known as "private accommodation," room and board charges are paid only at the *hospital's* average *semi-private room* rate. However, a private room will be covered as any other covered service if a private room is ordered by the *physician* in charge of the patient for isolation purposes (this may include, but is not limited to, infectious disease

or behavior management of a *Plan participant*), or if the facility in which the patient is confined contains only private rooms.

- Charges for the use of an operating room, delivery room, and recovery room.
- Charges for the use of an observation room in excess of 23 hours.
- Charges for *hospital services in intensive care units and cardiac care units*.
- Charges for anesthetic materials.
- Charges for administration of anesthetics when administered by an employee of the *hospital* as a regular *hospital* service or through approved contractual arrangements.
- Charges for dressings, bandages, casts, and splints.
- Charges for X-rays, laboratory services, pathological services, and machine diagnostic tests.
- Charges for oxygen and other respiratory therapy, as provided by the *hospital*.
- Charges for physio-therapy, hydrotherapy, and other rehabilitative services, as provided by the *hospital*.

If a *Plan participant* seeks *emergency* services through a *hospital's emergency* room and is admitted as a *hospital* inpatient at that time due to that *emergency*, coverage for that inpatient *confinement* will be provided as an inpatient *hospital* benefit, not as an *emergency* room benefit.

Extended Skilled Nursing Facility: In lieu of *hospital confinement*, benefits are provided for services rendered by an *extended skilled nursing facility* according to the **SCHEDULE OF BENEFITS** and **PLAN LIMITATIONS AND PROVISIONS**.

The *medical services* and supplies of this benefit are provided under the terms of an approved *extended skilled nursing facility* treatment plan.

Hospital Maternity Care

Under the Newborns' and Mothers' Health Protection Act of 1996, group health plans and health insurance issuers generally may not restrict benefits for any *hospital* length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending *provider*, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a *provider* obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). You or your *covered dependents* are not required to give birth in a *hospital* or to stay in the *hospital* for a fixed period of time following birth.

If your *physician* feels that a longer stay is necessary, you must obtain prior approval from *UMR*. See the **PRE-CERTIFICATION OF INPATIENT SERVICES** section.

Obstetrical Care – Hospital: Benefits are provided for obstetrical care and conditions of pregnancy to the *employee* and *covered dependents* during the period of *hospital confinement*. The payment of obstetrical benefits is determined as of the date the services are rendered. A child becomes a *covered dependent* at birth, provided the child is enrolled in the *Plan* within 31 days of the date of birth. *Hospital* benefits are paid according to the **SCHEDULE OF BENEFITS**.

Newborn Care: Benefits are provided for inpatient examination of a newborn infant during the period of *hospital confinement*. The *Plan* covers charges for circumcision at the time of birth.

Obstetrical Services: Benefits are provided for obstetrical services rendered by the *physician* in charge of the case or by another licensed *provider*, including services customarily rendered as prenatal and

Medical Benefits

postnatal care. Benefits are also payable for prenatal care, delivery services, and postnatal care rendered by a Certified Nurse Midwife (CNM). Benefits for obstetrical services are provided to the *employee* and *covered dependents*.

It is the responsibility of the *employee* to obtain the appropriate form from Human Resources and add the baby to the *Plan* within 31 days of the child's birth.

Mental Health and Substance Abuse Inpatient, Partial Hospitalization, and Intensive Outpatient Services

Mental Health Inpatient, Partial Hospitalization, and Intensive Outpatient Services

Benefits to a *Plan participant* who is admitted to a *mental health treatment facility*, or to a *hospital* for *mental health* care, are limited as outlined in **PLAN LIMITATIONS AND PROVISIONS**.

Benefits are provided for inpatient, partial hospitalization, and intensive outpatient *mental health* care only at a licensed facility.

Inpatient *mental health* care charges do not apply to the out-of-pocket maximum. Even if the out-of-pocket maximum is reached, the *Plan* continues to pay according to the **SCHEDULE OF BENEFITS** until the maximum benefits are reached.

Substance Abuse Inpatient, Partial Hospitalization, and Intensive Outpatient Services

Benefits to a *Plan participant* who is admitted to a *substance abuse treatment facility*, or to a *hospital* for *substance abuse* care, are limited as outlined in **PLAN LIMITATIONS AND PROVISIONS**.

Benefits are provided for inpatient, partial hospitalization, and intensive outpatient *substance abuse* care only at a licensed facility.

Inpatient *substance abuse* care charges do not apply to the out-of-pocket maximum. Even if the out-of-pocket maximum is reached, the *Plan* continues to pay according to the **SCHEDULE OF BENEFITS** until the maximum benefits are reached.

Providers' In-Hospital Services

The *Plan* provides benefits according to the **SCHEDULE OF BENEFITS** for the following professional services performed by a licensed *provider*:

In-Hospital Concurrent Medical Care: Benefits are provided for services rendered concurrently by a *physician* other than the attending *provider* when warranted by the need for the skills of a specialist. A patient is eligible for concurrent medical care if he or she has a separate and complicated diagnosis that, if left untreated, would adversely affect his or her prognosis, and if management of the condition requires the skills of a specialist.

In-Hospital Medical Services: Benefits are provided for professional services rendered by the attending *provider* while the *Plan participant* is hospitalized. The *Plan* pays benefits for *Plan participants* who receive *medical services*, beginning on the first day of such hospitalization.

Surgical Inpatient and Outpatient Services

Anesthesia Services: Benefits are provided for the administration of spinal, rectal, or local anesthesia, or a drug or other anesthetic agent by injection or inhalation. Benefits are also payable for services rendered by a Certified Registered Nurse Anesthetist (CRNA).

Surgical Assistants: Benefits are provided for a licensed *provider* who actively assists the operating surgeon in the performance of surgical services when the condition of the patient and type of surgical services requires such assistance. Benefits are also provided for services rendered by a licensed surgical *physician's* assistant.

Surgical Services: Benefits are provided for *surgical procedures*, including treatment for fractures and dislocations and routine preoperative and postoperative care.

When more than one *surgical procedure* is performed during the same operative session, the benefit is paid as follows:

- 100% of the applicable PPO or *UCR* rate is considered for calculating the correct *Plan* benefit of the most complex procedure.
- 50% of the applicable PPO or *UCR* rate is considered for calculating the correct *Plan* benefit of each subsequent procedure.

Professional Interpretation Services Inpatient and Outpatient

Benefits are provided for the interpretation of diagnostic tests.

Emergency Room Services

Benefits are provided for:

- *Emergency* room services due to an accident.
- *Emergency* room services due to an *illness*.

Benefits are also provided for the *provider's* charges for surgical or medical care rendered in an *emergency* room.

Outpatient Services

For a *Plan participant* requiring outpatient care, the *Plan* pays the following benefits when provided in an outpatient department of a *hospital* or in an *ambulatory care center*. The following charges are covered according to the **SCHEDULE OF BENEFITS**.

Outpatient Diagnostic Examinations: Benefits are provided for services such as X-ray examinations, electrocardiograms (EKG), venous Doppler studies, magnetic resonance imaging (MRI), computerized axial tomography (CAT scan), basal metabolism tests, and electroencephalograms (EEG), when the study is directed toward the diagnosis of a definite condition, disease, or *injury*.

Outpatient Surgery/Surgery Center: Benefits are provided for services administered at a *surgery center*, in an outpatient department of a *hospital*, or in a *physician's* office, including the *physician* and anesthesiologist charges.

Pre-Admission Testing: Benefits are provided for *pre-admission testing* for expenses *incurred* within 7 days prior to the *hospital* admission for the scheduled procedure.

Outpatient Therapy Services

The following outpatient therapy services are paid according to the **SCHEDULE OF BENEFITS**.

Cardiac Rehabilitation: Benefits are provided for a *hospital* outpatient department cardiac rehabilitation program.

Chemotherapy Services: Benefits are provided for expenses *incurred* for chemotherapy treatment when prescribed and billed for by a licensed *provider*.

Dialysis: Benefits are provided for kidney dialysis when not reimbursed by *Medicare*.

Intravenous Therapy: Benefits are provided for intravenous therapy.

Occupational Therapy: Benefits are provided for the use of work-related skills to treat or train the physically or emotionally ill, to prevent *disability*, to evaluate behavior, and to restore *disabled* persons to health or to social or economic independence. These services must be performed by a licensed

Medical Benefits

occupational therapist, who evaluates the self-care, work, play, and leisure time task performance skills of well and *disabled* clients of all ages, and plans and implements programs, social activities, and interpersonal activities designed to restore, develop, and maintain the client's ability to accomplish satisfactorily those daily tasks required of his or her specific age and necessary to his or her particular role adjustment.

Physical Therapy: Benefits are provided for rehabilitation concerned with restoration of function and prevention of *disability* following disease, *injury*, or loss of a body part. The therapeutic properties of exercise, heat, cold, electricity, ultraviolet light, and massage may be used to improve circulation, strengthen muscles, encourage return of motion, and train or retrain an individual to perform the activities of daily living. These services must be performed by a licensed physical therapist, who is legally responsible for planning, conducting, and evaluating a physical therapy program for patients referred by a *physician*.

Radiation Therapy: Benefits are provided for treatment by X-ray, radium, external radiation, or radioactive isotopes (including the cost of materials unless supplied by a *hospital*), when performed and billed for by the licensed *provider* in charge of the case.

Speech Therapy: Benefits are provided for the evaluation and treatment of *Plan participants* who have voice, speech, language, swallowing, cognitive, or hearing disorders. These services must be performed by a licensed and certified speech therapist.

Doctor's Office Services

Outpatient Diagnostic X-ray and Lab: Benefits are provided for diagnostic X-ray, laboratory, and pathological services given in a *physician's* office that are required for the diagnosis of any condition, disease, or *injury*, and that are customarily billed by the *provider* who made such examination.

Chiropractic Services

Benefits are provided for spinal manipulation therapy and related charges, including X-rays. Chiropractic *maintenance care* is not covered. See **PLAN LIMITATIONS AND PROVISIONS** for limitations on chiropractic services.

Outpatient Mental Health and Substance Abuse Services

Outpatient Mental Health Care: Benefits are provided for outpatient *mental health* care by a licensed psychologist, psychiatrist, or *social worker*. See **PLAN LIMITATIONS AND PROVISIONS** for limitations on outpatient *mental health* care.

Outpatient *mental health* care charges do not apply to the out-of-pocket maximum. Even if the out-of-pocket maximum is reached, the *Plan* continues to pay according to the **SCHEDULE OF BENEFITS** until the maximum benefits are reached.

Outpatient Substance Abuse Care: Benefits are provided for outpatient *substance abuse* care by a licensed *provider*. See **PLAN LIMITATIONS AND PROVISIONS** for limitations on outpatient *substance abuse* care.

Outpatient *substance abuse* care charges do not apply to the out-of-pocket maximum. Even if the out-of-pocket maximum is reached, the *Plan* continues to pay according to the **SCHEDULE OF BENEFITS** until the maximum benefits are reached.

Preventative Care Benefit

Each *Plan participant* is provided a preventative care benefit to cover the costs of selected preventative health care tests. The following tests are paid according to the **SCHEDULE OF BENEFITS** and are limited as listed in **PLAN LIMITATIONS AND PROVISIONS**.

- **GYN Exam.**
- **Hemocult Test.**
- **Immunizations.**
- **Lipid Profile (Cholesterol Exam).**
- **Mammogram Test.**
- **Pap Test.**
- **Preventative Exam.**
- **Preventative Lab.**
- **Preventative Testing.**
- **Preventative X-rays.**
- **Prostate Exam.**
- **PSA (Prostate Specific Antigen) Test.**
- **Well Child Care.**

Other Services

Ambulance Service: Benefits are provided for local professional ambulance service to the nearest facility able to treat your condition when that condition warrants the level of skills and equipment typically provided by such ambulance service.

This ambulance service may include an air ambulance or regularly scheduled airline or railroad transportation to the nearest *hospital* qualified to provide the necessary treatment.

Durable Medical Equipment: Benefits are provided for *durable medical equipment* approved for rental (or, at the *Plan's* option, purchase). Benefits for *durable medical equipment* are not to exceed the purchase price.

Home Health Care: *Home health care* is an outpatient service that is rendered to a patient in a home setting in lieu of *hospital confinement*. Benefits are provided for *home health care* when services are rendered by a licensed and/or accredited *home health care* agency. While *custodial care* may be rendered in the home and therefore is a form of *home health care*, it is excluded under the *Plan*.

Home health care services may include the skills and services of a nurse (RN or LPN), physical therapist, occupational therapist, speech therapist, and medical *social worker*.

These outpatient *medical services* are covered to the extent that such charges would have been considered *covered charges* had a person required *confinement* in a *hospital* as a registered bed patient, or *confinement* in a *skilled nursing facility*.

Home health care requires review from *UMR* to determine *medical necessity*. A determination of *medical necessity* is based upon, but is not limited to, the level of skill required, the number of hours required, whether or not the treatment plan is appropriate (and whether or not it includes any related patient/family training goals). Ongoing authorization is required and is based upon regular updates from the *home health care* agency or *provider*.

The nursing care may be provided by a registered nurse (RN) or licensed practical nurse (LPN) who does not ordinarily live in your home and who is not a member of your immediate family. The services provided by a nurse are divided into two categories: nursing visits and nursing care.

