

**GRAND VALLEY STATE
UNIVERSITY
GROUP BENEFIT PLAN**

**PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION**

**Preferred Provider Organization (PPO)
High Deductible Health Plan (HDHP)**

Amended and Restated Effective January 1, 2023

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SCHEDULE A
GRAND VALLEY STATE UNIVERSITY
SCHEDULE OF MEDICAL BENEFITS
Preferred Provider Organization (PPO) Plan
High Deductible Health Plan (HDHP)
Effective Date: January 1, 2023

Plan Year: The 12-month period beginning each January 1 and ending each December 31.

Network Benefits are provided by a network provider (except as otherwise provided by the summary plan description (SPD), and may require prior certification with the Benefit Administrator (except in a medical emergency). For a directory of Priority Health and Cigna Open Access network providers, call the Customer Service Department at **616 956-1954 or 800 956-1954** or access the Find a Doctor tool on the Priority Health website at priorityhealth.com. For a current status of Upper Peninsula Health Plan (UPHP) Network providers, visit their website at www.uphp.com.

Non-Network Benefits are provided by non-network providers. Services may require the satisfaction of deductibles and coinsurance amounts, and are subject to reasonable and customary charges. Some benefits must be prior certified with the Benefit Administrator (except in a medical emergency).

Prior Certification: Prior certification is required for all inpatient hospital or facility services. Your provider must access the Priority Health provider portal to prior certify services. If you are receiving intensive treatment for mental health services, including inpatient hospitalization and partial hospitalization, your provider must notify our Behavioral Health Department as soon as possible at **(616) 464-8500** or **(800) 673-8043** for assistance. You do not need prior certification from Priority Health for hospital stays for a mother and her newborn of up to 48 hours following a vaginal delivery and 96 hours following a cesarean section. Other services requiring prior certification are:

- Home Health Care
- Skilled Nursing, Sub acute & Long-term Acute Facility Care
- Inpatient Rehabilitation Care
- Durable Medical Equipment over \$1,000
- Pain Management Services
- Gender Dysphoria or Reassignment Services
- Transplants
- Advanced Diagnostic Imaging Services
- Prosthetic Devices over \$1,000
- Morbid Obesity Treatment

The full list of services that require prior certification is included in the SPD and may be updated from time to time. A current listing is also available by calling the Priority Health Customer Service Department at **(616) 956-1954** or **(800) 956-1954**. Other services may be prior certified by you or your provider to determine medical/clinical necessity before treatment. Prior certification is not a guarantee of coverage or a final determination of benefits under this plan.

Deductibles:

The deductible is the dollar amount of covered services you must incur during the plan year before benefits will be paid. The deductible is applicable to all covered services except:

- Network preventive health services that are listed in Priority Health's preventive health care guidelines.
- Network routine maternity services provided in your physician's office (deductible **will** apply to delivery, facility charges and anesthesia charges associated with the delivery).

If you have individual coverage, you must meet the individual deductible below. If you have more than one person in your family, you have family coverage and the family deductible below must be met. The family deductible can be satisfied by only one family member or by any combination of family members.

Network deductible amounts apply to non-network deductible amounts, and non-network deductible amounts apply to network deductible amounts.

The deductible amounts renew each plan year. This plan does not carry over any deductible amounts incurred in the prior plan year. The network benefits deductible will include any monies paid for covered pharmacy services.

Notwithstanding the above, the following costs shall not apply towards the deductible: Non-covered services; services that exceed the annual day or dollar benefit maximums for a specific benefit (denied as non-covered services); penalties paid for failure to prior certify services; and any amounts paid by participants for non-network benefits that exceed reasonable and customary.

Out-of-Pocket Limits:

The out-of-pocket limit limits the total amount of covered expenses that you or your covered dependents will pay during a plan year. Once the applicable out-of-pocket limit is met, all further medical and pharmacy covered services for that plan year will be paid at 100% of Priority Health’s contracted rate for network benefits and at 100% of the lesser of billed charges or reasonable and customary charges for non-network benefits.

Network out-of-pocket limit amounts apply to non-network out-of-pocket limit amounts; and non-network out-of-pocket limit amounts apply to network out-of-pocket limit amounts.

If you have individual coverage, you must meet the individual out-of-pocket limit below. If you have more than one person in your family, you have family coverage and the family out-of-pocket limit below must be met. The family out-of-pocket limit can be satisfied by only one family member or by any combination of family members.

Notwithstanding the above, the following out-of-pocket costs do not apply towards the out-of-pocket limit: Expenses for non-covered services, services that exceed the annual day or dollar benefit maximums for a specific benefit (denied as non-covered services); and costs paid by participants to provider for non-network benefits that exceed reasonable and customary.

BENEFITS	NETWORK BENEFIT	NON-NETWORK BENEFIT
Deductibles	\$2,000 per individual; \$4,000 per family per plan year.	\$4,000 per individual; \$8,000 per family per plan year.
Benefit Percentage Rate	100% paid by the plan; 0% paid by the participant, unless otherwise noted.	80% paid by the plan; 20% paid by the participant, unless otherwise noted.
Out-of-Pocket Limits (Annual out-of-pocket costs for health care, including deductibles, coinsurance and copayments, including prescription drug copayment cap, are limited under the ACA.)	\$2,250 per individual; \$4,500 per family per plan year.	\$6,250 per individual; \$12,500 per family per plan year.
BENEFITS	NETWORK BENEFIT	NON-NETWORK BENEFIT
Preventive Health Care Services - Preventive Health Care Services are described in Priority Health’s Preventive Health Care Guidelines available in the member center the website at priorityhealth.com or you may request a copy from the Customer Service Department. Priority Health’s Guidelines include preventive services required by legislation. The list below also includes procedures approved by your Employer in addition to those included in the Priority Health Guidelines.		
Routine Adult Physical Exams, Screening and Counseling	Covered at 100%. Deductible does not apply.	Covered at 80% after deductible.
Women’s Preventive Health Care Services	Covered at 100%. Deductible does not apply.	Covered at 80% after deductible.
Routine Laboratory Tests, Screening and Counseling	Covered at 100%. Deductible does not apply.	Covered at 80% after deductible.
PSA Tests, Prostate Exams and Colon/Rectal Screenings	Covered at 100%. Deductible does not apply.	Covered at 80% after deductible.
Well Child and Adolescent Care, Screening and Assessments	Covered at 100%. Deductible does not apply.	Covered at 80% after deductible.
Immunizations	Covered at 100%. Deductible does not apply.	Covered at 80% after deductible.
Routine Eye Exam and Glaucoma Testing* (Combined Network/Non-Network Benefit.)	Covered 100%. Deductible does not apply. One exam each two years.	Covered at 80% after deductible up to a maximum benefit of \$40. One exam each two years.
*This is a PriorityVision benefit administered by EyeMed. For a complete list of network providers near you, use the online Find a Doctor directory at priorityhealth.com and choose “PriorityVision”, or call the Priority Health Customer Service Department at 877 572-4001.		

BENEFITS	NETWORK BENEFIT	NON-NETWORK BENEFIT
Medical Office/Home Services		
Office/Home Visits and Consultations (Includes visits <i>not</i> listed in Priority Health’s Preventive Health Care Guidelines or routine maternity services.) Face-to-face and telehealth (includes telephonic and telemedicine.) (Including medication management visits.)	Covered at 100% after deductible.	Covered at 80% after deductible.
Virtual Care Services (E.g. Spectrum Health or MDLive acute virtual care providers.)	Covered at 100% after deductible.	Covered at 80% after deductible.
Retail Health Clinic Visits (Located within the United States.)	Covered at 100% after deductible.	Covered at 100% after deductible for visits at reasonable and customary for evaluation and management services only.
Office Surgery (Performed in physician’s office.)	Covered at 100% after deductible.	Covered at 80% after deductible.
Office Injections (Performed in physician’s office.)	Covered at 100% after deductible.	Covered at 80% after deductible.
Allergy Office Services (Including allergy testing and injections, including serum costs.) (Performed in physician’s office.)	Covered at 100% after deductible.	Covered at 80% after deductible.
Diagnostic Radiology and Lab Services (Performed in physician’s office.)	Covered at 100% after deductible.	Covered at 80% after deductible.
Advanced Diagnostic Imaging Services - Includes MRI, CAT Scans, PET Scans, CT/CTA and Nuclear Cardiac Studies Prior certification required. (Performed in physician’s office.)	Covered at 100% after deductible.	Covered at 80% after deductible.
Obstetrical Services by Physician (Including prenatal and postnatal care.)	Routine prenatal visits are covered at 100%, deductible waived under the Preventive Health Care Services benefits above. See the Hospital Services section for facility, delivery and nursery service benefits.	Covered at 80% after deductible.
Maternity Education Classes	Attendance at an approved maternity education program is covered at 100% after deductible.	Not covered.
Education Services (Other than as provided in Priority Health’s Preventive Health Care Guidelines.)	Covered at 100% after deductible.	Covered at 80% after deductible.
Hospital Services		
Inpatient Hospital and Inpatient Longterm Acute Care Services Prior certification is required except in emergencies or for hospital stays for a mother and her newborn of up to 48 hours following a vaginal delivery and 96 hours following a cesarean section. Prior certification phone number is (800) 269-1260 .	Covered at 100% after deductible.	Covered at 80% after deductible.

BENEFITS	NETWORK BENEFIT	NON-NETWORK BENEFIT
Hospital Services (continued)		
Inpatient Professional and Surgical Charges Evaluation and Management for Inpatient and Observation services covered at the Network rate when at a network facility.	Covered at 100% after deductible.	Covered at 80% after deductible.
Human Organ Tissue Transplants Covered only with prior certification from Benefit Administrator.	Covered at 100% after deductible.	Approved transplants are covered at the network benefit level.
Travel, Meals and Lodging Expenses Associated with an Organ Transplant (Combined Network/Non-Network Benefit.) Limitations apply.	Covered at 100% after deductible up to a maximum lifetime benefit of \$10,000.	Travel, Meals and Lodging Expenses associated with an approved transplant are covered at the network benefit level.
Approved Clinical Trial Expenses (Includes routine expenses related to an approved clinical trials.)	Covered at 100% after deductible.	Covered at 80% after deductible.
Outpatient Hospital Care and Observation Care Services (Including ambulatory surgery center or freestanding facility charges.)	Covered at 100% after deductible.	Covered at 80% after deductible.
Outpatient Hospital Professional and Surgical Charges	Covered at 100% after deductible.	Covered at 80% after deductible.
Obstetrical Services in Hospital (Includes delivery, facility and anesthesia services.)	Covered at 100% after deductible.	Covered at 80% after deductible.
Hospital and Freestanding Facility Diagnostic Laboratory & Radiology Services	Covered at 100% after deductible.	Covered at 80% after deductible.
Hospital and Freestanding Facility Advanced Diagnostic Imaging Services - Includes MRI, CAT Scans, PET Scans, CT/CTA and Nuclear Cardiac Studies Prior certification required.	Covered at 100% after deductible.	Covered at 80% after deductible.
Certain Surgeries and Treatments <ul style="list-style-type: none"> • Reconstructive surgery: blepharoplasty of upper eyelids, breast reduction, panniculectomy, rhinoplasty, septorhinoplasty and surgical treatment of male gynecomastia • Skin Disorder Treatments: Scar revisions, keloid scar treatment, treatment of hyperhidrosis, excision of lipomas, excision of seborrheic keratoses, excision of skin tags, treatment of vitiligo and port wine stain and hemangioma treatment. • Varicose veins treatments • Sleep apnea treatment procedures 	Covered at 100% after deductible. Certain surgeries and treatments are covered only if medically/necessary. In addition, age limitations may apply to certain surgeries and treatments.	Covered at 80% after deductible. Certain surgeries and treatments are covered only if medically/necessary. In addition, age limitations may apply to certain surgeries and treatments.
Morbid Obesity Treatment <ul style="list-style-type: none"> • Gastric or intestinal bypasses. • Stomach Stapling. • Lap Band. • Charges for diagnostic services Prior certification required.	Covered at 100% after deductible.	Covered at 80% after deductible.
If the services of a surgical assistant are required for a surgical procedure, the non-network covered expenses will be the lesser of: (1) the amount charged by the assistant; or (2) 20% of the amount allowable to the physician who performed the surgery.		

BENEFITS	NETWORK BENEFIT	NON-NETWORK BENEFIT
Medical Emergency and Urgent Care Services		
Emergency Room Services	Covered at 100% after deductible.	Paid at the Network benefit level. Reasonable and customary limitations apply.
Ambulance Services	Covered at 100% after deductible.	Paid at the Network benefit level. Reasonable and customary limitations apply.
Urgent Care Facility Services	Covered at 100% after deductible.	Covered at 80% after deductible.
Behavioral Health Services - Prior certification by our Behavioral Health Department is required, except in emergencies, for inpatient services as noted below: Call (616) 464-8500 or (800) 673-8043.		
Inpatient Mental Health & Substance Use Disorder Services (Including subacute residential treatment facility and partial hospitalization.) Prior certification required except in emergencies.	Covered at 100% after deductible.	Covered at 80% after deductible.
Outpatient Mental Health & Substance Use Disorder Services Face-to-face and telehealth (includes telephonic and telemedicine) (Including medication management visits.)	Covered at 100% after deductible.	Covered at 80% after deductible.
Family Planning and Reproductive Services		
Infertility Counseling & Treatment Covered for diagnosis and treatment of underlying cause only. Limitations and exclusions apply.	Covered at 100% after deductible.	Covered at 80% after deductible.
Vasectomy	Covered at 100% after deductible.	Covered at 80% after deductible.
Tubal Ligation/Tubal Obstructive Procedures (Included as part of the Women's Preventive Health Services benefits.)	Covered at 100%, deductible waived when performed at outpatient facilities. If received during an inpatient stay, only the services related to the tubal ligation/tubal obstructive procedure are covered in full, deductible waived.	Covered at 80% after deductible.
Birth Control Services Medical Plan (i.e. doctor's office) (Included as part of the Women's Preventive Health Services benefits.) Includes; diaphragms, implantables, injectables, and IUD (insertion and removal), etc.	Covered at 100%, deductible waived.	Covered at 80% after deductible.
Gender Dysphoria or Reassignment Services Prior certification required.	Covered at 100% after deductible.	Covered at 80% after deductible.
Rehabilitative Medicine Services – Not related to Autism Treatment		
Physical and Occupational Therapy (Including aquatic, massage and vision therapy.) (Combined Network/Non-Network Benefit.)	Covered at 100% after deductible up to a benefit maximum of 30 visits per plan year. *	Covered at 80% after deductible up to a benefit maximum of 30 visits per plan year. *
Speech Therapy (Combined Network/Non-Network Benefit.)	Covered at 100% after deductible up to a benefit maximum of 30 visits per plan year. *	Covered at 80% after deductible up to a benefit maximum of 30 visits per plan year. *
Cardiac Rehabilitation and Pulmonary Rehabilitation (Combined Network/Non-Network Benefit.)	Covered at 100% after deductible up to a benefit maximum of 30 visits per plan year. *	Covered at 80% after deductible up to a benefit maximum of 30 visits per plan year. *
*Visits will be reviewed for additional visit allowance based on medical necessity after reaching the 30 visit maximum per plan year.		

BENEFITS	NETWORK BENEFIT	NON-NETWORK BENEFIT
Services Related to the Treatment of Autism Spectrum Disorder		
Physical, Occupational and Speech Therapy; Applied Behavior Analysis (ABA) for Autism Treatment	Covered at 100% after deductible. Prior certification required for ABA.	Covered at 80% after deductible. Prior certification required for ABA.
Other Services		
Prescription Drugs – Administered by CVS Caremark Includes coverage for specified drugs and medications required by PPACA. More information about prescription drug coverage is available at www.caremark.com or by calling (888) 549-5789.	Covered prescription drugs apply to the plan deductible and out-of-pocket maximum. Copayments apply after satisfaction of the deductible and have an annual limit of \$250 single and \$500 dual/family. <u>Retail Pharmacy (up to 31 days):</u> Generic Drugs: \$4 copayment Preferred Brand Name Drugs: \$20 copayment Non-Preferred Brand Name Drugs: \$40 copayment <u>Mail Service Program (up to 90 days):</u> Generic Drugs: \$8 copayment Preferred Brand Name Drugs: \$40 copayment Non-Preferred Brand Name Drugs: \$80 copayment <u>Retail 90 Program (up to 90 days):</u> Generic Drugs: \$12 copayment Preferred Brand Name Drugs: \$60 copayment Non-Preferred Brand Name Drugs: \$120 copayment Check with Caremark RX plan for specialty drug benefits.	
Durable Medical Equipment Prior certification is required for charges over \$1,000. <ul style="list-style-type: none">• <u>Surgical bras after mastectomy:</u> Limited to 4 bras per plan year.• <u>Compression Stockings:</u> Limited to 12 pairs per plan year.	Covered at 100% after deductible.	Covered at 80% after deductible.
Prosthetic & Orthotic/Support Devices Prior certification is required for charges over \$1,000.	Covered at 100% after deductible.	Covered at 80% after deductible.
Wigs, Toupees and Hairpieces Covered when prescribed by a physician for a medical condition.	Covered at 100% after deductible.	Covered at 80% after deductible.
Chiropractic Services and Osteopathic Manipulation Therapy Visits (Combined Network/Non-Network Benefit.) (Including maintenance care and massage therapy.)	Covered at 100% after deductible up to a benefit maximum of 30 visits per plan year.	Covered at 80% after deductible up to a benefit maximum of 30 visits per plan year.
Temporomandibular Joint Syndrome (TMJS) Treatment (Combined Network/Non-Network Benefit.)	Covered at 100% after deductible.	Covered at 80% after deductible.
Orthognathic Surgery & Treatment	Not covered.	Not covered.
Cochlear Implants	Not covered.	Not covered.
Non-Hospital Facility Services – Including skilled nursing care services received in a: <ul style="list-style-type: none">• Skilled Nursing Care Facility• Subacute Facility• Inpatient Rehabilitation Facility• Hospice Facility Prior certification required, except for hospice facilities.	Covered at 100% after deductible up to a maximum of 120 days per plan year.	Covered at 80% after deductible up to a maximum of 120 days per plan year.

BENEFITS	NETWORK BENEFIT	NON-NETWORK BENEFIT
Other Services (continued)		
Home Health Services (Combined Network/Non-Network Benefit.) Prior certification required.	Covered at 100% after deductible up to a maximum of 60 visits per plan year.	Covered at 80% after deductible up to a maximum of 60 visits per plan year.
Hospice Services (Includes hospice, bereavement and respite services.)	Covered at 100% after deductible.	Covered at 80% after deductible.
Hemodialysis, Radiation Therapy and Chemotherapy	Covered at 100% after deductible.	Covered at 80% after deductible.
Private Duty Nursing (Combined Network/Non-Network Benefit.)	Covered at 100% after deductible up to a benefit maximum of 60 visits per plan year	Covered at 80% after deductible up to a benefit maximum of 60 visits per plan year.
Hearing Services (Combined Network/Non-Network Benefit.)	Covered at 100% after deductible. Hearing aids are limited to a \$750 maximum benefit per ear every 36 months.	Covered at 80% after deductible. Hearing aids are limited to a \$750 maximum benefit per ear every 36 months.
Eye Care Services Covered for treatment of medical conditions and diseases of the eye only.	Covered at 100% after deductible.	Covered at 80% after deductible.
Coverage Information		
Waiting Period Requirement	Benefits become effective upon the date of hire.	
Full-Time Employee	30 hours worked per week.	
Household Member	A household member may qualify as a covered dependent upon meeting the criteria as set-forth in the <i>Eligibility</i> section of the plan.	
Dependent Children	Covered up to the end of the month in which they turn age 26 or up to the date they turn age 27 if enrolled in a qualified course of study. Over age 26 if mentally or physically incapacitated dependent.	
Motor Vehicle Injuries	Are not covered except in limited circumstances.	
Motorcycle Injuries	Coordinated with any available motorcycle insurance.	

In accordance with the terms and conditions of the SPD, you are entitled to covered services when these services are:

- A. Medically/clinically necessary; and
- B. Not excluded in the SPD.

You will be responsible for services rendered that are beyond those prior certified as medically/clinically necessary.

If the hospital confinement extends beyond the number of prior certified days, the additional days will not be covered unless:

- The extension of days is medically/clinically necessary, and
- Prior certification for the extension is obtained before exceeding the number of prior certified days.

For emergency admissions, the Benefit Administrator should be notified by the end of the next business day following the admission or as soon as reasonably possible.

Coverage maximums up to a certain number of days or visits per plan year are reached by combining either network or non-network benefits up to the limit for one or the other but not both. (Example: If the network benefit is for 60 visits and the non-network benefit is for 60 visits, the maximum benefit is 60 visits, not 120 visits.)

SECTION 1. ABOUT THIS PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

The Company hereby amends and restates the Grand Valley State University Group Benefit Plan (the "Plan"). This plan document and summary plan description (PDSPD) amends and restates the group employee benefits plan maintained by the Company for eligible employees and their eligible dependents prior to the amended and restated date of January 1, 2023. The Plan is a self-funded group plan under Sections 105 and 106 of the Internal Revenue Code of 1986, as amended (the "Code"), to provide certain group benefits for eligible employees and dependents. This Plan as it may be further amended from time to time, together with all documents expressly incorporated by reference, as they may be amended from time to time, shall constitute the Company's employee benefit plan.

This PDSPD describes the medical benefits that are covered for employees and their eligible dependents ("participants"). This PDSPD replaces and supersedes any PDSPD you may have received in the past.

This Plan only covers non-occupational injuries and non-occupational illnesses, and except as otherwise provided, only covers medically/clinically necessary services or supplies that are furnished while a person is a participant.

The Company has adopted a Code Section 125 Flexible Benefits Plan (the "Flexible Benefits Plan") under which participants may elect to reduce taxable compensation and have the amount of the reduction credited to pay any required contribution for the selected level of coverage under this Plan. The Flexible Benefits Plan and each employee's enrollment form, to the extent required, are incorporated by reference into this Plan.

Employees who are enrolled in the Plan's High Deductible Health Plan (HDHP) option may be eligible to establish and maintain a Health Savings Account (HSA). The terms of the HSA are governed by Section 223 of the Internal Revenue Code and the terms of the trust or custodial agreement establishing the HSA.

The Company may extend this Plan to any subsidiary or other related entity under common control of or with the Company ("participating employer"). The related entity must agree in writing to participate in the Plan and to be bound by its provisions. The Company shall specify the date as of which the entity shall become a participating employer. Any reference to the Company shall be deemed to include any participating employer.

Terms are found in the *Definitions* section of this PDSPD or may be defined when first used in this document. The terms "we," "us," "our," "Company" and "Plan Administrator" refer to Grand Valley State University (GVSU). The terms "you," "your," and "yourself" refer to the participant, whether enrolled in the Plan as an employee or as a covered dependent. The term "Benefit Administrator" refers to Priority Health Managed Benefits, Inc. ("Priority Health").

This Plan is not a health maintenance organization ("HMO") or an insurance arrangement. Instead, the Plan has a self-funded arrangement, which means that benefits are paid out of the Company's general assets. If we do not cover expenses that are eligible for payment under the Plan for any reason, you may have to pay those expenses. The Benefit Administrator processes claims but does not insure payment of any of your covered health expenses. The Benefit Administrator will promptly process complete and proper claims for benefits. If there are delays in processing claims, you will have no greater rights to interest or other remedies than you would otherwise have by law.

This Plan is not a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). Questions regarding the Plan's status can be directed to the Plan Administrator. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 866 444-3272 or visit them online at dol.gov/ebsa/healthreform.

If you have any questions about eligibility or coverage, first contact the Company. If you need more help, contact the Benefit Administrator's Customer Service Department at:

Priority Health Managed Benefits, Inc.
1231 East Beltline, N.E.
Grand Rapids, MI 49525-4501
616 956-1954 or 800 956-1954

or send a secure e-mail from the Benefit Administrator's website at priorityhealth.com.

SECTION 2. PLAN ADMINISTRATION

Information regarding the administration of the Plan is detailed below.

Plan Name: Grand Valley State University Group Benefit Plan

Plan Sponsor/Plan Administrator: Grand Valley State University
1090 James H. Zumberge Hall (1090 JHZ)
Allendale, Michigan 49401
616 331-2220

Benefit Administrator: Priority Health Managed Benefits, Inc.
1231 East Beltline, NE
Grand Rapids, Michigan 49525-4501
616 956-1954 or 800 956-1954

Employer Identification Number: 38-1684280

Effective Date of Plan: January 1, 2014; amended and restated January 1, 2018, and January 1, 2023.

Type of Plan: Group Health Plan (Welfare Benefit Plan)

Plan Year: The 12-month period beginning each January 1 and ending each December 31 that corresponds to the period on which the Plan is reported for Form 5500 Series purposes and on which benefit limitations and maximums are calculated.

Plan Administrator and Named Fiduciary: Grand Valley State University is the Plan Administrator and Named Fiduciary of the Plan. As the Plan Administrator, Grand Valley State University has the authority to control and manage the operation and administration of the Plan.

Type of Plan Administration: This Plan is self-funded and benefits are paid out of the general assets of Grand Valley State University. Priority Health Managed Benefits, Inc., a licensed third-party administrator (“TPA”), has been contracted by the Plan Administrator to perform certain administrative duties for the Plan, including the processing of all benefit claims. The address of the TPA is: Priority Health Managed Benefits, Inc., 1231 East Beltline, NE, Grand Rapids, MI 49525-4501, 616 956-1954 or 800 956-1954.

Plan Costs: The cost to participate in this Plan is shared by the Company and the employee. We will determine the amount to be contributed by participants in the form of premium in order to be covered under the Plan. You may contact the Company for additional information regarding participant contributions.

Funding of the Plan: Benefits under the Plan are not funded through an insurance arrangement. Benefits and administrative costs are paid directly from the Company’s general assets.

Excess Contributions: If Company contributions exceed the amount deductible under Code Section 162, such excess may be:

- Returned. Returned to the Company within one year if due to a mistake of fact or within one year of final disallowance of the deduction; or
- Applied. Retained and applied to reduce the Company contribution for the plan year following the year of contribution or the year of final disallowance of the deduction.

Plan Asset Distribution after Termination of the Plan: Information concerning asset distribution after termination of the Plan shall be made available by the Plan Administrator at no cost upon written request.

Plan Benefits: Benefits available under this Plan are detailed in this PDSPD. You will need to refer to this PDSPD in order to determine the terms and conditions of your benefits under the Plan, including any cost-sharing provisions, benefit maximums or other limits on benefits that apply to your coverage.

Plan Amendment and Termination: There are no vested rights to any benefits under this Plan. We may at our discretion amend or terminate this Plan or any benefits provided under the Plan at any time.

Governing Law: To the extent not preempted by any other law, the Plan will be governed by the law of Michigan.

Additional SPDs: This Plan may also include additional SPDs for other benefit plans provided by the Company for its employees.

Agent for Service of Legal Process: AVP Human Resources
Grand Valley State University
1090 James H. Zumberge Hall (1090 JHZ)
Allendale, Michigan 49401

Service of legal process may also be made upon the Plan Administrator.

Fiduciary Responsibilities: The responsibilities of the Company and the Plan Administrator are as set forth in this Plan.

Plan Sponsor Responsibility: The Plan Sponsor shall have the following administrative responsibilities:

- Contributions. Payment of Company contributions;
- Administrator. Appointment and removal of the Plan Administrator;
- Expenses. Payment of the expenses of administering the Plan;
- Amendment. Amendment of the Plan; and
- Termination. Termination of the Plan.

Plan Administrator: The Company is the Plan Administrator of the Plan. The Plan Administrator is a Named Fiduciary responsible for the operation and management of the Plan. The Company may appoint a committee consisting of one or more persons for such term as it shall select to act as Plan Administrator (the "committee"). Any usual and reasonable expenses of the committee shall be paid by the Company.

