Kalamazoo College, G-1013

Benefit Description	Black Plan		Orange Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Benefit Year	January 1 through December 31		January 1 through December 31	
Comprehensive Medical Benefit Total Deductible per Benefit Year	$1,000/person $2,000/family	$1,500/person $3,000/family	$0/person $0/family	$500/person $1,000/family
• Employee's Deductible Responsibility	50% of the eligible charge to the following maximums: $500/person $1,000/family	The MRA does not reimburse out-of-network deductibles; total deductible charges are paid by the covered person or family	$0/person $0/family	$500/person $1,000/family
• Kalamazoo College's Deductible Responsibility Kalamazoo College's deductible responsibility will be paid via a Medical Reimbursement Account (MRA).	50% of the eligible charge to the following maximums: $500/person $1,000/family	The MRA does not reimburse out-of-network deductibles; total deductible charges are paid by the covered person or family	Not applicable; the Orange Plan does not have an MRA	Not applicable; the Orange Plan does not have an MRA
General Benefit Percentage	90% after deductible (10% coinsurance)	70% after deductible (30% coinsurance)	100% (0% coinsurance)	80% after deductible (20% coinsurance)
Coinsurance Maximum Out-of-Pocket per Benefit Year	$1,000/person $2,000/family	$1,500/person $3,000/family	Not applicable	$1,500/person $3,000/family
Total Maximum Out-of-Pocket per Benefit Year (Includes Deductible, Coinsurance, Medical Co-payments, and Prescription Drug Co-payments)	$7,150/person $14,300/family	Not applicable	$7,150/person $14,300/family	Not applicable
Special Notes about the Comprehensive Medical Benefit: 1. An individual within a family has to meet only the per-person deductible specified above before the Plan will begin paying benefits. Additionally, an individual within a family has to meet only the per-person Coinsurance Maximum Out-of-Pocket before the Plan's general benefit percentage will increase to 100% for the remainder of the Benefit Year for the applicable benefit tier or the per-person Total Maximum Out-of-Pocket for In-Network charges before medical and prescription drug co-payments will no longer be charged for the remainder of the Benefit Year. 2. The deductible and Coinsurance Maximum Out-of-Pocket do not include co-payments of any type or medical- and prescription drug-related expenses that constitute a penalty for noncompliance, exceed the usual and customary charge allowed by the Plan, exceed the limits of the Plan, or are otherwise excluded. There is no concurrent accrual of deductible or Coinsurance Maximum Out-of-Pocket amounts; in-network and out-of-network amounts are separate. 3. The Total Maximum Out-of-Pocket amounts do not include medical- and prescription drug-related expenses that constitute a penalty for noncompliance, exceed the usual and customary charge, exceed limits of the Plan, or are otherwise excluded.				
Outpatient Physician Services (Includes Office Visits, Telemedicine E-Visits, and Second Surgical Opinions) Physician's Fee for an Examination	*Telemedicine E-Visits Billed by Amwell*: $-0- co-payment per visit, then 100% (deductible waived) Contact Amwell at (844) 733-3627 or www.amwell.com *Non-Specialist Office and Telemedicine E-Visits:* $20 co-payment per visit, then 100% (deductible waived)	*Telemedicine E-Visits Billed by Amwell*: Not applicable *Non-Specialist Office and Telemedicine E-Visits:* 70% after deductible	*Telemedicine E-Visits Billed by Amwell*: $-0- co-payment per visit, then 100% Contact Amwell at (844) 733-3627 or www.amwell.com *Non-Specialist Office and Telemedicine E-Visits:* $10 co-payment per visit, then 100%	*Telemedicine E-Visits Billed by Amwell*: Not applicable *Non-Specialist Office and Telemedicine E-Visits:* 80% after deductible