Medical Benefits

Nursing visits are defined as services rendered by an RN or LPN in the home care setting as ordered by a *physician*. These services are rendered on an intermittent basis for initial and ongoing assessment, treatment, and/or training. A nursing visit includes tasks and skills that a caregiver may be able to perform after appropriate training. One visit is equal to less than eight hours within the same 24-hour period. These benefits are limited as listed in **PLAN LIMITATIONS AND PROVISIONS**.

Nursing care is defined as services rendered by an RN or LPN in the home care setting as ordered by a *physician*. The services are rendered on an hourly or per diem basis for patients who require ongoing assessment, treatment, evaluation, and training. Nursing care includes tasks and skills that a caregiver may be able to perform after appropriate training. Nursing care for the purpose of training one or more caregivers is covered under this *Plan* provision. Trainable services are identified as part of the initial assessment by the home health nurse and are to be included in the treatment plan. If the nursing care agency indicates that the caregiver has refused to participate or has elected not to provide the services to the patient in those areas identified as trainable, then this refusal is considered to be a matter of convenience for the caregiver. In this case, trainable nursing services would be excluded under the *Plan*. Only those services for which a caregiver cannot be trained and that are *medically necessary* are covered under this provision. Nursing care includes hourly care that extends at least eight hours per day. These benefits are limited as listed in **PLAN LIMITATIONS AND PROVISIONS**.

Medical social services, defined as the practice involving the disciplined application of social work values, principles, and methods, are also covered. These services are provided to a patient in a home environment if a patient and/or *family* is having difficulty adjusting to physical, psychological, financial, environmental, or familial limitations that inhibit recovery from an *illness* or *injury*. A Masters-prepared *social worker* (MSW) may provide advice and counsel, and instruct in the utilization of appropriate community resources. Social work services rendered in the home are subject to the overall home health visit maximum as defined in **PLAN LIMITATION AND PROVISIONS**.

Hospice Care: *Hospice* care benefits for a terminally ill *Plan participant* are provided according to the **SCHEDULE OF BENEFITS**. The *medical services* and supplies of this benefit are provided under the terms of an approved *hospice* care plan and may include:

- Room and board for *confinement* in a *hospice*.
- Services and supplies furnished by the *hospice* while the patient is confined.
- Part-time nursing care by or under the supervision of a registered nurse.
- Nutrition services and/or special meals.
- *Respite services*.
- Counseling services by a licensed *social worker* or a licensed counselor.
- Bereavement counseling by a licensed *social worker* or a licensed counselor for the *employee* and/or *covered dependent(s)*.

Prescription Drugs

Grand Valley State University provides a special prescription discount program through Caremark. *Plan participants* must contact Human Resources for more information.

Replacement of Organs/Tissues and Related Services

You must complete the Pre-Certification of Inpatient Services Program prior to hospitalization for an organ transplant, bone marrow transplant, or tissue replacement to establish the *medical necessity* of the procedure. During the pre-certification process, *UMR* may recommend that you receive transplantation services at a Center of Excellence.

Inpatient services for transplantation are covered according to the **SCHEDULE OF BENEFITS** and the lifetime maximum of the *Plan*. Services and supplies rendered in connection with the procedure that are considered to be *investigational* or *experimental* are not covered.

Solid Organs

This *Plan* provides benefits for the transplantation of solid human organs (with other human organs) and related services. This *Plan* excludes transplantation of non-human organs.

Bone Marrow Transplants

This *Plan* provides benefits for *medically necessary* bone marrow transplantation procedures, including, but not limited to, synergic and allogenic (homologous) bone marrow transplantation, as well as autologous bone marrow transplantation procedures.

Finding a donor who is an acceptable match for donation is important to the success of an allogenic (homologous) bone marrow transplant. Because an immediate family member has the greatest chance of being a match, benefits for determining bone marrow matching are provided only for members of the immediate family and only if the proposed bone marrow transplantation is *medically necessary* and is not considered *experimental* or *investigational*. For purposes of this section, immediate family members include mother, father, biological children, and biological siblings. If a donor match cannot be identified in the immediate family, the *Plan* will cover matching through a national registry.

Tissue Replacement

This *Plan* also provides benefits for the replacement of human tissue (with human tissue or prosthetic devices).

Other Benefits Related to Transplantation

Benefits are also provided for:

- the preparation, acquisition, transportation, and storage of human organs, bone marrow, or human tissue.
- transportation of the *Plan participant*, if the organ recipient, to and from the site of the transplant procedure.

Specific rules apply as to the payment of benefits for the donor and recipient of the transplanted organ, bone marrow, or tissue.

- When the transplant recipient and donor are both covered under this *Plan*, payment for covered services is provided for both, subject to each *Plan participant's* respective benefit maximums.
- When the transplant recipient is covered under this *Plan* but the donor is not, payment for covered services is provided for both the recipient and the donor to the extent that charges for such services are not payable by any other source. Benefits payable on behalf of the donor are charged to the recipient's claim and applied to the recipient's maximums.
- When the transplant recipient is not covered under this *Plan* but the donor is covered, payment for covered services attributable to the donor is provided to the extent that charges for such services are not payable by any other source. Benefits are not provided for services attributable to the recipient.

Other Covered Medical Expenses

The *Plan* covers charges that are reasonable for many services and supplies. The following are covered:

- **Abortion, elective.**

Medical Benefits

- **Accidental injury to sound natural teeth.**
 - ◆ A sound *natural tooth* is defined as one that is a virgin, or unrestored, tooth, or as one that, if it has a pre-existing restoration, has two or fewer surfaces restored and the restoration does not encompass more than 1/3 of the width of the occlusal surface or involve a cusp.
 - ◆ An *injury* caused by chewing or biting is not considered an *accidental injury*.
- **Alternative care** when all of the following criteria have been satisfied:
 - ◆ It is not otherwise excluded by this *Plan*; and
 - ◆ It is demonstrated that providing alternative care will result in a cost savings to the *Plan*; and
 - ◆ The alternative care is *medically necessary* and appropriate; and
 - ◆ The alternative care is provided with the consent of the *Plan participant*, or his or her representative, and with the approval of the *Plan participant's* licensed health care *provider*, and is approved by Grand Valley State University; and
 - ◆ The alternative care replaces treatment that would be covered under this *Plan*; and
 - ◆ The alternative care expenses do not exceed the maximum allowed under this *Plan* for the treatment replaced by the alternative care; and
 - ◆ The alternative care is provided in lieu of hospitalization, the *Plan participant* meets utilization review criteria for inpatient hospitalization for the entire period the alternative care is provided.
- **Birth control devices** (such as intrauterine devices, or IUDs).
- **Blood transfusions and blood products** to the extent the blood bank supply is not replaced.
- **Corrective shoes.**
- **Cosmetic services** in connection with a congenital malformation or *accidental injury*, if *medically necessary*.
- **Enteral nutrition and non-oral food supplements** under the following conditions:
 - ◆ They are for a patient with permanent non-function of the small bowel or of the structures that normally permit food to reach the small bowel.
 - ◆ They are for a patient with disease of the small bowel that impairs digestion and absorption of an oral diet to the point that the patient would become critically ill without the enteral feeds.
 - ◆ They are life-sustaining for a critically ill patient.
- **Growth hormone therapy**, if *medically necessary*.
- **Home and office calls** by *physicians* for diagnosis and treatment.
- **Infertility treatment:** *medically necessary* treatment and procedures that treat the medical condition that results in *infertility* or sterility (e.g., endometriosis, blockage of fallopian tubes, varicocele, etc.).
- **Mastectomy:** mastectomy and all stages of reconstruction of a breast on which a mastectomy has been performed due to cancer or tumor fibrocysts, including the cost of prostheses and physical complications of all stages of mastectomy, including lymphedemas, as such services are recommended by the attending *physician* in consultation with the patient.
 - ◆ If you have received a mastectomy **at any time**, and you are continuing to receive any benefits under this *Plan* directly related to that mastectomy on or after **January 1, 1999**, this provision includes coverage for any reconstructive surgery on the opposite breast necessary to produce a symmetrical appearance.

- **Norplant.**
- **Obesity**, morbid.
- **Orthotics and supportive devices**, rigid or semi-rigid, that limit or stop motion of a weak or diseased body part. Custom-made orthotics provided by a chiropractor are covered and are not subject to the annual maximum for chiropractic care.
- **Oxygen**, only for medical purposes, and an oxygen concentrator, when deemed by the *Plan* to be *medically necessary*.
- **Prosthetic devices and supplies**: purchase, fitting, needed adjustment, repairs, and replacements of prosthetic devices and supplies that replace all or part of a missing body extremity (except teeth) and its adjoining tissues, or that replace all or part of the function of a permanently useless or malfunctioning body organ or extremity.
 - ◆ The *Plan* covers charges for contact lenses following cataract surgery.
 - ◆ The *Plan* covers charges for orthopedic inserts and their fitting as prescribed by a *physician* as being *medically necessary*.
- **Self-inflicted illness or injury.**
- **Sterilization procedures, elective** (adult male and female).
- **Stockings (compression)**, when prescribed for vascular conditions and purchased through a *durable medical equipment* supplier. This benefit is limited as listed in **PLAN LIMITATIONS AND PROVISIONS**.
- **Surgical dressings, splints, casts**, and other devices used in the reduction of fractures and dislocations, as well as other similar items that serve only a medical purpose, excluding items usually stocked in the home.
- **Syringes, needles**, and other similar items that serve only a medical purpose, excluding items usually stocked in the home.
- **Ultrasound test**: one routine ultrasound test per pregnancy. Additional ultrasound tests will be covered only if *medically necessary*. Ultrasound tests for the sole purpose of determining the sex of the fetus will not be covered.
- **Uterine monitoring (outpatient)**, only if *medically necessary*.
- **Wig or hairpiece**, when prescribed by a *physician* and needed due to a medical condition.

Care Outside the United States

Benefits equivalent to those in *hospitals* in the United States are provided to *Plan participants* in the event of an *emergency* while traveling or vacationing outside the United States. If you receive such services, pay the *provider* and then submit the bill to *UMR* for reimbursement. Only *medically necessary* treatment as in the case of *emergency illnesses* and *accidental injuries* is covered when services are rendered by a *provider* outside the United States. Routine or preventative care is not covered. Any hospitalization requires the Pre-Certification of Inpatient Services steps to be completed.

Employees (and their *covered dependents*) residing outside the United States, and *covered dependents* with commitments outside the United States that are approved by the *Plan Administrator*, are eligible for benefits for medical coverage and *hospital* services equivalent to those provided to *Plan participants* within the United States. When obtaining services outside the United States, the *Plan participant* is

Medical Benefits

encouraged to obtain a pre-determination of benefits before receiving services from the *provider*. Benefits are provided only for services rendered by facilities that meet the standards of their localities comparable to those established by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or for services rendered by *physicians* meeting the credentials of their localities comparable to the credential of Board Certification from the American Medical Association (AMA). Benefits are not provided for any services considered *experimental* or *investigational*.

Exclusions and Limitations — Medical

The following services and supplies are NOT covered by this *Plan*:

- ∅ **Absence of coverage:** charges that would not have been made in the absence of coverage.
 - ◇ This includes charges that are submitted to the *Plan* equal to any amount that the *provider* has discounted his or her fees or has “written off” amounts due.
- ∅ **Acupuncture.**
- ∅ **Artificial insemination.**
- ∅ **Birth control drugs,** whether or not dispensed by prescription, that are purchased or prescribed for the sole purpose of preventing conception, unless covered by the provisions of your prescription drug card program.
- ∅ **Breast surgery or services:** altering the size or shape of the breast, male or female, whether elective or not.
 - ◇ This exclusion does not apply to reconstructive surgery performed as a result of a mastectomy due to cancer or tumor fibrocysts, either on the affected breast or, for mastectomy benefits received on or after **January 1, 1999**, on the opposite breast for the purpose of achieving a symmetrical appearance.
 - ◇ This exclusion does not apply to breast reduction surgery if a treatment plan is submitted in advance to *UMR* and the *Plan participant* has multiple medical conditions that are worsened by the natural size of the breasts.
- ∅ **Charges in excess of the semi-private room rate,** except as otherwise noted.
- ∅ **Chiropractic maintenance care.**
- ∅ **Civil insurrection or riot:** treatment or services for *injuries incurred* or exacerbated while participating in a civil insurrection or riot.
- ∅ **Claims** received by *UMR* later than 15 months from the date of service.
- ∅ **Cochlear implants.**
- ∅ **Completion of claim forms.**
- ∅ **Complications** due to, and services related to, non-covered services, whether or not *medically necessary*.
- ∅ **Cosmetic services or aesthetic services** (including complications).
 - ◇ This exclusion does not apply to an *accidental injury* or *illness*, if *medically necessary*.
 - ◇ This exclusion does not apply to correct a congenital anomaly, if *medically necessary*.
- ∅ **Court-ordered services,** unless documented to be *medically necessary*.
- ∅ **Custodial care,** except as specified.

