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	$750/person $1,500/family	$1,500/person $3,000/family	$0/person $0/family	$500/person $1,000/family
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, but do include all other eligible charges, including charges for Mental Health and Substance Abuse (MHSA) benefits that are provided through Behavioral Health Systems, Inc. (BHS). The deductible and Coinsurance Maximum Out-of-Pocket do not include 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 include deductibles, coinsurance, all co-payments, and charges for MHSA benefits that are provided through BHS. 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:* $25 co-payment per visit, then 100% (deductible waived) *Specialist Office and Telemedicine E-Visits:* $40 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 *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% *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 *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. 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: 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.				
Preventive Diabetes Disease Management and Support through Teladoc Health©	100%; deductible waived When diagnosed with an eligible condition, covered persons can register at www.teladochealth.com to receive diabetes-management support and information, including items and services such as a blood glucose meter, testing strips, lancets, access to expert support coaches, and more. Contact Teladoc Health at 1-800-TELADOC (1-800-835-2362) or visit www.teladochealth.com for additional information about qualifying conditions and services available.		100%; deductible waived When diagnosed with an eligible condition, covered persons can register at www.teladochealth.com to receive diabetes-management support and information, including items and services such as a blood glucose meter, testing strips, lancets, access to expert support coaches, and more. Contact Teladoc Health at 1-800-TELADOC (1-800-835-2362) or visit www.teladochealth.com for additional information about qualifying conditions and services available.	

Benefit Description	Black Plan		Orange Plan	
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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
Emergency Room Treatment Physician's Fee for an Examination in the Emergency Room	Deductible applies, then $150 co-payment* per visit 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	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 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
Non-Surgical Obesity 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	
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 Other Outpatient Providers	90% after deductible	70% after deductible	100%	80% after deductible
Other Outpatient Services Chemotherapy Radiation Therapy Hemodialysis	90% after deductible	70% after deductible	100%	80% after deductible

Benefit Description	Black Plan		Orange Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
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)	*Services Performed in a Freestanding Outpatient Imaging Center (includes a Physician's Office):* 90%; deductible waived *Services Performed in a Hospital Facility:* 90 after deductible	*Services Performed in a Freestanding Outpatient Imaging Center (includes a Physician's Office):* 70% after deductible *Services Performed in a Hospital Facility:* 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
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 Note about the Outpatient Infusion/Injection Therapy Benefit: The infusion or injection of medications that are self-administered or that are administered in most outpatient settings will generally be subject to the Plan's Certification Requirement (see above) if the per-dosage cost is $2,000 or more per 30-day supply. A covered person can call the Certification telephone number on the health plan identification card to determine if a prescribed medication is subject to the Plan's Certification Requirement. Additionally, the Plan will require those infusions and injections to be purchased or administered at the most cost-effective site of service that is able to safely and appropriately provide the covered person with the treatment (examples of cost-effective sites of service include, but are not necessarily limited to, a physician's office, a pharmacy, or a free-standing infusion center). The Plan will not cover costs for or associated with the outpatient infusion or injection of select products if the covered person does not use the most cost-effective site of service that can safely and appropriately provide the treatment.				
Chiropractic Care Spinal Manipulations, Therapy Treatments, and a Physician's Fee for an Initial or Periodic Evaluation	$25 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

Benefit Description	Black Plan		Orange Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Hearing Care Exams, Evaluations, Conformity Tests, and Hearing Aids $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	90% after deductible	70% after deductible	100%	80% after deductible
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 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)	$25 co-payment per day, then 100% (deductible waived)	50% after deductible	$10 co-payment per day, then 100%	50% after deductible
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. Outpatient infusion or injection of select products if the per-dosage cost will be $2,000 or more per 30-day supply*

*A covered person can call the Certification telephone number on the health plan identification card to determine if a prescribed medication is subject to the Certification Requirement.

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.

Miscellaneous Plan Provisions

Special Note for Individuals Contributing to a Health Savings Account (HSA)
If an individual enrolled in this Plan is also enrolled in a high-deductible health plan (HDHP) through a spouse's employer or another source and that person contributes to a health savings account (HSA), enrollment in this Plan, which is not an HDHP, will render that individual ineligible to contribute to an HSA for the entire plan year.