Plan Administrator Responsibilities: The Plan Administrator shall have responsibility for the general administration of the Plan and shall have full discretion in the exercise of the following duties and powers:

- Plan Benefits. Establish or determine Company and participant contributions to the Plan and employee and dependent coverage, charges, deductibles, benefits, maximum benefits and all other amounts payable under the Plan;
- Construction. To interpret the Plan, construe disputed or ambiguous terms of the Plan, decide all questions of eligibility for coverage and benefits, and the amount, manner and time of payment of any benefits, including final review of denied claims;
- Procedures. To prescribe procedures and forms to be used by participants for applications for participation; and claim determination;
- Disclosure. To make disclosures to participants required by law including a summary of the Plan, summary annual reports, and notice of rights to COBRA continuation coverage;
- Reporting. To make governmental reports required by law including annual and periodic reports to the Internal Revenue Service and the Department of Labor (including, without limitation, Forms 5500 and 990);
- Information. To receive from and transmit to the Company and participants such information as shall be necessary for the proper administration of the Plan;
- Financial Reports. To receive and retain reports of the financial condition of the Plan;
- Payments. To authorize payments under provisions of the Plan;
- Agents. To appoint fiduciaries, individuals, or entities to assist in the administration of the Plan and other agents it deems advisable, including legal counsel;
- Insurance. Select, if necessary, an insurance carrier and to determine the amount and type of insurance;
- Rules. To promulgate rules and decisions of uniform and consistent application subject to the provisions of the Plan, and governing law; and
- Enforce. To enforce the Plan, and any insurance contract on behalf of the participants and the Company.

Allocation and Delegation of Fiduciary Responsibilities: The Plan Administrator or the Committee may delegate responsibility for the administration, operation, or management of the Plan to a person or may allocate such responsibility among two or more persons. The allocation or delegation shall be in writing. The written document shall specify the date of the action and the effective date of the allocation or delegation; shall identify the responsibility allocated or delegated; and shall identify by name, office, or other reference, the person to whom the responsibility is allocated or delegated. Such responsibility shall become the responsibility of the person identified as of the effective date, and shall remain the responsibility of the person until a superseding action is taken or until the effective date of a resignation or rejection of the responsibility by the person. The allocation or delegation shall be communicated to the person to whom the responsibility is assigned and written acknowledgment of the communication and acceptance of the responsibility shall be made by the person. If there is a conflict, the powers of and actions by the Plan Administrator shall be controlling.

Indemnification: The Company shall indemnify and hold harmless each member of the committee, if a committee is appointed, and each of its employees to whom responsibilities for the operation and administration of this Plan have been delegated, against any and all claims, loss, damages, expense, and liability arising from any action or failure to act, except when the same is due to gross negligence or willful misconduct of such person. The Company may choose, at its own expense, and discretion, to purchase and keep in effect liability insurance for each such person to cover a part or all of any such claims, loss, damage, expense and liability.

Fiduciary Standards: Each fiduciary of this Plan shall act solely in the interest of participants and beneficiaries:

- Prudently. With the care, skill and diligence of a prudent person;
- Exclusive Purpose. For the exclusive purpose of providing benefits to participants and paying expenses of plan administration; and
- Prohibited Transaction. To avoid engaging in a prohibited transaction by law unless an exemption is obtained.

Inter-Relationship of Fiduciaries: Each of the fiduciaries warrants that any directions given, information furnished, or action taken by it shall be in accordance with the provisions of the Plan, authorizing such direction, information or action. Furthermore, each of the fiduciaries may rely upon any direction, information or action of another fiduciary as being proper and is not required to inquire into the propriety of any such direction, information or action. It is intended that each of the parties shall be responsible for the proper exercise of its own responsibilities.

Third-Party Administrator Appointment: PRIORITY HEALTH MANAGED BENEFITS, INC., a licensed third-party administrator, is delegated by the Plan Administrator under contract with the responsibility to perform certain responsibilities of the Plan Administrator, including all duties provided hereunder to Priority Health. The duties of Priority Health shall be evidenced by a written instrument that shall specifically set forth the responsibilities allocated to Priority Health and the remuneration to be provided to Priority Health. Priority Health does not itself undertake to directly furnish any benefits or services under the Plan. The obligations of Priority Health are limited to arranging for a network of health care providers and administering claims for benefits. Health care providers are solely responsible for exercising independent health care judgments. Priority Health is solely responsible for making benefit determinations in accordance with the Plan and its contracts with Network Providers, but it expressly disclaims any right or responsibility to make clinical treatment decisions. Such decisions may only be made by health care providers in consultation with the participant. Such health care providers and the participant may elect to begin or continue treatments despite Priority Health's denial of coverage for such treatments, and the participant will be responsible for the cost of such treatments. Participants and health care providers may appeal any of Priority Health's benefit decisions in accordance with the Plan's Appeal Procedure.

Stop Loss Insurance Contract: The Company may enter an excess or stop-loss insurance contract ("Insurance Contract") to protect the general assets of the Company from catastrophic claims under this Plan. The proceeds of any such policy are payable to the Company, not to the Plan, are not used to provide benefits under the Plan, in no way represent the security for payment of benefits under the Plan and are not assets of the Plan.

SECTION 3. ELIGIBILITY

Our employees, and their dependents, may enroll as participants upon the employee's date of hire. Employees and their dependents must also meet the other requirements described below.

Employee Eligibility.

A person may enroll as an employee if the person:

- Is classified by us as an employee who regularly works full-time 30 or more hours per week; or
- Employees eligible to continue their benefits under a phased retirement agreement approved by the Company; and
- Meets all other eligibility requirements of this Plan.

Note: The Company has grandfathered faculty and staff, who is classified by us as an employee who regularly works at least 20 hours per week prior to July 1, 2016, to retain their eligibility for coverage under this Plan.

For purposes of this Plan, it does not include the following classifications of workers as determined by the Company in its sole discretion:

- Temporary or leased employees;
- An independent contractor (as defined in this Plan);
- A consultant who is paid on other than a regular wage or salary by the Company; and
- A member of the Company's Board of Directors, an owner, partner, or officer, unless engaged in the conduct of the business on a full-time regular basis.

For purposes of this Plan, eligibility requirements are used only to determine a person's initial eligibility for coverage under this Plan. An employee may retain eligibility for coverage under this Plan if the employee is temporarily absent on an approved leave of absence, with the expectation of returning to work following the approved leave as determined by the Company's leave policy, provided that contributions continue to be paid on a timely basis. The Company's classification of an individual is conclusive and binding for purposes of determining eligibility under this Plan. No reclassification of a person's status, for any reason, by a third-party, whether by a court, governmental agency or otherwise, without regard to whether or not the Company agrees to such reclassification, shall change a person's eligibility for benefits.

Married participants that are both employed by the Company may elect to be covered as either an employee or a covered dependent under this Plan, but not both.

An employee who is also eligible for coverage as a dependent child may participate in this Plan as an employee, or as a dependent, but not both.

An eligible employee who is covered under this Plan who retires as an official retiree may be eligible to enroll in the GVSU retiree medical plan.

Note: Eligible employees and dependents who decline to enroll in this Plan must state so in writing. In order to preserve potential special enrollment rights, eligible individuals declining coverage must state in writing that enrollment is declined due to coverage under another group health plan or health insurance policy. Proof of such plan or policy may be required upon application for special enrollment. See the *Enrollment* section.

Dependent Eligibility.

To be enrolled as a covered dependent a person must be a resident of the United States and meet the requirements in one of the categories as detailed below:

Dependent Spouse:

Your legal spouse who is a husband or wife of the opposite sex provided he or she is not covered as an employee under this plan. For purposes of eligibility under this Plan, a legal spouse does not include a common-law marriage spouse, even if such partnership is recognized as a legal marriage in the state in which the couple resides. An eligible dependent does not include an individual from whom you have obtained a legal separation or divorce. Documentation on a covered person's marital status may be required by the Plan Administrator.

If both spouses are employees of the Company, the dependent children may be covered under this Plan by one spouse, but not both.

Household Member (Domestic Partner):

Your household member, so long as he or she meets the definition of household member as stated in the *Definitions* section of this Plan, and the person is not covered as an employee under this Plan. When a person no longer meets the definition of household member, that person no longer qualifies as your dependent.

Dependent Child:

A dependent child that resides in the United States until the child reaches the end of the month of his or her 26th birthday or to his or her 27th birthday if enrolled in a qualified course of study. The term "child" includes the following dependents:

- A natural biological child;
- A step child;
- A legally adopted child or a child legally placed for adoption as granted by action of a federal, state or local governmental agency responsible for adoption administration or a court of law if the child has not attained age 26 as of the date of such placement;
- A child under your (or your spouse's or household member's) legal guardianship as ordered by a court;
- A child who is considered an alternate recipient under a Qualified Medical Child Support Order (QMCSO); and
- A child of a household member.

A dependent does not include the following:

- A foster child;
- A grandchild;
- Any other relative or individual unless explicitly covered by this Plan; or
- A dependent child if the child is covered as a dependent of another employee at this Company.

Court Appointed Guardianship:

Special rules apply to a child for whom the employee or the employee's spouse is the court-appointed permanent or limited guardian. The child may be enrolled from the moment he or she is in your physical custody. We will not cover any expenses incurred for the child's care before he or she is in your physical custody. "Physical custody" means that the child is legally and physically placed in your home. If we ask for proof that the child meets the above requirements, you must give us acceptable proof, such as a court order, within 31 days. The child is eligible for coverage until the end of the day on which he or she turns 18 years of age or no longer meets the eligibility requirement of this provision.

Physically or Mentally Incapacitated – Over Age 26:

We will continue to provide coverage for the employee's and the employee's spouse's unmarried and incapacitated dependent child past age 26. A dependent is incapacitated if all of the following apply:

- The dependent is the child of the employee or the employee's spouse;
- The dependent is not capable of self-sustaining employment and unable to independently socialize without assistance because of a mental or physical disability that is incapacitating. Certain diagnoses, including but not limited to attention deficit disorder or depression, by themselves, are not evidence of incapacity. Learning disabilities or the inability to "hold a job" in the absence of mental retardation are not evidence of incapacity. Examples of diagnoses that may constitute an incapacitating condition include Down Syndrome and traumatic brain injury;
- The incapacity must have started before age 26; and
- The dependent relies on the employee for more than half of his or her support, as determined under Section 152 of the Internal Revenue Code, as amended.

We must receive proof from you that the dependent is incapacitated within 31 days after the dependent reaches age 26 if the child is already covered or within 31 days of initial enrollment. After that, you must give us proof when we ask for it, from time to time, but not more often than once each year.

Coverage under this provision continues until the earliest of:

- The child ceasing to be a covered dependent of the employee as defined in this Plan; or
- The child's incapacity ends; or
- We do not receive satisfactory proof of the child's incapacity within 31 days of requesting such proof; or
- The dependent's coverage as a dependent ends for any reason other than reaching the maximum age for dependent children (such as marriage).

Qualified Medical Child Support Orders.

A Qualified Medical Child Support Order ("QMCSO") is a court or administrative order that requires you to provide coverage for a child. A child will be enrolled in the Plan under a QMCSO if you provide us with a copy of the QMCSO and the child is otherwise eligible for coverage as a covered dependent under the Plan. If we receive a copy of the QMCSO but you do not enroll the child for coverage, the child may be enrolled by the Friend of the Court or by the child's other parent through the Friend of the Court. If you are not currently enrolled in the Plan we reserve the right to enroll you in the Plan in order to facilitate the addition of the child under the QMCSO. The child will be enrolled without regard to enrollment season restrictions.

Coverage for a child enrolled under the Plan by a QMCSO will not be terminated unless (1) required contributions are not made as required by the Plan; or (2) we receive written proof that the QMCSO is no longer in effect; or (3) we receive written proof that the child has or will have comparable coverage beginning on or before this Plan's coverage is terminated; or (4) the child no longer meets the eligibility requirements of the Plan, or (5) the child's coverage is terminated for cause.

A copy of our QMCSO procedures may be obtained from the Plan Administrator, free of charge.

Right to Check a Dependent's Eligibility Status: The Plan reserves the right to check the eligibility status of a dependent at any time throughout the year. You and your dependent have a notice obligation to notify the Plan should the dependent's eligibility status change throughout the plan year. Please notify your Human Resources Department regarding status changes.

Important: It is your responsibility to notify the Plan Sponsor within 60 days if your dependent no longer meets the criteria listed in this section. If, at any time, the dependent fails to meet the qualifications of totally disabled, the Plan has the right to be reimbursed from the dependent or employee for any medical claims paid by the plan during the period that the dependent did not qualify for extended coverage. Please refer to the *Continuation of Coverage* section in this document.

Employees have the right to choose which eligible dependents are covered under the Plan.

SECTION 4. ENROLLMENT

This section describes how you become enrolled in the Plan. You cannot re-enroll in the Plan if your coverage has been terminated for cause. Read the *Termination of Coverage* section of this PDSPD to learn more about termination for cause.

The employee must complete the Company's enrollment process to enroll in the Plan. The employee must list every person being enrolled, and provide the requested information. This includes information about other insurance or health coverage any individual may have. Coverage is provided without regard to health status or medical need. If your coverage is effective retroactively, any services you received during that time are subject to the terms and provisions of this PDSPD.

Open Enrollment Period for Employees and Eligible Dependents.

An "open enrollment period" is a time established by the Company when eligible employees and their eligible dependents have the option to enroll in the Plan or make changes to current plan coverage.

Each eligible employee may enroll for coverage (or enroll any eligible dependents), or may change the level of coverage during the annual open enrollment period. The annual open enrollment period will typically be the last week in October to the first week in November. The Company will provide eligible employees written notice prior to the start of an annual open enrollment period each plan year. Elections go into effect on the first day of the plan year following each annual open enrollment period. If an employee does not complete the enrollment process for the Company, the election for the prior plan year will be automatically continued.

Enrollment of Newly Eligible Employees and Dependents.

An employee may enroll for coverage (and enroll eligible dependents) when the employee first becomes eligible for coverage between open enrollment periods. The employee must apply to the Company for coverage within 31 days after first becoming eligible. Any employee or dependent that was not enrolled when first eligible may only enroll during a later open enrollment period or during a special enrollment period as described below.

Special Enrollment Periods.

A "special enrollment period" is a period of enrollment (other than the open enrollment period or an enrollment period for newly eligible employees) during which an individual with special enrollment rights may elect to enroll in this Plan. An employee and his or her eligible dependents may enroll during a special enrollment period in the following situations:

Enrollment of Newly Eligible Dependents.

If an eligible employee gains a new dependent as a result of marriage, birth, adoption, or placement for adoption, the following individuals may be enrolled in the Plan if they are not currently enrolled: (1) the employee; (2) the employee's spouse; and (3) any new dependents. The employee must complete the Company's enrollment or change process within 31 days after the marriage, birth, adoption, or placement for adoption.

Coverage will be effective on the date of the marriage, birth, adoption, or placement for adoption. You must also meet all the other eligibility requirements of the Plan to enroll.

The employee must complete a request to enroll a newborn child for coverage. The request must be returned to our designated person within 31 days after the child is born.

Loss of Other Coverage.

If you or your dependents are eligible for coverage but did not enroll under this Plan because you were covered under another group health plan or had other health insurance coverage, you may be eligible to enroll in the Plan during a special enrollment period. The following individuals may be enrolled in the Plan if they are not currently enrolled: (1) the employee; (2) the employee's spouse; and (3) any other dependents. The following requirements must be met:

- You declined coverage (in writing if the Plan required such a statement at that time) when it was previously offered because you or your dependents were covered under another group health plan or had other health insurance coverage; and
- The other coverage was COBRA continuation and it ran out; or the other coverage was not COBRA continuation coverage and it ended because you lost eligibility (including as a result of divorce, legal separation, loss of dependent status, death, termination or reduction in hours of employment, or loss of eligibility because you no longer live or work in the other health plan service area, the Plan no longer offers any benefits to a class of similarly situated individuals or because the employer stopped making contributions); and
- You must request enrollment within 31 days after the other coverage (as stated above) ended; and
- You must provide proof of loss of other coverage that is acceptable to us.

An individual who loses coverage for the following reasons is not eligible for a special enrollment period:

- The individual did not pay premiums on a timely basis; or
- The individual chose to drop coverage for any reason, including an increase in premium or change in benefits. Exception: If you voluntarily drop your other coverage during the annual open enrollment period for that other coverage, you are eligible to enroll in this Plan during a special enrollment period; or
- The individual's coverage was terminated for cause, such as for making a fraudulent claim or giving false information.

Enrollment due to loss of other coverage will be effective on the first day following the loss of other coverage.

Medicaid/Children's Health Insurance Program Changes.

If you or your eligible dependents (including your spouse) are eligible for, but not enrolled for coverage, you may enroll yourself and/or your dependents during a special enrollment period if either of the following requirements is met:

- The Medicaid or CHIP coverage of you or your eligible dependent is terminated as a result of loss of eligibility and you request coverage no later than 60 days after the date the Medicaid or CHIP coverage terminates; or
- You or your eligible dependent become eligible for a premium assistance subsidy for coverage under a Medicaid plan or CHIP (including any waiver or demonstration project) and you request coverage no later than 60 days after the date you are determined to be eligible for such assistance.

Late Enrollment.

If you did not enroll when newly eligible under this Plan and you do not meet the requirements of a special enrollment period, you must wait to enroll during a later open enrollment period.

Notification of Change in Status.

You must let us know about any changes that affect coverage under the Plan by completing the Company's change process. You may also call the Benefit Administrator's Customer Service Department or contact the Benefits Office by phone at (616) 331-2220 or by email at healthandwellness@gvsu.edu regarding any changes. You must notify us of the following changes:

- Change of address;
- Change in covered dependent status (including divorce or the death of a spouse or covered dependent);
- Eligibility for Medicare, Medicaid and Children's Special Healthcare Services; or
- Gain or loss of other health coverage.

These are just examples; you must let us know about any other change that affects coverage for any individual enrolled in this Plan.

You must let us know about a change within 31 days after the change happens. This allows us to make sure you and your eligible dependents are enrolled correctly. We will review services you have received since the effective date of the change to determine if the services are covered and how they should have been paid.

Relation to Section 125 Cafeteria Plan.

This Plan may also allow additional changes to enrollment due to change in status events under the Company's Section 125 Cafeteria Plan. Please refer to the GVSU Flexible Benefits Plan for more information.

SECTION 5. EFFECTIVE DATES OF COVERAGE

General Rules.

After you are enrolled as described in the *Enrollment* section of this PDSPD, and except as detailed below, your coverage will begin on the latest of:

- The effective date of the Plan; or
- The first day of the plan year following an open enrollment period, if you enroll during that open enrollment period; or
- The date you are first eligible under the *Eligibility* section of this PDSPD, if you are a newly eligible employee or dependent; or
- The first day following loss of other coverage, if you enroll during a special enrollment period because of loss of other coverage or because of a Medicaid or CHIP plan change; or
- The date of marriage or the date of a dependent's birth, adoption, or placement for adoption if you are eligible to enroll during a special enrollment period because of gaining a dependent; or
- The date a child is placed in your physical custody if coverage is being provided as a result of a court-appointed permanent or limited guardianship; or
- The date a child is enrolled due to a QMCSO.

If your coverage is effective retroactively, any care you receive is subject to the terms of this PDSPD, including prior certification requirements or use of network providers.

Predecessor Plan.

If you were a participant in a predecessor plan sponsored by us on the day before the effective date, and if you are otherwise eligible for coverage under this Plan, you will automatically be a participant in this Plan on the effective date. We may require you to complete a new enrollment.

SECTION 6. TERMINATION OF COVERAGE

The employee's coverage under this Plan will terminate on the earliest of:

- The date on which the Plan terminates; or
- The date on which the employee's employment terminates; or
- The date on which eligibility requirements are no longer satisfied, and any Company sponsored continuation of coverage (e.g. due to a leave of absence or layoff) have been exhausted; or
- The date on which the employee voluntarily withdraws from the Plan. However, where required contributions for coverage are paid on a pre-tax basis through the Company's Section 125 plan, a voluntary withdrawal may only occur during the Annual Open Enrollment Period (if applicable) or midyear as a result of a Change in Status or other qualifying event under the Company's Section 125 plan; or
- The last day of the period for which the required contribution has been paid if the required contribution for the next period is not paid when due; or
- The date on which the employee's participation is terminated for cause as described below; or
- The date of the employee's death.

Dependent coverage will terminate when the employee's coverage terminates. Dependent coverage may end earlier in any of the following situations:

- The date on which the dependent no longer satisfies eligibility requirements of the Plan; or
- The date on which the dependent voluntarily withdraws from the Plan. However, where required contributions for coverage are paid on a pre-tax basis through the Company's Section 125 plan, a voluntary withdrawal may only occur during the Annual Open Enrollment Period (if applicable) or midyear as a result of a Change in Status or other qualifying event under the Company's Section 125 plan; or
- The last day of the period for which the required contribution for the dependent's coverage has been paid if the required contribution for the next period is not paid when due; or
- The date on which the dependent's coverage is terminated for cause, as detailed below; or
- The date of the dependent's death.

Termination For Cause.

The Plan Administrator can terminate your coverage for cause immediately if you commit or attempt to commit fraud against the Plan or Benefit Administrator or you are dishonest with the Plan about some important or material matter. For example, we may terminate your coverage if:

- you provide wrong or misleading information that affects the coverage we provide to you and/or your covered dependents;
- you allow someone else to use your ID card or receive benefits in your place; or
- you enroll someone in this Plan who is not eligible for coverage.

Termination may be effective the day you committed the fraud or were dishonest with the Plan Administrator or Benefit Administrator. The Plan can collect from you the costs for covered services that you received after the effective date of termination and the Plan paid for, plus our cost of recovering those charges (including attorney's fees).

Your coverage will not be terminated based on your health or your health care needs. Your coverage will not be terminated just because you used the Plan's inquiry and appeal procedure to make a complaint.

The Plan will only rescind your coverage as permitted by federal law, which allows rescission for fraud or material misrepresentation.

SECTION 7. CONTINUATION OF COVERAGE

Extension of Coverage for Family and Medical Leave.

If you are on a qualified leave of absence under the Family and Medical Leave Act of 1993 as amended (the "FMLA"), you may continue coverage for yourself and any covered dependents during that leave. The coverage will be on the same basis and at the same participant contribution rate as if you were actively at work. If you do not return from FMLA leave for any reason other than the continuation, recurrence, or onset of a serious health condition (as defined in the FMLA) or other circumstance determined by the Plan Administrator to be beyond your control, we may recover the amount paid by us to maintain coverage for you during the leave. If you fail to pay your required participant contribution for coverage during the leave, your coverage will be suspended, but you will have the right to the reinstatement of coverage when you return to work from FMLA leave.

Continuation of Coverage under COBRA.

"COBRA" stands for the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, which was enacted to provide for continued coverage for eligible individuals ("Qualified Beneficiaries") who would otherwise lose coverage due to specific circumstances ("Qualifying Event"). COBRA applies to employers with 20 or more employees on at least 50% of the employer's typical business days during the prior calendar year.

Qualified Beneficiary. "Qualified Beneficiary" means an employee, spouse of the employee, and dependent child of the employee who is covered under this Plan on the day before a COBRA Qualifying Event takes place (detailed below) and loses coverage as a result of the Qualifying Event. A Qualified Beneficiary also includes any child born to or placed for adoption with, the covered employee during the period of COBRA continuation coverage. Each individual Qualified Beneficiary has the same rights under the Plan as an active employee.

We use the pronouns "you" and "your" in the following paragraph regarding COBRA to refer to each person covered under the Plan who is, or may become, a Qualified Beneficiary.

Eligibility for COBRA Continuation Coverage. If your participation in the Plan terminates because you have a Qualifying Event, you may continue coverage under COBRA for specific periods of time. A "Qualifying Event" happens when:

- 18-Month Qualifying Events. Coverage of an employee, spouse or dependent child terminates because the employee terminated employment for any reason (except gross misconduct), or because the employee's hours were reduced below the minimum required for coverage (an "Employee Qualifying Event"); or
- 36-Month Qualifying Events. A spouse's or dependent child's coverage terminates because of any of the following (a "Dependent Qualifying Event"):
 - (a) The employee died; or
 - (b) The employee became divorced or legally separated; or
 - (c) The employee became entitled to Medicare; or
 - (d) A dependent child loses eligibility as a covered dependent under the Plan.

You must be covered under this Plan on the day before the Qualifying Event occurs to be eligible for COBRA coverage. A child who is born to or placed for adoption with a covered employee during the COBRA coverage period is also a Qualified Beneficiary eligible for COBRA coverage from the date of birth or placement for adoption, so long as the Plan Administrator is notified of the birth or adoption within 30 days of the event. An employee may be a Qualified Beneficiary only in the event of the employee's termination or reduction in hours of employment.

FMLA and COBRA. If an employee on FMLA leave does not return to work, a Qualifying Event occurs as of the earlier of the day the FMLA leave expires or the day the employee notifies us that he or she is not returning to work. COBRA coverage is available if the employee was covered under the Plan on the day before FMLA leave began even if the employee was not covered during FMLA leave.

Type of Coverage. COBRA coverage will be the same as the coverage provided to plan participants who have not experienced a Qualifying Event. If coverage under the Plan is changed for plan participants who have not experienced a Qualifying Event, COBRA coverage will be changed in the same manner.

Duration of COBRA Continuation Coverage. COBRA continuation coverage will extend for a maximum of 18 months for an Employee Qualifying Event and a maximum of 36 months for a Dependent Qualifying Event except as described below:

- *29-Month Disability.* If it is determined that you are disabled under either Title II or Title XVI of the Social Security Act at the time of an Employee Qualifying Event, or at any time during the first 60 days of COBRA coverage following an Employee Qualifying Event, COBRA continuation coverage may extend for you and other covered family members for up to 11 additional months (beyond the initial 18 months) for a total continuation period of 29 months if you provide the required notice and evidence of the disability determination to the Plan Administrator in a timely manner. You must provide the Plan Administrator with written notice of the disability determination within the 60 day time period described below under "COBRA Notice Requirements, Participants Notice" but no later than the end of the initial 18 months of COBRA continuation coverage. This extended coverage will terminate on the last day of the calendar month that begins 30 days after the date of a final determination that you are no longer disabled.
- *Multiple Qualifying Events.* If a second Qualifying Event that is a 36-month Dependent Qualifying Event occurs during an 18-month Employee Qualifying Event extension, COBRA continuation coverage for a spouse and dependent child may continue for an additional 18 months. If a covered dependent is added after continued coverage began, the Plan will not continue the dependent's coverage past the original 18 months (except in the case of a newborn or newly adopted child who becomes covered as described above). You must notify the Plan Administrator of the second Qualifying Event within the 60 day time period described below under "COBRA Notice Requirements, Participants Notice". The multiple qualifying event extension is also available where a second Qualifying Event that is a 36-month Dependent Qualifying Event occurs during the additional 11-month disability extension. The multiple qualifying event extension is available only if the second qualifying event would have caused a loss of coverage under the Plan if the first qualifying event had not occurred.

COBRA continuation coverage will never extend for more than 36 months, measured from the date of the original Employee Qualifying Event.

- *36-Month Medicare Rule.* If a covered employee becomes entitled to Medicare before the occurrence of an Employee Qualifying Event, (termination or reduction in hours), the maximum COBRA period for covered dependents can extend to the later of 36 months from the date of Medicare entitlement or 18 months (29 months if there has been a disability extension) from the date of the Employee Qualifying Event.

Termination of COBRA. Your COBRA continuation coverage will terminate for any of the following reasons:

- The date you reach the end of the 18, 29 or 36 month maximum coverage period; or
- The date we no longer offer a group health plan to any of our employees; or
- The date as of which your premium for COBRA continuation coverage is not timely paid; or
- The date after your election of COBRA that you first become covered under another group health plan; or
- The date after your election of COBRA, on which you first become enrolled in Part A or Part B of Medicare; or
- The date your coverage is terminated for cause on the same basis as for similarly situated nonCOBRA beneficiaries, such as for submission of a fraudulent claim.

COBRA Notice Requirements. Your COBRA continuation coverage will be effective on the date your regular coverage ends. For COBRA coverage to be available you must: (a) timely notify the Plan Administrator or its designee of an event permitting a dependent extension of participation as required below; (b) timely elect coverage under this section; and (c) timely pay all required participant contributions.

- *Company Notice.* We will notify the Plan Administrator or its designee within 30 days of the death of a participant; the termination of a participant's employment; the reduction in hours of a participant's employment; or a participant becoming entitled to benefits under Medicare.