- Ø **Dental hospital admissions**, except for the *medical necessity* of a concomitant condition.
- Ø **Dental prescriptions** (e.g., Peridex, fluoride). These items may be covered under your prescription drug card program.
- Ø **Dental services**.
- Ø **Diagnostic studies**: room and board or general nursing care for *hospital* admissions solely for diagnostic studies.
- Ø **Dietary supplements**: products taken by mouth that contain a “dietary ingredient” intended to supplement the diet. These are typically over-the-counter products used in conjunction with a regular diet.
- Ø **DNA testing**.
- Ø **Drugs and medicines** that, as required by law, may be dispensed only by a registered pharmacist on the written prescription of a *physician* (excluded by the medical provisions of the *Plan*). Prescription drugs may be covered under your prescription drug card program and prescription drug mail service program.
 - ◇ This exclusion does not apply to drugs and medicines dispensed by a registered pharmacist on the written prescription of a *physician* while the *Plan participant* is an inpatient in a *hospital*.
- Ø **Educational, vocational, or training purposes**, services or supplies.
 - ◇ This exclusion does not apply to educational services rendered for diabetic counseling, peritoneal dialysis, or any other educational service deemed to be *medically necessary* by the *Plan*.
- Ø **Environmental change**, hospitalization (such as hospitalization for children or adolescents due to family adjustment or relationship disorders).
- Ø **Experimental treatment**, procedures, facilities, equipment, drugs, devices, supplies, or services.
 - ◇ In some cases, the applications of an established procedure, as a course of treatment for a specific condition, may be considered *experimental*, and hence, not covered by this *Plan*.
- Ø **Eyeglasses, contact lenses, refractions**, or the examination for their prescription and fitting.
 - ◇ This exclusion does not apply to soft lenses or sclera shells intended for use as corneal bandages.
 - ◇ This exclusion does not apply to intraocular lenses following cataract surgery or to correct congenital aphakia.
 - ◇ This exclusion does not apply to the first pair of contact lenses or glasses following cataract surgery.
- Ø **Family counseling**, outpatient.
- Ø **Felonious act**: treatment or services for *injuries incurred* while committing a felonious act for which the individual is convicted.
- Ø **Fertility drugs**.
- Ø **Foot care services, routine**, including, but not limited to, cutting or removal of corns or calluses, the trimming of nails, and other hygienic and preventative and *maintenance care*, performed in the absence of localized *illness, injury*, or symptoms involving the foot.
- Ø **Gamete intrafallopian transfer (GIFT)**.
- Ø **Genetic testing and/or counseling**.
- Ø **Government services**: services furnished by a government or division thereof, except a program for civilian employees of a government.

Medical Benefits

- Ø **Halfway house.**
- Ø **Hearing aids or devices**, or the examination for their prescription and fitting.
- Ø **Immediate family:** treatment provided by a member of your immediate family.
- Ø **Impacted teeth:** extraction of impacted teeth.
- Ø **Impotence treatment and medications.**
- Ø **In vitro fertilization.**
- Ø **Maintenance care.**
- Ø **Marital counseling.**
- Ø **Massage therapy**, unless applied in conjunction with other active physical therapy modalities for a specific *illness* or *injury*.
- Ø **Medically unnecessary services:** services that are not *medically necessary* to the care and treatment of any *injury* or *illness*, except where otherwise specified.
- Ø **Military service:** treatment or services resulting from or prolonged as a result of performing a duty as a member of the *military service* of any state or country.
- Ø **Missed appointments.**
- Ø **Nicorette gum.** This item may be covered under your prescription drug card program.
- Ø **Nicotine transdermal patches.** These items may be covered under your prescription drug card program.
- Ø **No charge:** services for which the *Plan participant* incurs no charge.
- Ø **Not eligible:** charges *incurred* while not eligible for a benefit, such as prior to your effective date or subsequent to your coverage termination date.
- Ø **Obesity treatment**, including any care that is primarily dieting or exercise for weight loss.
 - ◇ This exclusion does not apply to benefits for surgical or non-surgical treatment of morbid obesity if a treatment plan has been submitted to and approved by the *Plan* prior to initiation of treatment.
- Ø **Oral supplements or augmentation** for inborn errors of metabolism.
- Ø **Orthognathic surgery** (jaw realignment surgery) to correct retrognathia, apertognathia, prognathism, open bite malocclusion, or transverse skeletal deformities.
- Ø **Other plan:** charges for services, in whole or in part, available to and covered for the *Plan participant* under any other group plan sponsored by the *employer*.
- Ø **Patient convenience:** expenses *incurred* in the modification of homes, vehicles, or personal property to accommodate patient convenience items. This includes, but is not limited to, the installation of ramps, elevators, air conditioners, air purifiers, TDD/TTY communication devices, personal safety alert systems, exercise equipment, and cervical pillows.
- Ø **Penalties** for non-compliance with the Pre-Certification of Inpatient Services Program or non-compliance with the Pre-Certification of Outpatient Services Program.
- Ø **Penile implants.**
- Ø **Personal hygiene** or convenience items.
- Ø **Physical therapy admissions:** room and board or general nursing care for *hospital* admissions solely for physical therapy.

- ∅ **Premarital tests** not incidental to the treatment of a manifested *injury* or *illness*.
- ∅ **Prenatal vitamins.** These items may be covered under your prescription drug card program.
- ∅ **Preoperative and postoperative visits** made by your surgeon or assistant surgeon on or after the date of your surgery, if billed as a separate line item.
 - ◇ This exclusion does not apply to preoperative or postoperative visits that are appropriate to bill separately based on medical and procedural coding criteria.
- ∅ **Prohibited by law:** charges for which the *Plan* is prohibited by law or regulation from providing benefits.
- ∅ **Radial keratotomy, keratomileusis, or other vision correction procedures.**
- ∅ **Reimbursement:** *injuries* resulting from an accident for which you are reimbursed or entitled to be reimbursed by another party or insurer; however, the *Plan* may make payment on these claims with the understanding that the *Plan* will be reimbursed in accordance with the subrogation provision contained in the **SUBROGATION** section of this SPD.
- ∅ **Residential care facility.**
- ∅ **Reversal of sterilization**, male or female. Complications of such a procedure are covered.
- ∅ **Sclerotherapy** for varicose veins.
- ∅ **Services furnished** or available to the *Plan participant*, in whole or in part, under the laws of the United States, or any state, or political subdivision thereof, or for which the *Plan participant* would have no legal obligation to pay in the absence of this or any similar coverage.
- ∅ **Sex change or implantation.**
- ∅ **Sexual dysfunctions.**
- ∅ **Smoking cessation programs**, services and treatment. These items may be covered under your prescription drug card program.
- ∅ **Surrogate parent agreement**, whether written or oral.
- ∅ **Tax and shipping** levied on *medically necessary* items and services.
 - ◇ This exclusion does not apply to surcharges required to be paid in applicable states.
- ∅ **Teeth or gum treatment**, or the fitting or wearing of dentures.
 - ◇ This exclusion does not apply to treatment of *accidental injury* to sound *natural teeth*.
- ∅ **Telephone and television** service while confined as an inpatient.
- ∅ **Telephone consultations.**
- ∅ **Travel**, even though prescribed by a *physician*.
 - ◇ This exclusion may not apply to a *Plan participant* who is an organ transplant recipient to travel to and from the site of the transplant.
- ∅ **UCR, over:** the portion of any charge that is in excess of the *UCR* charge for a particular service or supply.
- ∅ **Vitamins.** These items may be covered under your prescription drug card program.
- ∅ **War:** treatment or services resulting from or prolonged as a result of participating in a war or act of war, declared or undeclared.
 - ◇ This exclusion does not apply to any *Plan participant* who is not a member of the armed forces.

Medical Benefits

- Ø **Weekend *hospital* admissions, elective.**
- Ø **Without approval:** services furnished without the recommendation and approval of a *physician* acting within the scope of his or her license.
- Ø **Work-related *illness* or *injury*:** treatment for an *illness* or *injury* arising out of, or in the course of, any employment for wage or profit, including, but not limited to, employment with Grand Valley State University, without regard to whether such *illness* or *injury* entitles the *employee* or *covered dependent* to Workers' Compensation or similar benefits.
- Ø **Zygote intrafallopian transfer (ZIFT).**

HEALTH MANAGEMENT SERVICES AND SPECIAL PROVISIONS

It is important to remember that this *Plan* covers only those procedures, services, and supplies that are *medically necessary* unless otherwise specified.

Services that are NOT considered to be *medically necessary* include, but are not limited to:

- Procedures of unproven value or of questionable current usefulness.
- Procedures that could be unnecessary when performed in combination with other procedures.
- Diagnostic procedures that are unlikely to provide a *physician* with additional information when used repeatedly.
- Procedures that are not ordered by a *physician* or that are not documented in a timely fashion in the patient's medical record, or that can be performed with equal effectiveness at a lower level of care facility (e.g., on an outpatient basis).

For example, a medically unnecessary *hospital* admission would be one that does not require acute *hospital* bed patient care and could have been provided in a *physician's* office, *hospital* outpatient department, or lower level of care facility without reduction in the quality of care provided and without harm to the patient. Also, a *hospital* admission primarily for observation, evaluation, or diagnostic study that could be provided adequately and safely on an outpatient basis is considered to be medically unnecessary.

Case Management

Case management is a service that your *employer* has included in your benefit *Plan* at no cost to you. *UMR* case managers are registered nurses with extensive clinical experience.

When you are suffering from a serious *injury* or *illness* and require extensive treatment, you may be offered case management. You or your family may request this service at any time.

When you request this service, a case manager will contact you by phone and/or by mail to request your consent. Should you decide to give consent for case management, the case manager can:

- Help you make the best use of your health care benefits.
- Be an advocate in regards to benefits and helping you obtain needed services within the confines of your benefit *Plan*.
- Provide you with information about your particular *illness(es)* and treatment options.
- Help you access needed resources, medications, and/or medical equipment.
- Answer your questions about the plan of treatment, help you prepare for medical appointments, and help you get information about your medical claims.

You may request a case manager at any time by calling *UMR* at the toll-free number on your ID card and asking the operator to connect you with your claims team representative.

Case managers will maintain your confidentiality according to federal guidelines. Once assigned a case manager, you may call anytime at the toll-free number your case manager provides.

Pre-Certification of Inpatient Services

A *hospital* stay can be a serious and expensive part of your course of treatment. This *Plan* has a special program, Pre-Certification of Inpatient Services, to make sure that you are not hospitalized unnecessarily.

Health Management Services and Special Provisions

If you are admitted to (or registered as a patient at) a *hospital* or a *rehabilitation facility*, whether for *emergency* treatment, elective non-*emergency* treatment, or maternity care in excess of 48 hours for normal delivery or 96 hours for cesarean delivery, you or a member of your family should call *UMR*. The completion of this program is the sole responsibility of the *Plan participant*. This program is not required for an extended *hospital* stay for an observation in excess of 23 hours.

Urgent Care or Emergency Admissions

It is important to remember that, if a *Plan participant* needs medical care for a condition that could seriously jeopardize his or her life, there is no need to contact the *Plan* for prior approval. The *Plan participant* should obtain such care without delay.

If you or a *covered dependent* must be admitted on an *emergency* basis, follow the *physician's* instructions carefully and contact *UMR* by telephone within two business days after the admission date.

The contact may be made by you, a family member, or your *provider*. The *Plan* does not require you or a *covered dependent* to obtain approval of a health care service prior to getting treatment for an urgent care or *emergency* situation, so there are no "pre-service urgent care claims" under the *Plan*. In an urgent care or *emergency* situation, simply follow the *Plan's* procedures with respect to any notice that may be required after receipt of treatment, and file the claim as a post-service claim.

Non-Emergency Admissions

For inpatient services that are scheduled in advance, call *UMR* as soon as possible before actual services are rendered.

UMR's nurse and your admitting *hospital* review your inpatient treatment plan before and during your hospitalization. The objective is to help you obtain all the information you need to make informed decisions. The *UMR* nurse:

- checks *medical necessity* of the *hospital* admission and length of stay against generally accepted medical standards, and
- suggests alternate treatment settings, if appropriate.

You will be notified by mail of the approved length of stay. Additional days may be assigned based on *medical necessity*.

Pre-Certification Penalty

This program requires the support and cooperation of each *Plan participant*. The final decision regarding treatment and hospitalization is yours. Maximum allowable *Plan* benefits are paid as long as you follow the above instructions and procedures for any inpatient hospitalization. However, if you fail to notify *UMR* of any inpatient hospitalization as required above, allowed charges will be reduced as follows and you will be responsible for payment of the part of the charge that is not paid by the *Plan*.

If you fail to follow these steps, the *Plan* pays your claim at a reduced amount. The applicable covered charges are reduced by \$300, and then the benefits payable under this *Plan* are calculated. The reduction of the claim, for which you are responsible, cannot be used to satisfy the annual deductible or the annual out-of-pocket maximum.

Pre-Determination of Medical/Surgical Benefits

The Pre-Determination of Medical/Surgical Benefits Program allows you to make an informed decision before committing to a specific treatment. Participation in this program provides assurance in advance that the recommended service is *medically necessary*, is an allowable expense under the *Plan*, and is a *UCR* charge.