Benefit Description	Black Plan		Orange Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Outpatient Physician Services, cont. Physician's Fee for an Examination	*Specialist Office and Telemedicine E-Visits:* $35 co-payment per visit, then 100% (deductible waived)	*Specialist Office and Telemedicine E-Visits:* 70% after deductible	*Specialist Office and Telemedicine E-Visits:* $10 co-payment per visit, then 100%	*Specialist Office and Telemedicine E-Visits:* 80% after deductible
All Other Charges Billed in Connection with the Examination	Paid the same as any other illness; annual frequency limits and cost-sharing provisions such as deductibles, coinsurance, or co-payments may apply depending upon the type of service rendered	Paid the same as any other illness; annual frequency limits and cost-sharing provisions such as deductibles, coinsurance, or co-payments may apply depending upon the type of service rendered	Paid the same as any other illness; annual frequency limits and cost-sharing provisions such as deductibles, coinsurance, or co-payments may apply depending upon the type of service rendered	Paid the same as any other illness; annual frequency limits and cost-sharing provisions such as deductibles, coinsurance, or co-payments may apply depending upon the type of service rendered
Special Notes about the Outpatient Physician Services Benefit: 1. Eligible charges for outpatient miscellaneous medical supplies, anesthesia, surgery, diagnostic X-rays, diagnostic lab tests, and infusion/injection therapy performed by an in-network provider and billed with a place of service code "11" (physician's office) or "20" (urgent care center) shall be paid at 100% and all applicable deductible amounts shall be waived. The co-payment applicable to the physician's exam will still be assessed. However, this benefit does not apply to advanced types of X-rays, imaging services, and nuclear radiology services billed by a physician's office or urgent care center. 2. The term "Non-Specialist" means a physician, physician's assistant, nurse practitioner, or other eligible provider who provides Medical Care in family practice, general practice, outpatient or intensive outpatient behavioral care services, internal medicine, obstetrics and gynecology, or pediatrics. For the purposes of this benefit, the term "Medical Care" does not include any services otherwise addressed in this handout (e.g., chiropractic care). The term "Specialist" means a physician with advanced education and training in a recognized medical specialty who is not a Non-Specialist as defined above. Specialists are often licensed or certified in their medical specialty.				
Routine Preventive Care Physician's Fee for an Examination Routine X-Rays and Lab Tests Flu Shots and Other Routine Immunizations FDA-Approved Contraceptive Methods and Sterilization Procedures for Women with Reproductive Capacity Mammograms, Colonoscopies, and Other Routine Services	100%; deductible waived	70% after deductible	100%	80% after deductible
Special Notes about Routine Preventive Care: 1. Coinsurance or an office visit co-payment may be imposed on preventive care services if either the visit is billed separately from the preventive care service or the services are provided during an office visit whose primary purpose is not preventive care (and the services are not billed separately). 2. The Routine Preventive Care Benefit will provide coverage for certain evidence-based items (with A or B ratings) in the recommendations of the United States Preventive Services Task Force; routine immunizations, including those immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (see the preventive care summary on the Claim Administrator's Website for a list of these immunizations); evidence-based preventive care and screenings for infants, children, and adolescents provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and additional women's preventive care and screenings in comprehensive guidelines supported by the HRSA.				
Routine Immunizations Administered in a Pharmacy or at the Department of Community Health (Includes Injection Fee Charges)	100%; deductible waived	100%; deductible waived	100%	100%; deductible waived
Special Note about the Routine Immunizations Benefit: The covered person may have to initially pay for these charges in full and then submit the expense directly to the Claim Administrator for reimbursement.				