- *Participant Notice.* You must notify the Plan Administrator or its designee in writing of a divorce, legal separation, child ceasing to have covered dependent status, or a second qualifying event under this Plan within 60 days of the occurrence, or if within 60 days after the date coverage would end because of the Qualifying Event. If you or your covered dependent are eligible for a 29-month COBRA continuation coverage because of disability, you must notify the Plan Administrator or its designee of the Social Security disability determination within 60 days after the latest of: (a) the date of the Social Security Administration disability determination; (b) the date of the employee's Qualifying Event; or (c) the date coverage would be lost under the Plan because of the employee Qualifying Event; and before the end of the initial 18 months of the COBRA continuation coverage. You must also notify the Plan Administrator or its designee within 30 days of any final determination by the Social Security Administration that you (or your covered dependent) are no longer disabled. If you do not make the required notifications in writing within the above time frames, COBRA continuation coverage will not be available. You must mail or hand-deliver the above notices to the Plan Administrator. If mailed, your notice must be post-marked no later than the deadline described above.
- *Plan Administrator Notice.* Within 14 days of receiving notice of a Qualifying Event, the Plan Administrator or its designee will send a COBRA election notice to each individual participant whose coverage would be terminated absent the COBRA continuation coverage right.
- *Participant Election.* You must elect COBRA continuation coverage within 60 days from the date your coverage would terminate, or the date that you are sent a COBRA election notice, whichever is later. If you do not elect coverage within the 60-day period, we will consider this to be a refusal of coverage. Each individual covered by the Plan on the day before a Qualifying Event has an independent right to COBRA continuation coverage regardless of whether coverage is elected for any other family member.

COBRA Premiums. If you enroll for COBRA continuation coverage, you must pay the applicable premium for that coverage ("COBRA Premium"). The COBRA Premium will be equal to 102% (150% for each month of the additional 11-month COBRA continuation coverage for disability if the disabled individual is part of the coverage group) of a reasonable estimate of the cost of providing participation for similarly situated beneficiaries. That cost will be determined based on IRS rules.

Payment of COBRA Premiums. If you enroll for COBRA continuation coverage, your initial COBRA Premium must be paid within 45 days from the date you elect coverage. The initial premium is the amount necessary to purchase coverage retroactive to the date your coverage would have terminated because of a Qualifying Event. Each additional COBRA Premium is due before the first day of each month of coverage. You are responsible to insure that your COBRA Premiums are paid timely. If a COBRA Premium is not paid within 30 days after its due date (45 days for the initial COBRA Premium), your COBRA continuation coverage rights will terminate. The termination will be effective as of the last day for which the Plan received a COBRA Premium, and you will have no right to reinstatement. Payment of the premium is considered to have been made as of the date sent (typically the date postmarked by the Post Office on the mailing envelope).

Reimbursement of Reasonable and Customary Charges. If you are eligible for COBRA continuation coverage, and you receive services before you enroll for COBRA continuation coverage and before you pay the required COBRA Premium, you must pay for those services when provided. The Plan will reimburse you the reasonable and customary charges for those services, minus any required copayments, if you enroll for COBRA continuation coverage within the required 60-day period, you timely pay the COBRA Premium, and you submit a claim for reimbursement of those charges.

Address Changes: To protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members.

Continued Coverage For Household Members.

Household members do not qualify as qualified beneficiaries under federal COBRA law. Therefore, under federal law household members do not have the right to elect COBRA independently and separately from the eligible employee.

However, this Plan allows household members to elect to continue coverage under a "COBRA-like" extension, separately and independently of eligible employees, subject to the same terms and conditions as outlined for qualified beneficiaries under the COBRA law, when a qualifying event occurs.

Continuation of Coverage for Military Service.

If an employee is absent from work because of military service, he or she may elect to continue coverage under the Plan for the employee and his or her eligible dependents. The continuation coverage period will extend for up to 24 months from the first day of the absence (or, if earlier, until the day after the date the employee is required to apply for or return to reemployment under the Uniformed Services Employment and Reemployment Rights Act of 1994 (the "USERRA")). The participant contribution for the continued coverage will be the same as the COBRA Premium for a COBRA beneficiary, except that if the employee is absent for less than 31 days, the participant contribution will be the same as for similarly situated active employees.

An employee who does not elect to be covered during military service, or whose coverage terminates because the continuation period expires, may reinstate coverage under this Plan when he or she returns to work as required under the USERRA. Coverage will be reinstated without any waiting period.

These continuation requirements apply to the extent they provide an employee absent from work because of military service with more favorable coverage than COBRA continuation coverage (such as coverage for a longer period of time or less costly coverage).

Notice of Absence for Military Service. You must give your Company advance written notice of your absence for military service unless providing the notice is impossible, unreasonable or precluded by military necessity.

Election of Continuation Coverage. You must elect continuation coverage in writing no later than 60 days after you leave work for military service, or if giving notice within 60 days is impossible, unreasonable or precluded by military necessity, in which case you must give your Company written notice of your absence within 60 days after doing so is no longer impossible, unreasonable or precluded by military necessity. If you make a timely election of continuation coverage and pay any unpaid premium amounts due, then your continuation coverage will be retroactive to your date of absence.

Termination of Coverage. If you do not give your Company notice of your absence for military service, your coverage will end immediately upon your absence. If you provide your Company notice of your absence but do not elect continuation coverage as provided above, then your coverage will end after you have been absent for military service for 30 days. If you elect continuation coverage but fail to make timely premium payments, then your continuation coverage will be terminated if you fail to make a payment within 30 days of when the payment is due.

Company Sponsored Continuation.

A period of employer sponsored continuation shall not be counted toward any COBRA continuation coverage period under this Plan.

Medical Leave of Absence.

An employee on a medical leave of absence may continue coverage (and coverage for eligible dependents) during the leave through the end of the day following 6 months after the medical leave began. This leave will run concurrently with any available FMLA coverage. The participant contribution shall be at the same rate as for an active employee.

Approved Leave of Absence.

An employee on an approved leave of absence may continue coverage (and coverage for eligible dependents) during the leave through the end of the day following 12 months after which the leave of absence began. This leave will not run concurrently with any available FMLA coverage. The participant contribution shall be at the same rate as for an active employee.

No Conversion Option.

This Plan does not provide a conversion plan option.

SECTION 8. OBTAINING COVERED SERVICES – MEDICAL BENEFITS

This Plan is a Preferred Provider Organization (“PPO”) group health plan for your medical benefits. The Plan provides a network of medical care providers (“network providers”) who have agreed to provide services for specified fees. Under the Plan, you may choose to use either network or non-network providers for covered services (as described in the *Medical Benefits* section of this PDSPD), at the point in time when the covered services or supplies are desired. In order to receive network services, you are responsible to ensure that the provider participates in the network at the time the service is rendered.

Network and Non-Network Providers.

As a participant in the Plan you may obtain medical services directly from a network provider, allowing you to receive “network benefits”. You will be responsible for the deductibles, copayments, coinsurance or out-of-pocket amounts shown under the heading of “network benefits” in the *Schedule of Medical Benefits* in this PDSPD. Generally, network benefits will cost you less out-of-pocket than non-network benefits. If you receive services from a non-network provider you will receive “non-network benefits” (except as otherwise specified in this PDSPD). You will be responsible for the deductible, copayment and coinsurance amounts shown under the heading of “non-network benefits” in the *Schedule of Medical Benefits* of this PDSPD. At any time during your course of treatment, you have the option to return to a network provider for medical care. If you do, the Plan will cover care by a network provider at the network benefit level.

Certain services must be prior certified by the Benefit Administrator in order to be covered by the Plan, unless otherwise specified. If the Benefit Administrator does not prior certify a service or supply as described in this PDSPD, you may be responsible to pay the cost of that service or supply as described in the *Prior Certification* section of this PDSPD.

Network providers can provide your medical care, including your primary or routine health care and specialty care. A network provider can provide or coordinate services such as lab tests and x-rays, prescribe medicines or therapies, and arrange hospitalization. Only those services provided by a network provider will be covered as network benefits, except as this PDSPD says otherwise.

Generally, you will have the lowest out-of-pocket amounts and the most cost savings with the network benefit option. The non-network benefit option typically involves a higher out-of-pocket expense. But the non-network benefits option allows you to choose any provider, anywhere, and at any time.

To verify the current network status of network providers, contact the provider network number listed on your ID card or detailed on the *Schedule of Medical Benefits*. You are responsible for determining whether a provider is part of the network before receiving services. Unless otherwise specified in this PDSPD, benefits will be paid based on the network status of the provider as of the day that services are received.

Termination of Providers' Participation.

A network provider, or the Benefit Administrator, can terminate the provider's contract and you will need to change to a different network provider to maintain network benefits. Unless you qualify as a Continuing Care Patient, we do not promise that you will be able to receive services from a specific network provider the entire time you are covered by this Plan. If your network provider no longer participates in the network, you will need to select a different network provider to continue receiving network benefits. You may decide to continue treatment with the non-contracted provider; however, benefits will be covered under the non-network benefits.

A Continuing Care Patient can continue their network benefits with a terminated provider for either 90 days or until the patient no longer qualifies as a Continuing Care Patient (whichever happens first); after this you will need to select a different network provider to continue receiving network benefits. You may decide to continue treatment with the non-contracted provider; however, benefits will be covered under the non-network benefits.

Contact the Benefit Administrator’s Customer Service Department or visit their website at priorityhealth.com for assistance in finding a new network provider.

Referral Care.

Your physician, or a health professional, may refer you to another provider when it would be more appropriate for you to receive care from a different type of health professional or specialist. The provider to whom you are referred may or may not participate in the network. If you want to receive the network benefits level, ask your provider to refer you to a network provider. You may also contact the Benefit Administrator's Customer Service Department or visit their website at priorityhealth.com to find a network provider who can provide the referral care.

A provider might refer you for or suggest a service that the Plan does not cover. The Plan will not cover a service that would not be covered otherwise just because a provider referred you or suggested the service.

A Second Medical Opinion.

A second medical opinion from a specialist may be appropriate for certain health conditions and proposed surgeries. You may request a second medical opinion from a specialist provider who has skills and training substantially similar to those of the physician making the original treatment recommendation without prior certification. Benefits for second opinion services will be based on the network status of the provider at the time of service. Any tests, procedures, treatments or surgeries recommended by the consulting provider must be performed by a network provider to receive benefits at the network benefits level.

Review of Health Care Services and Supplies.

The Benefit Administrator can review services and supplies that health professionals recommend or provide to decide whether those services and supplies are covered under this Plan. If the Benefit Administrator decides that the services and supplies are not covered, the Benefit Administrator will let you know. If you disagree with the decision and want that decision to be reviewed, you must follow the procedures described in the *Appeals* section of this PDSPD.

PriorityRewards.

PriorityRewards is group wellness coverage designed to help you shop smart and stay healthy.

If it is medically/clinically necessary for you to receive any of the services included on the Procedure List, use the Cost Estimator Tool to shop for care. In addition to helping you find low cost care, the Cost Transparency Tool will also present you with educational materials about the elective procedure or service you are searching for, tips for a successful recovery, potential alternatives, and more. If you use the Cost Transparency Tool to shop prior to obtaining services and receive the service at a facility that charges a Fair Market Price or below Fair Market Price, you will earn a reward.

By participating in **PriorityRewards**, you have access to a Procedure List and Cost Transparency Tool by visiting priorityhealth.com. If you are not sure if you are enrolled in **PriorityRewards**, please contact Priority Health's Customer Service Department at **888 389-6645**.

A. Definitions

The following definitions apply to the provisions of **PriorityRewards** only.

Fair Market Price. The amount specified on the Cost Transparency Tool as the amount an informed shopper should be expected to pay, taking into account the range of prices charged all across a geographic region.

At or below Fair Market Price Provider or Facility. A provider or facility who charges a Fair Market Price (as specified on the Cost Transparency Tool) while also maintaining high quality standards.

Procedure List. A short list of services that, when performed at a facility that is at or below Fair Market Price may qualify you for a reward. This list is available at priorityhealth.com or by calling Priority Health's Customer Service Department at **888 389-6645**. The list may change periodically.

Cost Transparency Tool. An interactive web tool that allows you to look up any of the services included on the Procedure List, compare the cost of facilities where these services are performed in your area, and learn more about the procedure or service you are about to undergo.

Above Fair Market Price Provider or Facility. A provider or facility who charges more than the Fair Market Price (as specified on the Cost Transparency Tool) for covered services included on the Procedure List.

B. Earning and Using Rewards

To receive a reward after obtaining any of the services included on the Procedures List, you **must** complete the following steps:

- Use the Cost Transparency Tool, available at priorityhealth.com to find providers in your area who have been designated as at or below fair price.
- Obtain the needed service from any one of those at or below Fair Market Price Providers or facilities.

Once you've earned your first reward, a reward card will be issued to you. For each reward you earn thereafter, the Benefit Administrator will issue you a new reward credit.

Only the covered services included on the Procedure List will qualify you for rewards. Any covered services that are not included on the Procedure List will not be subject to the rewards.

Services that are received during a medical emergency or when urgent care is needed are not subject to the provisions of **PriorityRewards**. All medical emergency and urgent care services shall be covered according to the terms and conditions stated in the Plan and in the *Schedule of Medical Benefits* and will not be eligible for a reward.

Additional Information.

The Benefit Administrator will provide you with the following information when you request it by calling or writing their Customer Service Department:

- The current network status of providers.
- The professional credentials of network participating providers.
- The type of financial relationship between the provider network and the Benefit Administrator or Plan Administrator.
- Any prior certification requirements and any limitations, restrictions or exclusions on services, benefits or providers.
- Clinical review criteria the Benefit Administrator uses to determine whether services or supplies are medically/clinically necessary in a particular situation.
- Information on how new technology is evaluated for coverage under the Plan.

You may request this information by calling or writing to the Benefit Administrator's Customer Service Department at the phone numbers or address below:

Priority Health Managed Benefits, Inc.
1231 East Beltline, N.E.
Grand Rapids, MI 49525-4501
616 956-1954 or 800 956-1954

or send a secure e-mail on the Benefit Administrator's website at priorityhealth.com

SECTION 9. PRIOR CERTIFICATION

Some services and supplies require prior certification by the Benefit Administrator in order to be covered under this Plan. The complete and detailed list of these services is available by calling the Benefit Administrator's Customer Service Department or on their website at priorityhealth.com. This list may change throughout the year as new technology and standards of care emerge.

Below are the general categories of services and supplies that require prior certification by the Benefit Administrator:

- All inpatient services, except hospice care services in a hospice care facility.

You do not need prior certification from your PCP or the Benefit Administrator to seek care in a medical emergency or when urgent care is needed. Additionally, inpatient hospital stays for a mother and her newborn of up to 48 hours following a vaginal delivery and 96 hours following a cesarean section do not require prior certification. However, you are encouraged to notify the Benefit Administrator at least 60 days before your due date so they are better prepared to assist you at that time.

- Outpatient services outlined on the Benefit Administrator's website.
- Bariatric surgery.
- Durable medical equipment charges over \$1,000.00 and all rentals.
- Prosthetics and orthotics charges and all shoe inserts over \$1,000.00.
- Stimulators.
- High-tech radiology examinations, including but not limited to: positron-emission tomography (PET) scans, magnetic resonance imaging (MRI), computed tomography (CT scans) and nuclear cardiology studies.
- Selected injectable drugs.
- Home health care, including home infusion services and intermittent skilled services. Hospice care services in the home do not require prior certification.
- Supplemental feedings administered via tube or IV.
- Transplants and evaluations for transplants.
- Genetic testing.
- Clinical trials.
- Comprehensive pain and headache programs.
- Additional items as outlined on the Benefit Administrator's website at priorityhealth.com.

Non-Urgent Requests.

Contact the Benefit Administrator as soon as a provider recommends a service or supplies that require prior certification. In most cases, they will approve, partially approve, or deny a request for prior certification within 15 days of receipt. In some cases, they may ask you for additional information or additional time in which to make their determination. Based on the approval or denial, you and your provider can decide if you want to go forward with the proposed services or obtain the supplies.

Urgent Requests.

For urgent requests, we must respond within 72 hours. A request is considered urgent if delaying treatment would put your life in serious danger, interfere with your full recovery or delay treatment for severe pain.

For both urgent and non-urgent requests you may contact the Benefit Administrator's Customer Service Department to find out our decision. You and the provider recommending the services will receive a letter from the Benefit Administrator if the services will not be covered.

If you obtain services that the Benefit Administrator says are not covered or services in excess of what they say is covered, you are responsible for payment for those services. If you want the Benefit Administrator's decision to be reviewed, you may contact them. The *Appeals* section of this Plan tells you how to do that.

Reevaluation of Decision on Prior Certification.

At any time, your physician may ask the Benefit Administrator to reevaluate a prior certification decision they have made.

Retrospective Review.

It is important to get prior certification so that you know ahead of time if the services or supplies you seek will be covered. If required prior certification is not obtained, the Benefit Administrator will review the claim after you receive the services. If it is determined that the care received was medically/clinically necessary and appropriate, the care will be covered and a penalty may be applied. If it is determined that the care received was not medically/clinically necessary and appropriate, the charges will not be covered.

Prior Certification Numbers.

Providers must access the Priority Health provider portal to prior certify services. If you are receiving intensive treatment for mental health services, including inpatient hospitalization and partial hospitalization, your provider must notify the Benefit Administrator's Behavioral Health Department as soon as possible for assistance. Call the Benefit Administrator's Behavioral Health department at **616 464-8500** or **800 673-8043** for assistance.

Utilization Review.

The Benefit Administrator conducts a utilization review when you are admitted to any acute care hospital or other non-acute care facility to assure that you are receiving the right care in the right setting. Utilization reviews are performed:

- On-site at facilities and/or telephonically, including review of medical record information; and
- According to these timeframes established in the Benefit Administrator's utilization review policies:
 - a) Acute care hospital for a medical emergency or urgent care admission – upon admission or notification of admission.
 - b) Acute care hospital continued stay – at day 3 or sooner as determined by your condition and plan of treatment, and every 1-2 days thereafter until discharge.
 - c) Non-acute care facility admission – upon admission.
 - d) Non-acute care facility continued stay – 7 to 14 day intervals or sooner as determined by your condition or plan of treatment.

SECTION 10. MEDICAL BENEFITS

Network Benefits.

You are entitled to coverage for the benefits described below when those services meet the following criteria:

- Medically/clinically necessary (as defined in this PDSPD and according to the Medical and Behavioral Health policies established by the Benefit Administrator with the input of physicians not employed by the Benefit Administrator or according to criteria developed by reputable external sources and adopted by the Benefit Administrator); or
- Routine or preventive care as described in this PDSPD; and
- Provided by a network provider, (or as otherwise detailed by this PDSPD); and
- Prior certified by the Benefit Administrator when prior certification is considered necessary; and
- Not excluded or limited elsewhere in this PDSPD. You should carefully review the rest of this PDSPD for more information about the extent of your coverage.

If a covered participant receives services at a network facility, any eligible radiology, anesthesiology, pathology, emergency, special diagnostic services, evaluation and management services (during inpatient or observation care only), or any other ancillary physician charges that are related to these services will be paid at the network benefit level. Benefits for provider types other than those listed will be paid based on the provider's network status at the time of service.

You are responsible for those deductibles, copayments or coinsurance amounts listed in the *Schedule of Medical Benefits*.

Participants are responsible for determining whether a provider is part of the network before receiving services. Unless otherwise specified in this PDSPD, benefits will be paid based on the network status of the provider as of the day that services are received. To verify the current network status of a provider, contact the provider network number listed on your ID card or detailed in the *Schedule of Medical Benefits*.

Non-Network Benefits.

We will cover the services described below when those services are:

- Medically/clinically necessary (as defined in this PDSPD and according to the Medical and Behavioral Health policies established by the Benefit Administrator with the input of physicians not employed by the Benefit Administrator or according to criteria developed by reputable external sources and adopted by the Benefit Administrator); or
- Routine or preventive care as described in this PDSPD; and
- Ordered or performed under the supervision of a physician or health professional; and
- Approved in advance by the Benefit Administrator when prior certification is considered necessary; and
- Not excluded or limited elsewhere in this PDSPD or *Schedule of Medical Benefits*. You should carefully review the rest of this PDSPD for more information about the extent of your coverage.

You are responsible for (1) those copayments, coinsurance and all deductibles listed in the *Schedule of Medical Benefits* attached to this PDSPD, and (2) unless it is a Surprise Billing Service, any amount over the reasonable and customary charge as defined in the *Definitions* section of this PDSPD.

For Surprise Billing Services you will be responsible for in-network cost sharing amounts based on the QPA for the non-network services received.

Medical Benefits.

Abortions (Elective).

Advanced Diagnostic Imaging Services. This includes, but is not limited to positron-emission tomography (PET) scans, magnetic resonance imaging (MRI), computed tomography (CT scans) and nuclear cardiology studies.

Allergy Services. Allergy testing, oral allergen sensitization, evaluations and injections, including serum costs. See the *General Exclusions From Coverage* section of this PDSPD for specific allergy tests that are not covered.

Ambulance Services. “Ambulance” includes a motor vehicle or rotary aircraft that is primarily used or designated as available to provide transportation and basic life support, limited advanced life support or advanced life support.

In a medical emergency, we will cover EMT and ambulance service to the nearest medical facility that can provide medical emergency care. Note: Coverage for ground ambulance services provided by a non-participating provider is based on reasonable and customary charges for those covered services. Coverage for emergency air ambulance services provided by a non-participating provider is based on the QPA.

Any other non-emergent transportation is not covered unless certified in advance by the Benefit Administrator.

Ambulatory Surgical Services and Supplies. Outpatient services and supplies furnished by a surgery center along with a covered surgical procedure on the day of the procedure.

Autism Spectrum Disorder Treatment. Autism Spectrum Disorder treatment includes coverage for diagnosis of Autistic Disorder, Other Specified Pervasive Development Disorder, and Other Pervasive Development Disorders (Asperger’s Disorder, Rhett’s Disorder).

Coverage is provided for outpatient treatment of Autism Spectrum Disorder when performed by an approved facility or agency. Prior certification is required by your Benefit Administrator for Applied Behavior Analysis treatment. Call their Behavioral Health Department at **616 464-8500** or **800 673-8043** for assistance.

Covered services include:

- Multidisciplinary evaluation and assessment.
- Individualized Treatment Plan.
- Applied Behavior Analysis treatment of Autism Spectrum Disorder provided by an approved program.
- Habilitation therapies, including physical, occupational and speech therapy.
- Medication management.

Coverage Limitations. Covered services for Autism Spectrum Disorder under this Plan:

- must be medically/clinically necessary as determined in accordance with the Benefit Administrator’s medical policies; and
- will be considered when performed by an approved facility or agency along with other criteria set forth in the Benefit Administrator’s medical policies; and
- is limited to specific treatments outlined in the Benefit Administrator’s medical policies.

Cancer Therapy Drugs and Clinical Trials. Drugs for cancer therapy and the reasonable cost of administering them are covered regardless of whether the federal Food and Drug Administration (FDA) has approved the cancer drugs to be used for the type of tumor for which the drugs are being used. Certain drugs may not be covered if a majority of experts believe that further studies or clinical trials are needed to determine the toxicity, safety or efficacy of the drugs. Limitations apply.

Routine patient costs in connection with approved clinical trials (all stages) for cancer or a life-threatening illness/condition may be covered if approved in advance by the Benefit Administrator.

Coordination of Benefits for drugs for approved clinical trials: Drugs for approved clinical trials will be covered by CVS/Caremark prescription drug benefits before coverage under your medical benefit will apply.

Certain Surgeries and Treatments. Surgeries and treatments are covered as listed in the *Schedule of Medical Benefits* and only when medically/clinically necessary according to the criteria set forth in the applicable Benefit Administrator’s medical policies.

Chemotherapy. Services and supplies related to chemotherapy.

Chiropractic and Osteopathic Manipulation Services. Services including maintenance care provided by a chiropractor or covered provider relating to the manual manipulation of the spine. This includes office visits, pre-manipulation assessments, physical therapy services such as traction, spinal manipulation, patient education on rehabilitative exercises, massage therapy, and x-rays. Support devices, nutritional supplements or vitamins provided or recommended by a chiropractor are not covered.

Clinical Trials. “Qualified individuals” are covered if they participate in an “approved clinical trial.” If one or more network providers are participating in a clinical trial, nothing shall be construed as preventing a plan or issuer from requiring that a qualified individual participate in the trial through such a network provider if the provider will accept the individual as a participant in the trial.

You are considered to be a qualified individual if you meet the following conditions:

- (a) You are eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition.
- (b) Either—
 - (i.) the referring health professional is a network provider and has concluded that your participation in such trial would be appropriate based upon you meeting the conditions described in paragraph (a); or
 - (ii.) you or the referring health care provider provides medical and scientific information establishing that your participation in such trial would be appropriate based upon you meeting the conditions described in paragraph (a).

An “approved clinical trial” means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is described in any of the following subparagraphs:

- (a) Federally funded trials.— The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
 - (i.) The National Institutes of Health.
 - (ii.) The Centers for Disease Control and Prevention.
 - (iii.) The Agency for Health Care Research and Quality.
 - (iv.) The Centers for Medicare & Medicaid Services.
 - (v.) Cooperative group or center of any of the entities described in clauses (i) through (iv) or the Department of Defense or the Department of Veterans Affairs.
 - (vi.) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
 - (vii.) Any of the following if the conditions described in paragraph (2) are met:
 - i. The Department of Veterans Affairs.
 - ii. The Department of Defense.
 - iii. The Department of Energy.
- (b) The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.
- (c) The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

Routine patient costs in connection with approved clinical trials (all stages) for cancer or a life-threatening illness/condition may be covered if approved in advance by the Benefit Administrator.

Contraceptive Medications and Devices. Women’s contraceptive devices are covered under Preventive Health Care Services benefits as described in this Plan. Priority Health’s Preventive Health Care Guidelines are available in the member center on the Benefit Administrator’s website at priorityhealth.com or you may request a copy from the Benefit Administrator’s Customer Service Department. Please refer to your Prescription Benefit plan for further contraceptive coverage.

Dental Services.

- Facility, ancillary and anesthesia services may be covered for pediatric participants when:
 - a) Multiple extractions or multiple restorations for children under the age of seven;
 - b) A total of six or more teeth are extracted in various quadrants;
 - c) There are dental treatment needs for which local anesthesia is ineffective because of acute infection, anatomic variation or allergy;
 - d) Extensive oral-facial and/or dental trauma for which treatment under local anesthesia would be ineffective or compromised;
 - e) A patient has a serious medical condition that may interfere with routine dental work; and
 - f) Medical services that are medically necessary such as suturing of lacerations required in connection of an accident.
- Facility, ancillary and anesthesia relating to dental services for adults require prior certification from the Benefit Administrator.
- Removal of sound natural teeth required in preparation for other medical procedures that are covered under this Plan.

Check with both your dental and medical benefit providers prior to any dental services to verify which plans, medical and/or dental, the dental services will be covered under.

Diabetic Services and Supplies. The following services and supplies are covered for participants with diabetes:

- Blood glucose monitors and diabetes test strips;
- Syringes and lancets;
- Diabetes educational classes to insure that persons with diabetes are trained to the proper self-management and treatment of their diabetic condition;
- Certain diabetic supplies such as syringes, needles, lancets, blood glucose test strips and inhaler assist devices. These supplies may also be purchased at a participating pharmacy and your prescription drug copayment will apply;
- Insulin pumps may be covered under the DME benefit;
- Shoe inserts; and
- Special shoes when medically/clinically necessary according to the criteria set forth in the medical policies of the Benefit Administrator.

These supplies may be purchased at a Durable Medical Equipment (DME) provider and your DME benefit will apply as listed in the *Schedule of Medical Benefits* of this Plan.

Dietician Services. Dietician consultations must be obtained from a network dietician upon referral from a network provider to be covered as preventive health care services. See Priority Health's Preventive Health Care Guidelines.

Durable Medical Equipment. "Durable Medical Equipment" (DME) is equipment intended for repeated use in order to serve a medical need, is generally not useful to a person in the absence of an illness or injury, and is appropriate for use in the home. Examples of covered DME are manual wheelchair, CPAP machines and glucose monitoring devices. DME over \$1,000 must be approved in advance by the Benefit Administrator. For a complete list of covered DME, go to priorityhealth.com or call the Benefit Administrator's Customer Service Department.

Note: Certain devices and supplies are covered under the Preventive Health Care Services benefits of this Plan. Priority Health's Preventive Health Care Guidelines are available in the member center on the Benefit Administrator's website at priorityhealth.com or you may request a copy from the Benefit Administrator's Customer Service Department.

Covered services include:

- DME prescribed by a physician or health professional.
- Repair or replacement, fitting and adjustment of covered DME needed as the result of normal use, body growth or body change.
- Training or education on the use of DME.
- Disposable supplies necessary for the proper functioning or application of the DME.
- Shoe inserts.
- Specialty shoes when medically necessary as determined by the Benefit Administrator.

Note: Inhaler assist devices and some diabetic supplies such as syringes, needles, lancets and blood glucose test strips are covered as a prescription drug benefit or DME benefit, depending on where you obtain the supplies.