When your *physician* recommends that you undergo a specific course of treatment, contact *UMR* for Pre-Determination of Medical/Surgical Benefits. *UMR*:

- reviews the proposed treatment for *medical necessity*,
- checks the treatment's eligibility for coverage and the extent of coverage relative to your *Plan*, and
- reviews the proposed charges and the reasonableness of planned treatment and fees.

Upon review of the information, *UMR* returns to you and to your *physician* a determination outlining the *medical necessity* of the proposed treatment, the proposed treatment's eligibility as a *covered charge*, and whether the surgeon's fees are within the *UCR* charges for that procedure. The decision regarding treatment remains with you and your *physician*.

Pre-determination of benefits does not guarantee payment. Exact benefits are determined based on the eligibility of the *Plan participant* at the time services are rendered.

This *Plan* does not provide benefits for certain services unless a pre-determination of benefits is obtained in advance. Refer to the **EXCLUSIONS AND LIMITATIONS — MEDICAL** section.

It is important to remember that, if a *Plan participant* needs medical care for a condition that could seriously jeopardize his or her life, there is no need to contact the *Plan* or *UMR* for pre-determination of benefits. The *Plan participant* should obtain such care without delay.

Pre-Certification of Outpatient Services

With the exception of urgent care or *emergency* outpatient services as explained below, the Pre-Certification of Outpatient Services Program allows you to verify, in advance of receiving a service, that the recommended service is *medically necessary*, is an allowable expense of the *Plan*, and is within reasonable costs. If your *physician* recommends surgical treatment for morbid obesity, contact *UMR* as instructed below.

Urgent Care or Emergency Outpatient Services

It is important to remember that, if a *Plan participant* needs medical care for a condition that could seriously jeopardize his or her life, there is no need to contact the *Plan* for prior approval. The *Plan participant* should obtain such care without delay.

If you or a *covered dependent* must obtain outpatient medical treatment or services on an *emergency* basis, follow the *physician's* instructions carefully and contact *UMR* by telephone within two business days after the date on which the medical treatment or services were provided.

The contact may be made by you, a family member, or your *provider*. The *Plan* does not require you or a *covered dependent* to obtain approval of a health care service prior to getting treatment for an urgent care or *emergency* situation, so there are no "pre-service urgent care claims" under the *Plan*. In an urgent care or *emergency* situation, simply follow the *Plan's* procedures with respect to any notice that may be required after receipt of treatment, and file the claim as a post-service claim.

Non-Emergency Outpatient Services

For outpatient services that are scheduled in advance, call *UMR* as soon as possible before actual services are rendered.

Pre-Certification Penalty

This program requires the support and cooperation of each *Plan participant*. The final decision regarding treatment is yours. Maximum allowable *Plan* benefits are paid as long as you follow the above instructions and procedures for surgical treatment of morbid obesity. However, if you fail to notify *UMR*

Health Management Services and Special Provisions

as required above, allowed charges will be reduced as follows and you will be responsible for payment of the part of the charge that is not paid by the *Plan*.

If you fail to follow these steps, the *Plan* pays your claim at a reduced amount. The applicable covered charges are reduced by \$300, and then the benefits payable under this *Plan* are calculated. The reduction of the claim, for which you are responsible, cannot be used to satisfy the annual deductible or the annual out-of-pocket maximum.

Employee Assistance Program

Grand Valley State University recognizes the need to provide a resource for those personal and family stresses that affect everyone at one time or another. The Employee Assistance Program (EAP) is a confidential way for individuals, couples, and *families* to obtain professional help to reduce the impact of everyday stresses. EAP services include pre-admission certification, assessment, counseling, and referral for such problems as *mental health* concerns, family and marital problems, emotional stress, depression and anxiety, *substance abuse*, parent/child conflict, and family budgeting.

Contact Human Resources for more detailed information about this program.

HOW TO FILE A CLAIM

UMR, the *claims administrator*, is responsible for keeping the records of each *Plan participant's* benefits and for processing claims filed with the *Plan*. Each *Plan participant* is responsible for making sure that claims are submitted on a timely basis. Ordinarily, this will not require the submission of a claim form since most *providers* submit bills for service directly to *UMR*.

In some cases you may be required to submit a bill and claim form directly to *UMR*. See the **SUBMISSION OF CLAIMS** section for detailed instructions on claim submission. In either case, you must make sure that all bills are submitted according to the **TIMELY FILING PROVISION** section of this document.

Timely Filing Provision

You or your *provider* may submit claim requests anytime during the calendar year, January 1 through December 31. **All claims incurred must be received by UMR no later than 15 months from the date you received the services. Claims filed later than that date will be denied.**

Benefits are based upon the *Plan's* provisions at the time the charges were *incurred*.

A pre-service non-urgent claim (including a concurrent claim that also is a pre-service non-urgent claim) is considered to be filed when the request for approval of treatment or services is made and received by the *claims administrator* in accordance with the *Plan's* procedures.

A post-service claim is considered to be filed when the following information is received by the *claims administrator*, together with a Form HCFA or Form UB92:

- The date of service;
- The name, address, telephone number, and tax identification number of the *provider* of the services or supplies;
- The place where the services were rendered;
- The diagnosis and procedure codes;
- The amount of charges (including re-pricing information);
- The name of the *Plan*;
- The name of the covered *employee*; and
- The name of the patient.

Upon receipt of this information, the claim will be deemed to be filed with the *Plan*.

A claim may not be resubmitted if it has already been submitted, denied, appealed, and denied on appeal, whether in whole or in part. A previously denied appeal is never to be considered a new claim, even if filed in accordance with the *Plan's* procedures.

The *claims administrator* will determine if enough information has been submitted to enable proper consideration of the claim. If it has not, more information may be requested as provided herein. This additional information must be received by the *claims administrator* within 45 days from receipt by the *Plan participant* of the request for additional information. **Failure to provide the information by this deadline may result in claims being declined or reduced.**

How to File a Claim

Hospital Claims

Most *hospitals* will submit your claim directly to *UMR*. You need only present your identification card to the *hospital* admitting office when you or a *covered dependent* is admitted as a *hospital* inpatient or receives treatment as a *hospital* outpatient.

When you are discharged or a few days after discharge, you should receive an itemized bill from the billing office. If the bill does not indicate that it has been submitted to *UMR*, contact the billing office for clarification of the *hospital's* billing procedures.

Physician Claims

In most cases, when you or a *covered dependent* receives treatment at a *physician's* office, the office submits the claim directly to *UMR* on your behalf. If it does not, you must submit the claim directly. In those instances, see the **SUBMISSION OF CLAIMS** section.

Other Expenses

Each time you *incur* expenses for *covered charges*, you must keep a receipt that can be submitted with your claim form. You must keep separate records for each *Plan participant*. To make a claim, complete a claim form, attach the appropriate receipts, and send the information to *UMR*. Be sure to include:

- Patient's full name.
- Nature of treatment or service rendered.
- License number of professional, e.g., registered nurse.

Submission of Claims

If you find that you must submit a claim directly to *UMR*, follow these guidelines so that your claim can be processed as easily and quickly as possible:

- Visit www.myumr.com to obtain the required forms for submitting a claim.
- A separate claim form should be submitted for each *Plan participant*.
- You are responsible for completing the *employee* section of the claim form and for submitting the form to *UMR*.
- Request that the *provider* complete the remaining portions. (Frequently the *provider's* receipt contains the pertinent information.)
- The form must be signed by the *employee* or *covered dependent* (except in the case of a minor).
 - ◆ When you make a claim for a *covered dependent* who is a *full-time student*, *UMR* requires that you submit a copy of the student's current schedule (once per year).
- Information must be provided for each section of the claim form or it will be returned, and processing delayed.
- Each claim should include all necessary *provider* bills. The claim cannot be processed without these documents. Forward the claim form and necessary receipts to *UMR*.
 - ◆ All bills must include:
 - * Group *Plan* number: **010108GU**.
 - * Patient's full name.

- * Diagnosis.
 - * Type of service or supply.
 - * Itemized charge.
 - * Date(s) of service.
 - * *Provider's* name, title, tax ID number, and address.
- Be sure to designate on the form whether payment is to be made to you directly or to your *provider*.
 - Canceled checks, balance due statements, or cash register receipts are not acceptable forms of statements for services rendered and are not accepted in place of bills.
 - When requested, you must furnish any required information regarding other group or third party medical benefits for which the *Plan participant* is eligible.
 - The *Plan participant* is required to fully and truthfully complete the claim for benefits and supply any pertinent information from personal or professional sources, as may be required by *UMR*.
 - If you need to contact *UMR*, be sure to identify yourself as a *Plan participant* of the Grand Valley State University Early Retiree Base Medical Plan.

Release of Information

Part of the claim form is a release of information. You must allow *UMR* to review your medical records, as needed, if the *Plan* is to provide coverage. The *Plan Administrator* may, without the consent of or notice to any person, release to or obtain from any organization or person any information that the *Plan Administrator* deems to be necessary. This information is used only to determine your benefits. Sometimes additional information is needed before coverage can be provided. This usually relates to the coordination of benefits, subrogation, or the eligibility of certain children.

Effective Date

Payment for *covered charges* is made only when charges are *incurred* on or after the *Plan participant's* effective date of coverage and prior to the *Plan participant's* effective date of termination of coverage.

Questions

Anytime you have questions about your benefits or require assistance in making a claim, contact *UMR* at:

United Medical Resources, Inc.
P.O. Box 145804
Cincinnati, Ohio 45250-5804

513-619-3000
Cincinnati and Northern Kentucky
1-800-950-4867 Toll-Free

8:30 a.m. to 5:00 p.m. EST/EDT
Monday through Friday

When you contact *UMR*, be sure to provide the following information:

How to File a Claim

- Your name (and name of patient if not the same).
- The name of your *employer*.
- The name of your *Plan*, the Grand Valley State University Early Retiree Base Medical Plan.
- Your member identification number.
- The date(s) of service.
- The name of the service *provider*.

Claims Procedures

Plan participants must follow the procedures outlined below to obtain payment of health benefits under this *Plan*.

Claims

All claims and questions regarding health claims should be directed to the *claims administrator*. The *Plan Administrator* is ultimately and finally responsible for adjudicating such claims and for providing full and fair review of the decision on such claims in accordance with the following provisions. Benefits under the *Plan* will be paid only if the *Plan Administrator* decides, at its discretion, that the *Plan participant* is entitled to them. The responsibility to process claims in accordance with the SPD may be delegated to the *claims administrator*, provided, however, that the *claims administrator* is not a fiduciary of the *Plan* and does not have the authority to make decisions involving the use of discretion.

Each *Plan participant* claiming benefits under the *Plan* will be responsible for supplying, at such times and in such manner as the *Plan Administrator*, at its sole discretion, may require, written proof that the expenses were *incurred* under the *Plan*. If the *Plan Administrator*, at its sole discretion, determines that the *Plan participant* has not *incurred covered charges* under the *Plan*, or if the *Plan participant* fails to furnish such proof as is requested, no benefits will be payable under the *Plan*.

Under the *Plan*, there are three types of health claims: pre-service non-urgent, concurrent, and post-service.

Pre-Service Non-Urgent Claims

A “pre-service claim” is a claim for a benefit under the *Plan* where the *Plan* conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

A “pre-service urgent care claim” is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the *Plan participant* or the *Plan participant’s* ability to regain maximum function, or, in the opinion of a *physician* with knowledge of the *Plan participant’s* medical condition, would subject the *Plan participant* to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

It is important to remember that, if a *Plan participant* needs medical care for a condition that could seriously jeopardize his or her life, there is no need to contact the *Plan* for prior approval. The *Plan participant* should obtain such care without delay.

Further, because the *Plan* does not require the *Plan participant* to obtain approval of a health care service in an urgent care situation prior to getting treatment, there are no pre-service urgent care claims under this *Plan*; rather, the *Plan* requires pre-approval only for pre-service non-urgent claims. In an urgent care situation, the *Plan participant* simply follows the *Plan’s* procedures with respect to any notice that may be required after receipt of treatment, and files the claim as a post-service claim.

Concurrent Claims

A “concurrent claim” arises when the *Plan* has approved an ongoing course of treatment to be provided over a period of time or number of treatments, and either (a) the *Plan* determines that the course of treatment should be reduced or terminated, or (b) the *Plan participant* requests extension of the course of treatment beyond that which the *Plan* has approved.

If the *Plan* does not require the *Plan participant* to obtain approval of a health care service prior to getting treatment, then there is no need to contact the *Plan Administrator* to request an extension of a course of treatment. The *Plan participant* simply follows the *Plan*’s procedures with respect to any notice that may be required after receipt of treatment, and files the claim as a post-service claim.

Post-Service Claims

A “post-service claim” is a claim for a benefit under the *Plan* after the services have been rendered.

Timing of Claim Decisions

The *Plan Administrator* will notify the *Plan participant*, in accordance with the provisions set forth below, of any adverse benefit determination (and, in the case of pre-service non-urgent claims and concurrent claims, of decisions that a claim is payable in full) within the following timeframes:

Pre-Service Non-Urgent Care Claims

- If the *Plan participant* has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but no later than 15 days after receipt of the claim, unless an extension has been requested; then prior to the end of the 15-day extension period.
- If the *Plan participant* has not provided all of the information needed to process the claim, then the *Plan participant* will be notified as to what specific information is needed as soon as possible, but no later than 5 days after receipt of the claim. The *Plan participant* will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the *Plan Administrator* and the *Plan participant* (if additional information was requested during the extension period).