Benefit Description	Black Plan		Orange Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Urgent Care Center Visits Physician's Fee for an Examination	$50 co-payment per visit, then 100% (deductible waived)	70% after deductible	$20 co-payment per visit, then 100%	80% after deductible
All Other Charges Billed in Connection with the Examination	Paid the same as any other illness; annual frequency limits and cost-sharing provisions such as deductibles, coinsurance, or co-payments may apply depending upon the type of service rendered	Paid the same as any other illness; annual frequency limits and cost-sharing provisions such as deductibles, coinsurance, or co-payments may apply depending upon the type of service rendered	Paid the same as any other illness; annual frequency limits and cost-sharing provisions such as deductibles, coinsurance, or co-payments may apply depending upon the type of service rendered	Paid the same as any other illness; annual frequency limits and cost-sharing provisions such as deductibles, coinsurance, or co-payments may apply depending upon the type of service rendered
Special Notes about the Urgent Care Center Visits Benefit: Eligible charges for outpatient miscellaneous medical supplies, anesthesia, surgery, diagnostic X-rays, diagnostic lab tests, and infusion/injection therapy performed by an in-network provider and billed with a place of service code "11" (physician's office) or "20" (urgent care center) shall be paid at 100% and all applicable deductible amounts shall be waived. The co-payment applicable to the physician's exam will still be assessed. However, this benefit does not apply to advanced types of X-rays, imaging services, and nuclear radiology services billed by a physician's office or urgent care center.				
Emergency Room Treatment Physician's Fee for an Examination in the Emergency Room	Deductible applies, then $150 co-payment* with the balance of the charge paid at 100% *may waive if admitted	Paid as in-network	$150 co-payment* per visit, then 100% *may waive if admitted	Paid as in-network
All Other Services Billed by the Hospital or Any Other Provider in Connection with the Emergency Room Visit	100% after deductible	Paid as in-network	100%	Paid as in-network
Special Note about the Emergency Room Treatment Benefit: The Plan does not require certification for emergency services.				
Ambulance Transportation (Ground or Air)	$50 co-payment per trip, then 100% (deductible waived)	Paid as in-network	100%	Paid as in-network
Certification Requirement	Certification is required for all inpatient hospital admissions, observational stays at the hospital, select surgical procedures, and certain outpatient services listed at the end of this summary			
Inpatient Hospital Services Room and Board, Surgical Services, and Ancillary Services	90% after deductible	70% after deductible	100%	80% after deductible
Inpatient Physician Services Hospital Visits, Surgical Procedures, and Anesthesiology	90% after deductible	70% after deductible	100%	80% after deductible
Obesity Treatment Non-Surgical Treatment Surgical Treatment	Paid the same as any other illness; annual frequency limits and cost-sharing provisions such as deductibles, coinsurance, or co-payments may apply depending upon the type of service rendered		Paid the same as any other illness; annual frequency limits and cost-sharing provisions such as deductibles, coinsurance, or co-payments may apply depending upon the type of service rendered	
Special Note about Obesity Treatment Benefit: The Plan will cover only one surgery to treat obesity per covered person per in a lifetime, except gastric band adjustments that are part of the covered person's treatment plan are not subject to this limit. Moreover, conversion from one surgical procedure to another more complex surgical procedure is not covered. Additionally, the Plan will cover treatment or complications that arise during or subsequent to a surgical procedure to treat obesity and will pay the charges in the same manner as any other Illness. Such treatment is also not subject to the lifetime surgical limit.				