Coverage Limitations:

- Coverage is for standard durable medical equipment only. Equipment must be appropriate for home use.
- Coverage is limited to one piece of same-use equipment. We may substitute one type or brand of DME for another when the items are comparable in meeting your medical needs. Wheelchair coverage is generally limited to a manually operated wheelchair unless another model is prior certified by the Benefit Administrator.
- DME may be rented, purchased or repaired. The decision to rent, purchase, repair or replace DME is at the Benefit Administrator's discretion. We may limit replacement of DME to the expected life of the equipment.

Education Services. Education used to manage chronic disease states such as diabetes or asthma and for maternity classes at an approved maternity education program.

Emergency Care Services. If you have a medical emergency, seek help immediately. All care needed to treat a medical emergency will be covered at the network benefits level. This includes care provided by non-network providers. Note: Coverage for medical emergency services provided by a non-network provider is based on the QPA for those covered services. The following are covered services:

- Facility and Provider Services. Services and supplies that you receive for any condition that the Benefit Administrator, following its review of the claim and other information, determines to have been a medical emergency at the time.
- Follow-Up Care. Services you receive from a provider because of a medical emergency after the medical emergency has ended. You may choose to seek all follow-up care from a network provider. Any follow-up care that is provided by a non-network provider will be covered at the non-network benefits level.

If you are treated by a non-network provider, at either a network or non-network facility, you will be responsible for the in-network cost sharing amount based on the QPA for the emergency care services received.

If you are confined in a hospital after a medical emergency, you (or someone on your behalf) must let the Benefit Administrator know about your confinement as soon as it is reasonably possible to provide that notice. If the confinement is for mental health inpatient or partial hospitalization, your provider must notify the Benefit Administrator's Behavioral Health Department as soon as possible at **616 464-8500** or **800 673-8043** for assistance.

Eye Care. Treatment of medical conditions and diseases of the eye. Contacts or glasses that are medically/clinically necessary as determined by the Benefit Administrator are covered. See the *General Exclusions From Coverage* section of this PDSPD for vision services that are not covered.

Family Planning and Reproductive Services. The following are covered services for each participant even if they are not provided in connection with the diagnosis and treatment of an illness or injury:

- Diagnostic, counseling, and planning services for treatment of the underlying cause of infertility. Examples of covered services include, among other things, sperm count, endometrial biopsy, hysterosalpingography, and diagnostic laparoscopy.
- Childbirth education.
- Certain genetic counseling, testing and screening services when approved in advance by the Benefit Administrator.
- Sterilization procedures such as tubal ligations, salpingectomy, tubal obstructive procedures and vasectomy. Tubal ligation or salpingectomy is covered under the preventive health care services of this Plan. Priority Health's Preventive Health Care Guidelines are available in the member center on the Benefit Administrator's website at priorityhealth.com or you may request a copy from the Benefit Administrator's Customer Service Department. Other women's sterilization procedures are subject to your regular surgical expense benefits of the Plan.

Infertility treatment and services are not covered except as specifically detailed in this PDSPD.

Food, Supplements and Formula.

- Supplemental feedings administered via tube. This type of nutrition therapy is also known as enteral feeding. Formulas intended for this type of feeding as well as supplies, equipment, and accessories needed to administer this type of nutrition therapy are covered.
- Supplemental feedings administered via an IV. This type of nutrition therapy is also known as parenteral nutrition. Nutrients, supplies and equipment needed to administer this type of nutrition are covered.

Foot Care (Podiatry). Care that is recommended by a physician as a result of infection. The following charges for foot care will also be covered:

- Treatment of any condition resulting from weak, strained, flat, unstable or unbalanced feet, when surgery is performed.
- Treatment of corns, calluses and toenails when at least part of the nail root is removed or when needed to treat a metabolic or peripheral vascular disease.
- Physician office visit for diagnosis of bunions. Treatment of bunions when an open cutting operation or arthroscopy is performed.

Gender Dysphoria Treatment. Services for Gender Dysphoria will be considered under this Plan when all criteria listed in the Benefit Administrator's medical policies are met.

Hearing Services. This includes the following:

- Exams, tests, services and supplies to diagnose and treat a medical condition.
- Purchase or fitting of hearing aids.

Hemodialysis/Peritoneal Dialysis. Treatment of a kidney disorder by hemodialysis or peritoneal dialysis as an inpatient in a hospital or other facility or for expenses in an outpatient facility or in the covered person's home.

High-Tech Radiology Examinations. See the Advanced Diagnostic Imaging Services benefit of this section of the Plan.

Home Health Care. Intermittent skilled services furnished in the home by a physical therapist, occupational therapist, respiratory therapist, speech therapist, licensed practical nurse or registered nurse.

Home health care is covered when you are:

- confined to the home;
- under the care of a physician;
- receiving services under a plan of care established and periodically reviewed by a physician; and
- in need of intermittent skilled nursing care or physical, speech, or occupational therapy.

Custodial care is not covered, even if you receive home health care or skilled nursing services at the same time you receive custodial care.

Hospice Care. The following hospice care services, provided as part of an established hospice care program, are covered when your physician informs the Benefit Administrator that your condition is terminal and hospice care would be appropriate:

- Inpatient Hospice Care. Short-term inpatient care in a licensed hospice facility is covered when skilled nursing services are required and cannot be provided in other settings.
- Outpatient Hospice Care. Outpatient care is covered when skilled nursing services by a registered nurse or a licensed practical nurse are required or when medical social services under the direction of a physician are required. Outpatient hospice care is any care provided in a setting other than a licensed hospice facility. Hospice care provided while you are in a hospital or skilled nursing facility is considered outpatient hospice care.

- Respite. Respite care in a facility setting is covered as outlined in the Benefit Administrator's medical policies.
- Bereavement Counseling. Benefits are payable for bereavement counseling services which are received by a covered person's close relative when directly connected to the covered person's death and bundled with other hospice charges. Counseling services must be given by a licensed social worker, licensed pastoral counselor, psychologist or psychiatrist.

Hospice care services are limited to treatment, services or supplies otherwise described in this *Medical Benefits* section of this PDSPD.

Hospital and Longterm Acute Care.

- Hospital Inpatient Care. Hospital and longterm acute inpatient services and supplies including services performed by physicians and health professionals, room and board, general nursing care, drugs administered while you are confined as an inpatient, and related services and supplies. If you are admitted to hospital inpatient care from an emergency room visit, the charges for emergency room services are covered under the hospital inpatient care benefits and cost share described in your *Schedule of Medical Benefits*. Non-emergency inpatient hospital stays must be approved in advance by the Benefit Administrator. Note: Inpatient hospital stays for a mother and her newborn of up to 48 hours following a vaginal delivery and 96 hours following a cesarean section do not require prior certification.
- Hospital Outpatient Care. Hospital services and supplies listed under hospital inpatient care above that you receive on an outpatient basis. Hospital observation care received after an emergency room visit is considered hospital outpatient care. If you are placed in hospital observation care following an emergency room visit, the charges for emergency room services are covered under the hospital outpatient care and hospital observation care benefits and cost share described in your *Schedule of Medical Benefits*.

Injectable and Infusible Drugs. The following drugs are covered as medical benefits: injectable and infusible drugs administered in an inpatient or emergency setting; and injectable and infusible drugs requiring administration by a health professional in a medical office, home or outpatient facility. The Benefit Administrator will manage the treatment setting for infusible drug services and may direct you to an infusion center or home setting. We may require selected specialty drugs be obtained by your provider through a specialty pharmacy. Note: Coverage for specialty drugs authorized by CVS CareMark but administered in a physician's office (covered under the Plan as a medical benefit) are to be coordinated between CVS and the medical plan for coverage.

Maternity and Newborn Care. In accordance with the Newborns' and Mothers' Health Protection Act of 1996, this Plan does not restrict benefits for a hospital length of stay in connection with childbirth for the mother and newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. The mother and newborn have the right to an inpatient stay of no less than 48 hours following a normal vaginal delivery or no less than 96 hours following a cesarean section. If delivery occurs in the hospital, the hospital length of stay for the mother or newborn begins at the time of delivery (or in the case of multiple births, at the time of the last delivery). If delivery occurs outside a hospital, the hospital length of stay begins at the time the mother or newborn is admitted as a hospital inpatient in connection with childbirth. The determination of whether an admission is in connection with childbirth is a medical decision to be made by the attending provider.

The following are covered services:

- Hospital and Provider Services. Services and supplies furnished by a hospital or health professional for prenatal care including genetic testing, postnatal care, hospital delivery, and care for the complications of pregnancy.
- Newborn Child Care. If the birth mother is the employee or a covered dependent under this Plan, this Plan covers the hospital and professional inpatient claims for a newborn's initial stay in connection with the delivery for up to 48 hours for a vaginal delivery and up to 96 hours following a cesarean section (including necessary care and treatment of medically diagnosed congenital defects and birth abnormalities). **You must properly enroll your newborn within 31 days after the child is born in order to continue coverage for a newborn beyond the initial 48 hours following a vaginal delivery or the first 96 hours following a cesarean section.** If the mother (who is not our employee and/or is not covered under this Plan) does not elect to add coverage for the newborn under her employer's plan, her plan does not cover the newborn's expenses or she has no health coverage, the newborn expenses may be covered under this Plan, provided our employee has properly enrolled the newborn to this Plan. **The employee must properly enroll the newborn within 31 days of birth. The *Enrollment* section of this PDSPD explains the proper enrollment procedures.**
- Maternity Education Programs.

- Complications of a Pregnancy. Complications of a pregnancy, as defined in the *Definitions* section of this Plan, are covered as any other illness under the terms and conditions of this Plan.

Maternity care benefits will be extended to all females covered on the Plan. If a dependent child becomes pregnant, benefits will extend to the mother only. For coverage to extend to the newborn (grandchild), the employee must assume legal guardianship of the newborn.

Medical Supplies. Medical supplies that are received during inpatient or in connection with a home health visit are covered at the benefit level detailed in this PDSPD. Some medical supplies are covered under your Durable Medical Equipment benefits, including such supplies as catheters, syringes, ostomy supplies, feeding tubes and lancets. See the *General Exclusions from Coverage* section of this PDSPD for information on medical supplies that are not covered.

Mental Health Services. This plan covers evaluation, consultation and treatment necessary to determine a diagnosis and treatment plan for both acute and chronic mental health conditions. Both crisis intervention and solution-focused treatment are covered. Covered services must be:

- provided by one of the following:
 - A United States board eligible or board certified psychiatrist licensed in the state where the treatment is provided.
 - A therapist with a Ph.D. or master's degree that denotes a specialty in psychiatry (Psy.D.).
 - A state licensed psychologist.
 - A state licensed or certified Social Worker practicing within the scope of his or her license or certification.
 - Licensed Professional Counselor.
 - Nurse Practitioner.
 - If outside of the United States, outpatient services must be provided by an individual who has received a diploma from a medical school recognized by the government agency in the country where the medical school is located. The attending physician must meet the requirements, if any, set out by the foreign government or regionally recognized licensing body for treatment of Mental Health Disorders.
- provided in licensed behavioral health treatment facilities; and
- clinically proven to work for your condition.

Mental health services are available in a variety of settings. You may be treated as an inpatient or as an outpatient depending on your particular condition. Services will generally be provided in the least restrictive place that will allow for the best results for any particular condition. If you don't know where to go for treatment, call the Benefit Administrator's Behavioral Health Department at **616 464-8500** or **800 673-8043** to speak with a trained clinician who can assist you. Covered treatment settings include:

- Acute Inpatient Hospitalization. This is the most intensive level of care. Prior certification from the Benefit Administrator's Behavioral Health department is required for inpatient services except in a medical emergency. Upon discharge, you will be referred to a less intensive level of care.
- Residential Treatment. This is 24-hour confinement in a subacute residential setting licensed by the state with structured, licensed health care professionals accessible 24 hours a day and 7 days a week. A licensed foster-care facility serving as your residence is not covered and does not meet the definition of "Residential Treatment". Prior certification from the Benefit Administrator's Behavioral Health department is required for Residential Treatment services.
- Partial Hospitalization. This is a non-residential level of service that is similar in intensity to acute inpatient hospitalization. You are generally in treatment for more than four hours but less than eight hours daily. Prior certification from the Benefit Administrator's Behavioral Health department is required for partial hospitalization services.
- Intensive Outpatient Treatment. This is outpatient treatment that is provided with more frequency and intensity than routine outpatient treatment. You are generally in treatment for up to four hours per day, and up to five days per week. You may be treated individually, as a family or in a group.
- Outpatient Treatment. This is the least intensive, and most common type of service. It is provided in an office setting, face-to-face, telephonic, telemedicine, or through secure electronic portal, generally from 45-50 minutes (for individuals) to 90 minutes (for group therapies) per day by a licensed behavioral health professional.

Coverage Limitations: The following coverage limitations apply with respect to certain conditions. Treatment for medical complications related to these conditions, including but not limited to neuropsychological testing when appropriate, is covered under your medical benefits.

- Eating disorders, and feeding disorders of infancy or childhood, are covered at all levels of care described above based on the Benefit Administrator's medical and behavioral health policies.
- Personality disorders are covered only for specific psychological testing to clarify the diagnosis.
- Organic brain disorders are covered for initial evaluation to clarify the diagnosis and for follow-up psychiatric medication management. Inpatient services for participants with organic brain disorders, such as closed head injuries, Alzheimer's and other forms of dementia, are covered based on the Benefit Administrator's medical and behavioral health policies.
- Autism Disorder, including Asperger's Disorder and Pervasive Developmental Disorder not otherwise specified, are covered for evidence based treatment services and limitations related to Autism Spectrum Disorder as described in the Autism Benefits of this Plan.
- Intellectual disabilities are covered for initial evaluation and follow-up psychiatric medication management.
- Behavioral health residential treatment must be medically/clinically necessary as determined in accordance with the Benefit Administrator's medical and behavioral health policies.

Oral Surgery. Coverage for oral surgery is limited to the following:

- Treatment of fractures of facial bones.
- Biopsy and removal of tumors or cysts of the jaw, other facial bones, soft tissues of the mouth, lip, tongue, accessory sinuses, salivary glands or the ducts.
- Rebuilding or repair of soft tissues of the mouth or lip needed to correct anatomical functional impairment caused by congenital birth defect or accidental injury. Rebuilding or repair for cosmetic purposes is not covered.
- Treatment for oral and/or facial cancer.
- Treatment for conditions affecting the mouth, other than the teeth.
- Medical and surgical services required to correct accidental injuries, including emergency care to stabilize dental structures following injury to sound natural teeth.
- Treatment of cleft palate or cleft lip. Such coverage includes medically necessary oral surgery and pre-graft palatal expander.

Dental surgery in preparation for implants (unless due to accidental injury) or dentures, including preparation of the bone, or dental surgery done in connection with any of the covered services listed above, is not covered.

Orthodontic treatment is not a covered service even when provided along with oral surgery under this medical plan.

Check with both your dental and medical benefit providers prior to any oral surgery to verify which plans, medical and/or dental, the surgery will be covered under.

Orthognathic Surgery. "Orthognathic surgery" is surgical treatment to restructure the bones or other parts of the jaw to correct a congenital birth defect, the effects of an illness or injury, or to correct other functional impairments. We will only cover the following orthognathic surgery services:

- Referral care for evaluation and orthognathic treatment.
- Cephalometric study and x-rays.
- Orthognathic surgery and post-operative care, including hospitalization, if necessary.

Note: These services are only covered when approved in advance by the Benefit Administrator and, if they deem necessary, a dental consultant.

Orthodontic treatment is not a covered service even when provided along with orthognathic surgery under this medical plan.

Pain Management. Evaluation and treatment of chronic and/or acute pain as specified in the Benefit Administrator's medical and behavioral health policies.

Prescription Drugs. Prescribed medications which are administered or dispensed as part of treatment while in the hospital or at a medical facility (including claims billed on a claim form from a long-term care facility, assisted living facility or skilled nursing facility) and that require a physician's prescription. This does not include paper (script) claims obtained at a retail pharmacy, which are covered under the Prescription Benefit plan. Please refer to your Prescription Drug Benefit plan for coverage information.

Preventive Health Care Services. Preventive Health Care Services described below and in Priority Health's Preventive Health Care Guidelines are covered as shown in the *Schedule of Medical Benefits*. Drugs listed under the preventive health care guidelines are not covered under the medical plan. Please refer to your Prescription Benefit plan for coverage information.

Priority Health's Preventive Health Care Guidelines are available in the member center on the Benefit Administrator's website at priorityhealth.com or you may request a copy from their Customer Service Department. Covered services shall include and comply with the requirements of the Patient Protection and Affordable Care Act (PPACA) as amended by the Health Care and Education Reconciliation Act and applicable regulations.

Subject to Benefit Administrator guidelines and standard coverage limitations, the following are categories of covered services, even though they are not provided in connection with the diagnosis and treatment of an illness or injury:

- Routine adult physical examinations, which includes screening and counseling services.
- Women's preventive health care services (including pregnant women) which includes required visits/assessments, screenings/testing/counseling including breast cancer screening, breastfeeding support (includes prescribed supplies, breast pump and counseling), sterilization procedures (limited to tubal ligation or salpingectomy) and specified contraception methods. (Note: You are responsible for the deductible (if any) and other cost-sharing for sterilization procedures other than tubal ligation or salpingectomy.)
- Routine laboratory tests.
- Screenings and counseling services for adults.
- Specified laboratory and screening services as listed below:
 - Basic metabolic panel;
 - Comprehensive metabolic panel
 - TSH (thyroid stimulating hormone);
 - Complete Blood Count (CBC) with differential;
 - Urinalysis;
 - Albumin; urine, microalbumin, quantitative;
 - Urine creatinine;
 - Blood glucose testing;
 - Glycated hemoglobin or glycosylated hemoglobin (HGB)/A1C
- Prostate and rectal/colon cancer screening tests as directed by your physician.
- Well child and adolescent care, which includes assessments and screenings.
- Immunizations (doses, recommended ages, and recommended population vary).
- Tobacco cessation products. Tobacco cessation drug treatment benefits may be covered under your prescription drug benefits. Please refer to your Prescription Drug Benefit plan for coverage information.

Private Duty Nursing Services. Medically necessary care when it is required 24 hours a day.

Prosthetic and Orthotic/Support Devices. Covered services include when determined to be medically necessary by the Benefit Administrator: surgically implanted devices, such as a replacement hip, implanted hearing devices (cochlear implants/BAHA devices), or heart pacemaker; externally worn prosthetic devices; purchased, repaired or replaced prosthetics and orthotics; and we will cover repair or replacement, fitting and adjustment of covered prosthetic and orthotic/support devices that is needed as a result of normal use, body growth or change. Prosthetic and Orthotic/Support Devices over \$1,000 must be approved in advance by the Benefit Administrator.

You may call the Benefit Administrator's Customer Service Department or go to priorityhealth.com to find out if the prosthetic or orthotic/support device you need is covered.

Provider Care. Services (including health maintenance and well child care), provided by a physician or health professional during an office visit, hospital visit, virtual care visit, telehealth visit, or home visit for the diagnosis and treatment of an illness or injury.

Radiation Therapy. Radium and radioactive isotope therapy treatment.

Radiology Examinations and Laboratory Procedures. Diagnostic and therapeutic radiology services, laboratory tests and other such services are covered unless excluded elsewhere in this PDSPD.

Reconstructive Surgery. Coverage is provided for reconstructive surgery to correct congenital birth defects and/or effects of illness or injury, if:

- The defects and/or effects of illness or injury cause clinical functional impairment. “Clinical functional impairment” exists when the defects and/or effects of illness or injury: (1) causes significant disability or major psychological trauma (psychological reasons do not represent a medical or surgical necessity unless you are undergoing psychotherapy for issues solely related to the illness or injury for which the reconstructive surgery is requested); or (2) interfere with employment or regular attendance at school; or (3) require surgery that is a component of a program of reconstructive surgery for congenital deformity or trauma; or (4) contribute to a major health problem, and
- The Benefit Administrator must reasonably expect the surgery to correct the condition.

The Plan will cover to completion treatment that needs to be performed in stages so long as you remain covered under the Plan. The Benefit Administrator will review the above services in consultation with your physician.

Reconstructive Surgery Following Mastectomy. In accordance with the Women’s Health and Cancer Rights Act of 1998, benefits are provided for the following mastectomy-related services:

- Reconstruction of the breast on which a mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses; and
- Treatment of physical complications resulting from the mastectomy, including lymphedemas.

Coverage will be provided in a manner determined in consultation with the patient and attending physician. Benefits are provided on the same basis as other standard surgical procedures.

Rehabilitative Medicine Services. Short-term rehabilitative medicine services are covered if: treatment is provided for an illness, injury or congenital defect for which you have received corrective surgery; and treatment is provided in an outpatient setting or in the home; and you are not eligible for these services from any federal or state agency or any local political subdivision, including school districts; if you are an eligible student, these services are not the responsibility of the school system or another public agency under the IDEA law; and they result in meaningful improvement in your ability to do important day-to-day activities that are necessary in your life roles within 90 days of starting treatment; and a provider refers, directs and monitors the services.

Note: Covered services and limitations related to Autism Spectrum Disorder are described in the Autism Spectrum Disorder Treatment benefits of this Plan.

Covered services include therapy and/or rehabilitative medicine services that result in meaningful improvement in your ability to perform functional day-to-day activities that are significant in your life roles, including the following:

- Cardiac and pulmonary rehabilitation;
- Physical and occupational therapy;
- Speech therapy for treatment of medical diagnoses, including therapy for stuttering due to a neurological disorder;
- Respiratory therapy;
- Aquatic therapy by a qualified physical therapist;
- Massage therapy by a qualified physical therapist;
- Vision therapy/orthoptics: Office-based vision therapy/orthoptics is covered as a treatment for children and only when medically/clinically necessary, as determined according to the Benefit Administrator’s medical policies; and
- Biofeedback for treatment of medical diagnoses when medically/clinically necessary, as determined according to the Benefit Administrator’s medical policies.

The Plan allows coverage for occupational, physical, or speech therapy for developmental delays due to an accident or illness such as Bell's palsy, Wolf-Hirschhorn Syndrome, CVA (stroke), apraxia, cleft palate/lip, recurrent/chronic otitis media, vocal cord nodules, down's syndrome and cerebral palsy.

Retail Health Clinic. Evaluation and management and certain laboratory services provided by a provider in a Retail Health Clinic located within the United States.

Sex Change or Transformation. See the Gender Dysphoria Treatment benefits of this *Medical Benefits* section of the Plan.

Skilled Nursing Services – at a Skilled Nursing Facility, Subacute Facility, or Inpatient Rehabilitation Facility. Care and treatment (including therapy, and room and board in semi-private accommodations) at (a) a skilled nursing facility, (b) a subacute facility, or (c) an inpatient rehabilitation facility when the Benefit Administrator has approved a treatment plan in advance.

See the non-hospital facility services category of your *Schedule of Medical Benefits* for the number of days covered under your Plan.

Sleep Studies. Services for sleep studies are covered if they are (1) provided in an appropriate setting; and (2) determined to be medically/clinically necessary by the Benefit Administrator.

Substance Use Disorder Services. Substance use disorder services, including counseling, medical testing, diagnostic evaluation and detoxification and other medically necessary services are covered in a variety of settings. You may be treated in an inpatient or outpatient setting, depending on your particular condition. Services will generally be provided in the least restrictive place that will allow for the best results for any particular condition. If you don't know what the most appropriate treatment setting is for your condition, call the Benefit Administrator's Behavioral Health Department at **616 464-8500** or **800 673-8043** for assistance. The Benefit Administrator follows the American Society of Addiction Medicine (ASAM) Patient Placement Criteria.

Inpatient substance use disorder services (including Residential Treatment and partial hospitalization) require prior certification from the Benefit Administrator's Behavioral Health Department, except in a medical emergency. Outpatient substance use disorder services do not require referral from the Benefit Administrator.

Covered treatment includes:

- **Inpatient Detoxification.** These are detoxification services that are provided while you are an inpatient in a hospital or subacute unit. When provided in a medical setting, services are managed jointly by the Benefit Administrator's Behavioral Health and Health Management Departments.
- **Medically Monitored Intensive Inpatient Treatment.** Following full or partial recovery from acute detoxification symptoms, this type of care is provided at an inpatient facility or subacute unit.
- **Residential Treatment.** This is 24-hour confinement in a subacute residential setting licensed by the state with structured, licensed health care professionals accessible 24 hours a day and 7 days a week. A licensed foster-care facility serving as your residence is not covered and does not meet the definition of "Residential Treatment". Prior certification from the Benefit Administrator's Behavioral Health department is required for Residential Treatment services.
- **Partial Hospitalization.** This is an intensive, non-residential level of service provided in a structured setting, similar in intensity to inpatient treatment. You are generally in treatment for more than four hours but generally less than eight hours daily.
- **Intensive Outpatient Programs.** These are outpatient services provided by a variety of health professionals at a frequency of up to four hours daily, and up to five days per week.
- **Outpatient Treatment.** This is the least intensive level of service. It is provided in an office setting, face-to-face, telephonic, telemedicine or through secure electronic portal, generally from 45-50 minutes (for individuals) to 90 minutes (for group therapies) per day.
- **Outpatient/Ambulatory Detoxification.** These detoxification services may be provided on an outpatient basis within a structured program when the consequences of withdrawal are non-life-threatening. These services are covered under your medical benefits.

Coverage Limitations

- Behavioral health residential treatment must be medically/clinically necessary as determined in accordance with the Benefit Administrator's medical and behavioral health policies.

Surgery. The charges for the surgeon, assistant surgeon (when necessary), anesthesiologist, facility, and related expenses, including a second and third surgical opinion.

If the services of a surgical assistant are required for a surgical procedure, the non-network covered expenses will be the lesser of: (1) the amount charged by the assistant; or (2) 20% of the amount allowable to the physician who performed the surgery.

Temporomandibular Joint Syndrome (TMJS) Treatment. "Temporomandibular Joint Syndrome" or "TMJS" means muscle tension and spasms related to the temporomandibular joint, facial, and cervical muscles, causing pain, loss of function and neurological dysfunction. Your coverage is limited to the following services:

- Medical care or services to treat dysfunction or TMJS resulting from a medical cause or injury.
- Office visits for medical evaluation and treatment of TMJS.
- Specialty referral for medical evaluation and treatment of TMJS.
- X-rays of the temporomandibular joint including contrast studies, but not dental x-rays.
- Myofunctional therapy.
- Surgery to the temporomandibular joint such as condylectomy, meniscectomy, arthrotomy, and arthrocentesis.

Bite splints, orthodontic treatment, or other dental services to treat temporomandibular joint syndrome are not covered.

Transplants. Evaluations for transplants and transplants of the following organs at a facility approved by the Benefit Administrator, but only when the Benefit Administrator has prior certified the transplant as medically/clinically necessary:

- Bone marrow or stem cell.
- Cornea.
- Heart.
- Kidney.
- Liver.
- Lung.
- Pancreas.
- Small bowel.

In addition, Plan will cover the following expenses: Computer organ bank searches and any subsequent testing necessary after a potential donor is identified, unless covered by another health plan; Typing or screening of a potential donor only if the person proposed to receive the transplant is a plan participant; Donor's medical expenses directly related to or as a result of donation surgery if the person receiving the transplant is a plan participant and the donor's expenses are not covered by another health benefit plan; and One comprehensive evaluation per transplant except as permitted by the Benefit Administrator's medical policies.

Donor's medical expenses directly related to or as a result of a donation surgery will only be covered for 30 days following discharge from the hospital.

Travel Expenses. Applies to a covered person who is a recipient or a donor if the recipient is also a covered person under this Plan.

If the covered person lives more than 50 miles from the transplant facility, the Plan will pay for travel and housing, up to the maximum listed on the *Schedule of Medical Benefits*. Expenses will be paid for the covered person and:

- One or two parents of the covered person (if the covered person is a dependent child, as defined in this Plan); or
- An adult to accompany the covered person.

Covered travel and housing expenses include the following:

- Transportation to and from the transplant facility including:
 - Airfare.
 - Tolls and parking fees.
 - Gas/Mileage.
- Lodging at or near the transplant facility including:
 - Apartment rental.
 - Hotel rental.

Lodging for purposes of this Plan does not include private residences.

Lodging reimbursement that is greater than \$50 per person per day, may be subject to IRS codes for taxable income.

Benefits shall be payable for up to one year from the date of the transplant while the covered person is receiving services at the transplant facility.

Urgent Care Center Services. Services and supplies provided at an urgent care center. An “urgent care center” is a licensed facility utilized to treat non-life threatening conditions that require immediate medical attention to limit severity and prevent complications.