Concurrent Claims

- **Plan Notice of Reduction or Termination:** If the *Plan Administrator* is notifying the *Plan participant* of a reduction or termination of a course of treatment (other than by *Plan* amendment or termination), before the end of such period of time or number of treatments. The *Plan participant* will be notified sufficiently in advance of the reduction or termination to allow the *Plan participant* to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.
- **Request by Plan Participant Involving Non-Urgent Care:** If the *Plan Administrator* receives a request from the *Plan participant* to extend the course of treatment beyond the period of time or number of treatments that is a claim not involving urgent care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a pre-service non-urgent claim or as a post-service claim).

Post-Service Claims

- If the *Plan participant* has provided all of the information needed to process the claim, in a reasonable period of time, but no later than 30 days after receipt of the claim, unless an extension has been requested; then prior to the end of the 15-day extension period.

How to File a Claim

- If the *Plan participant* has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the *Plan participant* will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period; then the *Plan participant* will be notified of the determination by a date agreed to by the *Plan Administrator* and the *Plan participant*.

Extensions – Pre-Service Non-Urgent Care Claims

This period may be extended by the *Plan* for up to 15 days, provided that the *Plan Administrator* both determines that such an extension is necessary due to matters beyond the control of the *Plan* and notifies the *Plan participant*, prior to the expiration of the initial 15-day processing period, of the circumstances requiring the extension of time and the date by which the *Plan* expects to render a decision.

Extensions – Post-Service Claims

This period may be extended by the *Plan* for up to 15 days, provided that the *Plan Administrator* both determines that such an extension is necessary due to matters beyond the control of the *Plan* and notifies the *Plan participant*, prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time and the date by which the *Plan* expects to render a decision.

Calculating Time Periods

The period of time within which a benefit determination is required to be made will begin at the time a claim is deemed to be filed in accordance with the procedures of the *Plan*.

Notification of an Adverse Benefit Determination

In the event of an adverse benefit determination, the *Plan Administrator* will provide a *Plan participant* with a notice, either in writing or electronically, containing the following information:

- A reference to the specific portion(s) of the SPD upon which a denial is based;
- Specific reason(s) for a denial;
- A description of any additional information necessary for the *Plan participant* to perfect the claim and an explanation of why such information is necessary;
- A description of the *Plan*'s review procedures and the time limits applicable to the procedures, including a statement of the *Plan participant*'s right to bring a civil action following an adverse benefit determination on final review;
- A statement that the *Plan participant* is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the *Plan participant*'s claim for benefits;
- The identity of any medical or vocational experts consulted in connection with a claim, even if the *Plan* did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);
- Any rule, guideline, protocol, or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the *Plan participant*, free of charge, upon request); and
- In the case of denials based upon a medical judgment (such as whether the treatment is *medically necessary* or *experimental*), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the *Plan* to the *Plan participant*'s medical circumstances, or a statement that such explanation will be provided to the *Plan participant*, free of charge, upon request.

Appeal of Adverse Benefit Determinations

Full and Fair Review of All Claims

In cases where a claim for benefits is denied, in whole or in part, and the *Plan participant* believes the claim has been denied wrongly, the *Plan participant* may appeal the denial and review pertinent documents. The claims procedures of this *Plan* provide a *Plan participant* with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination. More specifically, the *Plan* provides:

- *Plan participants* at least 180 days following receipt of a notification of an initial adverse benefit determination within which to appeal the determination;
- *Plan participants* the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;
- For a review that does not afford deference to the previous adverse benefit determination and that is conducted by an appropriate named fiduciary of the *Plan*, who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
- For a review that takes into account all comments, documents, records, and other information submitted by the *Plan participant* relating to the claim, without regard to whether such information was submitted or considered in the prior benefit determination;
- That, in deciding an appeal of any adverse benefit determination that is based, in whole or in part, upon a medical judgment, the *Plan* fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual;
- For the identification of medical or vocational experts whose advice was obtained on behalf of the *Plan* in connection with a claim, even if the *Plan* did not rely upon their advice; and
- That a *Plan participant* will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the *Plan participant's* claim for benefits in possession of the *Plan Administrator* or the *claims administrator*; information regarding any voluntary appeals procedures offered by the *Plan*; any internal rule, guideline, protocol, or other similar criterion relied upon in making the adverse determination; and an explanation of the scientific or clinical judgment for the determination, applying the terms of the *Plan* to the *Plan participant's* medical circumstances.

Requirements for Appeal

The *Plan participant* must file the appeal in writing within 180 days following receipt of the notice of an adverse benefit determination. To file an appeal in writing, the *Plan participant's* appeal must be mailed to the *claims administrator* at:

United Medical Resources, Inc.
P.O. Box 145804
Cincinnati, Ohio 45250-5804
Attention: Appeals

It is the responsibility of the *Plan participant* to submit proof that the claim for benefits is covered and payable under the provisions of the *Plan*. Any appeal must include:

- The name of the *Plan participant*;

How to File a Claim

- The *Plan participant*'s member identification number;
- The group name or identification number;
- All facts and theories supporting the claim for benefits. **Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the *Plan participant* will lose the right to raise factual arguments and theories that support the claim if the *Plan participant* fails to include them in the appeal;**
- A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and
- Any material or information the *Plan participant* has that indicates that the *Plan participant* is entitled to benefits under the *Plan*.

It is noted that an appeal filed by a health care *provider* on behalf of a *Plan participant* is not considered an appeal under the *Plan*; all appeals must be filed by the *Plan participant*. If the *Plan participant* provides all of the required information, it may be that the expenses will be eligible for payment under the *Plan*.

Timing of Notification of Benefit Determination on Review

The *Plan Administrator* will notify the *Plan participant* of the *Plan*'s benefit determination on review within the following timeframes:

Pre-Service Non-Urgent Care Claims: Within a reasonable period of time appropriate to the medical circumstances, but no later than 30 days after receipt of the appeal.

Concurrent Claims: Within the appropriate time period based upon the type of claim (pre-service non-urgent or post-service).

Post-Service Claims: Within a reasonable period of time, but no later than 60 days after receipt of the appeal.

Calculating Time Periods: The period of time within which the *Plan*'s determination is required to be made will begin at the time an appeal is filed in accordance with the procedures of this *Plan*, without regard to whether all information necessary to make the determination accompanies the filing.

Manner and Content of Notification of Adverse Benefit Determination on Review

The *Plan Administrator* will provide a *Plan participant* with notification, in writing or electronically, of a *Plan*'s adverse benefit determination on review, setting forth:

- The specific reason or reasons for the denial;
- Reference to the specific portion(s) of the SPD on which the denial is based;
- The identity of any medical or vocational experts consulted in connection with the claim, even if the *Plan* did not rely upon their advice;
- A statement that the *Plan participant* is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the *Plan participant*'s claim for benefits;
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the *Plan participant* upon request;

- If the adverse benefit determination is based upon a medical judgment, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the *Plan* to the *Plan participant's* medical circumstances, will be provided free of charge upon request;
- A statement of the *Plan participant's* right to bring an action following an adverse benefit determination on final review; and
- The following statement: “You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency.”

Furnishing Documents in the Event of an Adverse Determination

In the case of an adverse benefit determination on review, the *Plan Administrator* will provide such access to, and copies of, documents, records, and other information described above as appropriate.

Decision on Review to Be Final

If, for any reason, the *Plan participant* does not receive a written response to the appeal within the appropriate time period set forth above, the *Plan participant* may assume that the appeal has been denied. The decision by the *Plan Administrator* or other appropriate named fiduciary of the *Plan* on review will be final, binding, and conclusive, and will be afforded the maximum deference permitted by law. **All claim review procedures provided for in the *Plan* must be exhausted before any legal action is brought. Any legal action for the recovery of any benefits must be commenced within one year after the *Plan's* claim review procedures have been exhausted.**

Resubmitting a Denied Claim

A claim may not be resubmitted if it has already been submitted, denied, appealed, and denied on appeal, whether in whole or in part. A previously denied appeal is never to be considered a new claim, even if filed in accordance with the *Plan's* procedures.

Appointment of Authorized Representative

A *Plan participant* is permitted to appoint an authorized representative to act on his or her behalf with respect to a benefit claim or appeal of a denial. An assignment of benefits by a *Plan participant* to a *provider* will not constitute appointment of that *provider* as an authorized representative. To appoint such a representative, the *Plan participant* must complete a form that may be obtained from the *Plan Administrator* or the *claims administrator*. In the event a *Plan participant* designates an authorized representative, all future communications from the *Plan* will be with the representative, rather than the *Plan participant*, unless the *Plan participant* directs the *Plan Administrator*, in writing, to the contrary.

Physical Examinations

The *Plan* reserves the right to have a *physician* of its own choosing examine any *Plan participant* whose condition, *sickness*, or *injury* is the basis of a claim. All such examinations will be at the expense of the *Plan*. This right may be exercised when and as often as the *Plan* may reasonably require during the pendency of a claim. The *Plan participant* must comply with this requirement as a necessary condition to coverage.

Autopsy

The *Plan* reserves the right to have an autopsy performed upon any deceased *Plan participant* whose condition, *sickness*, or *injury* is the basis of a claim. This right may be exercised only where not prohibited by law.

How to File a Claim

Payment of Benefits

All benefits under this *Plan* are payable, in U.S. dollars, to the covered *employee* whose *sickness* or *injury*, or whose *covered dependent's sickness* or *injury*, is the basis of a claim. In the event of the death or incapacity of a covered *employee* and in the absence of written evidence to this *Plan* of the qualification of a guardian for his or her estate, this *Plan* may, at its sole discretion, make any and all such payments to the individual or institution that, in the opinion of this *Plan*, is or was providing the care and support of such *employee*.

Assignments

Benefits for medical expenses covered under this *Plan* may be assigned by a *Plan participant* to the *provider*; however, if those benefits are paid directly to the *employee*, the *Plan* will be deemed to have fulfilled its obligations with respect to such benefits. The *Plan* will not be responsible for determining whether any such assignment is valid. Payment of benefits that have been assigned will be made directly to the assignee unless a written request not to honor the assignment, signed by the covered *employee* and the assignee, has been received before the proof of loss is submitted.

Recovery of Payments

The *Plan* reserves the right to deduct from any benefits properly payable under this *Plan* the amount of any payment that has been made:

- In error;
- Pursuant to a misstatement contained in a proof of loss or a fraudulent act;
- Pursuant to a misstatement made to obtain coverage under this *Plan* within two years after the date such coverage commences;
- With respect to an ineligible person;
- In anticipation of obtaining a recovery in subrogation if a *Plan participant* fails to comply with the *Plan's* provisions regarding subrogation; or
- Pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational *injury* or disease to the extent that such benefits are recovered. This provision will not be deemed to require the *Plan* to pay benefits under this *Plan* in any such instance.

The deduction may be made against any claim for benefits under this *Plan* by a covered *employee* or by any of his or her *covered dependents* if such payment is made with respect to the covered *employee* or any person covered or asserting coverage as a dependent of the covered *employee*.

Medicaid Coverage

A *Plan participant's* eligibility for any state Medicaid benefits will not be taken into account in determining or making any payments for benefits to or on behalf of such *Plan participant*. Any such benefit payments will be subject to the state's right to reimbursement for benefits it has paid on behalf of the *Plan participant*, as required by the state Medicaid program, and the *Plan* will honor any subrogation rights the state may have with respect to benefits that are payable under the *Plan*.

PLAN ADMINISTRATION

Plan Administrator

The *Plan* is administered by the *Plan Administrator*. An individual or entity may be appointed by the *Plan Sponsor* to be *Plan Administrator* and serve at the convenience of the *Plan Sponsor*. If the *Plan Administrator* resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the *Plan Sponsor* will appoint a new *Plan Administrator* as soon as reasonably possible.

The *Plan Administrator* will administer this *Plan* in accordance with its terms and will establish its policies, interpretations, practices, and procedures. It is the express intent of this *Plan* that the *Plan Administrator* will have maximum legal discretionary authority to construe and interpret the terms and provisions of the *Plan*, to make determinations regarding issues that relate to eligibility for benefits (including the determination of what services, supplies, care, and treatments are *experimental*), to decide disputes that may arise relative to a *Plan participant's* rights, and to decide questions of *Plan* interpretation and those of fact relating to the *Plan*. The decisions of the *Plan Administrator* as to the facts related to any claim for benefits and the meaning and intent of any provision of the *Plan*, or its application to any claim, will receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this *Plan* will be paid only if the *Plan Administrator* decides, at its discretion, that the *Plan participant* is entitled to them.

Duties of the Plan Administrator

The duties of the *Plan Administrator* include the following:

- To administer the *Plan* in accordance with its terms;
- To determine all questions of eligibility, status, and coverage under the *Plan*;
- To interpret the *Plan*, including the authority to construe possible ambiguities, inconsistencies, omissions, and disputed terms;
- To make factual findings;
- To decide disputes that may arise relative to a *Plan participant's* rights;
- To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them, and to uphold or reverse such denials;
- To keep and maintain all records pertaining to the *Plan*;
- To appoint and supervise a third party administrator to pay claims;
- To perform all necessary reporting;
- To establish and communicate procedures to determine whether a *medical child support order* is a *QMCSO*;
- To delegate to any person or entity such powers, duties, and responsibilities as it deems appropriate; and
- To perform each and every function necessary for or related to the *Plan's* administration.