Benefit Description	Black Plan		Orange Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Outpatient Surgery and Surgery-Related Services				
Charges Billed by an Ambulatory Surgery Center (Place of Service Code "24")	90%; deductible waived	70% after deductible	100%	80% after deductible
Charges Billed by a Physician's Office (Place of Service Code "11") or Urgent Care Center (Place of Service Code "20")	100%; deductible waived	70% after deductible	100%	80% after deductible
Charges Billed by Other Outpatient Providers	90% after deductible	70% after deductible	100%	80% after deductible
Special Note about the Outpatient Services Benefit: Eligible charges for anesthesia performed by an in-network provider and billed with a place of service code "11" (physician's office) or "20" (urgent care center) shall be paid at 100% and all applicable deductible amounts shall be waived. Any co-payment applicable to a physician's exam will still be assessed.				
Outpatient Services Chemotherapy Radiation Therapy Hemodialysis	90% after deductible	70% after deductible	100%	80% after deductible
Outpatient Diagnostic Lab Tests and X-Rays				
Advanced Types of X-Rays, Imaging Services, and Nuclear Radiology Services (Including, but Not Necessarily Limited to, CT, CTA, MRI, MRA, Nuclear Cardiology Studies, and PET Scans)	$150 co-payment per service, then 100% (deductible waived)	70% after deductible	100%	80% after deductible
All Other X-Rays and Lab Test Services (Includes Pathology Tests and Ultrasounds)	90% after deductible	70% after deductible	100%	80% after deductible
Special Notes about Outpatient Diagnostic Lab Tests or X-Rays: 1. Advanced types of X-rays, imaging services, and nuclear radiology services administered in an inpatient hospital setting will not be subject to a co-payment per service (if applicable) and instead will be paid at the Inpatient Hospital Services level of benefits. 2. Eligible outpatient diagnostic X-rays and lab tests that are performed by an In-Network provider and billed with a place of service code "11" (physician's office) or "20" (urgent care center) shall be paid at 100% and all applicable deductible amounts shall be waived. The co-payment applicable to the physician's exam will still be assessed. This benefit does not apply to advanced types of X-rays, imaging services, and nuclear radiology services billed by a physician's office or urgent care center.				
Medically Necessary and Elective Abortions	Paid the same as any other illness; annual frequency limits and cost-sharing provisions such as deductibles, coinsurance, or co-payments may apply depending upon the type of service rendered		Paid the same as any other illness; annual frequency limits and cost-sharing provisions such as deductibles, coinsurance, or co-payments may apply depending upon the type of service rendered	
Allergy Services Injections, Serum, and Testing	100%; deductible waived	70% after deductible	100%	80% after deductible
Outpatient Infusion/Injection Therapy	90% after deductible	70% after deductible	100%	80% after deductible
Special Notes about the Outpatient Infusion/Injection Therapy Benefit: 1. The infusion or injection of select products will be subject to the Plan's Certification Requirement (see above). The list of the select products can be accessed by logging on to www.asrhealthbenefits.com or by calling ASR Health Benefits at (800) 968-2449. 2. Eligible charges for infusion/injection therapy performed by an in-network provider and billed with a place of service code "11" (physician's office) or "20" (urgent care center) shall be paid at 100% and all applicable deductible amounts shall be waived. Any co-payment applicable to the physician's exam will still be assessed.				

Benefit Description	Black Plan		Orange Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Chiropractic Care Spinal Manipulations, Therapy Treatments, and a Physician's Fee for an Initial or Periodic Evaluation	$20 co-payment per day, then 100% (deductible waived)	50% after deductible	$10 co-payment per day, then 100%	50% after deductible
Diagnostic Spinal X-Rays	90% after deductible	70% after deductible	100%	80% after deductible
30 Visits* Allowed per Covered Person per Benefit Year for All Chiropractic Care (In-Network and Out-of-Network Services Combined) *A visit includes one or more chiropractic services rendered by one provider in a day, but does not include a visit where the only service that the covered person received was chiropractic X-rays.				
Durable Medical Equipment, Prosthetics, and Orthotics	90% after deductible	50% after deductible	100%	50% after deductible
Hearing Care Exams, Evaluations, Conformity Tests, and Hearing Aids	90% after deductible	70% after deductible	100%	80% after deductible
$300 Maximum Benefit Paid for Audiometric Examinations, Hearing Aid Evaluations, and Conformity Tests per Covered Person in Any 36-Consecutive-Month Period				
$500 Maximum Benefit Paid for a Hearing Aid per Covered Person per Ear in Any 36-Consecutive-Month Period				
Special Note about the Hearing Care Benefit: Certain services billed by a physician or that are performed for the maintenance or reprogramming of a hearing aid (or other eligible device) are not eligible for coverage under this benefit and are instead are eligible for coverage under the Plan's Outpatient Physician Visits benefit. In such instances, an office visit co-payment may be charged for In-Network services (cost-sharing provisions will depend on whether the provider is a Specialist or Non-Specialist, as well as the type of service rendered).				
Outpatient Rehabilitative Services Physical Therapy, Speech Therapy, and Occupational Therapy	$20 co-payment per day, then 100% (deductible waived)	50% after deductible	$10 co-payment per day, then 100%	50% after deductible
50 Outpatient Visits Allowed per Covered Person per Benefit Year for Any and All Eligible Diagnoses/Conditions (In-Network and Out-of-Network Services Combined)				
Autism Spectrum Disorder Services Outpatient Rehabilitative Services (Annual Frequency Limits May Apply; See Above Benefit for Details), Nutritional Counseling, and Other Medically Necessary Services, Including Mental Health Services, for Autism Spectrum Disorder	Paid the same as any other illness; annual frequency limits and cost-sharing provisions such as deductibles, coinsurance, or co-payments may apply depending upon the type of service rendered	Paid the same as any other illness; annual frequency limits and cost-sharing provisions such as deductibles, coinsurance, or co-payments may apply depending upon the type of service rendered	Paid the same as any other illness; annual frequency limits and cost-sharing provisions such as deductibles, coinsurance, or co-payments may apply depending upon the type of service rendered	Paid the same as any other illness; annual frequency limits and cost-sharing provisions such as deductibles, coinsurance, or co-payments may apply depending upon the type of service rendered
Applied Behavior Analysis (ABA) Therapy	$20 co-payment per day, then 100% (deductible waived)	Paid as in-network	$10 co-payment per day, then 100%	Paid as in-network