Voluntary Sterilizations. See the Family Planning and Reproductive Services benefit in this section of the Plan.

Weight Loss Services (Morbid Obesity Treatment). Covered services include certain surgical treatments when co-morbid health conditions exist and all reasonable non-surgical options have been tried. Your *Schedule of Medical Benefits* gives more details about which surgeries require prior certification by the Benefit Administrator.

Wigs, Toupees, Hairpieces. Covered when prescribed by a physician and needed due to a medical condition.

SECTION 11. GENERAL EXCLUSIONS FROM COVERAGE

The following is a list of exclusions from your coverage. The Plan will not cover any service, treatment or supply listed as an exclusion, unless coverage is required under applicable state or federal law. Further, these exclusions will not apply to the extent a court or other judicial body requires the Plan to provide coverage.

Acupuncture and Non-Traditional Services. This includes, but is not limited to, holistic and homeopathic treatment, yoga, Reiki and Rolf therapy. Massage therapy services are covered as detailed in the *Medical Benefits* section of this PDSPD.

Adaptive Aids/Self-Help Items. Services and supplies designed for self-assistance. Examples include, among other things, reachers or feeding, dressing and bathroom aids and augmentive communication devices, and protective beds.

Against Medical Advice/Noncompliance. Services or supplies determined by the Benefit Administrator to be ineffective, unproductive or compromised because:

- You have voluntarily discharged yourself against the advice of a provider from a facility where you are receiving treatment,
- You have been discharged from a facility because of your noncompliance with treatment, or
- You have been noncompliant with treatment directed by your provider and agreed to by you, regardless of service setting.

Also not covered are services or supplies when discharging yourself from a facility against medical advice, your being discharged from a facility for noncompliance, or your noncompliance with treatment you and your provider have agreed to in any setting is determined to be a major contributing factor to requiring the follow-up service or supply (e.g., an emergency room visit shortly following your leaving against medical advice from a facility for a related illness or injury).

Noncompliance with treatment includes but is not limited to:

- Failure to take prescribed medication.
- Failure to follow through with outpatient treatment after inpatient or other intensive level of care.
- Failure to comply with treatment plans or care contracts between you and a provider or you and the Benefit Administrator.

Allergy Testing and Treatments. Specific allergy testing services and treatment, including skin titration (Rinkle Method); cytotoxicity testing (Bryan's Test); MAST testing; urine autoinjections; bronchial or provocative and neutralization testing for allergies. Allergy services are covered as detailed in the *Medical Benefits* section of this PDSPD.

Autism Spectrum Disorder Treatment. Services not covered include:

- Applied Behavioral Analysis (ABA) treatments not approved in advance by the Benefit Administrator.
- Treatments for Autism Spectrum Disorder that are in conflict with the Benefit Administrator's medical policies including, but not limited to:
 - (a) Chelation therapy.
 - (b) Dietary/vitamin supplement therapies.
 - (c) Craniosacral therapy.

See the *Medical Benefits* section of this PDSPD for information about covered Autism Spectrum Disorder expenses.

Clerical Expenses. Charges in connection with the preparation of reports, claim forms or any other necessary documentation.

Clinical Ecology and Environmental Medicine. "Clinical ecology" and "environmental medicine" means medical practice that is based on the belief that exposure to low levels of numerous common substances in the environment can be responsible for a variety of symptoms affecting numerous body systems. This Plan does not cover services or supplies needed to make changes to your physical environment even when those changes are recommended as treatment for an illness or injury.

Clinical Trial. The Plan will not cover the following in connection with an approved clinical trial:

- the investigational item, device, or service, itself;
- items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
- a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Close Relative. Any services provided by a physician or health professional when that person resides in the same household or is a close relative of the employee or his/her dependents. A “close relative” a member of the immediate family. Immediate family includes you, your spouse, your household member, mother, father, grandmother, grandfather, step parents, step grandparents, siblings, step siblings, half siblings, children, your household member’s children, step children and grandchildren. This includes any services that a plan participant may perform on themselves.

Cosmetic, Plastic, or Reconstructive Services. Cosmetic, plastic, or reconstructive services, including prescription drugs, that are done primarily to improve the way any part of the body looks or are not medically/clinically necessary (as determined by the Benefit Administrator). Coverage may be excluded for, among other things: abdominoplasty (to remove excess fat); blepharoplasty of lower lids; breast augmentation except when provided for post-mastectomy reconstructive services as otherwise provided in this PDSPD; chemical peel for acne; collagen implants; diastasis recti repair; removal of excessive hair growth by any method, even if caused by a medical condition; excision or repair of excess or sagging skin, except panniculectomy and treatment for lipedema; fat grafts, unless an integral part of another covered procedure; hair transplants or repair of any congenital or acquired hair loss, including hair analysis; liposuction unless an integral part of another covered procedure or liposuction for lipedema; spider vein removal; rhytidectomy (wrinkle removal); rhinophyma treatment; salabrasion; scar revision, except for facial scars; tattoo removal; and orthodontic treatment, even when provided along with reconstructive surgery. Excision of skin tags, seborrheic keratoses, treatment of vitiligo and keloid treatment (by laser, injection or surgery) is payable as shown in the *Schedule of Medical Benefits*.

Psychological reasons do not represent a medical or surgical necessity unless you are undergoing psychotherapy for issues solely related to the illness or injury for which cosmetic surgery is requested.

Court Ordered Services. Services required by court order and services required to file or respond to an action with the courts, (including evaluation and testing) or services required as a condition of parole or probation. The Plan will cover these services if they are medically/clinically necessary, you have not exhausted your benefits, and the services are provided according to this PDSPD.

Custodial and Maintenance Care. Any care you receive if, in the Benefit Administrator's opinion, you have reached the maximum level of mental and/or physical function and you will not improve significantly more. Custodial and maintenance care includes room and board, therapies, nursing care, home health aides, and personal care designed to help you in the activities of daily living. This also includes home care and adult day care that you receive, or could receive, from members of your family.

Dental Services and Dental Surgery. Dental services, (except as this PDSPD provides otherwise) including, among other things: routine dental services, except as included on the Priority Health Preventive Health Care Guidelines; dental x-rays; dental surgery such as root canals and extractions; orthodontia; orthodontic x-rays (even when provided in conjunction with other treatment or surgery); orthognathic surgery (except as specifically detailed in this PDSPD); dental prostheses, including implants and preparation of bones to receive implants (unless due to accidental injury) and dentures; rebuilding and repair of soft tissues of the mouth or lip for cosmetic purposes; bite splints used for dental purposes or for TMJS; treatment of congenital or developmental defects, such as missing teeth or abnormally developed teeth; treatment services and supplies related to periodontal/inflammatory gum disease, and pediatric dental service.

Inpatient or outpatient hospital services, such as anesthesia and facility charges, received in connection with excluded dental services are not covered unless deemed medically/clinically necessary by the Benefit Administrator.

Durable Medical Equipment. Services not covered include:

- Equipment that is not conventionally used for the medical need for which it was prescribed.
- Equipment and devices solely for the convenience of you or your caregiver.
- The purchase or rental of personal comfort items, convenience items, or household equipment that have customary non-medical purposes, such as protective beds, chair lifts, air purifiers, water purifiers, exercise equipment, non-allergenic pillows, mattresses or waterbeds, spas, tanning equipment, and other similar equipment even if they are medically/clinically necessary.
- Modifications to your home, living area, or motorized vehicles. This includes equipment and the cost of installation of equipment, such as central or unit air conditioners, escalators, elevators, swimming pools, and car seats.
- Items designed for self-assistance, safety, communication assistance and other adaptive aids. This includes, but is not limited to, reachers, feeding, dressing and bathroom aids, augmentive communication devices, car seats, and protective beds.
- Non-standard DME unless we approve the non-standard equipment in advance.
- All repairs and maintenance that result from misuse or abuse.
- Replacement of lost or stolen DME.

Wheelchair coverage is generally limited to a manually operated wheelchair unless prior approved by the Benefit Administrator. We reserve the right to limit replacement of durable medical equipment to the expected life of the equipment.

Ear Plugs.

Educational Services. The following educational services are not covered:

- Services for remedial education, including school based services.
- Education testing, therapy or training, including intelligence testing. Necessary testing and evaluations should be requested from and conducted by the child's school district.
- Services, treatment or diagnostic testing related to learning disabilities, cognitive disorders and developmental delays.
- Classes covering such subjects as stress management, parenting and lifestyle changes.

Experimental, Investigational or Unproven Services. Any drug, device, treatment or procedure that is experimental, investigational or unproven. A drug, device, treatment or procedure is experimental, investigational or unproven if one or more of the following applies:

- The drug or device has not been approved by the Food and Drug Administration (FDA) and, therefore, cannot be lawfully marketed in the United States; or
- An institutional review board or other body oversees the administration of the drug, device, treatment or procedure or approves or reviews research concerning safety, toxicity or efficacy; or
- The patient informed consent documents describe the drug, device, treatment or procedure as experimental or investigational or in other terms that indicate the service is being evaluated for its safety, toxicity or efficacy; or
- Reliable evidence shows that the drug, device, treatment or procedure is:
 - (a) The subject of on-going phase I or phase II clinical trials; or
 - (b) The research, experimental study, or investigational arm of on-going phase III clinical trials; or
 - (c) Otherwise under study to determine its toxicity, safety, or efficacy as compared with a standard means of treatment or diagnosis; or
- Believed by a majority of experts to require further studies or clinical trials to determine the toxicity, safety, or efficacy of the drug, device, treatment or procedure as compared with a standard means of treatment or diagnosis.

“Reliable Evidence” includes any of the following:

- (a) Published reports and articles in authoritative medical and scientific literature; or
- (b) A written protocol or protocols used by the treating facility or the protocol(s) of another facility studying the same or a similar drug, device, treatment or procedure; or
- (c) Patient informed consent documents used by the treating facility or by another facility studying the same or a similar drug, device, treatment or procedure.

Coverage is available for routine patient costs in connection with certain approved clinical trials (all stages) for cancer or a life-threatening illness/condition. For information about which trials are covered, your physician should contact the Benefit Administrator's Medical Management Department.

The exclusion of coverage for experimental, investigational, or unproven treatment may be reviewed for exception if the condition is 1) a terminal disease, or 2) a chronic, life threatening, severely disabling disease that is causing serious clinical deterioration. Individual case review may allow coverage for care or treatment that is investigational, yet promising for the conditions described. Medical coverage policy applies.

Food Supplements and Formula. Except for formula specifically intended for tube feeding and nutrients necessary for IV feeding, all food, formula and nutritional supplements are not covered. This includes, but is not limited to, infant formula, protein or caloric boosting supplements, vitamins, Ensure, Osmolyte and herbal preparations or supplements, even if approved by the FDA.

Foot Care. Routine foot care, including corn and callous removal, nail trimming, cleaning, soaking, skin cream application of the feet, other hygienic or maintenance care, and shoes unless attached to a brace or prescribed for a person with diabetes.

Gender Dysphoria Treatment. Any procedure or treatment that is not medically/clinically necessary or is considered cosmetic, experimental or investigational.

Gene Therapy. Services intended to restore defective or insufficient structural or functional proteins, is not a covered service. Gene therapy includes attempts to replace or modify a mutated gene, inactivate a mutated gene, or introduce a new gene into the body.

Hair Analysis.

Hair Loss. Services or supplies in connection with hair loss, including drugs or medications, or hair transplants.

Health Promotion Classes. Classes relating to such subjects as stress management, parenting and lifestyle changes. Education classes to manage chronic disease states such as diabetes or asthma are covered.

Hearing Care. Services and supplies related to hearing care, including ear plugs, including examinations performed during a covered hearing screening.

Illegal Acts. Treatment, services and supplies in connection with any injury or illness caused by (1) your commission of or attempt to commit a felony, or other illegal act; or (2) engagement in an illegal occupation; or (3) operation of a motor vehicle with a blood alcohol content in excess of the legal limit; or (4) intentional use of illegal drugs. The Plan reserves the right to recover the costs of services and supplies that were initially covered by the Plan and later determined to have been caused by an illegal act.

Incarceration or Detention. Services or treatment while in detention or incarcerated in a facility such as a youth home, jail or prison, when in the custody of law enforcement officers, or when on release for the sole purpose of receiving medical or dental treatment.

Infertility Treatment. Services and supplies relating to treatment for infertility including, among other things, artificial insemination; in-vitro fertilization; embryo or ovum transfer procedures; any other assisted reproduction procedure; fees to a surrogate parent; harvest preservation and storage of eggs or sperm, and services to reverse voluntary sterilizations. Diagnosis and treatment of the underlying cause of infertility is covered as detailed in the *Medical Benefits* section of this PDSPD.

Injectable Drugs. Drugs that are intended to be self-administered as defined by the federal Food and Drug Administration. See the Prescription Drug Benefits of the Plan for coverage information. This includes self-administered drugs for certain diseases, such as arthritis, growth deficiency, hepatitis, multiple sclerosis, and for certain other illnesses or injuries.

Items or Services Received from or Ordered by any Provider Included on the Office of Inspector General's List of Excluded Individuals/Entities. The Plan will not pay for and the Benefit Administrator will not process claims for items or services furnished, ordered, or prescribed by any provider listed or identified on any of the following lists or databases: The U.S. Department of Health & Human Services Office of Inspector List of Excluded Individuals and Entities (LEIE), the U.S. General Services Administration Excluded Parties List System (EPLS), the U.S. Department of Treasury Office of Foreign Assets Control Specially Designated Nationals (SDN) List, or on any individual state provider exclusion or sanction list or database including, but not limited to, state Office of Medicaid Inspector exclusion lists.

You will be responsible for the full payment of items or services furnished, ordered, or prescribed by any provider included on any of list or databases identified above. This includes items or services such as prescriptions written by or medical equipment ordered by a provider included on any of list or databases identified above.

Leave of Absence. Bed-hold charges incurred when you are on an overnight or weekend pass during an inpatient stay.

Marital and Relationship Enhancement Counseling. Services and treatment related to marital or relationship enhancement counseling are not covered.

Mental Health Services. The following services are not covered:

- Care provided in non-licensed residential or institutional facility or other facility on a temporary or permanent basis is not covered, including the costs of living and being cared for in: transitional living centers; foster care facilities; therapeutic boarding schools; wilderness therapy programs; custodial care; or halfway house services.
- Counseling and other services for: antisocial personality; insomnia and other non-medical sleep disorders; marital and relationship enhancement; and religious oriented counseling provided by a religious counselor who is not a participating provider.
- Experimental/investigational or unproven treatments and services.
- Scholastic/educational testing is not covered. Intelligence and learning disability testing and evaluations should be requested and conducted by the child's school district.

Motor Vehicle Accidents. For Residents of States with No-Fault Insurance (including Michigan).

Benefits are not payable under this Plan for injuries received in an accident involving a motor vehicle or that arise 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 whether no-fault benefits are actually paid.

Important: If you are a resident of the State of Michigan or another state with no-fault insurance, it is your responsibility to obtain legally required no-fault motor vehicle insurance and designate it as the primary (not secondary) payer of medical benefits for you and your family in the event of an auto accident. You will not have any medical expense coverage available for auto-related injuries under this Plan.

Exception: This exclusion shall not apply to the medical expenses of a participant who is injured in a motor vehicle accident that:

- No-fault motor vehicle insurance does not cover and would not cover even in the absence of this plan, provided the participant either maintained all legally required no-fault motor vehicle insurance at the time of the accident or was not required by law to maintain such insurance; or
- Is the result of an underlying medical condition or domestic violence, to the extent coverage is required by HIPAA.

If either of these exceptions applies, the Plan will be the secondary payer and any insurer or other plan that may have liability for the medical expenses will be primary to this Plan.

Residents of States Without No-Fault Insurance.

Benefits are not payable under this Plan for injuries received in an accident involving a motor vehicle or that arise out of the ownership, operation, maintenance, or use of a motor vehicle as a motor vehicle unless, at the time of the accident, the individual is covered by insurance for his or her own injuries (such as uninsured/under-insured motorist or personal injury coverage) with a per person coverage limit of at least \$25,000.

Important: If you are a resident of a state without no fault insurance and the owner or registrant of a motor vehicle, it is your responsibility to obtain medical coverage through your auto insurance policy with a per person coverage limit of at least \$25,000. This Plan will then be the secondary payer and any insurer or other plan that may have liability for the medical expenses will be primary to this Plan.

Exception: The above exclusion will not apply if:

- The participant is not required by law to carry any motor vehicle insurance whatsoever (as a result of not being the owner or registrant of a motor vehicle), including but not limited to, coverage under the state's financial responsibility law; or
- The accident is the result of an underlying medical condition or domestic violence, to the extent coverage is required by HIPAA.

In those circumstances, this Plan will be the secondary payer and any insurer or other plan that may have liability for the medical expenses will be primary to this Plan.

“Motor Vehicle” is defined as shown in the *Definitions* section of this Plan.

No Legal Obligation To Pay. Any service or supply that you would not have a legal obligation to pay for without this coverage. This includes, without limitation, any service performed or item supplied by a relative of yours if, in the absence of this coverage, you would not be charged for the service or item.

No-Show Charges. Any missed-appointment fee charged by a provider because you failed to show up at an appointment, except in the case of a medical emergency.

Not Medically/Clinically Necessary. Services and supplies that we determine are not medically/clinically necessary according to medical and behavioral health policies established by the Benefit Administrator with the input of physicians not employed by the Benefit Administrator or according to criteria developed by reputable external sources and adopted by the Benefit Administrator are not covered.

All of the following are considered not to be medically/clinically necessary:

- Those services rendered by a health professional that do not require the technical skills of such a provider;
- Those services and supplies furnished mainly for the personal comfort or convenience of you, anyone who cares for you, or anyone who is part of your family;
- Those services and supplies furnished to you as an inpatient on any day on which your physical or mental condition could safely and adequately be diagnosed or treated as an outpatient;
- Any service or supply beyond those services sufficient to safely and adequately diagnose or treat your physical or mental condition; and
- Additional or repeated services or treatments of no demonstrated additional benefit.

If coverage is denied because a service or supply was not medically/clinically necessary, that is a determination about benefits and not a medical treatment determination or recommendation. You, with the provider, may choose to go ahead with the planned treatment at your own expense, and appeal the denial of your claim for coverage as described in the *Appeals* section of this PDSPD.

Obstetrical Delivery In The Home or Free Standing Birthing Center. Services and supplies related to obstetrical delivery when scheduled to occur in the home or free standing birthing center.

Occupational Illness or Injury. An illness or injury that arises out of, or in the course of, any work for pay or profit, or that in any way results from an illness or injury that arises out of or in the course of work for pay or profit. This exclusion does not apply to sole proprietors, partnerships (if all employees are partners) and stock corporations (if all employees are corporate officers and own 10% or more stock in the corporation). This applies whether or not you apply for Worker's Compensation benefits.

Oral Surgery. Rebuilding or repair for cosmetic purposes; orthodontic treatment, even when provided along with oral surgery; and dental surgery in preparation for implants (unless due to accidental injury) or dentures, including preparation of the bone, or dental surgery done in connection with any of the covered services listed in the *Medical Benefits* section of this PDSPD.

Organ, Tissue and Blood Cell Transplants. Community wide searches for a donor; donor expenses, even those of participants, for transplant recipients that are not covered under this Plan; and transplants of organs when the transplant is considered experimental or investigational. See the *Medical Benefits* section of this PDSPD for information about covered transplant expenses.

Outpatient Supplies. Outpatient medical consumable or disposable supplies (except as otherwise covered in this PDSPD), including, among other things, gloves, bandages, diapers, adhesive tape, alcohol wipes and elastic bandages.

Personal Comfort or Convenience Items, Household Fixtures and Equipment. Services and supplies not directly related to your care, such as, among other things: guest meals and accommodations; telephone charges; travel expenses; take-home supplies; and similar costs. The purchase or rental of household fixtures, such as, among other things: escalators; elevators; swimming pools; and similar fixtures. The purchase or rental of household equipment that have customary non-medical purposes, including among other things: exercise cycles; air purifiers; central or unit air conditioners; water purifiers; non-allergenic pillows; mattresses or waterbeds; spas; tanning equipment and other similar equipment, and non-standard services and supplies for the convenience of the patient or caregiver.

Prescription Drugs. Prescription medication, which is administered or dispensed as take home drugs as part of treatment while in the hospital or at a medical facility and that require a physician's prescription. Please refer to your Prescription Drug Benefit plan for coverage information.

Prosthetic and Orthotic/Support Devices. Certain prosthetics, such as certain supportive/orthotic devices such as elastic and neoprene sleeves. All repairs and maintenance that result from misuse or abuse; appliances that have been lost or stolen; and prosthetic or orthotic devices that are not conventional, not medically necessary as determined by the Benefit Administrator or for the convenience of the participant or their caregiver; or prosthetic devices for a plan participant with a potential functional level of K0 are not covered. Note: K0 (Level 0) means the plan participant does not have the ability or potential to ambulate or transfer safely with or without assistance, and a prosthesis does not enhance the quality of life or mobility. See the *Medical Benefits* section of this PDSPD for covered prosthetic and orthotic services.

Providers Barred from Reimbursement. Services and supplies received from providers who either have been terminated from the provider network for failing to meet the Benefit Administrator's credentialing criteria, or providers who have been identified as being noncompliant with the Benefit Administrator's quality standards and programs.

Radiology and Laboratory Tests. Radiology services and laboratory tests performed more frequently than medically advised.

Rehabilitation and Therapy Services.

- Therapy is not covered if there is not meaningful improvement to the patient's ability to perform functional day-to-day activities that are significant in the patient's life roles within 90 days of therapy initiation.
- Therapies for intellectual disabilities including physical, occupational, speech, cognitive, and sensory integration therapy. (See Autism Spectrum Disorder Treatment benefit of the *Medical Benefits* section for covered services and limitations.)
- Cognitive rehabilitative therapy. Cognitive rehabilitative therapy is defined as neurological training or retraining.
- Craniosacral therapy.
- Prolotherapy.
- Rehabilitation services received from non-health professionals.

- Relational, education and sleep therapy and any related diagnostic testing. This exclusion does not apply to therapy or testing provided as part of a covered inpatient hospital service.
- Services outside the scope of practice of the servicing provider.
- Strength training and exercise programs.
- Summer programs meant to maintain physical condition during periods when school programs are unavailable.
- Therapy for the purpose of maintaining physical condition or maintenance therapy for a chronic condition, including but not limited to cerebral palsy and intellectual disabilities.
- Therapy to correct an impairment, unless short-term Rehabilitative Medicine Services treatment is for (a) an illness; (b) an injury; or (c) a congenital defect for which you have received corrective surgery as described under the short-term rehabilitative therapy benefits in the *Medical Benefits* section of this Plan.
- Vocational rehabilitation, including work training, work related therapy, work hardening, work site evaluations and all return to work programs.

Short-term rehabilitative therapy is covered as described in the *Medical Benefits* section.

Religious Counseling. Services and treatment related to religious counseling.

Residential or Assisted Living. Non-skilled care received in a home or facility on a temporary or permanent basis. Examples include room and board, health care aides and personal care designed to help in the activities of daily living or to keep you from continuing unhealthy activities.

Sex Therapy. Services and treatment related to sex therapy.

Skilled Nursing Services – Skilled Nursing, Subacute and Inpatient Rehabilitation Facility Care.

- Admission to a skilled nursing, subacute or inpatient rehabilitation facility is not covered if the necessary care or therapies can be provided safely in a less intensive setting, including the home or a provider office.
- Care provided in a facility required to protect you against self-injurious behavior is not covered.
- Custodial care is not covered, even if you receive covered skilled nursing services or therapies along with custodial care.
- Leave of Absence. Bed-hold charges incurred when you are on an overnight or weekend pass during an inpatient stay.
- Residential Facility or Assisted Living Facility care. Non-skilled care received in a residential facility or assisted living facility on a temporary or permanent basis is not covered. Examples of such care include room and board, health care aides, and personal care designed to help you in activities of daily living or to keep you from continuing unhealthy activities.

Substance Use Disorder. The following services are not covered:

- Non-skilled care received in a home or facility on a temporary or permanent basis. Examples of such care include room and board, wilderness therapy programs, custodial care, halfway house services and health care aids.
- Experimental/investigational or unproven treatments and services.

Third Party Requirements. Services required or recommended by third parties, including, but not limited to: physical examinations in excess of one per year performed by your physician (unless specified elsewhere as covered under the Plan); and diagnostic services and immunizations related to: getting or keeping a job, getting or keeping any license issued by a governmental body, getting insurance coverage, adopting children, obtaining or maintaining child custody, school admissions or attendance, and services required to participate in athletics.

The Plan shall now cover immunizations required for foreign country travel at the same benefit level of any other preventive immunization.

Treatment in a Federal, State, or Governmental Entity. The following are excluded to the extent permitted by law:

- Services and supplies provided in a hospital owned or operated by any federal, state, or other governmental entity.
- Services and supplies provided for conditions relating to military service, if you are legally entitled to the services and supplies and if you have reasonable access to the services and supplies at a governmental facility.

- Services and supplies provided while in detention or incarcerated in a facility such as a youth home, jail or prison, when in the custody of law enforcement officers or on release for the sole purpose of receiving medical treatment.

Treatment in a Foreign Country. Services or supplies incurred outside the United States if the covered person traveled to such a location for the primary purpose of obtaining medical services, drugs or supplies. This exclusion does not apply for treatment of medical emergencies or urgent care situations.

Vision Care. Services and supplies relating to vision care, including, among other things: eye refractions (tests to determine an eyeglass prescription), eyeglasses, eyeglass frames, all types of contact lenses or corrective lenses, eye exercises, visual training, orthoptics, sensory integration therapy, radial keratotomy, laser surgery and other refractive keratoplasties and pediatric vision services. Contacts or glasses that are medically/clinically necessary as determined by the Benefit Administrator are covered. See the *Medical Benefits* section of this PDSPD for information about other covered eye care services.

Vocational Rehabilitation. Work-related therapy, work hardening and evaluations of the worksite.

War or Act of War. Any services as a result of war or an act of war, whether declared or undeclared, if incurred while serving (including part-time service and national guard service) in the Armed Forces of the United States or any other country.

Weight Control. Weight loss services, supplies equipment or facilities in connection with weight control or reduction, whether or not prescribed by a physician or associated with an illness, including, but not limited to, food, food supplements, gastric balloons, unproven and/or unapproved weight loss surgeries, jaw wiring, liposuction, physical fitness or exercise programs and physician weight loss programs. Specific surgeries may be covered if determined to be medically/clinically necessary and approved by the Benefit Administrator as detailed in your *Schedule of Medical Benefits*.

The plan does not limit a covered person's right to choose his or her own medical care. If a medical expense is not a covered benefit, or is subject to a limitation or exclusion, a covered person still has the right and privilege to receive such medical service or supply at the covered person's own personal expense.

SECTION 12. PRESCRIPTION DRUG BENEFIT PLAN – ADMINISTERED BY CVS CAREMARK

Note: The Medicare Prescription Drug Improvement and Modernization Act of 2003 provides all Medicare eligible individuals the opportunity to obtain prescription drug coverage through Medicare. Medicare eligible individuals generally must pay an additional monthly premium for this coverage. In addition, electing Medicare Part D may affect Your ability to get prescription coverage under this plan. Individuals may be able to postpone enrollment in the Medicare prescription drug coverage if their current drug coverage is at least as good as Medicare prescription drug coverage. If individuals decline Medicare prescription drug coverage and do not have coverage at least as good as Medicare prescription drug coverage, they may have to pay an additional monthly penalty if they change their mind and sign up later. Medicare eligible individuals should have received a notice informing them whether their current prescription drug coverage provides benefits that are at least as good as benefits provided by the Medicare prescription drug coverage and explaining whether election of Medicare Part D will affect coverage available under this plan. For a copy of this notice, please contact the Plan Administrator.

DEFINITIONS.

Generic Drug means a prescription drug that has the equivalency of the brand name drug with the same use and metabolic disintegration. This plan will consider as a generic drug any Food and Drug Administration-approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

Non-Participating Pharmacy means any retail or mail order pharmacy that is not contracted by the pharmacy benefits administrator and is excluded from the network of pharmacies.

Participating Pharmacy means any retail or mail order pharmacy that is contracted by pharmacy benefits administrator to be included in a network of pharmacies at a contracted amount.

Pharmacy means a licensed establishment where prescription drugs are filled and dispensed by a pharmacist licensed under the laws of the state where the pharmacist practices.

Pharmacy Benefits Administrator is an organization that manages payment for prescriptions and services under the Plan.