PLAN INFORMATION

Plan Name

Grand Valley State University Early Retiree Base Medical Plan

Plan Sponsor and Plan Administrator

Grand Valley State University
140 Lake Michigan Hall, 1 Campus Drive
Allendale, Michigan 49401-9403
616-331-2220

Plan Sponsor's identification number: 38-1681480

Plan Type

This is a group health plan that offers hospitalization and medical benefits.

This *Plan* provides benefits for medical expenses *incurred* as a result of an *accidental injury, injury, illness, or sickness*. It does not provide benefits for the actual *accidental injury, injury, illness, or sickness*.

Plan Effective Date

The effective date of the amended *Plan* as described in this SPD is January 1, 2008.

Eligible Participants

Please refer to the **ELIGIBILITY AND ENROLLMENT** section.

Claims Administrator

United Medical Resources, Inc.
P.O. Box 145804
Cincinnati, Ohio 45250-5804
513-619-3000
Cincinnati and Northern Kentucky
1-800-950-4867 Toll-Free

Plan Funding

This *Plan* is self-funded by contributions from the *Plan Sponsor* and the *employees*. Benefits are paid from the general assets of the *Plan Sponsor*. *Employee* contributions are calculated annually and are used to pay claims.

Plan Service of Legal Process

The *Plan's* agent for service of legal process is:

Grand Valley State University
Plan Administrator
140 Lake Michigan Hall, 1 Campus Drive
Allendale, Michigan 49401-9403
Attn: D. Scott Richardson, Associate Vice President for Human Resources

Plan Information

This *Plan* is a legal entity. Service of legal process may be made upon the *Plan Administrator*.

Benefit Records — Calendar Year

The benefit records are kept January 1 through December 31 for processing claims.

Plan Records — Plan Year

The fiscal records are kept January 1 through December 31 for Department of Labor reporting.

Benefit Committee

The members of the Benefit Committee (*employees* of Grand Valley State University) are as follows:

D. Scott Richardson, Associate Vice President for Human Resources
David D. Smith, Director, Benefit Services
Grand Valley State University
140 Lake Michigan Hall, 1 Campus Drive
Allendale, Michigan 49401-9403

Administration of Plan

The *Plan* is a self-insured welfare benefit plan. *UMR* is not an insurance company or carrier, but merely processes claims under the *Plan* on behalf of the *Plan Administrator*. The *Plan Sponsor* has a stop loss, or excess loss, insurance policy to finance large claims under the *Plan*. The stop loss carrier does not directly pay benefits of the *Plan*. Rather, the insurance carrier pays the *Plan Sponsor* consistent with the self-insured status of the *Plan*, and the use of stop loss is merely a means of financing by the *Plan Sponsor*.

Plan Modification, Amendment, and Termination

The *Plan Sponsor* has established this *Plan* with the intention of maintaining it for an indefinite period of time. However, the *Plan Sponsor* may, at its sole discretion, at any time, amend or terminate the *Plan*, in whole or in part. This includes the right, at its sole discretion:

- to amend or terminate this *Plan*, in whole or in part, at any time.
- to amend or terminate retiree benefits of this *Plan*, in whole or in part, at any time.
- to change, increase, or decrease *Plan* contributions (if any), in whole or in part, at any time.

No consent is required on the part of any *Plan participant* for the *Plan Sponsor* to take any of the actions indicated above.

The preceding provisions will apply regardless of any oral or written statement to any person to the contrary.

Any such amendment or termination will be enacted, if the *Plan Sponsor* is a corporation, by resolution of the *Plan Sponsor's* directors and officers, which will be acted upon as provided in the *Plan Sponsor's* Articles of Incorporation or Bylaws, as applicable, and in accordance with applicable federal and state law. In the event that the *Plan Sponsor* is a different type of entity, then such amendment or termination will be taken and enacted in accordance with applicable federal and state law and any applicable governing documents. In the event that the *Plan Sponsor* is a sole proprietorship, then such action will be taken by the sole proprietor, at his or her sole discretion.

If the *Plan* is terminated, the rights of the *Plan participants* are limited to expenses *incurred* before termination. All amendments to the *Plan* will be effective as of a date established by the *Plan Sponsor*.

HIPAA PRIVACY AND SECURITY

Disclosure of Summary Health Information to the Plan Sponsor

In accordance with the Privacy Standards, the *Plan* may disclose Summary Health Information to the *Plan Sponsor*, if the *Plan Sponsor* requests the Summary Health Information for the purpose of (a) obtaining premium bids from health plans for providing health insurance coverage under this *Plan* or (b) modifying, amending, or terminating the *Plan*.

“Privacy Standards” means the Standards for Privacy of Individually Identifiable Health Information issued pursuant to the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA).

“Summary Health Information” may be individually identifiable health information. It summarizes the claims history, claims expenses, or type of claims experienced by individuals in the *Plan*, but excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

Disclosure of Protected Health Information (PHI) to the Plan Sponsor for Plan Administration Purposes

In order that the *Plan Sponsor* may receive and use PHI for *Plan* administration purposes, the *Plan Sponsor* agrees to:

- Not use or further disclose PHI other than as permitted or required by the SPD or as required by law (as defined in the Privacy Standards);
- Ensure that any agents, including subcontractors, to whom the *Plan Sponsor* provides PHI received from the *Plan* agree to the same restrictions and conditions that apply to the *Plan Sponsor* with respect to such PHI;
- Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or *employee* benefit plan of the *Plan Sponsor*, except pursuant to an authorization that meets the requirements of the Privacy Standards;
- Report to the *Plan* any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the *Plan Sponsor* becomes aware;
- Make available PHI in accordance with Section 164.524 of the Privacy Standards (45 CFR 164.524);
- Make available PHI for amendment and incorporate any amendments to PHI in accordance with Section 164.526 of the Privacy Standards (45 CFR 164.526);
- Make available the information required to provide an accounting of disclosures in accordance with Section 164.528 of the Privacy Standards (45 CFR 164.528);
- Make its internal practices, books, and records relating to the use and disclosure of PHI received from the *Plan* available to the Secretary of the U.S. Department of Health and Human Services (HHS), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the *Plan* with Part 164, Subpart E, of the Privacy Standards (45 CFR 164.500 et seq.);
- If feasible, return or destroy all PHI received from the *Plan* that the *Plan Sponsor* still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and

HIPAA Privacy and Security

- Ensure that adequate separation between the *Plan* and the *Plan Sponsor*, as required in Section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504[f][2][iii]), is established as follows:
 - ◆ The following *employees*, or classes of *employees*, or other persons under control of the *Plan Sponsor*, will be given access to the PHI to be disclosed:
 - Director, Benefit Services
 - Benefit Specialist
 - Employment and Benefits Assistant
 - ◆ The access to and use of PHI by the individuals described above will be restricted to the *Plan* administration functions that the *Plan Sponsor* performs for the *Plan*.
 - ◆ In the event any of the individuals described above do not comply with the provisions of the SPD relating to use and disclosure of PHI, the *Plan Administrator* will impose reasonable sanctions as necessary, at its discretion, to ensure that no further non-compliance occurs. Such sanctions will be imposed progressively (for example, an oral warning, a written warning, time off without pay, and termination), if appropriate, and will be imposed so that they are commensurate with the severity of the violation. “*Plan* administration” activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend, or terminate the *Plan* or solicit bids from prospective issuers. *Plan* administration functions include quality assurance, claims processing, auditing, monitoring, and management of carve-out plans, such as vision and dental. They do not include any employment-related functions or functions in connection with any other benefit or benefit plans.

The *Plan* will disclose PHI to the *Plan Sponsor* only upon receipt of a certification by the *Plan Sponsor* that (a) the SPD has been amended to incorporate the above provisions and (b) the *Plan Sponsor* agrees to comply with such provisions.

Disclosure of Certain Enrollment Information to the Plan Sponsor

Pursuant to Section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504[f][1][iii]), the *Plan* may disclose to the *Plan Sponsor* information on whether an individual is participating in the *Plan* or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered by the *Plan* to the *Plan Sponsor*.

Disclosure of PHI to Obtain Stop Loss or Excess Loss Coverage

The *Plan Sponsor* hereby authorizes and directs the *Plan*, through the *Plan Administrator* or the *claims administrator*, to disclose PHI to stop loss carriers, excess loss carriers, or managing general underwriters (MGUs) for underwriting and other purposes in order to obtain and maintain stop loss or excess loss coverage related to benefit claims under the *Plan*. Such disclosures will be made in accordance with the Privacy Standards.

Disclosure of Electronic PHI to the Plan Sponsor for Plan Administration Functions

To enable the *Plan Sponsor* to receive and use electronic PHI for *Plan* administration functions (as defined in 45 CFR 164.504[a]), the *Plan Sponsor* agrees to:

- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the *Plan*;

- Ensure that adequate separation between the *Plan* and the *Plan Sponsor*, as required in 45 CFR 164.504(f)(2)(iii), is supported by reasonable and appropriate security measures;
- Ensure that any agent, including a subcontractor, to whom the *Plan Sponsor* provides electronic PHI created, received, maintained, or transmitted on behalf of the *Plan*, agrees to implement reasonable and appropriate security measures to protect the electronic PHI; and
- Report to the *Plan* any security incident of which it becomes aware.

Any terms not otherwise defined in this SPD will have the meanings set forth in the Security Standards.

Other Disclosures and Uses of PHI

With respect to all other disclosures and uses of PHI, the *Plan* will comply with the Privacy Standards.

MISCELLANEOUS INFORMATION

Conformity With Applicable Laws

This *Plan* will be deemed to be amended automatically to conform as required by any applicable law, regulation, or order or judgment of a court of competent jurisdiction governing provisions of this *Plan*, including, but not limited to, stated maximums, exclusions, or limitations. In the event that any law, regulation, or order or judgment of a court of competent jurisdiction causes the *Plan Administrator* to pay claims that are otherwise limited or excluded under this *Plan*, such payments will be considered as being in accordance with the terms of this SPD. It is intended that the *Plan* will conform to the requirements of any applicable law.

Fraud

The following actions by any *Plan participant*, or a *Plan participant's* knowledge of such actions being taken by another, constitute fraud and will result in immediate termination of all coverage under this *Plan* for the entire *family* of which the *Plan participant* is a member:

- Attempting to submit a claim for benefits (including attempting to fill a prescription) for a person who is not a *Plan participant*;
- Attempting to file a claim for a *Plan participant* for services that were not rendered or drugs or other items that were not provided;
- Providing false or misleading information in connection with enrollment in the *Plan*; or
- Providing any false or misleading information to the *Plan*.

Headings

The headings used in this SPD are for convenience of reference only. *Plan participants* are advised not to rely on any provision because of the heading.

Gender and Number

Pronouns and other similar words used in the masculine gender are to be read as the feminine gender where appropriate and the singular form of words is to be read as the plural where appropriate.

No Waiver or Estoppel

No term, condition, or provision of this *Plan* will be deemed to have been waived, and there will be no estoppel against the enforcement of any provision of this *Plan*, except by written instrument of the party charged with such waiver or estoppel. No such written waiver will be deemed a continuing waiver unless specifically stated therein, and each such waiver will operate only as to the specific term or condition waived and will not constitute a waiver of such term or condition for the future or as to any act other than the one specifically waived.

Right to Receive and Release Information

For the purpose of determining the applicability of and implementing the terms of these benefits, the *Plan Administrator* may, without the consent of or notice to any person, release or obtain any information necessary to determine the acceptability of any applicant or *Plan participant* for benefits from this *Plan*. In so acting, the *Plan Administrator* will be free from any liability that may arise with regard to such

Miscellaneous Information

action. Any *Plan participant* claiming benefits under this *Plan* must furnish to the *Plan Administrator* such information as may be necessary to implement this provision.

Right of Recovery

Whenever payments have been made by this *Plan* in a total amount, at any time, in excess of the maximum amount of benefits payable under this *Plan*, the *Plan* will have the right to recover such payments, to the extent of such excess, from any one or more of the following as this *Plan* determines: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations that the *Plan* determines are responsible for payment of such amount, and any future benefits payable to the *Plan participant*.

PLAN DEFINITIONS

Words you find in the body of the text that are *italicized* are defined in this section. The presence of the following definitions is not an indication that charges for particular care, supplies, or services are eligible for payment under the *Plan*; please refer to the appropriate sections of this SPD for that information. The singular form of terms in this section is intended to include the plural.