Benefit Description	Black Plan		Orange Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Behavioral Care (Includes Mental Health Care and Addictions Treatment) Inpatient/Partial Hospitalization Services Outpatient/Intensive Outpatient Services, including Telemedicine E-Visits	Paid the same as any other illness; annual frequency limits and cost-sharing provisions such as deductibles, coinsurance, or co-payments may apply depending upon the type of service rendered		Paid the same as any other illness; annual frequency limits and cost-sharing provisions such as deductibles, coinsurance, or co-payments may apply depending upon the type of service rendered	
Special Note about Behavioral Care Benefit: In the event that a co-payment applies to an eligible outpatient/intensive outpatient provider fee for an office visit, the non-specialist co-payment will be charged.				
Diagnosis or Treatment of Underlying Cause of Infertility	Paid the same as any other illness; annual frequency limits and cost-sharing provisions such as deductibles, coinsurance, or co-payments may apply depending upon the type of service rendered		Paid the same as any other illness; annual frequency limits and cost-sharing provisions such as deductibles, coinsurance, or co-payments may apply depending upon the type of service rendered	
Special Note about Infertility Coverage: The Plan does not cover infertility treatment services or prescription drugs, except to the extent a service is being provided to diagnose or treat any underlying cause(s) of infertility.				
Convalescent Care and Home Health Care	90% after deductible	70% after deductible	100%	80% after deductible
Hospice	90% after deductible	70% after deductible	100%	80% after deductible

Miscellaneous Plan Provisions

Services Requiring Certification:

1. Inpatient hospital confinements and observational stays
2. Select surgical procedures (a list of surgical procedures requiring certification can be accessed by logging on to www.asrhealthbenefits.com or by calling ASR Health Benefits at 800-968-2449)
3. Durable medical equipment if the purchase price or forecasted total rental cost is $2,500 or more
4. Home health care
5. Custom-made orthotic or prosthetic appliances if the purchase price is $2,500 or more
6. Oncology treatment
7. Infusion or injection of select products (a list of the products can be accessed by logging on to www.asrhealthbenefits.com or by calling ASR Health Benefits at 800-968-2449)

As required by the No Surprises Act, if a covered person receives services in the following situations, the services will be paid at the in-network benefit level: (1) Emergency care; (2) Transportation by air ambulance; or (3) Nonemergency care at an in-network facility provided by an out-of-network physician or laboratory, unless the covered person provides informed consent.

Additionally, if a covered person receives eligible treatment at an in-network facility, any charges for the following will be paid at the in-network benefit level, even if provided by an out-of-network physician or laboratory: (1) Anesthesiology, pathology, radiology, or neonatology; (2) Assistant surgeons, hospitalists, or intensivists; (3) Diagnostic services (including radiology and laboratory services); and (4) Items and services provided by an out-of-network physician or laboratory if there was no in-network physician or laboratory that could provide the item or service at the in-network facility.

Coordination with Other Coverage for Injuries Arising out of Automobile Accidents

In the event that a covered person is injured in an accident involving an automobile, this Plan shall be the primary plan for purposes of paying benefits and the covered person's automobile insurance shall pay as secondary.