Preferred Brand means a list of carefully selected medications that can assist in maintaining quality care for patients while helping to reduce the cost of prescription drug benefits under the plan.

Prescription Drug means any drug that under Federal Drug Administration (FDA) or state law requires a written Prescription by a physician or dentist or any other health care provider licensed to write prescriptions by state law. Drugs that are available without a prescription are considered non-legend drugs.

Drugs and medicines prescribed by a licensed physician and dispensed by a licensed pharmacist are covered by the plan, except as otherwise provided by the plan. Outpatient prescription drugs will be covered subject to the applicable deductible and co-pay amounts, benefit percentages, and any limitations as stated in the *Schedule of Medical Benefits*.

A covered drug must be approved for use by the Food and Drug Administration for the purpose for which it is prescribed and dispensed by a licensed pharmacist or physician.

Includes coverage for specified drugs and medications required by PPACA.

Note: FDA approval of a drug does not guarantee inclusion as a covered item under the prescription drug program. Newly approved drugs may be subject to review by the Plan Sponsor before being covered or may be excluded altogether. In addition, the level of coverage for some prescriptions may vary depending on the medication's therapeutic classification. As a result, some medications (including, but not limited to, newly approved prescriptions) may be subject to quantity limits or may require prior authorization before being dispensed.

For a specific up-to-date list of covered and/or excluded prescription drugs, contact CVS Caremark.

The following are **excluded** through the prescription drug program (this list is **not** all-inclusive):

- Applicable exclusions listed under *General Exclusions From Coverage* section of this PDSPD.
- Prescription products if a prior authorization was necessary but not received or denied.
- Prescription products that are available over-the-counter.
- Prescription products that do not have Food and Drug Administration (FDA) approval for the purpose for which prescribed.
- All illegal drugs or supplies, even if prescribed by a duly licensed individual.
- Prescriptions that are in excess of the number of refills specified or dispensed more than one year after the order was written.
- Prescriptions which a covered person is entitled to receive without charge from any Workers' Compensation law, or any municipal, state or Federal program.
- Anorexiant.
- Formulas intended to induce hair growth (e.g. Rogaine, Propecia).
- Cosmetic injectables (e.g. Botox).
- Nutritional supplements (e.g. Ensure, Pedialyte).
- Retin-A (over age 25)*
*Retin-A will be covered over age 25 with a letter of medical necessity from the physician.

The covered person has a right to purchase an excluded product at his or her own cost if the product is excluded under this plan.

This plan does not coordinate prescription benefits.

For any prescription drug questions, please contact CVS Caremark at the following:

CVS Caremark
CVS CAREMARK
8801 E RAIN TREE DRIVE
MAIL CODE 064
SCOTTSDALE AZ 85260
(888) 549-5789

SECTION 13. SPECIAL LIMITATIONS

All network benefits must be received from a network provider, except as otherwise provided by this PDSPD. Both network and non-network benefits must be prior certified by the Benefit Administrator when required, (except as this PDSPD provides otherwise).

Coinsurance Maximum.

There may be a limit to the amount of coinsurance that you have to pay for covered services in a plan year. This limit is called a coinsurance maximum. The deductible and flat dollar copayments do not apply to your coinsurance maximum. The *Schedule of Medical Benefits* and any amendments provide more information about coinsurance maximums that may apply to you.

Out-of-Pocket Limit.

There may be a limit to the total amount of copayments, coinsurance and deductible expenses that you have to pay for covered services in a plan year. This limit is called your out-of-pocket limit. The *Schedule of Medical Benefits* and any amendments to this Plan provide more information about out-of-pocket limits that may apply to you.

No Forgiveness of Out-Of-Pocket Expenses.

The covered person is required to pay the out-of-pocket expenses (including deductibles, co-pays or required plan participation) under the terms of this Plan. The requirement that you and your dependent(s) pay the applicable out-of-pocket expenses cannot be waived by a provider under any “fee forgiveness”, “not out-of-pocket” or similar arrangement. If a provider waives the required out-of-pocket expenses, the covered person’s claim may be denied and the covered person will be responsible for payment of the entire claim. The claim(s) may be reconsidered if the covered person provides satisfactory proof that he or she paid the out-of-pocket expenses under the terms of this Plan.

Reasonable and Customary.

Except as otherwise specified in this PDSPD, the maximum benefit the Plan will pay for non-network providers for any covered service is the reasonable and customary charge.

Waived Balanced Billing Protections.

If you waive your protections to any Surprise Billing Services, you are responsible for (1) those copayments, coinsurance and all deductibles listed for non-network benefits in the *Schedule of Medical Benefits* attached to this PDSPD, and (2) any amount over the reasonable and customary charge as defined in the *Definitions* section of this PDSPD.

If you have waived your protections, the nonparticipating provider or nonparticipating facility must notify the Plan of this waiver to appropriately assign cost-sharing.

Services Received as a Participant.

The Plan will only pay for covered expenses you receive while this Plan is effective and you are a participant in the Plan. An expense is considered to be received on the date on which services, supplies or materials are provided to you. This Plan will only cover expenses incurred for the diagnosis or treatment of illness or injury, except as specifically provided elsewhere in this PDSPD.

Uncontrollable Events.

A natural disaster, war, riot, civil insurrection, epidemic, or other uncontrollable event may make the Plan Administrator's offices, personnel, or financial resources unable to provide for the payment of covered expenses. Neither the Plan nor the Benefit Administrator will be liable if you do not receive those services or payments or if they are delayed. But the Plan and the Benefit Administrator will make a good faith effort to see that the services or payments are provided, considering the impact of the event.

Right to Amend or Terminate Plan.

You do not have any vested right to any current or future benefits under this Plan. Your right to benefits is limited to claims you incur before any of the following occurs: amendment of the Plan, termination of the Plan, expiration of the applicable limitations period, or termination of your participation (including termination of any extension period for which you have properly elected and paid).

Amendment.

The Company may amend, modify, change, or revise all or any part of the Plan at any time; provided, however, that no amendment shall retroactively deprive any participant of any benefit for an eligible covered expense incurred prior to the date of the amendment, modification, change, or revision. We will promptly notify you of any change.

Termination.

The following provisions shall apply to termination of the Plan:

- **By Company.** Even though the Company presently intends this Plan to be a continuing benefit program, the Company may discontinue or terminate this Plan at any time.
- **Mandatory.** The Plan shall terminate upon liquidation or discontinuance of the business of the Company; adjudication of the Company as a bankrupt; or a general assignment by the Company to or for the benefit of its creditors.
- **Change of Form.** The Plan also shall terminate upon the merger or consolidation of the Company into another entity which is the survivor; the consolidation or other reorganization of the Company; or the sale of substantially all of the Company's assets unless the successor or purchasing corporation shall adopt this Plan within 90 days thereafter.

Company Action.

Company action to amend or terminate the Plan shall be by resolution of the Board of Trustees of the group or other similar governing body of the Plan Sponsor adopted in accordance with the articles of incorporation and bylaws of the Company or by a written instrument executed by a duly authorized officer of the Company.

SECTION 14. CLAIM PROVISIONS

Claims Submission.

All claims under this Plan must be submitted to the Benefit Administrator or its designee. Providers of service may submit itemized bills directly to the Benefit Administrator. When that is not possible, you may submit a claim using a claim form or any other method that the Benefit Administrator requires.

Claims may be submitted to **Priority Health Managed Benefits, Inc., P.O. Box 232, Grand Rapids, MI 49501-0232.**

Authorized Representative. The Plan will allow you to designate an authorized representative to act on your behalf with respect to a benefit claim. To designate an authorized representative, you must request a designation form from the Benefit Administrator. The designation form will detail the extent to which your authorized representative will be acting on your behalf for purposes of these claims provisions and whether the Benefit Administrator and Plan Administrator should direct all information and notifications to which you are entitled to your authorized representative rather than to you. For all pre-service, concurrent care and urgent care claims, the Plan will automatically allow your treating physician to act as your authorized representative.

Proof of Claim. You (or your authorized representative) must submit any information the Benefit Administrator or Plan Administrator reasonably requires in making a determination about payment, denial, or review of a claim. A claim must contain the claimant's name, identifying information (such as the contract number or a birth date), a specific medical condition or symptom, and a specific treatment, service or product for which approval or payment of benefits is requested. A claim that does not include this information may not be considered a valid claim for benefits ("failed claim submission"). Additional information such as medical records, claim forms, itemized bills, proof of satisfaction of any deductibles or other insurance coverage information may also be needed to determine benefits and must be submitted as soon as possible to fall within the claim timing period below. You must authorize the release of any medical records or other information that the Benefit Administrator or Plan Administrator may require in considering your claim.

Timing. Written proof of a claim must be filed within 12 months after the date you incur the charge. A claim will be considered timely filed if notice or proof of the claim is filed as soon as possible after the end of a physical problem or other inability that prevented earlier filing. The Plan may not pay benefits for a claim unless valid proof of claim (see above) is received within 12 months after the end of the plan benefit year in which the charge was incurred.

Initial Claim Determination.

The procedure for filing claims depends on whether a claim is classified as an urgent care claim, pre-service claim, or post-service claim. The Benefit Administrator will classify each claim.

You must follow the procedure for submitting a claim as outlined in this section of the PDSPD. In the case of a "failed claim submission" the Benefit Administrator will notify you (or your authorized representative) within five days (or within 24 hours in the case of an urgent care claim) of the failure and the procedures to be followed to file a valid claim.

Urgent Care Claims.

An urgent care claim is a special type of pre-service claim. A claim involving urgent care is any pre-service claim for medical care or treatment with respect to which the application of the time periods that otherwise apply to pre-service claims could seriously jeopardize the claimant's life or health or ability to regain maximum function or would in the opinion of a physician with knowledge of the claimant's medical condition – subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is subject of the claim.

The Benefit Administrator will approve, partially approve, or deny an urgent care claim, taking into account medical exigencies. You (or your authorized representative) will be notified of the decision (whether adverse or not) no later than 72 hours after receipt of your claim unless you agree to extend the decision-making period. If you (or your authorized representative) have submitted incomplete information, notification will be made by the Benefit Administrator within 24 hours that your information was incomplete and of the procedures to file a valid claim. The Benefit Administrator will give you (or your authorized representative) a reasonable amount of time (but not less than 48 hours) to provide the specified information. The Benefit Administrator will notify you of its determination no later than 48 hours after it receives your information, unless you agree to extend the decision-making period.

Any health professional with knowledge of your medical condition (such as your treating physician) is authorized to submit an urgent care claim on your behalf. For urgent claims, the Plan will automatically allow your treating physician to act as your authorized representative.

Pre-Service Claims.

A 'pre-service claim' is a request by you (or your authorized representative) for prior certification of health services when prior certification is a requirement of the Plan. The Benefit Administrator will initially approve, partially approve, or deny a pre-service claim. You (or your authorized representative) will be notified of the decision (whether adverse or not) no later than 15 days after the receipt of your claim unless you agree to extend the decision-making period. If matters beyond the Plan's control require more than 15 days, the Benefit Administrator will have an additional 15-day period to complete its review, and will notify you of the need for an extension within the first 15-day period. If the Benefit Administrator requires additional information in order to decide your claim, you (or your authorized representative) will be notified of the additional information you have to submit. The Benefit Administrator will give you (or your authorized representative) a reasonable amount of time (but not less than 45 days) to provide the specified information. The Benefit Administrator will notify you of its determination no later than 15 days after it receives your initial claim, not including the days that were necessary to receive additional information, unless you agree to further extend the decision-making period.

Post-Service Claims.

A 'post-service claim' is any claim for a benefit under the Plan for health services that have already been received.

The Benefit Administrator will initially approve, partially approve, or deny a post-service claim and notify you of its decision no later than 30 days after it receives your claim. If matters beyond the Plan's control require more than 30 days, the Benefit Administrator will have an additional 15-day period to complete its review, and will notify you of the need for an extension within the first 30-day period. If the Benefit Administrator requires additional information in order to decide your claim, you (or your authorized representative) will be notified of the additional information you have to submit. The Benefit Administrator will give you (or your authorized representative) a reasonable amount of time (but not less than 45 days) to provide the specified information. The Benefit Administrator will notify you of its determination no later than 30 days after it receives your initial claim, not including the days that were necessary to receive additional information, unless you agree to further extend the decision-making period.

Concurrent Care Claims.

A concurrent care decision occurs where the Plan approves an ongoing course of treatment to be provided over a period of time or for a specified number of treatments. There are two types of concurrent care claims: (a) where reconsideration of the approval results in a reduction or termination of the initially approved period of time or number of treatments; and (b) where an extension is requested beyond the initially approved period of time or number of treatments.

The Benefit Administrator will notify you of a decision to reduce or terminate an ongoing course of treatment in a sufficient amount of time for you to appeal and obtain a determination on appeal before the benefit is reduced or terminated.

For any request to extend an ongoing course of treatment, the Benefit Administrator will initially approve, partially approve, or deny your claim and notify you of its decision as soon as possible, taking into account medical exigencies. In the case of an urgent concurrent claim, you (or your authorized representative) will be notified of the decision no later than 24 hours after receipt of the request if the request is made and at least 24 hours before the prescribed period of time or number of treatments expires. If your request involving an urgent concurrent claim is not made at least 24 hours prior to the expiration of your treatment, your request will be treated in accordance with the urgent care claim timeline described in this section. If a request to extend a course of treatment does not involve urgent care, the request will be treated as a new benefit claim and decided within the time frames appropriate to the type of claim, i.e., as a pre-service claim or post-service claim.

All requests for extensions of treatment will be subject to any benefit maximum or limitations under this Plan.

Initial Adverse Benefit Determinations.

If the Benefit Administrator makes a decision to deny your claim for benefits (“adverse benefit determination”) regarding an urgent care, pre-service, or post-service claim or concurrent care decision, it will send you a written or electronic notice that will include:

- Information sufficient to identify the claim involved, including the date of service, health care provider, claim amount (if applicable).
- The specific reason(s) for the adverse determination, including any denial code and its corresponding meaning, as well as a description of the Plan’s standard, if any, used in denying the claim.
- The specific plan provision(s) on which the determination was based.
- A description of any additional material or information necessary to perfect the claim and an explanation of why this material or information is necessary.
- A description of the Plan’s internal and external voluntary review procedures and time limits for those procedures. This will include a statement of your right to bring a lawsuit following an adverse benefit determination on review.
- Information on how to contact any applicable consumer assistance ombudsman established under the Public Health Service Act to assist individuals with the claims process.
- A statement that you are entitled to receive, upon request and without charge the diagnosis code and its corresponding meaning, and treatment code and its corresponding meaning.
- A statement that you are entitled to receive, upon request and without charge, copies of any internal rule, guideline, protocol, or other similar criterion (“internal criteria”) that was relied upon in making an adverse benefit determination, if applicable to your claim.
- A statement that you are entitled to receive, upon request and without charge, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, if the adverse benefit determination was based on a medical necessity or experimental treatment or similar exclusion or limit.
- A description of the “expedited review process” if the adverse benefit determination is for an urgent care claim.

An oral description of the above information may be provided within 72 hours for an urgent care claim, provided that written or electronic notification is furnished to you not more than three days later.

If you are not satisfied with a benefit determination, you may appeal it as detailed in the *Appeals* section of this PDSPD.

SECTION 15. APPEALS

Informal Inquiries (Pre-Appeal/Non-Appeal).

If you have any questions or concerns regarding your coverage or benefits under this Plan you may contact the Company or the Benefit Administrator's Customer Service Department at **616 956-1954** or **800 956-1954**. The Benefit Administrator recognizes that not all of your questions or concerns involve benefit denials. The Benefit Administrator will make every effort to resolve your inquiry at the time of your call, or as soon as reasonably possible. The Benefit Administrator's representatives may require additional information to review your request.

If you have an inquiry, complaint or problem that the Customer Service Department cannot resolve informally or you are unhappy with the resolution, you may choose to go immediately to the appeals process (detailed below) if your inquiry is related to a denial of benefits ("adverse benefit determination").

Appeal Procedure.

If you receive a denial of benefits ("adverse benefit determination") you may appeal the decision. You may also appeal the Plan Administrator's decision regarding your eligibility to participate in the Plan or the Plan Administrator's rescission (retroactive termination) of your coverage. The appeal will be conducted by the Benefit Administrator. Your appeal request must be in writing and submitted to the Benefit Administrator within 180 days after you receive your initial adverse benefit determination.

Written request for an appeal should be submitted to:

Priority Health Managed Benefits, Inc.
Attention: Appeal Coordinator
1231 East Beltline NE,
MS 1145
Grand Rapids, MI 49525-4501
Fax: 616 975-8894

The request may be sent by facsimile or by first-class mail.

In the case of a denied urgent care claim, you may request the Benefit Administrator to conduct an expedited review on appeal. You may submit your request either orally or in writing. All necessary information, including the Benefit Administrator's decision on appeal, may be transmitted between you (or your authorized representative) and the Benefit Administrator by phone, facsimile, or other available similarly expeditious method.

You may submit written comments, documents, records, and other information relating to your claim. These should be submitted to the Benefit Administrator. You may request access to and copies of all documents, records, and other information relevant to the claim, at no cost to you. You may also request the identity of any medical or vocational experts whose advice was obtained in connection with your adverse benefit determination.

The Benefit Administrator will take into account all comments, documents, records, evidence, testimony and other information you submit relating to your appeal, whether or not that information was submitted or considered in any previous benefit determinations. The Benefit Administrator will not rely on any decision made in a previous adverse benefit determination, but will review the full record of the claim and make an independent determination. The individuals conducting appeals will not be the individuals who made any prior adverse determinations on your claim nor subordinates of those individuals.

If your appeal is based in whole or in part on medical judgment, including whether a particular treatment, drug, or other item is experimental, investigational or not medically necessary or appropriate, the Benefit Administrator will consult with a health professional. The health professional will have the appropriate training and experience in the field of medicine involved in the medical judgment. Any health professional engaged for these purposes will not be the individual consulted for any prior adverse benefit determinations on your claim, nor subordinates of those individuals.

Authorized Representative.

The Plan will allow you to designate an authorized representative to act on your behalf with respect to an appeal. To designate an authorized representative, you must request an appeal form from the Benefit Administrator. The form will detail the extent to which your authorized representative will be acting on your behalf for purposes of these appeals provisions, and whether the Benefit Administrator should direct all information and notifications to which you are entitled to your authorized representative rather than to you.

Appeal Notification.

Your appeal will be classified as an urgent care, pre-service, or post-service claim appeal at the time the appeal is being processed. This could result in your claim being classified in a different category of appeal than it was for the initial benefit determination. For example, a claim initially classified as an urgent care claim could become a post-service claim appeal if you have received medical treatment or services by the time you appeal.

Urgent Care Claims.

The Benefit Administrator will notify you of its decision on appeal (whether adverse or not) as soon as possible, taking into account the medical exigencies. In the case of an urgent care claim appeal, you (or your authorized representative) will be notified as soon as possible but not later than 72 hours following receipt of your appeal request unless you agree to further extend the decision-making period.

Pre-Service Claims.

The Benefit Administrator will notify you of its decision on appeal (whether adverse or not) within a reasonable period of time, but not later than 30 days after it receives your appeal request unless you agree to further extend the decision-making period.

Post-Service Claims.

The Benefit Administrator will notify you of its decision on appeal (whether adverse or not) within a reasonable period of time, but not later than 60 days after it receives your appeal request unless you agree to further extend the decision-making period.

The Benefit Administrator's decision will be final and binding.

Adverse Benefit Determination on Appeal.

After it reviews your appeal, the Benefit Administrator will send you a written or electronic notice of its benefit determination. If the benefit determination is adverse, the notice will include:

- The reason(s) for the adverse determination, including any denial code and its meaning, as well as a description of the Plan's standard, if any, used in denying the claim and a discussion of the decision.
- The specific plan provision(s) on which the determination was based.
- Information sufficient to identify the claim involved, including the date of service, health care provider, claim amount (if applicable).
- A description of any additional material or information necessary for your claim to be approved and an explanation of why this material or information is necessary.
- A statement that you are entitled to receive, upon request and without charge the diagnosis code and its corresponding meaning, and treatment code and its corresponding meaning.
- A statement that you are entitled to receive, upon request and without charge, reasonable access to and copies of all documents, records, and other 'relevant' information (as defined above).
- An explanation of the voluntary internal level of appeal, if any, and the external review procedure that the Plan makes available, including applicable time limits.
- Information on how to contact any applicable consumer assistance ombudsman established under the Public Health Service Act to assist individuals with the claim process.
- A statement of your right to bring a civil action.

- A statement that you are entitled to receive, upon request and without charge, copies of any internal rule, guideline, protocol, or other similar criterion (“internal criteria”) that was relied upon in making an adverse benefit determination, if applicable to your appeal.
- A statement that you are entitled to receive, upon request and without charge, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, if applicable to your appeal.
- A statement that 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.
- Any new or additional evidence considered, relied on or generated by the Plan in connection with the appeal of your claim. This evidence will be provided to you as soon as possible and sufficiently in advance of the date the Plan must provide notice of its decision on the appeal in order to provide you with a reasonable opportunity to respond prior to that date.

Before the Plan can issue an adverse benefit determination on review based on a new or additional reason or “rationale”, you will be provided, free of charge, with the rationale. The rationale will be provided as soon as possible and sufficiently in advance of the date the Plan must provide notice of its decision upon appeal in order to provide you with a reasonable opportunity to respond prior to that date.

The Benefit Administrator’s decision as set forth in the Notice of Final Internal Adverse Benefit Determination will be considered final and binding on all parties, unless you voluntarily submit your claim to external review, as described below.

Federal External Claim Review Procedures.

This section does not apply to individuals covered by a self-funded health plan that is established or maintained by a state or Local Unit of Government. For individuals covered by a self-funded health plan that is established or maintained by a state or Local Unit of Government, see State External Claim Review Procedures.

State External Claim Review Procedures.

If you are covered by a self-funded health plan that is established or maintained by a state or Local Unit of Government, this section applies to you. Once you have exhausted the internal appeals procedures described above, you or your authorized representative has the right to request an external review by the Michigan Department of Insurance and Financial Services (DIFS). Your Notice of Final Internal Adverse Benefit Determination will contain an explanation on how to submit information to DIFS. This external review procedure is voluntary and you are not required to seek to have your claim reviewed under this procedure in order to have your claim determined by a court.

Within 127 days of the date you received the Notice of Final Internal Adverse Benefit Determination, or should have received it, you may send a written request for an external review as follows:

- online at <https://difs.state.mi.us/Complaints/ExternalReview.aspx>; or
- send your request form (http://www.michigan.gov/difs/0,5269,7-303-12902_12907---,00.html) to one of the following:

email: DIFS-HealthAppeal@michigan.gov

Mail:

Office of General Counsel - Healthcare Appeals Section
 Department of Insurance and Financial Services (DIFS)
 P. O. Box 30220
 Lansing, Michigan 48909-7720

Fax: 517.284.8838

Delivery Service:

Office of General Counsel - Healthcare Appeals Section
 Department of Insurance and Financial Services (DIFS)
 530 W. Allegan St., 7th Floor
 Lansing, Michigan 48933-1521
 Phone: 877.999.6442

State Expedited Appeal Procedure.

Priority Health will follow a faster review process if you or your Physician tells us, verbally or in writing, that the normal time it takes for us to complete the Appeal procedure would:

- put your life in serious danger
- interfere with your full recovery, or
- delay treatment for severe pain

Priority Health will make a decision within 72 hours (three days) from the time we get your request. This timeline begins when we receive your request. During non-business hours, you can leave a message at 877.954.1035 (toll free) to make a request.

As soon as the expedited review is finished, Priority Health will contact you by telephone to tell you our decision. Priority Health will also send a letter no more than two business days later with our decision.

If you are not happy with the outcome, you may appeal to DIFS within 10 days after you receive Priority Health's decision about your expedited review. You may also ask DIFS for an expedited review if:

- You have already asked for an expedited review by Priority Health; and
- Your Physician tells DIFS, whether in writing or by telephone, that waiting for Priority Health's decisions before requesting an expedited external review would put your life in danger or would interfere with your full recovery.

DIFS's expedited review will be done within 72 hours (three days) from the time DIFS receives it from you.

Exclusive Method of Resolving Claims.

The procedures outlined above will be the only procedures used to resolve adverse benefit determinations and will only apply to issues that the Plan Administrator has control over, such as administrative or claim issues. They will not apply if someone other than the Plan (for example, a physician or other health professional) is blamed for negligence.

Legal Actions.

No legal or equitable actions may be brought under the Plan before you have exhausted the appeal procedures described above. Further, no legal action can be brought to recover any benefit under the Plan after three years from the date you have exhausted the appeal procedures described above.

SECTION 16. COORDINATION OF BENEFITS

Purpose of Coordination of Benefits.

Coordination of Benefits (“COB”) is the system that determines how benefits are applied when you are covered by more than one health care plan. The “primary plan” is responsible for paying the full benefit amount allowed by the participant’s benefit plan. The “secondary plan” is responsible for paying any part of the benefit not covered by the primary plan as long as the secondary plan covers the benefit. The secondary plan adjusts the amount of benefits paid according to the COB rules of their plan. The total paid by both plans may provide payment up to, but cannot exceed 100% of the allowable expense, for those services. The amount that each plan is required to pay is known as its “liability”. When this Plan is secondary, we use the Full/Traditional method for coordinating benefit payments with another plan as shown in the Effects on Benefits provisions of this section.

This Plan will coordinate benefits with the following types of plans:

- Group insurance, or any other arrangement of coverage for individuals in a group, whether on an insured or uninsured basis;
- Coverage for which partial or full employer contributions or deductions are made from your compensation, annuity or retirement benefits;
- Labor-management trustee, union welfare, employer organization or employee benefit organization plans;
- Any government program or coverage required or provided by statute, including Medicare or Medicaid; and
- Any policy or insurance, including no-fault insurance, relating to or providing for the payment of health benefits as a result of bodily injury arising out of the operation of an automobile or other motor vehicle.

We will not consider an individual medical policy a “Plan” (other than a motor vehicle policy) if the policy is not required by law and if we or another employer does not contribute a share of the cost of, or make any payroll deductions to, that policy. Coordination with a motor vehicle policy shall be administered on a secondary basis as specifically detailed in this document and will occur only where this plan’s motor vehicle exclusion does not exclude coverage for injuries received in an accident involving a motor vehicle.

The coordination of benefits provision does not apply to any accident benefit, weekly income benefits or prescription drug benefit (except for Medicare Part D benefits as required by law).

Information About Coverage From Other Plans.

The enrollment form asks for information about your coverage from other plans. That information is very important and you must give it to us truthfully. If your coverage from another plan changes in any way, you must advise the Benefit Administrator or us. You must cooperate with the Company and the Benefit Administrator to coordinate coverage under this Plan with coverage from other plans, including providing us with copies of court orders and other documents that may determine which plan is primary.

Order of Benefit Determination if You Are Covered by Two Plans.

Decisions about the order of your benefits will be made under the following rules, in the following order:

- (1) No COB Provision. A plan without a coordination of benefits provision is always primary.
- (2) Coverage as Other Than a Dependent. A plan covering you as an employee (rather than a dependent) is always primary. If you also receive Medicare, the Social Security Act of 1965, as amended, may require Medicare to provide its benefits after the Plan covering you as a dependent, but before the Plan covering you as an employee.
- (3) Coverage as a Dependent Children of Married or Never Married Parent Who Reside in the Same Household (The “Birthday Rule”). Dependents are covered first by the Plan of the parent whose birthday falls earlier in the calendar year (month and day only). If the parents’ birthdays are on the same date, the Plan that has covered the parent for a longer time period is primary. This rule applies except in the circumstances detailed in (4) below.