- ***accidental injury***: an accidental physical *injury* to the body caused by unexpected means that does not arise out of or in the course of employment.
- ***ambulatory care center***: any licensed public or private establishment that does not provide services or other accommodations for patients to stay overnight, but does provide:
 - < an organized medical staff of *physicians*.
 - < permanent facilities that are equipped and operated for the purpose of medical and/or surgical care.
 - < continuous *physician* services and registered professional nursing services whenever a patient is in the facility.
- ***cardiac care unit***: see *intensive care unit*.
- ***claims administrator***: United Medical Resources, Inc. (*UMR*), the organization designated by the employer to administer claims to the *Plan*.
- ***Company***: Grand Valley State University.
- ***confinement***: all periods of hospitalization of a *Plan participant* that result from the same or related causes. All periods of *hospital confinement* that result from the same or related causes are considered one period of *hospital confinement*, if the time from discharge to the readmission is within a 90-day period.
- ***cosmetic services***: services designed to alter appearance without restoring function.
- ***covered charges***: expenses or charges that are eligible for payment under the *Plan*.
- ***covered dependent***: a *spouse* or *dependent child* who is eligible for coverage and enrolled under the *Plan*.
- ***custodial care***: any type of service designed essentially to assist the recipient, whether *disabled* or not, in the activities of daily living. This would include, but not be limited to, bathing, dressing, toileting, cooking and feeding, housecleaning, transportation, and shopping. All services rendered by a home health aide are *custodial care*.
- ***dependent child***: any unmarried:
 - < natural child of the *employee*, stepchild of the *employee*, legally adopted child (or legally placed child pending adoption) of the *employee*, child for whom the *employee* has legal custody, or child for whom the *employee* is the legal guardian, provided the child meets the dependency ruling by the IRS as found in Section 105 of the Internal Revenue Code;
 - < child named in a divorce decree as being the responsibility of the *employee* for health benefits coverage; or
 - < child named in a *Qualified Medical Child Support Order* as being the responsibility of the *employee* for health benefits coverage.

Note: Residency is not required for a child whose parents are divorced, legally separated, or separated under a written separation agreement, or who have lived apart at all times during the last six months of the calendar year; who receives over one-half of his or her support from his or her parents; and who is in the custody of one or both parents for more than one-half of the calendar year.

The *dependent child* must also be one of the following:

- < under 19 years of age (to the end of the day preceding his or her 19th birthday).
 - < age 19-27 (to the end of the day preceding his or her 27th birthday) if the child meets the criteria of a *full-time student* as outlined in the **ELIGIBILITY OF FULL-TIME STUDENTS** section.
 - < a *disabled dependent child* age 19 or older as outlined in the **ELIGIBILITY FOR DISABLED CHILDREN** section.
- **disability (or disabled):** the inability of an *employee* (because of *injury* or *illness*) to perform the material duties pertaining to his or her employment with the *employer*. *Disability* of a *covered dependent* is the inability (because of *injury* or *illness*) to perform all regular and customary activities usual for that *covered dependent's* age and family status. An *employee* or *covered dependent* is not considered to be suffering from a *disability* if he or she is performing any work or engaging in any occupation or employment for wage or profit, unless related to rehabilitation.
 - **disabled:** see *disability*.
 - **durable medical equipment:** equipment that is:
 - < able to withstand repeated use,
 - < primarily and customarily used to serve a medical purpose,
 - < prescribed by a *physician*,
 - < not generally useful to a person in the absence of *illness* or *injury*, and
 - < provided solely for use by the patient.
 - **emergency:** any service that, if delayed, would result in harm to the patient. For this *Plan*, an *emergency* is any event that requires immediate attention, based on the *Plan's* review of the *emergency* room report. This review is based on the age of the patient, the time of day, the presenting symptoms, and the patient's medical history.
 - **emergency illness:** a sudden and serious condition such that a *prudent layperson* could expect the patient's life would be jeopardized, the patient would suffer severe pain, or serious impairment of his or her bodily functions would result unless immediate medical care is rendered. Examples of an *emergency illness* may include, but are not limited to: chest pain; hemorrhaging; syncope; fever equal to or greater than 103° F; presence of a foreign body in the throat, eye, or internal cavity; or a severe allergic reaction.
 - **employee:** an *employee* or retiree of Grand Valley State University.
 - **employer:** Grand Valley State University, its subsidiaries, and the affiliated businesses that are designated by Grand Valley State University as participating *employers* in the *Plan*, as well as any other businesses that are designated by Grand Valley State University as participating *employers* in the *Plan*.
 - **experimental (or investigational):** any drug, surgical or medical treatment, procedure, equipment, device, service, or supply that, at the time provided or sought to be provided, is not recognized as conforming to accepted medical practice or to be a safe, effective standard of medical practice for a particular condition by those practicing within the appropriate medical specialty. Meeting at least one of the two following criteria establishes any of the above-stated items as *experimental* or *investigational*:
 - < it is within the research, *investigational*, or *experimental* stage of development or is performed within or restricted to use in clinical trials; or

- < in the case of a drug, substance, or device, has not been approved by the United States Food and Drug Administration. This includes the application of “approved” drugs not approved for the treatment of specific conditions or if a drug has been labeled “Caution: limited by federal law to investigational use,” even though a charge may be made to the patient. Off-label use of FDA-approved medications will be evaluated and considered for approval if there is compelling evidence that their use would represent the standard of care. This evidence includes:
 - * practice guidelines or position papers from relevant professional societies, or
 - * well-controlled studies directly applicable to the patient and the diagnosis in the absence of equally well-designed studies that do not support its use.
- **extended skilled nursing facility:** an institution, or part of an institution, that meets all of the following criteria:
 - < It is licensed pursuant to the law or approved by the appropriate authority.
 - < It provides 24-hour nursing care and/or rehabilitation services for sick and injured patients on an inpatient basis.
 - < It has nursing care and service policies developed with the advice of, and subject to review by, professional personnel.
 - < It has a *physician*, a registered nurse, or other medical staff responsible for the execution of the aforementioned nursing care, and service policies developed with the advice of, and subject to review by, professional personnel.
 - < It requires every patient to be under the care of a *physician*.
 - < It makes a *physician* available to furnish medical care in case of an *emergency*.
 - < It maintains clinical records on all patients, has appropriate methods for dispensing drugs and medicines, and has at least one registered nurse employed on a full-time basis.
 - < It provides for a group of *physicians* to periodically review *medical necessity* for admissions, continuation of *confinements*, duration of stay, and adequacy of care.

The term “*extended skilled nursing facility*” does not include an institution that is primarily for intermediate or *custodial care*.

- **family:** the *employee* and each *covered dependent* who participates in the *Plan* because of his or her relationship to the *employee*.
- **full-time student:** a student enrolled for a number of hours or courses considered full-time by the accredited educational institution where he or she is in attendance.
- **halfway house:** a residential facility providing transitional care to patients between their discharge from the *hospital* or other treatment and their return to the community.
- **home health care:** see *home health services*.
- **home health services:** a program for care and treatment established and approved in writing, including an estimation of the duration of such program by the attending *physician*, together with such *physician*’s certification that the proper treatment of the *injury* or *illness* would require *confinement* as a bed patient in a *hospital* in the absence of the services and supplies provided. Ongoing authorization is required and is based upon regular updates from the *home health care* agency or *provider*.
- **hospice:** a coordinated program of home, outpatient, and inpatient care for terminally ill patients with a prognosis of less than six months to live, operated by a licensed public agency or private organization, that provides all of the following:

- < nursing care by or under the supervision of a registered nurse.
 - < medical social services under the direction of a *physician*.
 - < medical supplies, including drugs and biologicals and the use of medical appliances.
 - < *physicians'* services.
 - < short-term inpatient care, including both palliative care and *respite services* and procedures.
- ***hospital***: an institution authorized to operate as a *hospital* by the state in which it is operating, engaged mainly in providing medical care and treatment of ill, pregnant, and injured persons on an inpatient basis for compensation, that meets the following criteria:
 - < It is constituted, licensed, and operated in accordance with the laws of jurisdiction in which it is located (for example, *hospitals* in Ohio must be licensed according to Chapter 1739 of the Ohio Revised Code), or
 - < It is accredited as a *hospital* by one of the following: a) the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); b) the American Osteopathic Hospital Association (AOHA); c) the American Osteopathic Association (AOA); or d) the Commission on Accreditation of Rehabilitative Facilities (CARF).
 - < It is a *hospital*, a *tuberculosis hospital*, or a *mental health hospital*, as these terms are defined by *Medicare*, that is qualified to participate and eligible to receive payment under and in accordance with the provisions of *Medicare* (with the exception of a mental institution owned and operated by a state or political subdivision thereof).
 - < It maintains on-premises diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment by or under the supervision of duly qualified *physicians*. (This does not apply to a mental institution.)
 - < It continuously provides on-premises, 24-hour nursing service by or under the supervision of a registered nurse.
 - < It is operated continuously with organized facilities for operative surgery on the premises. (This does not apply to a mental institution.)

The term "*hospital*" does not include a hotel, rest home, *extended skilled nursing facility*, *intermediate care facility*, nursing home, convalescent home, facility for *custodial care* of the mentally ill or of the aged, or an institution primarily for the treatment of drug addiction or alcoholism.

- ***illness***: a mental or physical disease or infirmity, including pregnancy or pregnancy-related conditions, of a *Plan participant*.
- ***incur (or incurred)***: the taking on of a *covered charge* on the date a service is rendered or a supply is obtained, unless otherwise specifically set forth in this SPD. With respect to a course of treatment or procedure that includes several steps or phases of treatment, *covered charges* are *incurred* for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, *covered charges* for the entire procedure or course of treatment are not *incurred* upon commencement of the first stage of the procedure or course of treatment.
- ***incurred***: see *incur*.
- ***infertility***: the inability to conceive naturally.
- ***injury***: an accidental physical *injury* to the body caused by unexpected external means that does not arise out of or in the course of employment. All *injuries* sustained in connection with one accident are considered to be one *injury*. The term "*injury*" does not include disease or infection, except pyogenic infection occurring through an accidental cut or wound.

- **intensive care unit:** a unit that accommodates critically or seriously ill or injured patients requiring constant audiovisual observation, specialized registered nursing and other nursing care, and special equipment or supplies immediately available on a standby basis, segregated from the rest of the *hospital* facilities. This includes *cardiac care units*.
- **intermediate care facility:** an institution recognized under and licensed under state law to provide, on a regular basis, health-related care and services to individuals who do not require the degree of care or treatment that a *hospital* or *extended skilled nursing facility* is designed to provide, but who, because of their mental or physical condition, require care and services (above the level of room and board) that can be made available to them only through institutional facilities. Public institutions for care of the mentally retarded or people with related conditions are also included.
- **investigational:** see *experimental*.
- **maintenance care:** treatment provided for the sole purpose of preventing a decline of a medical condition and that does not result in improvement of the condition, but is rather intended to maintain a level of symptoms or severity of a condition. *Maintenance care* programs are those for which the patient can independently administer care and treatment to prevent the worsening of a condition.
- **medical child support order:** any judgment, decree, or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that:
 - < provides for child support with respect to a *Plan participant's* child or directs the *Plan participant* to provide coverage under a health benefits plan pursuant to a state domestic relations law (including a community property law); or
 - < enforces a law relating to medical child support described in Social Security Act §1908 (as added by the Omnibus Budget Reconciliation Act of 1993 §13822) with respect to a group health plan.
- **medical necessity (or medically necessary):** services, procedures, and supplies that:
 - < are consistent with the symptom or the diagnosis and the treatment of an *illness* or *injury*,
 - < are required for the prevention, diagnosis, cure, or treatment of a health-related condition, including services necessary to prevent a decremental change in either medical or *mental health* status,
 - < are provided in accordance with generally accepted medical practice and professionally recognized standards,
 - < provide care safely given at the appropriate level of service,
 - < are not *experimental* services, *cosmetic services*, *maintenance care*, or *custodial care*, and
 - < are not provided solely for the convenience of the *Plan participant* or the *provider*.

In determining questions of *medical necessity*, consideration is given to the customary practices of *providers* in the community where the service is provided. However, the fact that a *provider* may prescribe, order, recommend, or approve a service or supply does not, of itself, make that service or supply *medically necessary*.

- **medical services:** professional services rendered by the attending *provider* that do not involve:
 - < operative or cutting procedures for the treatment of disease or *injury*.
 - < treatment of fractures, dislocations, and other *accidental injuries*.
 - < obstetrical procedures, including prenatal and postnatal care.
- **medically necessary:** see *medical necessity*.