If a covered person receives treatment from an out-of-network provider and the Plan Administrator determines that treatment was not provided by an in-network provider for one of the reasons specified below, the claim may be adjusted to yield in-network-level benefits:

A. There is not access to a Qualified in-network provider located within a Reasonable Distance from the covered person's residence.

B. It was not reasonable for the covered person to seek care from an in-network provider because of a medical emergency.

C. A covered person either traveled to a place where he or she could not reasonably be expected to know the location of the nearest in-network provider or traveled to a place where no in-network providers are available.

D. A covered person receives eligible treatment at an in-network facility and he or she had no choice over the physician that provides treatment.

E. A dependent child receives out-of-network treatment while attending a secondary school, college, university, or vocational/technical school.

The term "Qualified" as used above means having the skills and equipment needed to adequately treat the covered person's condition. The term "Reasonable Distance" as used above approximates a 50-mile radius.

Benefit Description	Black Plan	Orange Plan
Prescription Drugs Retail Prescription Drug Co-payments (30-Day Supply) A covered person is able to purchase a 60- to 90-day supply of an eligible medication at a retail pharmacy for the applicable mail-order co-payment stated below. A physician's prescription for the greater day supply is required.	$10/generic drug, $20/brand-name drug	$10/generic drug, $20/brand-name drug
Mail-Order Prescription Drug Co-payments (90-Day Supply)	$20/generic drug, $40/brand-name drug	$20/generic drug, $40/brand-name drug
Drugs Included in the Medication Assistance Program through AscendPBM	Special coverage terms may apply to certain high-cost drugs and Specialty Prescription Drugs included in the Medication Assistance Program through AscendPBM; contact the PBM to learn the co-payment that will be charged and other special terms that may apply	Special coverage terms may apply to certain high-cost drugs and Specialty Prescription Drugs included in the Medication Assistance Program through AscendPBM; contact the PBM to learn the co-payment that will be charged and other special terms that may apply

Special Notes about Prescription Drug Coverage:

1. The pharmacy will dispense generic drugs unless the prescribing physician requests "Dispense as Written" (DAW) or a generic equivalent is not available. If the covered person refuses an available generic equivalent and the prescribing physician has not requested DAW, the covered person must pay the applicable co-payment **plus** the difference in price between the brand-name drug and its generic equivalent.
2. Certain over-the-counter drugs will be covered under the Plan and shall be subject to the generic co-payments shown above. A physician's prescription for these products is required.
3. In accordance with the requirements of Health Care Reform, the Plan provides coverage for certain preventive care medications, including, but not limited to, certain FDA-approved contraceptive agents and smoking cessation products with a prescription as well as breast cancer medications that lower the risk of cancer or slow its development, without any cost-sharing provisions such as deductibles or co-payments. For more information about eligible preventive care medications, the covered person can contact the Pharmacy Benefits Manager (PBM) using the information on his/her identification card.
4. The Plan requires that a covered person purchase self-injectable medications through the Prescription Drugs benefit. For more information about self-injectable medications, the covered person can contact the PBM using the information on his/her identification card.
5. This benefit will cover charges (including serum and injection fee charges) for certain immunizations when administered at a pharmacy at 100% with no deductible or co-payment applied. For more information about eligible immunizations, the covered person can contact the PBM using the information on his/her identification card.
6. The Plan requires that specific criteria be met before certain high-cost brand-name medications are covered. The covered person must have tried a lower-cost PBM-approved equivalent medication within the required time frame before the Plan will cover the brand-name drug. Alternatively, a brand-name drug may be covered if the covered person's physician contacts the PBM and receives prior approval or certification. If a covered person chooses to fill a prescription for certain brand-name drugs without first trying a PBM-approved equivalent medication or getting prior approval from the PBM, coverage may be denied and the covered person may have to pay the full cost of the drug.
7. Certain prescription drugs may be acquired through the Plan's International Prescription Program vendor and may be available to covered persons with reduced or no cost-sharing provisions such as prescription drug co-payments. For more information about prescription drugs available through the International Prescription Program vendor, including the co-payment that will be charged or other special coverage terms that will apply, the covered person can contact the Pharmacy Benefits Manager (PBM) using the information on his/her identification card.
8. For any covered person who meets the necessary individual qualifications to receive external assistance through variable program benefits for prescribed medication(s), the Plan has the right, at its sole discretion, to require the use of a particular, preferred, or mandated program(s). When utilizing the Plan's preferred (or mandated) procurement avenue, the covered person's financial liability may be variable, reduced, or eliminated as determined by the Employer. Therefore, any whole or partial benefit for which a covered person individually qualifies is not a covered benefit under the Plan. Contact the PBM for more information about these program.
9. Eligible prescriptions for a Specialty Prescription Drug must be filled through the designated specialty pharmacy network or that drug purchase will not be eligible for coverage under the Plan. Contact the PBM or OptiMed specialty pharmacy for more information about this program. As used in this benefit, the term "Specialty Prescription Drug" means a prescription drug identified on the drug list maintained by the PBM that includes drugs typically used to treat complex medical conditions. Specialty Prescription Drugs may be injectable medications, high-cost medications, or medications with special delivery and storage requirements (e.g., they may require refrigeration). Specialty Prescription Drug purchases will be limited to a 30-day dispensing supply.