- (4) Coverage as Dependent Children of Parents who Divorced, Separated or Who Do Not Reside in the Same Household, benefits are coordinated as follows:
- a) If a court order assigns responsibility for providing health benefits to one parent, that parent's plan is primary.
 - b) If a court order assigns responsibility for providing health benefits to both parents, the primary plan is determined by applying the birthday rule in subsection (3) above.
 - c) If a court order assigns joint physical custody to both parents, the primary plan will be determined by applying the birthday rule in subsection (3) above.
 - d) If a court order fails to assign responsibility for providing health benefits to either parent or if no court order exists, health benefits are determined in the following order:
 - i. Plan of the parent with physical custody;
 - ii. Plan of the step-parent with physical custody;
 - iii. Plan of the parent without physical custody;
 - iv. Plan of the step-parent without physical custody.
- (5) If the dependent child is covered under either or both parents' plans and is also covered as a dependent under his or her spouse's plan the order of benefits is the plan that has covered the individual for the longer period of time is the primary plan and the plan that has covered the individual for the shorter period of time is the secondary plan. If the dependent child's coverage under his or her spouse's plan began on the same date as his or her coverage under either or both parents' plan, the order of benefits is determined by applying the birthday rule in subsection (3) above to the dependent child's parents, as applicable, and his or her spouse.
- (6) Coverage as a Laid Off or Retired Employee. If you are covered under two plans, one as a retiree and one as an active employee or a dependent of the active employee, the Plan that covers you as an active employee or as a dependent of an active employee is primary.
- (7) COBRA or Continuation Coverage. A plan that is non-COBRA or non-continuation coverage is primary when you are covered under both a non-COBRA or non-continuation plan and a COBRA or other type of continuation plan.
- (8) Longer/Shorter Length of Coverage. If none of the above rules determines how the order of benefits will be paid, the Plan that has covered you the longest will be primary. The length of time you are covered under a plan is measured from your first date of coverage under that plan. The start of a new plan does not include:
- A change in the amount or scope of a plan's benefits; or
 - A change in the entity that pays, provides or administers the Plan's benefits; or
 - A change from one type of plan to another (such as from a single employer plan to a multiple employer plan).
- (9) If none of the preceding rules determines the order of benefits, the allowable expenses shall be shared equally between the plans.
- (10) Motor Vehicle Insurance: Notwithstanding the above order of payment, this Plan's motor vehicle exclusion will exclude coverage under this Plan for injuries received in an accident involving a motor vehicle and the motor vehicle policy will be required to provide coverage. However, if one plan is a motor vehicle policy and this Plan's motor vehicle exclusion does not completely exclude coverage for injuries received in an accident involving a motor vehicle for one of the limited reasons stated in the Motor Vehicle Accident exclusion in the *General Exclusions From Coverage*, the motor vehicle policy shall be the primary plan. As the primary plan, the motor vehicle policy must provide benefits without considering this plan's coverage. In that circumstance, as the secondary plan, this Plan will then pay up to 100% of allowable expenses for covered services that were not covered by the primary plan, and that will not exceed the medical expenses actually incurred. A "Motor Vehicle Policy" is any policy of insurance, including no-fault insurance, relating to or providing for the payment of medical benefits as a result of bodily injury arising out of the operation of a motor vehicle, including any riders or collateral provision to such policy. "Motor Vehicle" is defined as shown in the *Definitions* section of this Plan.

Effect on Benefits.

This Plan will follow the above rules to determine which plan is the primary plan. If this Plan is the primary plan, your only covered services are the ones detailed in this PDSPD. If your other plan is the primary plan, then this Plan is a secondary plan. In that case, the primary plan must pay up to its highest benefit level. When the benefits under a primary plan are reduced because you did not comply with the provisions of the primary plan, the amount of that reduction will not be considered an allowable expense (as defined below) for determining this Plan's liability. Examples of such provisions include those related to second surgical opinions, pre-certification of services or use of network providers.

When this Plan is the secondary plan, we will not cover expenses unless all of the requirements for coverage under this PDSPD have been followed. If the rules of this Plan conflict with those of another plan, it may be impossible to receive benefits from both plans, and you may only be able to receive benefits from the primary plan. Duplicate coverage will never extend your benefits beyond those available under this PDSPD. This Plan will not pay claims or coordinate benefits for services that are not a covered benefit under this PDSPD.

Additional rules for coordination of benefits apply when this Plan is the secondary plan:

- The primary plan, as determined above, must provide its covered benefits without considering this Plan's coverage.
- If the primary plan does not cover services that this Plan covers, those services will be covered as if this Plan is the primary plan.
- If this Plan covers services not fully covered by the primary plan, this Plan will coordinate our coverage with the primary plan's coverage to pay up to 100% of allowable expenses or a provider's contracted rate, whichever is less, for those services.

"Allowable Expense" means a necessary, reasonable and customary expense for health care, or a provider's contracted rate, (prior to any reduction for deductibles, copayments or coinsurance) when the item of expense is covered at least in part by one or more plans covering the participant for whom the claim is made.

Release.

The Plan Administrator or its designee may release to and obtain from any other insurer, plan or party, any information that it considers necessary for coordination of benefits or recovery of overpayments. You must cooperate to provide all such information.

Conditional Benefit Payments and Recovery of Overpayments.

A payment made by another plan may include an amount that should have been paid under this Plan. If it does, this Plan may pay that amount directly to the other plan. The amount will then be treated as though it were a benefit this Plan had paid, and this Plan will not have to pay that amount again. The term "payment made" includes the reasonable cash value of the benefits provided in the form of services.

If the amount of the payments made by this Plan is more than should have been paid under the COB provision, or if services should have been paid by a primary plan, this Plan may recover the excess or the reasonable cash value of the services, as applicable, from one or more of: (a) the person or provider paid; (b) insurance companies; or (c) other organizations. We can recover these amounts as we choose. If you incur medical expenses for which another party is or may be responsible, we may provide coverage subject to our rights to reimbursement. You (or your legal guardian) must sign any agreements or other documents and cooperate with us to make sure we can recover any overpayments or obtain the reimbursement described in this section.

Plan's Right to Reimbursement and Subrogation Right.

Plan's Right to Reimbursement.

If the Plan pays benefits and another party (other than the participant or the Plan) is or may be liable for the expenses, the Plan has a right of reimbursement that entitles it to recover from the participant or another party 100% of the amount of benefits paid by the Plan to or on behalf of the participant.

The Plan's right to 100% reimbursement applies:

- Not only to any recovery the participant receives or is entitled to receive from the other party but also to any recovery the participant receives or is entitled to receive from the other party's insurer or a plan under which the other party has coverage.
- To any recovery from the participant's own insurance policy, including, but not limited to, coverage under any uninsured or underinsured policy provisions.
- To any recovery, even if the other party is not found to be legally at fault for causing the participant to incur the expenses paid or payable by the Plan.
- To any recovery, even if the damage recovered or recoverable from the other party, its insurer or plan, or the participant's policy are not for the same charges or types of losses and damages as those for which benefits were paid by the Plan.
- To any recovery, regardless of whether the recovery fully compensates the participant for his or her injuries and illnesses and regardless of whether the participant is made whole by the recovery.
- To any recovery resulting from a judgement by an Independent Dispute Resolution Entity related to items and payments covered by the federal No Surprises Act.
- To the entire amount of the recovery to the extent of the expenses payable by the Plan. The Plan's right to reimbursement from the recovery is in the first priority and is not offset or reduced in any way by the participant's attorney's fees or costs in obtaining the recovery. The Plan disavows any obligation to pay all or any portion of the participant's attorney's fees or costs in obtaining the recovery. The common fund doctrine and other similar common law doctrines do not reduce or affect the Plan's right to reimbursement.

Plan's Subrogation Right to Initiate Legal Action.

If a participant does not bring an action against the other party who caused the need for the benefits paid by the Plan within a reasonable period of time after the claim arises, the Plan shall have the right to bring an action against the other party to enforce and protect its right to reimbursement. In this circumstance, the Plan shall be responsible for its own attorney's fees.

Cooperation of Participant.

A participant shall do whatever is necessary and shall cooperate fully to secure the rights of the Plan. This includes assigning the participant's rights against any other party to the Plan and executing any other legal documents that may be required by the Plan. This also includes keeping the Plan notified of any efforts to recover money from the party who caused the need for the Plan to pay benefits, including providing the Plan with copies of all correspondence, court documents, pleadings, demands or any other communications relating to those efforts.

Plan's Right to Withhold Payment.

The Plan may withhold payment of benefits when it appears that a party other than the participant or the Plan may be liable for the expenses until such liability is legally determined. Further, as a precondition to paying benefits when it appears that the need for the benefits payable by the Plan was caused by another party, the Plan may withhold the payment of benefits until the participant signs an agreement furnished by the Plan Administrator setting forth the Plan's right to reimbursement and subrogation right. The Plan may also withhold payment if the participant or his representative does not cooperate with the Plan as may be required by the Plan. The Plan's right to withhold payment also includes the right to recoup payment from any provider to whom the Plan has paid benefits on behalf of the participant.

Preconditions to Participation and the Receipt of Benefits.

All of the following rules are preconditions to an individual's participation in the Plan and the receipt of Plan benefits:

- The participant agrees not to raise any make-whole, common fund, or other apportionment claim or defense to any action or case involving reimbursement or subrogation in connection with the Plan, and acknowledges that the Plan expressly disavows such claims or defenses.
- The participant agrees not to raise any ERISA jurisdictional or procedural issue that would defeat the Plan's claim to reimbursement or subrogation in connection with the Plan.

- The participant specifically acknowledges the Plan’s fiduciary right to bring an equitable reimbursement recovery action under Section 502 of ERISA should the participant obtain or be entitled to obtain a recovery from another party who is or may be liable for the expenses paid by the Plan and to obtain an equitable lien over any property or recovery to the extent of the expenses payable by the Plan.
- The participant specifically recognizes that the Plan has the right to intervene in any third party action to enforce its reimbursement rights. The participant consents to such intervention.
- The participant specifically agrees that the Plan has the right to obtain injunctive relief prohibiting the participant from accepting or receiving any settlement or other recovery related to the expenses paid by the Plan until the Plan’s right to reimbursement is fully satisfied. The participant consents to such injunctive relief.

Notice and Settlement of Claim.

A participant shall give the Plan Administrator written notice of any claim against another party as soon as the participant becomes aware that he may recover damages from another party. A participant shall be deemed to be aware that he may recover damages from another party upon the earliest of the following events:

- The date the participant retains an attorney in connection with the claim.
- The date a written notice of the claim is presented to another party or the other party’s insurer or attorney by the participant or by the participant’s insurer or attorney.

A participant shall not compromise or settle any claim against another party without the prior written consent of the Plan Administrator. If a participant fails to provide the Plan Administrator with written notice of a claim as required in this section, or if a participant compromises or settles a claim without prior written consent as required in this section, the Plan Administrator can, at its discretion, take back previously made payments equal to the amount of the Plan’s claim.

Provisional Payment of Disputed Claim.

In the event of a conflict between the Coordination of Benefits provisions of this Plan and any other plan, the Plan Administrator may take such action as it considers reasonably necessary to avoid hardship caused by a delay in payment of the disputed claim, including payment of such claim with reservation of the Plan’s rights of recovery from the other plan in accordance with the reimbursement and subrogation provisions of this Plan.

For purposes of this subsection, the term “you” or “participant” includes you and any person claiming through or on behalf of you, including relatives, heirs, assigns and successors.

SECTION 17. MEDICARE AND OTHER FEDERAL OR STATE GOVERNMENT PROGRAMS

Nonduplication of Benefits.

Your benefits under this Plan cannot duplicate any benefits you are, or could be, eligible for under Medicare or any other federal or state government program. If the Plan covers a service that is also covered by one of those programs, any sums payable under that program for that service must be paid to the Plan. The Plan will apply the rules for coordination of benefits described in the *Coordination of Benefits* section of this PDSPD after your benefits from the Plan have been calculated under the rules in this section. The Plan will reduce allowable expenses by any benefits available for those expenses under Medicare or any other federal or state governmental program to the extent permitted by law. You must fill out and return to us any information requested to make sure the Plan receives reimbursement by those programs.

Coordination With Medicare.

The following rules apply to coordination with Medicare, except as required otherwise by applicable law:

Election Against Coverage. Despite any other provision of this Plan, if you elect not to be covered by this Plan, Medicare will be the primary plan and the coverage provided by this Plan will not be available.

Participants Age 65 and Over. If you are a benefit eligible employee who is at least age 65 (or a benefit eligible employee's spouse who is at least age 65): (i) Medicare will be primary to this Plan for you if the Company has less than 20 employees; and (ii) this Plan will be primary to Medicare for you if the Company has 20 or more employees. If you are covered by Medicare because of age and if your coverage under this Plan is not due to your (or your spouse's) current employment, Medicare will be primary to this Plan.

Disabled Participants Under Age 65. If you are disabled and your coverage under this Plan is due to the current employment status of you, your spouse or parent: (i) this Plan will be primary to Medicare for you if this Plan is a large group health plan; and (ii) Medicare will be primary to this Plan for you if this Plan is not a large group health plan. A "Large Group Health Plan" is a plan maintained by an employer that had at least 100 employees on a typical business day during the previous calendar year. If you are covered by Medicare because of disability and if your coverage under this Plan is not due to the current employment status of you, your spouse or parent, Medicare will be primary to this Plan.

Participants Eligible for Medicare ESRD Benefits. Except as provided below, if you are entitled to or eligible for end-stage renal disease ("ESRD") Medicare benefits, this Plan will be primary to Medicare for the first 30 months of eligibility for Medicare ESRD benefits plus any applicable waiting period for those benefits. After that time, Medicare will be primary. If you have primary coverage under Medicare by reason of age or disability and you later become eligible for Medicare ESRD coverage, Medicare will remain primary to this Plan.

Participants Eligible for Medicare and COBRA. Coordination of Medicare and COBRA benefits centers around the "current employment status" of an individual. If an employee who is covered by a group health plan and entitled to Medicare terminates employment, ending the current employment status, Medicare becomes the primary plan, if COBRA is elected. The exception to this rule is if an individual is entitled to Medicare due to End Stage Renal Disease ("ESRD"). If an individual is entitled to Medicare, has ESRD and is on COBRA, COBRA (the group health plan) is primary plan for the first 30 months, and Medicare is secondary.

Eligibility for Medicare. In determining benefits payable under Medicare, you will be considered to be enrolled for and covered by both Parts A and B of Medicare, and other governmental benefits for which you are eligible, whether or not you are actually enrolled.

NOTE: If you are eligible for Medicare, and Medicare is the primary plan under the rules defined above, you must also enroll in and become covered by Medicare (Parts A and B), Medicare Part D coverage is optional.

Statutory and Regulatory Changes. Despite any other provision of this Plan, if any existing legislation or regulation is amended or altered, or if any new legislation or regulation is enacted or adopted, further permitting this Plan to be secondary to Medicare, this Plan will be secondary to Medicare as permitted by that legislation or regulation.

Children’s Health Insurance Program (CHIP).

This Plan will be considered primary to any CHIP coverage that supplements this Plan.

State Medical Assistance Plan.

When the Plan enrolls a person or determines or makes any payment for a person's benefits, the Plan will not consider the fact that the person is eligible for or is provided medical assistance under a state medical assistance plan approved under Title XIX of the Social Security Act (“Medicaid”). To the extent that payment has been made under a state Medicaid plan when the Plan is legally responsible to pay for health care benefits, the Plan will pay for benefits according to any state law that provides that the state has acquired the rights to such payment with respect to a participant. The Plan will pay benefits with respect to a participant in accordance with any assignment of rights made by or on behalf of the participant as required by a state Medicaid plan.

SECTION 18. NO RIGHTS UNDER ERISA

The Employee Retirement Income Security Act of 1974 (ERISA) does not apply to this Plan.

SECTION 19. HIPAA PRIVACY PROVISIONS

This section describes the rules that govern the Plan's use and disclosure of your protected health information and is intended to comply with the Plan amendment requirements of the HIPAA privacy regulations ("Privacy Rules"). For purposes of this section only, any references to "you" or "your" apply not only to current, former, and deceased participants, but also to any individual who is the subject of the PHI (such as spouses and dependents).

Information Protected by the Privacy Rules.

The Privacy Rules safeguard "protected health information" ("PHI"). PHI includes all of your individually identifiable health information that is transmitted or maintained by the Plan, regardless of its form (written, electronic or oral). "Individually identifiable health information" is information that:

- is created or received by a health plan, health care provider, health care clearinghouse, or employer;
- relates to your physical or mental health or condition, including information related to the provision of or payment for your health care; and
- identifies you (or reasonably could be used to identify you).

How the Plan May Use or Disclose Your PHI.

Overview of Disclosures. The Plan may not use or disclose your PHI unless the Privacy Rules specifically permit the Plan to do so, or unless you authorize the Plan to do so. The uses and disclosures that the Privacy Rules specifically permit include those for treatment, payment and health care operations of the Plan. The Plan also may use or disclose your PHI for certain "public policy" reasons listed below. Generally, if the Plan uses or discloses your PHI, the Plan must take reasonable steps to limit the information to the minimum amount necessary to accomplish the purpose of the use or disclosure.

Treatment, Payment, and Health Care Operations. "Treatment" generally means providing, coordinating, and managing your health care. This includes activities such as consultation among your health care providers or your being referred from one health care provider to another. "Payment" generally means the activities undertaken to obtain or provide payment for your health care under the Plan. This includes billing, claims management, eligibility and coverage determinations, subrogation, coordination of benefits, utilization review, and medical necessity determinations. "Health care operations" includes other activities related to treatment and payment, such as credentialing, auditing, reinsurance, etc.

Authorization. You may authorize the Plan to make certain uses and disclosures of your PHI. The Plan can rely on your written authorization for any use or disclosure of your PHI so long as the authorization contains the following elements:

- a specific and meaningful description of the information to be used or disclosed;
- the person(s) or category of persons authorized to make the requested use or disclosure;
- the person(s) or category of persons to whom the Plan is authorized to make the requested use or disclosure;
- a description of each purpose of the requested use or disclosure (this description can merely say, "at the request of the individual" if you initiate the authorization and do not provide a statement of the purpose);
- an expiration date or expiration event; and
- your signature and the date.

The authorization must also notify you of your right to revoke the authorization in writing at any time, so long as the Plan has not taken action in reliance on your authorization. The Plan may not condition treatment, payment, enrollment or eligibility for benefits on whether you sign the authorization (except in limited circumstances under the Privacy Rules with regard to enrollment or eligibility for benefits). Be aware that PHI disclosed pursuant to your authorization is potentially subject to re-disclosure by the recipient and might no longer be protected under the Privacy Rules.

Public Policy Disclosures. The Plan may disclose your PHI (other than PHI contained in psychotherapy notes) without obtaining your authorization in the following situations (as defined in the Privacy Rules):

- when required by law so long as the use or disclosure complies with and is limited to the relevant requirements of that law and complies with the special limitations surrounding disclosures about victims of abuse, neglect or domestic violence, disclosures for judicial and administrative proceedings, and disclosures for law enforcement purposes;
- for certain public health activities;
- to a government authority authorized by law when the Plan reasonably believes that you are a victim of abuse, neglect, or domestic violence;
- for certain health oversight activities authorized by law;
- for certain judicial and administrative proceedings;
- to a law enforcement official for certain law enforcement purposes;
- to coroners, medical examiners, or funeral directors;
- to organ procurement organizations regarding cadaveric organs, eyes, or tissue for certain donation and transplant purposes;
- for certain research purposes;
- to avert a serious threat to health or safety;
- for specialized government functions (such as separation or discharge from the military, determining eligibility for veterans' benefits, matters of national security or intelligence, etc.); and
- to the extent necessary to comply with workers' compensation or similar laws.

What the Plan Is Required to Do with Your PHI.

The Plan must do the following in accordance with the applicable provisions of the Privacy Rules (§ 164.524 to 164.528):

- upon your request, make your PHI available to you (other than psychotherapy notes or information compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative action or proceeding);
- upon your request, correct errors in your PHI;
- upon your request, provide you with an accounting of disclosures of your PHI made by the Plan (excluding disclosures made before the effective date or the date six years prior to the date on which you request an accounting). Note, however, that the Plan is not required to provide you with an accounting of disclosures made before the effective date or the date six years prior to the date on which you request an accounting of disclosures. Similarly, your right to an accounting of disclosures does not apply to disclosures made (1) to carry out treatment, payment, or health care operations; (2) to you; (3) incident to a use or disclosure otherwise permitted or required by the Privacy Rules; (4) pursuant to an authorization signed by you; (5) to persons involved in your care or for other permitted notification purposes (e.g., following a natural disaster); (6) for national security or intelligence purposes; (7) to correctional institutions or law enforcement officials; and
- make its internal practices, books, and records relating to the use and disclosure of PHI available to the Secretary of Health and Human Services for purposes of determining the Plan's compliance with the Privacy Rules.

Which Employees of the Plan Sponsor May Have Access to Your PHI.

Without your authorization, the Plan may not disclose PHI to the Plan Sponsor until the Plan has received a certification by the Plan Sponsor that the plan documents have been amended to protect PHI in accordance with the Privacy Rules, and that the Plan Sponsor agrees to abide by the amendment. Only the employees, or classes of employees, listed in the Plan Sponsor's HIPAA privacy policies and procedures will be given access to PHI.

What Employees of the Plan Sponsor May Do With Your PHI.

The Plan may disclose your PHI to the authorized employees of the Plan Sponsor described above. Authorized employees may then use or disclose your PHI only for the following plan administration functions:

- activities by the Plan to obtain premiums or to determine or fulfill its responsibility for coverage and provision of benefits under the Plan;
- activities to obtain or provide reimbursement for your health care;

- making eligibility and coverage determinations;
- making coordination of benefits determinations;
- adjudication of health benefit claims;
- final adjudication of appeals of claim denials;
- subrogation of health benefit claims;
- providing assistance to participants in eligibility and benefit matters;
- risk adjusting based on enrollee status and demographic characteristics;
- billing, claims management, collection activities, obtaining payment under a contract for reinsurance (including stop-loss insurance and excess loss insurance), and related health care data processing;
- review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges;
- utilization review activities, including pre-certification and pre-authorization of services, concurrent and retrospective review of services;
- limited disclosures to consumer reporting agencies;
- internal quality oversight review;
- credentialing and health care provider evaluation;
- underwriting, insurance rating and other activities relating to creation, renewal, or replacement of a contract of health insurance or health benefits (including stop-loss insurance, excess insurance, and professional liability insurance);
- medical review, legal services, and auditing functions (including fraud and abuse detection);
- business planning, management and general administration; and
- filing claims under stop-loss insurance, excess insurance, and professional liability insurance.

How the Plan Sponsor's Authorized Employees Will Be Disciplined If They Violate the Privacy Rules.

If an authorized employee uses or discloses PHI in ways other than those listed above, he or she will be subject to discipline, ranging from a verbal or written warning to suspension or termination, depending on the severity and circumstances of the violation.

Obligations of the Plan Sponsor under the Privacy Rules.

Once the Plan Sponsor has received PHI, it must do the following in accordance with the applicable provisions of the Privacy Rules (§ 164.524 to 164.528):

- not use or further disclose PHI other than as permitted or required by the Plan or as required by law;
- ensure that any agents, including subcontractors, to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to that PHI;
- not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or any of its other employee benefit plans, unless authorized by the employee;
- report to the Plan any use or disclosure of PHI of which the Plan Sponsor becomes aware that is inconsistent with the uses or disclosures allowed by the Plan;
- upon your request, make your PHI available to you (excluding any psychotherapy notes or information compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative action or proceeding);
- upon your request, correct errors in your PHI;
- upon your request, provide you with an accounting of disclosures of your PHI made by the Plan (excluding disclosures made before the effective date or the date six years prior to the date on which you request an accounting). Your right to an accounting of disclosures does not apply to disclosures made (1) to carry out treatment, payment, or health care operations (as defined in the Privacy Rules); (2) to you; (3) incident to a use or disclosure otherwise permitted or required by the Privacy Rules; (4) pursuant to an authorization signed by you; (5) to persons involved in your care or for other permitted notification purposes (e.g., following a natural disaster); (6) for national security or intelligence purposes; (7) to correctional institutions or law enforcement officials.
- make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining the Plan's compliance with the Privacy Rules;

- 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 PHI when no longer needed for the purpose for which the disclosure was originally made. If such return or destruction is not feasible, the Plan Sponsor must limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and
- ensure that adequate separation between the Plan and the Plan Sponsor is established, as required by the Privacy Rules.

Obligations of the Plan Sponsor under the Security Rules.

With respect to electronic forms of PHI, the Plan Sponsor must do the following in accordance with the applicable provisions of the Security Rules (§ 164.302 to 164.318):

- implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI created, received, maintained or transmitted on behalf of the Plan;
- ensure that adequate separation between the Plan and the Plan Sponsor supported by reasonable and appropriate security measures;
- ensure that any agents, including subcontractors, with access to PHI agree to implement reasonable and appropriate security measures to protect electronic PHI; and
- report to the Plan any significant security incident involving electronic PHI of which it become aware.

Genetic Information.

The Plan will not use or disclose Protected Health Information that is genetic information, as defined in 45 CFR §160.103, for determining eligibility (including enrollment and continued eligibility); the computation of premium or contribution amounts; or other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

SECTION 20. DEFINITIONS

Adverse Benefit Determination. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participants' eligibility to participate in a plan, including a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically/clinically necessary or appropriate.

Allowed Amount. Maximum amount on which payment is based for covered services. The allowed amount is determined by the Benefit Administrator. If a non-participating provider charges more than the allowed amount, you may have to pay the difference. See Balance Billing for additional information.

Amendment. A legal document that is part of your plan, that explains any additional benefits, limitations or other modifications to the coverage outlined in the Plan.

Appeal. A request for your plan to review a decision again.

Applied Behavior Analysis (ABA). Outpatient treatment involving behavioral modification techniques in which reinforcement, either positive or negative, is used to encourage or reduce certain behaviors. The treatment is delivered in a highly structured and intensive program with one-to-one instruction by a certified therapist.

Approved Drug List. A list of covered drugs that identifies tier placement and any utilization management (such as Prior Authorization, step therapy, and quantity limits) that are required. Tier placement determines what you pay for the drug, outlined in your *Schedule of Medical Benefits*.

Tier 1: This tier includes low-cost generic drugs—proven to be as safe as brand name drugs—and, on some formularies, select brand name drugs.

Tier 2: Includes preferred and lower cost brand name drugs, and some higher cost generic drugs. If you must take a brand name drug, we recommend working with your physician to choose one that is covered here, and the most affordable.

Tier 3: Non-preferred and expensive brand name drugs, as well as higher-cost generic drugs. These drugs may cost you a significant amount out of pocket, we recommend asking your physician if a tier 1 or 2 option can be prescribed instead.

Tier 4: Includes very expensive brand name and generic drugs, and preferred specialty drugs used to treat complex conditions. Specialty drugs often have high costs and may have special handling or storage requirements. They are usually dispensed by trained personnel at specialty pharmacies. If you need to take a specialty drug, we recommend working with your physician to choose one that is covered here.

Tier 5: Non-preferred specialty drugs, and the most expensive brand name and generic drugs are covered here because they offer limited clinical value. Most have a similar lower-cost option offering the same clinical value on tiers 1 through 4. We recommend asking your physician about alternatives.

Autism Spectrum Disorder. A developmental disorder of brain function which is classified as one of the pervasive developmental disorders. For purposes of this Plan, Autism Spectrum Disorder is treatment coverage for diagnosis of Autistic Disorder, Unspecified Pervasive Developmental Disorder, and Other Pervasive Developmental Disorders (Asperger's Disorder, Rhetts Disorder).

Autism Spectrum Disorders Treatment Plan. A written, comprehensive and individualized intervention plan that incorporates specific treatment goals and objectives. The Plan is (a) developed by a health professional who has the appropriate behavioral health credentials and who is operating within his or her scope of practice when the treatment of an Autism Spectrum Disorder is first prescribed; or (b) ordered by a physician or licensed psychologist.

Balance Billing. When a non-participating provider bills you for the difference between the provider's charge and the allowed amount. For example, if a non-participating provider charge is \$100.00 and the allowed amount for the service is \$70.00, the non-participating provider may bill you for the \$30.00 difference between the charge amount and the allowed amount. A participating provider may not balance bill you.

Behavioral Health Department. The department that assesses and arranges inpatient mental health and substance use disorder services for covered participants. The department is available for assessment 24 hours a day.

Benefit Administrator. PRIORITY HEALTH MANAGED BENEFITS, INC., 1231 East Beltline, NE, Grand Rapids, MI 49525-4501.

Benefit Maximum. The amount or day/visit maximum that will be paid out by the Plan for an individual benefit per participant while enrolled under this Plan. Benefit maximum amounts are as shown in the *Schedule of Medical Benefits*.

Brand Name Drug. A prescription drug approved by the Food and Drug Administration (FDA) that is protected by a patent, supplied by a single company and marketed under the manufacturer's brand name.

Child Placed for Adoption. A child in your custody for whom you have assumed and retain a legal obligation to provide partial or total support in anticipation of adoption.

CHIP/CHIPRA. A state's Children's Health Insurance Program under the Children's Health Insurance Program Reauthorization Act of 2009.

Chiropractor. A person who is licensed by the state to practice chiropractic care, a method of treating disease by the manipulation of body joints, especially of the spine.