- **Medicare:** the health insurance program for the aged and *disabled* under Title XVIII of the Social Security Act, as amended.
- **mental health:** all forms of *illness* in which psychological, intellectual, emotional, or behavioral disturbances are the dominating feature. This includes mental and nervous disorders such as neurosis, psychoneurosis, psychopathy, psychosis, and mental or emotional disease or disorders, whether or not wholly or partially caused by an organic condition. The *Plan* uses standard classification manuals such as the International Classification of Diseases (ICD-9) and the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association to determine whether a condition should be considered a mental disorder. Determination of a *mental health* condition is made regardless of its original cause.
- **mental health treatment facility:** a facility, or distinct part thereof, for the treatment of mental or nervous disorders, that meets all of the following criteria:
 - < It is nationally accredited, or it is a mental institution owned and operated by a state or political subdivision thereof.
 - < It is primarily engaged in providing, at a charge to its patients, a program for diagnosis, evaluation, and effective treatment of mental or nervous disorders.
 - < It is not primarily a school or a custodial, recreational, or training institution.
 - < It provides all normal, infirmity-level *medical services* required during the treatment period, whether or not related to the mental or nervous disorder.
 - < It provides, or has an agreement with, a *hospital* in the area to provide any other *medical services* that may be required.
 - < It is under the continuous supervision of a psychiatrist who has the overall responsibility for coordinating patient care, and who is at the facility on a regularly scheduled basis.
 - < It is staffed by *mental health physicians* who are directly involved in the treatment program, at least one of whom is present at all times during the treatment day.
 - < It continuously provides the services of a *mental health nurse* and a *mental health social worker*.
 - < It continuously provides skilled nursing services under the direction of a full-time registered nurse, with licensed nursing personnel on duty at all times.
 - < It requires a written, individual treatment plan prepared and maintained for each patient based on a diagnostic assessment of the patient's medical, psychological, and social needs with documentation that the plan is under the supervision of a *mental health physician*.
 - < It meets any applicable licensing standards established by the jurisdiction in which it is located.
- **military service:** uniformed services covered by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), which includes service in the Armed Forces, Army and Air National Guards, commissioned corps of the Public Health Service, Coast Guard, or any other category of service designated by the President of the United States.
- **national medical support notice (or NMSN):** a notice that contains the following information:
 - < The name of an issuing state agency;
 - < The name and mailing address (if any) of an *employee* who is a *Plan participant*;
 - < The name and mailing address of one or more alternate recipients (e.g., the child or children of the *Plan participant* or the name and address of a substituted official or agency that has been substituted for the mailing address of the alternate recipient[s]); and
 - < The identity of an underlying child support order.

- **natural tooth (or natural teeth):** a hard, bony appendage borne on the jaw.
- **NMSN:** see *national medical support notice*.
- **physician:** any doctor of medicine (MD), osteopathy (DO), podiatry (DPM), chiropractic (DC), dental surgery (DDS), or medical dentistry (DMD), duly qualified, currently licensed, and acting within the scope of his or her license at the time and place the service is rendered.
- **Plan:** the Grand Valley State University Early Retiree Base Medical Plan.
- **Plan Administrator:** Grand Valley State University.
- **Plan participant:** a covered *employee* or his or her *covered dependent*.
- **Plan Sponsor:** Grand Valley State University.
- **Plan Year:** the 12-consecutive-month period that ends on December 31.
- **pre-admission testing:** outpatient X-ray and laboratory tests that meet each of the following criteria:
 - < They are made within 7 days before admission as a registered bed patient in a *hospital*.
 - < They are for the same *injury* or *illness* causing the hospitalization of the *Plan participant*.
 - < They are ordered by the same *physician* (or his or her *physician* consultant) who ordered the hospitalization.
 - < They are accepted by the *hospital* where hospitalization is to occur, in lieu of similar tests being made during hospitalization.

The term “*pre-admission testing*” includes outpatient X-rays and laboratory tests that would have satisfied all the tests set forth in this section, except that the expected hospitalization does not occur because of the results of such tests. The term “*pre-admission testing*” does not include tests for routine physical check-ups.

- **provider:** the person, institution, or other entity who or that provided the service or supplies on account of which payment may be due under this *Plan*. Each *provider* must be duly qualified, currently licensed, and acting within the scope of his or her license at the time and place the service is rendered. For this *Plan*, depending upon the services provided and the eligibility of benefits, a recognized *provider* may include, but may not be limited to, any of the following:
 - < Advanced Registered Nurse Practitioner (ARNP)
 - < Audiologist (MACCC-A)
 - < Certified Chemical Dependency Counselor (CCDC)
 - < Certified Nurse Midwife (CNM)
 - < Certified Registered Nurse Anesthetist (CRNA)
 - < Chiropractor (DC)
 - < Doctor of Dental Medicine (DDM)
 - < Doctor of Dental Surgery (DDS)
 - < Doctor of Medical Dentistry (DMD)
 - < Doctor of Medicine (MD)
 - < Doctor of Optometry (OD)
 - < Doctor of Osteopathy (DO)
 - < Doctor of Podiatric Medicine (DPM)

- < Doctor of Psychology (PhD or PsyD)
- < Licensed Clinical Social Worker (LCSW)
- < Licensed Family Counselor (LFC)
- < Licensed Independent Social Worker (LISW)
- < Licensed Occupational Therapist (LOT)
- < Licensed Physical Therapist (LPT)
- < Licensed Practical Nurse (LPN)
- < Licensed Professional Clinical Counselor (LPCC)
- < Licensed Professional Counselor (LPC)
- < Licensed Social Worker (LSW)
- < Licensed Speech Therapist (MACCC-SLP)
- < Master of Social Work (MSW)
- < Medical Assistant (MA)
- < Nurse Practitioner
- < Physician's Assistant (PA)
- < Registered Nurse (RN)
- < Registered Physical Therapist (RPT)
- < Surgical Physician's Assistant

- ***prudent layperson***: a person with average knowledge of health and medicine who is not formally educated or specialized in the field of medicine.
- ***QMCSO***: see *Qualified Medical Child Support Order*.
- ***qualified beneficiary***: any individual covered by a group health plan on the day before a COBRA qualifying event. A *qualified beneficiary* may be an *employee*, an *employee's spouse*, or an *employee's dependent child*. A child who is born to or placed for adoption with the covered *employee* during a period of continuation coverage is considered a *qualified beneficiary*.
- ***Qualified Medical Child Support Order (or QMCSO)***: a *medical child support order* that creates or recognizes the existence of an alternate recipient's right to, or assigns to an alternate recipient the right to, receive benefits to which a *covered dependent* is entitled under this *Plan*. In order for such order to be a *QMCSO*, it must clearly specify the following:
 - < The name and last known mailing address (if any) of the *Plan participant* and the name and mailing address of each such alternate recipient covered by the order;
 - < A reasonable description of the type of coverage to be provided by the *Plan* to each alternate recipient, or the manner in which such type of coverage is to be determined;
 - < The period of coverage to which the order pertains; and
 - < The name of this *Plan*.

In addition, a *national medical support notice* will be deemed a *QMCSO* if it:

- < Contains the information set forth in the definition of "*national medical support notice*";

- < Identifies either the specific type of coverage or all available group health coverage. If the *employer* receives an *NMSN* that does not designate either specific type(s) of coverage or all available coverage, the *employer* and the *Plan Administrator* will assume that all are designated;
- < Informs the *Plan Administrator* that, if a group health plan has multiple options and the participant is not enrolled, the issuing agency will make a selection after the *NMSN* is qualified, and, if the agency does not respond within 20 days, the child will be enrolled under the *Plan's* default option (if any); and
- < Specifies that the period of coverage may end for the alternate recipient(s) only when similarly situated dependents are no longer eligible for coverage under the terms of the *Plan*, or upon the occurrence of certain specified events.

However, such an order need not be recognized as “qualified” if it requires the *Plan* to provide any type or form of benefit, or any option, not otherwise provided to the *Plan participants*, except to the extent necessary to meet the requirements of a state law relating to *medical child support orders*, as described in Social Security Act §1908 (as added by the Omnibus Budget Reconciliation Act of 1993 §13822).

- **rehabilitation facility:** a facility that meets all of the following criteria:
 - < The patient’s condition must require the 24-hour availability of a *physician* to provide treatments that can be provided only in an *in-hospital* setting. This need should be verifiable by entries in the patient’s medical record that reflect frequent and direct, *medically necessary physician* involvement in the patient’s care.
 - < The patient’s condition must require 24-hour availability of a registered nurse with specialized training or experience in rehabilitation.
 - < The patient must require an intense (at least 4 hours per day) level of physical and/or occupational therapy in addition to any other required therapies or services.
 - < The patient must require a multidisciplinary team approach to the delivery of the program. This includes a *physician*, psychiatrist, rehabilitation nurse, *social worker*, and/or psychologist.
 - < The patient’s records must reflect evidence of a coordinated program, e.g., documentation that periodic team conferences were held with regularity.
 - < The patient’s records should reflect a realistic goal and significant improvement. Coverage stops when progress toward the established goal is unlikely, or when it can be achieved in a less intensive setting.
- **residential care facility:** an establishment that furnishes food and shelter to adult persons unrelated to the proprietor and may provide care and services beyond food, shelter, and laundry to any one or more such persons. This includes boarding homes for sheltered care and homes for the aged.
- **respite services:** short-term or intermittent care for persons with chronic or debilitating conditions that provides an interval of rest or relief to family members or caregivers who are responsible for those services on a day-to-day basis. Coverage of these services is included in any *hospice* benefit, limitation, or exclusion.
- **semi-private room:** the charge made by a *hospital* for a room containing two or more beds.
- **Shared Savings Program:** a program providing access to discounts from *providers’* charges when services are rendered by those non-PPO *providers* that participate in the program. The *claims administrator* will use the *Shared Savings Program* to pay claims when doing so will lower eligible expenses. The *claims administrator* does not credential the *Shared Savings Program providers*, and the *Shared Savings Program providers* are not PPO *providers*. Accordingly, benefits for covered health services provided by *Shared Savings Program providers* will be paid at the non-PPO benefit percentage, unless otherwise indicated in the **SCHEDULE OF BENEFITS**. When the *claims administrator* uses

the *Shared Savings Program* to pay a claim, patient responsibility is limited to co-payments or coinsurance payments calculated on the contracted rate paid to the *provider*, in addition to any required annual deductible.

- **sickness:** any *illness*, other than an *injury*, not covered by Workers' Compensation laws or any occupational disease law. The term "sickness" includes pregnancy.
- **skilled nursing care:** services that:
 - < are deemed to be reasonable and *medically necessary*,
 - < are provided by a registered nurse or a licensed practical nurse,
 - < are under the direct supervision of a *physician*,
 - < include a plan of care established by a licensed *provider* and approved by the supervising *physician*, and
 - < are rendered intermittently to a patient who is homebound.
- **skilled nursing facility:** see *extended skilled nursing facility*.
- **social worker:** a properly licensed person holding the degree of Licensed Social Worker (LSW), Licensed Clinical Social Worker (LCSW), Licensed Independent Social Worker (LISW), Licensed Professional Clinical Counselor (LPCC), or Master of Social Work (MSW), legally qualified and licensed and acting within the scope of his or her license at the time and place the service is rendered.
- **spouse:** an *employee's* legally married husband or wife (not legally separated).
- **substance abuse:** the abuse of alcohol and/or drugs.
- **substance abuse treatment facility:** a facility for the treatment of alcoholism and drug abuse that meets all of the following criteria:
 - < It is nationally accredited.
 - < It is primarily engaged in providing, at a charge to its patients, a program for diagnosis, evaluation, and effective treatment of alcoholism and drug abuse.
 - < It provides all medical detoxification services necessary in addition to its effective treatment program.
 - < It provides all normal, infirmary-level *medical services* required during the treatment period, whether or not related to the alcoholism or drug abuse.
 - < It provides, or has an agreement with, a *hospital* in the area to provide any other *medical services* that may be required.
 - < At all times during the treatment period, it is under the supervision of a staff of *physicians* and provides skilled nursing services by licensed nursing personnel under the direction of a full-time registered nurse.
 - < It prepares and maintains a written individual plan of treatment for each patient based upon a diagnostic assessment of the patient's medical, psychological, and social needs, with documentation that the plan is under the supervision of a *physician*.
- **surgery center:** any public or private establishment that meets the following criteria:
 - < It has an organized medical staff of *physicians*.
 - < It is a permanent facility equipped and operated primarily for the purpose of performing *surgical procedures*.

- < It provides continuous *physician* services and registered professional nursing services whenever a patient is in the facility.
- < It does not provide services or other accommodations for patients to stay overnight.
- < It provides, or has an agreement with, a *hospital* in the area to provide any other *medical services* that may be required.
- ***surgical procedures:*** procedures limited to the following:
 - < a cutting operation.
 - < suturing of a wound.
 - < treatment of a fracture.
 - < reduction of a dislocation.
 - < electrocauterization.
 - < diagnostic and therapeutic endoscopic procedures.
 - < injection treatment of hemorrhoids and varicose veins.
 - < cardiac catheterization.
- ***total disability (or totally disabled):*** a person's complete inability to perform any and every duty of his or her occupation or any other work or employment for wage or profit, or his or her *covered dependent's* complete inability to perform the normal activities of a person of his or her age and sex in good health.
- ***totally disabled:*** see *total disability*.
- ***UCR:*** see *usual, customary, and reasonable charges*.
- ***UMR:*** United Medical Resources, Inc., the *claims administrator*.
- ***usual, customary, and reasonable charges (or UCR):*** charges made for health care services or supplies essential to the care of the individual that are in accordance with each of the following:
 - < the usual fee an individual *provider* most frequently accepts as payment for the same service within a geographic area for the majority of his or her patients for the procedure performed.
 - < the customary fee, established by the *Plan*, to be the charge for the range of usual amounts charged and accepted by most *providers* of similar training and experience and in comparable geographic economic areas for the procedure performed.
 - < the reasonable fee accepted as payment in light of all circumstances, including unusual circumstances involving medical complications or requiring additional time, skill, and experience.

The *Plan* uses industry-recognized sources to determine *UCR*.

Claims Administrator

United Medical Resources, Inc.
P.O. Box 145804
Cincinnati, Ohio 45250-5804

513-619-3000
1-800-950-4867 Toll-Free

8:30 a.m. – 5:00 p.m. EST/EDT

<http://www.umar.com>