Special Eligibility Provision for Working Spouses and Domestic Partners

A participant's spouse or domestic partner who is eligible for medical, dental, or vision coverage under his or her own employer's group health plan must enroll for that coverage at his or her next available enrollment opportunity. Coverage under the spouse's or domestic partner's own employer's group health plan will be considered his or her primary coverage, and this Plan will be the secondary coverage. **A participant's spouse or domestic partner who is eligible for coverage under his or her own employer's group health plan, but who declines to take that other coverage will not be eligible to enroll in or participate in the Plan.**

The participant is obligated to immediately report to the Plan Administrator any change that would affect his or her spouse's or domestic partner's eligibility under this Plan (i.e., the individual changes employers or the individual's employer offers its employees a medical, dental, or vision plan for the first time). If it is found that a spouse or domestic partner who is eligible for coverage under his or her own employer's group health plan has not enrolled for his or her own employer's group health plan as required by this provision, benefits for the spouse or domestic partner may be terminated. Coverage may not be retroactively rescinded except as permitted by law (e.g., in cases of fraud or intentional misrepresentation). Notice that coverage will be retroactively rescinded must be provided 30 days before proceeding with the termination process. Otherwise, coverage will be terminated prospectively once the error is discovered.

The following exceptions to this provision shall apply:

- A participant, spouse, or domestic partner who is an employee of Kalamazoo College and who is married to or in a domestic partner relationship with an individual who is also an employee of Kalamazoo College will not be penalized for declining to enroll separately as individual participants in this Plan.
- A spouse or domestic partner who is required to pay at least 50% or more of the total cost for medical, dental, or vision coverage under his or her employer's group health plan will not be subject to this provision and can enroll for primary / sole coverage under this Plan for that benefit type.

Employer-Funded Medical Reimbursement Plan – Benefit Description

The employer has established an Employer-Funded Medical Reimbursement Plan to cover eligible expenses not covered by the employer's group health plan or any other health care plan. The maximum amount per benefit year that may be reimbursed to a participant for medical expenses incurred under the Black Plan is **50 percent** of each claim applied toward the in-network deductible of the participant and the participant's enrolled dependents under the Black Plan (up to **$500** per Covered Person and **$1,000** per family). The participant shall pay the other **50 percent** of each claim applied toward the in-network deductible under the Black Plan (up to **$500** per Covered Person and **$1,000** per family).

Employer-Funded Medical Reimbursement Plan – How to File a Claim

To file a claim under this Plan, a Participant must first file a claim for health care expenses with the Employer's group health plan. **Any eligible expenses not covered under this claim by the Employer's plan will automatically be paid to the Participant or the provider from the Employer-Funded Medical Reimbursement Plan. The Participant does not need to take further action to obtain reimbursement nor send the EOB from the Employer's group health plan back to ASR.**