COBRA. The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Coinsurance. The percentage of covered health care costs for which the covered person has a financial responsibility, usually according to a fixed percentage. Often coinsurance applies after first meeting a deductible requirement.

Coinsurance Maximum. Your total percentage cost sharing for covered services that you pay in a plan year. Your coinsurance maximum applies toward your out-of-pocket limit. The *Schedule of Medical Benefits* provides information regarding your coinsurance maximum and any exclusions that apply to your coinsurance maximum.

Complications of Pregnancy. Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Examples of such conditions include acute nephritis, nephrosis, cardiac decompensation, missed abortion, hyperemesis gravidarum, pre-eclampsia, and similar medical and surgical conditions of comparable severity. It also includes conditions such as termination of ectopic pregnancy, and spontaneous termination of pregnancy, occurring during a period of gestation in which a viable birth is not possible. It does not include medically/clinically necessary or emergency cesarean section, false labor, occasional spotting, physician-prescribed rest during a pregnancy, morning sickness and similar conditions associated with the management of a difficult pregnancy not constituting a distinct complication of pregnancy.

Congenital Birth Defect. A condition that is present at birth.

Continuing Care Patient. An individual who, with respect to a provider or facility (a) is undergoing a course of treatment for a serious and complex condition from the provider or facility; (b) is undergoing a course of institutional or inpatient care from the provider or facility; (c) is scheduled to undergo nonelective surgery from the provider or facility, including receipt of postoperative care from such provider or facility with respect to such a surgery; (d) is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or (e) is or was determined to be terminally ill and receiving treatment for such illness from such provider or facility.

Copayment. The amount you must pay directly to a provider of covered services for those services and supplies. The copayments are listed in the *Schedule of Medical Benefits*.

Note: For the HDHP medical benefit option, copayments apply after first meeting a deductible requirement and the copayments apply as shown in the *Schedule of Medical Benefits*.

Note: For covered services with a flat dollar copayment, your cost share will be the lesser of the stated copayment or the allowed amount for the covered service. The allowed amount is the maximum amount on which payment is based for the covered service.

Covered Services, Covered Expenses, Coverage, Covered or Cover. Those services and supplies that you are entitled to under this Plan, if they are medically/clinically necessary and you have met all other requirements of the Plan. The Plan might limit payments for some of those services and supplies. When we say the Plan will “cover” a service or supply that means the Plan will treat the service or supply as a covered service. When we say the Plan will “cover” an expense, that means the Plan will treat it as a covered expense and pay the expense, subject to limitations in this PDSPD and the *Schedules of Benefits*.

Custodial Care. Care you receive if, in our opinion, you have reached the maximum level of mental and/or physical function and you will not improve significantly more. This type of care includes room and board, therapies, nursing care, home health aides and personal care designed to help you in the activities of daily living and home care and adult day care that you receive, or could receive, from a member of your family.

Deductible. The amount of covered expenses for covered services that a participant must incur during the benefit/plan year before the Plan will pay benefits as shown in the *Schedule of Medical Benefits*.

Note: For the HDHP medical benefit option, at the network level, deductibles apply to all covered services except certain preventive health care services and routine maternity care. For the non-network level, deductibles apply to all covered services. Deductibles are listed on the *Schedule of Medical Benefits* of this Plan.

Dependent. Any dependent of the employee: (a) who meets the eligibility requirements explained in this PDSPD; (b) who has been enrolled as required by this PDSPD; and (c) for whom all required participant contributions have been paid.

Disabled or Disability. Under the Social Security Act, you are disabled or have a disability if, taking into account your age, education and past work experience, you are unable to perform any substantial gainful activity by reason of a medically determinable physical or mental impairment or a combination of impairments, which can be expected to result in death or which has lasted or can be expected to last at least 12 consecutive months.

Durable Medical Equipment. Equipment that is: (a) made for repeated use; (b) mainly used for a medical purpose; (c) appropriate to use at home; and (d) generally not useful unless a person has an illness or injury.

Effective Date. The effective date of the Plan; the date you are eligible for coverage as defined in the *Eligibility* section of this PDSPD.

Emergency Medical Condition. An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

Emergency Transportation. Ambulance services for an emergency medical condition.

Emergency Room Care. Emergency services you get in an emergency room.

Emergency Services. Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

Employee. An employee is a person: (a) who meets all applicable eligibility requirements of the Plan; (b) who has enrolled for coverage; and (c) has paid any applicable participant contributions.

Enrollment Date. The first date of coverage under the Plan, or if there is a waiting period, the first day of the waiting period. The waiting period is any period that must pass before you are eligible to enroll under the terms of this Plan.

ERISA. The Employee Retirement Income Security Act of 1974, as amended.

Excluded Services. Health care services that your health plan doesn't pay for or cover.

Experimental, Investigational or Unproven Services. The Benefit Administrator uses the following criteria when evaluating new technologies, procedures and drugs:

- Evidence of clear therapeutic effectiveness when used in the general population as demonstrated in peer-reviewed clinical trials.
- Evidence of patient safety when used in the general population.
- Evidence that the medical community in general accepts the safety and effectiveness of the service outside of investigational setting.
- Evidence of clinical meaningful outcomes.
- Evidence that clinically meaningful outcomes can be attained at a reasonable cost.

FMLA. The Family and Medical Leave Act of 1993, as amended.

Generic Drug. A prescription drug approved by the Food and Drug Administration (FDA) that is produced and distributed without patent protection and contains the same active ingredient as the brand name drug.

Genetic Information. Information about the genetic tests of an individual or his family of covered individuals, and information about the manifestations of disease or disorder in family covered individuals of the individual. A “genetic test” means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, which detects genotypes, mutations, or chromosomal changes. It does not mean an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved. Genetic information does not include information about the age or gender of an individual.

GINA. The Genetic Information Nondiscrimination Act of 2008 (Public Law No. 110-233), which prohibits group health plans, issuer of individual health care policies, and employers from discriminating on the basis of genetic information.

Health Care Reform. The provisions of the Patient Protection and Affordable Health Care Act (PPACA), as amended by the Health Care and Education Reconciliation Act (Reconciliation Act), applicable to group health plan coverage to the fullest extent allowed by law.

Health Professional. An individual licensed, certified or authorized under state law to practice a health profession.

HIPAA. The Health Insurance Portability and Accountability Act of 1996, as amended.

Home Health Care. Health care services a person receives at home.

Hospice Care. Services for the terminally ill and their families, including pain management and other support services.

Hospital. An appropriately licensed acute care institution that provides inpatient medical care and treatment for ill and injured persons through medical, diagnostic, and major surgical facilities. All services must be provided on its premises under the supervision of a staff of physicians and with 24-hour nursing and physician services.

Hospital Inpatient Care. Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for hospital observation care may be considered outpatient care.

Hospital Observation Care. Short term treatment and monitoring that is provided on an outpatient basis. This type of care is commonly provided after you visit an emergency room to allow health professionals to determine if you can be discharged or if you need to be admitted as an inpatient for additional treatment. Hospital observation care is typically limited to 24-48 hours. Even when you are required to stay at the hospital overnight, if you are receiving observation care, you have not been admitted as an inpatient. See your *Schedule of Medical Benefits* for information about your hospital outpatient care benefit.

Hospital Outpatient Care. Care in a hospital that usually doesn't require an overnight stay.

Household Member Program (Domestic Partnership). Under the Household Member Program, a GVSU faculty/staff member who does not already enroll a spouse in the health plans may enroll one adult individual for benefit coverage, but only if all of the following eligible criteria are met:

- The faculty/staff member is eligible for GVSU's benefits.
- The household member, at the time of proposed enrollment, resides in the same residence as the faculty/staff member and has done so for the previous 18 continuous months, other than as a tenant.
- The household member is not a dependent of the employee as defined by the IRS.

Children of a household member are also eligible for this benefit if they are members of the faculty/staff member's household and meet IRS dependent criteria as well as the GVSU's dependent coverage policy (up to 26, or while a student).

Eligibility for coverage of a household member, or of a household member's dependent, ceases on the date that the above criteria are not met.

The following individuals are not eligible for participation in this program:

- Children of faculty/staff and their descendents (children, grandchildren).
- Parents of faculty/staff.
- Parents' other descendents (siblings, nieces, nephews).
- Grandparents and their descendents (aunts, uncles, cousins).
- Renters, boarders, tenants.

This program does not affect the rights of or criteria applicable to any faculty/staff member qualifying for enrollment in GVSU's benefit plans under any other applicable university policy. Household member enrollment must be completed during the open enrollment period or no more than 30 days after all of the above criteria are met.

Ill or Illness. A sickness or a disease, including congenital defects or birth abnormalities.

Incapacitated Dependent. A dependent is eligible for coverage as an incapacitated dependent if the dependent meets the requirements of the *Eligibility* section of this Plan.

Infertility. Incapable of producing offspring.

Injury or Injured. Accidental bodily injury including all related conditions and recurrent symptoms.

Intellectual Disabilities. Disabilities characterized by significant limitations both in intellectual functioning and in adaptive behavior, which covers many everyday social and practical skills originating before the age of 18.

Local Unit of Government. A self-funded health plan that is established or maintained by a political subdivision of this state, including, but not limited to, school districts, community and junior colleges, state universities, cities, villages, townships, charter townships, counties, charter counties, authorities created by the state, and authorities created by other local units of government.

Medicaid. Title XIX of the Social Security Act, as amended.

Medical Director. A duly licensed physician designated by the Benefit Administrator to supervise and manage the medical aspects of the Plan.

Medical Emergency. The sudden onset of an illness or injury, symptom or condition serious enough such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect that not seeking immediate medical attention could reasonably be expected to result in serious harm to your health, serious jeopardy to a pregnancy, serious impairment to bodily functions, or death.

Medically/Clinically Necessary. The services or supplies needed to diagnose or treat your physical or mental condition. Whether services or supplies are medically/clinically necessary is determined in accordance with Priority Health’s medical and behavioral health policies or adopted criteria that have been approved by community physicians and other providers. The determination is made by Priority Health’s Medical Director, or anyone acting at the medical director’s direction, in consultation with other physicians. Medically/clinically necessary mental health and substance use disorder services are determined by the Priority Health Behavioral Health Department.

In order to be considered medically/clinically necessary, the services or supplies must:

- be widely accepted as effective;
- be appropriate for the condition or diagnosis;
- be essential, based upon nationally accepted evidence-based standards;
- cost no more than a treatment that is likely to yield a comparable health outcome; and
- is the most appropriate level of care and site of service which can be safely and reasonably provided to you.
- for procedural services:
 - be surgically appropriate for the condition or diagnosis based on nationally accepted, evidence-based standards;
 - be personally appropriate following use of a shared decision making process to insure full informed consent; and
 - be medically appropriate based on adequate management of medical comorbidities and risk factors for death or complications.

The determination of whether proposed care is a covered service is independent of, and should not be confused with, the determination of whether proposed care is medically/clinically necessary.

Medicare. Title XVIII of the Social Security Act, as amended.

Mental Health Treatment Facility. A mental health treatment facility is a facility that: (a) meets applicable licensing standards; (b) provides a program for the diagnosis, evaluation and treatment of mental health conditions; (c) provides all normal infirmity-level medical services and arranges with a hospital for any other medical service that may be required; (d) is under the supervision of a psychiatrist; and (e) provides skilled nursing care by licensed nurses, who are directed by a registered nurse.

Morbid Obesity. A Body Mass Index (BMI) that is greater than or equal to 40 kg/m². If there are serious (life-threatening) medical condition(s) exacerbated by, or caused by obesity not controlled despite maximum medical therapy and patient compliance with medical treatment plan, a BMI greater than or equal to 35 kg/m² is applied. Morbid obesity for a covered person who is less than 19 years of age means a BMI that falls above the 95th percentile on the growth chart.

Motor Vehicle. Except as this PDSPD specifically provides otherwise, a motor vehicle means an automobile, trailer or any other vehicle that has more than two wheels and is operated or designed for operation on a public highway by power other than muscular power. A motor vehicle does not include a motorcycle, dirt bike, moped, all-terrain vehicle (“ATV”), off road vehicle (“ORV”), farm tractor or other implement of husbandry that is not subject to the requirements of a vehicle code.

Motorcycle. A two- or three-wheeled vehicle that is equipped with a motor that exceeds 50 cubic centimeters (cc) engine displacement. The number of wheels on any attachment to the vehicle will not count toward the number of wheels on the vehicle. A vehicle that is commonly recognized as an “off-road vehicle” (ORV) or “all-terrain vehicle” (ATV) shall not be deemed to be a motorcycle, nor will the off-road operation of a motorcycle cause it to be deemed instead an ORV or ATV.

Network. An organization that contracts with providers to provide discounted services to covered participants.

Network Provider. A health professional or other entity that contracts with the Benefit Administrator or a designated entity to provide network services to participants.

Network Services, Network Benefits. Except as specifically provided by this PDSPD, services rendered by a network provider. These services are covered as described in the *Medical Benefits* section of this PDSPD.

Newborn. A child 30 days old or younger.

NMHPA. The Newborns' and Mothers' Health Protection Act.

No-Fault Auto Insurance. The basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

Non-Covered or Excluded Services. Health care services that this Plan does not pay for or cover.

Non-Network Provider. A health professional or other entity who has not contracted with the Benefit Administrator or designated entity to provide network services to participants.

Non-Network Services, Non-Network Benefits, Non-Network. Services obtained from non-network providers. These services are covered as described in the *Medical Benefits* section of this PDSPD.

Non-Occupational Illness and Non-Occupational Injury. An illness or injury that does not arise out of (or in the course of) any work for pay or profit, and does not in any way result from an illness or injury that does arise from work for pay or profit. If we (or the Benefit Administrator) obtain proof that you are covered under a worker's compensation law or similar law, but that you are not covered for a particular illness or injury under that law, that illness or injury will be considered "non-occupational" regardless of cause.

Nurse Midwife. An individual licensed as a registered professional nurse who has been issued a specialty certification in the practice of nurse midwifery.

Open Enrollment Period. A period of time established by the Plan Administrator during which eligible employees and their eligible dependents may be enrolled as participants.

Out-of-Pocket Limit. The maximum amount of deductibles, copayments and coinsurance you will pay for covered services in a plan year. Once you reach this overall maximum, covered services will be covered at 100% with no cost to you. The *Schedule of Medical Benefits* provides information regarding your out-of-pocket limit and any exclusions that apply to your out-of-pocket limit.

Participant. A person enrolled with the Plan as an employee or covered dependent.

Pharmacy. An establishment where prescription drugs are legally dispensed.

Physician. A licensed medical doctor (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) or surgeon.

Plan. The health care plan maintained by us, including the plan document, this PDSPD, the *Schedules of Benefits*, all amendments and attachments.

Plan Administrator and Named Fiduciary. Grand Valley State University is the Plan Administrator and Named Fiduciary of the Plan. As the Plan Administrator, Grand Valley State University has the authority to control and manage the operation and administration of the Plan. Grand Valley State University has the responsibility and discretionary authority to review and make final decisions on all determinations of eligibility and all claims to benefits and to interpret the provisions of the Plan for purposes of resolving any inconsistency or ambiguity, making any factual determination, correcting any error, or supplying information to correct any omission in the Plan.

Plan Document. The document that addresses the establishment, administration and other aspects of the Plan.

Plan Year. The 12-month period beginning each January 1 and ending each December 31 that corresponds to the period on which the Plan is reported for Form 5500 Series purposes and on which benefit limitations and maximums are calculated.

Predecessor Plan. The group health plan maintained immediately before the effective date of this Plan.

Prescription Drug Assistance Program. Includes, but is not limited to, the following:

- Manufacturer Co-payment Assistance Programs
- Non-Profit Foundation Co-payment Grants
- Manufacturer Free Drug Programs
- Disease-Based Healthcare Grants
- Government-Sponsored Programs
- Prescription Savings Clubs, including organizations such as Amazon, GoodRx, etc.

Prescription Drug Coverage. Health plan benefits that help pay for prescription drugs and medications.

Prescription Drugs. Drugs and medications that by law require a prescription.

Preventive Health Services. Routine care described in Priority Health's preventive health care guidelines that are designated to maintain an individual in optimum health and to prevent unnecessary injury, illness or disability. These guidelines are available in the member center on Priority Health's website at priorityhealth.com or from Priority Health's Customer Service Department. Priority Health's guidelines are based on federal requirements for coverage of preventive health care services contained in Section 1001 of the Patient Protection and Affordable Care Act (PPACA) available at healthcare.gov.

Preventive Health Services means care consistent with IRS Code §223(c)(2)(c) and as listed in the *Schedule of Medical Benefits*, that can be paid by a high deductible health plan (HDHP) without the covered person satisfying the minimum deductible under the Plan.

Primary Care. Medical care received from a physician practicing in any of the following fields: Family Practice, General Practice, Gynecology, Internal Medicine, Obstetrics & Gynecology, Pediatrics, and Internal Medicine Pediatrics.

Prior Certify, Prior Certification, Prior Authorized or Prior Authorization. The process the Benefit Administrator uses to determine whether services or supplies are covered or not covered under the Plan. It may also include a decision to partially cover a service. See the *Prior Certification* section of the Plan for more information about when and how to obtain prior certification.

Provider. A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care facility, licensed, certified or accredited as required by state law.

Qualified Medical Child Support Order (QMCSO). A court order, judgment or decree issued by a court of competent jurisdiction providing for child support or health benefit coverage for a child of a participant, provided the order, judgment or decree meets all requirements established by law.

Qualified Payment Amount (QPA). The QPA is used to determine the cost-sharing amount you will pay for Surprise Billing Services. The QPA is based off what participating providers or facilities in the same geography are typically reimbursed for the service.

Reasonable and Customary Charges. Except as otherwise specified in this Plan, the maximum amount the Benefit Administrator will allow for non-participating providers for any covered service, will be the lesser of: (a) the provider's usual charge for furnishing the service; or (b) the charge we determine to be the prevailing charge level for the service or supply. Criteria considered in setting the reasonable and customary charge for a particular service or supply may include the complexity of the service, the range of services provided by a facility and geographical factors. With respect to medical emergency services performed within an emergency department of a hospital by a non-network provider and other Surprise Billing Services, whenever it states reasonable and customary within the Plan, the Plan will pay the QPA. If the covered service provided by a non-participating provider is **not** a Surprise Billing Service, the plan participant may be responsible for the balance remaining from the provider's charges less the Plan's payment. However, the Benefit Administrator will negotiate with the provider to eliminate participant responsibility for balance billing from non-participating providers resulting from a medical emergency.

Reconstructive Surgery. Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

Rehabilitative Medicine Services. Services that are restorative in nature and result in a meaningful improvement in your ability to perform functional day-to-day activities that are significant in your life role. These services may include physical, occupational and speech therapy, cardiac and pulmonary rehabilitation, and osteopathic and chiropractic manipulations.

Rescind or Rescission. To retroactively terminate coverage under the Plan.

Reside, Residence, Residency, or Resident. The physical presence of a plan participant at a particular address with the intention to permanently remain at that address. For purposes of this definition, “permanently remain” at an address shall refer to a period of time longer than 180 days. Proof of residence shall be evidenced by utility bills, rent or mortgage documents, voter registration, driver’s license, or other such verification when requested by the Plan.

Residential Treatment. Treatment provided in a state-licensed subacute facility with structured, licensed health care professionals. This treatment must be medically-monitored and must include access to the following: (i) medical services twenty-four (24) hours per day, seven (7) days per week; (ii) nursing services twenty-four (24) hours per day, seven (7) days per week; and (iii) physician emergency on call availability twenty-four (24) hours per day, seven (7) days per week. Services provided in a licensed foster-care facility serving as an individual’s residence are not covered and do not meet the definition of “Residential Treatment.”

Retail Health Clinic. A category of walk in clinic located in retail stores, supermarkets and pharmacies within the United States that treat uncomplicated minor illnesses and provide some preventive health care services.

Retail Pharmacy Services. Prescription drugs obtained at a retail participating pharmacy or through the mail order service. In general, covered retail pharmacy drugs are treated as outpatient prescription drug benefits when they can be self-administered regardless of the setting. Exceptions to this rule are outlined in the Benefit Administrator’s medical policies.

Schedule of Medical Benefits. The document that outlines how benefits will be paid for covered services received at either the network or non-network benefits level, including copayments, coinsurance and deductibles. It also lists any maximum limitations that apply to your health care benefits.

Service Area. The geographical area, designated by the Benefit Administrator or its designee that encompasses the boundaries of the provider network. The Benefit Administrator or its designee publishes precise service area boundaries and you may obtain that information from the Benefit Administrator’s Customer Service Department.

Skilled Nursing, Subacute or Rehabilitation Facility. A facility that is appropriately licensed to provide services in lieu of acute care in a hospital, including skilled nursing care and related services, subacute services and short-term rehabilitative therapy on an inpatient basis.

Special Enrollment Period. A period of enrollment other than an open enrollment period or enrollment period for newly eligible employees, during which an individual with special enrollment rights may elect to enroll in this Plan. The *Enrollment* section of this PDSPD describes the circumstances under which special enrollment rights are available.

Specialist or Specialist Provider. A physician who focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.

Specialty Drugs. Drugs listed in the approved drug list meeting certain criteria, such as drugs or drug classes whose cost on a per-month or per-dose basis exceeds the threshold established by the Centers for Medicare and Medicaid Services; or drugs that require special handling or administration; or drugs that have limited distribution; or drugs in selected therapeutic categories.

Specialty Pharmacy. A pharmacy that specializes in the handling, distribution, and patient management of specialty drugs.

Substance Use Disorder Treatment Facility. A substance use disorder treatment facility is a facility that: (a) meets licensing standards; (b) provides a program for diagnosis, evaluation and treatment of substance use disorder; (c) provides, on its premises, 24 hour detoxification services, infirmary level medical services or arranges with a hospital for any other medical services that may be required; (d) provides supervision by a staff of physicians, and; (e) provides skilled nursing care by licensed nurses who are directed by a registered nurse.

Summary of Material Modifications (SMM). A summary provided to participants that describes any material modifications made to the Plan through amendments.

Surprise Billing Services. As described in the Federal No Surprises Act, Surprise Billing Services are (1) Emergency Services provided by non-participating providers and non-participating emergency facilities including emergency air ambulance transportation; (2) post-stabilization services where non-medical travel to a participating provider or facility is not medically reasonable; and (3) services provided by non-participating providers in participating facilities where you do not consent to waive balance billing protections.

Urgent Care. Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

Urgent Care Center. A licensed facility, not including a hospital emergency room, which provides urgent care for the immediate treatment of an injury or illness.

USERRA. The Uniformed Services Employment and Reemployment Rights Act of 1994.

We, Us, Our or Company. Grand Valley State University.

WHCRA. The Women's Health and Cancer Rights Act of 1998.

You, Your or Yourself. Plan participants, whether enrolled with the Plan as an employee or covered dependent.

SECTION 21. GENERAL PROVISIONS

Independent Contractors.

Neither the Company, nor the Benefit Administrator directly provides any health care services under the Plan, or have a right or responsibility to make medical treatment decisions. Only you, in consultation with your health professionals may make medical treatment decisions. Network providers and other health professionals provide health care services as independent contractors. We assume no responsibility for participating providers and other health professional's treatment of you, their competency, or their acts or omissions. We are only obligated to provide participants a network of health care services.

Neither the Company, nor the Benefit Administrator will be liable for any claim or demand for injury or damage arising out of or in connection with the manufacturing, compounding, dispensing, or use of any prescription drug, or any other item, whether or not covered by the Plan.

The Company (in coordination with the Benefit Administrator) is responsible for making benefit determinations under the Plan and its contracts with network providers, consistent with terms of the Plan and subject to our ultimate discretion and control. Physicians and health professionals alone are responsible for making independent medical judgments.

You and your physician or health professional may begin or choose to continue medical treatment even if we deny coverage for those treatments. You will be responsible for the cost of those treatments. You (with your physician or health professional) may appeal any of our benefit decisions. Any inquiry, appeal or dispute must follow the procedure explained in the *Appeals* section of this PDSPD.

Entire Agreement.

The Plan (including the PDSPD, the *Schedule of Medical Benefits*, and any document expressly incorporated by reference into this PDSPD) constitutes the entire agreement. All previous negotiations, representations, or agreements are merged and void unless expressly incorporated into these documents (or into documents expressly incorporated herein by reference).

Non-Assignment.

Benefits are not subject to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution, or levy ("assignment") before actual receipt. Any assignment that violates this section is void. The right to receive a benefit under the Plan shall not be considered an asset in divorce, insolvency, or bankruptcy. This section shall not prevent direct billing by and payment to a provider.

Employment Rights.

The Plan does not create any employment rights nor restrict the Company's right to discharge an employee.

Participants' Rights.

The Plan does not give any employee or beneficiary: any interest in the Company's assets, business or affairs; the right to question any Company action or policy; or the right to examine the Company books and records. The rights of all participants are limited to the right to receive payment of benefits when due.

Severability.

If any provision of this Plan shall be contrary to its governing law, any other applicable statute or the purpose of intent of the Plan, the Plan shall remain in effect. The illegal provision shall be severed from the Plan and shall be of no effect to the extent and for the duration of the violation.

Construction.

Provisions shall be interpreted to maintain the tax qualification and benefit of the Plan and consistent with the express purpose and intention of the Plan. The use of the singular includes the plural and vice versa where applicable.

Conformity with Applicable Law.

This Plan is intended to conform to all laws and regulations that govern self-funded plans. If any part of this Plan is contrary to any applicable law or regulation, it will be deemed amended to the extent necessary to comply with the laws and regulations.

Conformity with the Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act.

This Plan is intended to meet, but not exceed, any requirements of the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act (collectively, PPACA”). If any part of this Plan does not comply with PPACA or appears to exceed the requirements of PPACA, it shall be deemed amended to the extent necessary to meet compliance.

Discretionary Authority of Plan Administrator.

The Plan Administrator has the responsibility and discretionary authority to review and make final decisions on all determinations of eligibility and all claims to benefits and to interpret the provisions of the Plan for purposes of resolving any inconsistency or ambiguity, making any factual determination, correcting any error, or supplying information to correct any omission in the Plan.

Mental Health Parity.

Pursuant to the Mental Health Parity and Addiction Equity Act of 2008, this Plan applies its term uniformly and enforces parity between covered health care benefits and covered mental health and substance disorder benefits relating to financial cost-sharing restrictions and treatment-duration limitations.

Genetic Information Nondiscrimination Act of 2008 (GINA).

Notwithstanding any provision of this Plan to the contrary, this Plan shall be operated and maintained in a manner consistent with GINA.

Uniformed Services Employment and Reemployment Right Act of 1994. (USERRA).

Notwithstanding any provision of this Plan to the contrary, this Plan shall be operated and maintained in a manner consistent with USERRA. The Plan Administrator shall, within the parameters of the law, establish uniform policies by which to provide such continuation coverage required by USERRA. See the *Continuation of Coverage* section of this Plan for further information regarding USERRA.

Legal Entity.

This Plan is the legal entity. Legal notice may be filed with, and legal process service upon, the Plan Administrator.

Workers’ Compensation Not Affected.

This Plan is not in lieu of and does not affect any requirement for coverage by workers' compensation insurance.

Recovery of Overpayment.

If the Plan pays benefits which should not have been paid under the Plan or pays benefits in excess of what should have been paid under the Plan, the Plan Administrator shall have the right to recover such payment of excess from any individual, insurance company, or other third-party payer, provider, or any other organization to or for whom the payment was made. Recovery may be in the form of an offset against future amounts owed under the Plan, by a lump-sum refund payment, or by any other method as the Plan Administrator, in its sole discretion, may require.

Information Received by Customer Service.

Information received during a customer service call concerning eligibility and/or covered services is not a guarantee of payment or verification of eligibility. Any payment of covered services or eligibility is subject to all the terms, conditions, limitations, and exclusions of your coverage on the date services are provided.

High Deductible Health Plan (HDHP) Benefit Option.

The HDHP benefit option of this Plan is intended to meet the “High Deductible Health Plan” requirements set forth in Section 223 of the Internal Revenue Code (IRC) and its subsequent notices, revenue rules, revenue procedures and amendments, if any, for the HDHP benefit option. If any part of the HDHP option of this Plan, including the *Schedule of Medical Benefits* or any amendments, does not conform to the IRC High Deductible Health Plan requirements, we will interpret it to conform to the IRC High Deductible Health Plan requirements, and amend the Plan accordingly.

The amended and restated Grand Valley State University Group Benefit Plan is adopted, by execution hereof, effective as of January 1, 2023.

GRAND VALLEY STATE UNIVERSITY

BY: _____
Grand Valley State University

ITS: _____

DATE: _____