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/Rx Formulary Tier 1 drug, $25/Rx Formulary Tier 2 drug, $50/Rx Formulary Tier 3 drug	$10/Rx Formulary Tier 1 drug, $25/Rx Formulary Tier 2 drug, $50/Rx Formulary Tier 3 drug
Mail-Order Prescription Drug Co-payments (90-Day Supply)	$20/Rx Formulary Tier 1 drug, $50/Rx Formulary Tier 2 drug, $100/Rx Formulary Tier 3 drug	$20/Rx Formulary Tier 1 drug, $50/Rx Formulary Tier 2 drug, $100/Rx Formulary Tier 3 drug
Specialty Prescription Drugs Co-payments (30-Day Supply)	Specialty Prescription Drugs may be eligible for Plan coverage, but additional special coverage terms apply. These drugs must generally be filled or coordinated through the Magellan Rx Pharmacy, LLC specialty pharmacy in order to be eligible for Plan coverage. Covered persons can contact Magellan Rx at (866) 554-2673 to learn more information, including the co-payment that will apply, or to obtain a list of drugs that can be filled only through the specialty pharmacy.	Specialty Prescription Drugs may be eligible for Plan coverage, but additional special coverage terms apply. These drugs must generally be filled or coordinated through the Magellan Rx Pharmacy, LLC specialty pharmacy in order to be eligible for Plan coverage. Covered persons can contact Magellan Rx at (866) 554-2673 to learn more information, including the co-payment that will apply, or to obtain a list of drugs that can be filled only through the specialty pharmacy.

Special Note about Specialty Prescription Drug Coverage: The Plan requires all covered persons to enroll in the Plan's advocacy program, the Select Drugs and Products℠ Program, when prescribed a Specialty Prescription Drug that has been listed on the Select Drugs and Products List. For additional information about the Select Drugs and Products℠ Program, the covered person can contact the Select Drugs and Products℠ Program vendor, Paydhealth, at (877) 869-7772. Failure to meet the Plan's prior authorization requirements and criteria, including enrollment in the Select Drugs and Products℠ Program when applicable, will result in a cost-containment noncompliance penalty equal to a 100% reduction in benefits payable (i.e., the covered person will have to pay the full cost of the drug).

Special Notes about Prescription Drug Coverage (All Eligible Products):

1. The Plan's Pharmacy Benefits Manager (PBM) maintains a list of Specialty Prescription Drugs, as well as lists of preferred and non-preferred generic and brand-name prescription drugs. A drug's coverage terms and co-payment is determined by the drug's categorization in these lists. The term "Rx Formulary Tier 1" means a category of prescription drugs that generally includes most generic drugs and may include some low-cost brand-name drugs. The term "Rx Formulary Tier 2" means a category of prescription drugs that includes preferred brand-name drugs and may include some high-cost generic drugs. The term "Rx Formulary Tier 3" means a category of prescription drugs that generally includes all non-preferred drugs. The term "Specialty Prescription Drug" means a prescription drug or biological product that has additional features associated with its use or acquisition. For additional information about the coverage status and category of a drug, as well as any prior authorization requirements, step-therapy provisions, quantity/age limits, and administrative review criteria that may apply, the covered person can contact the PBM using the information shown on the health plan identification card.
2. 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.
3. 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.
4. 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.
5. 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.
6. 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.
7. The Plan will require that specific criteria be met before certain high-cost brand-name medications or Specialty Prescription Drugs are covered. This criterion is known as a step-therapy provision. In general, the covered person must have tried a lower-cost PBM-approved equivalent medication before the Plan will cover the brand-name drug or Specialty Prescription Drug. If a covered person chooses to fill a prescription for certain brand-name drugs or Specialty Prescription Drugs without first trying a PBM-approved equivalent medication coverage may be denied and the covered person may have to pay the full cost of the drug.

Special coverage terms apply for eligible Specialty Prescription Drugs in addition to this step-therapy provision.

A brand-name drug that is not a Specialty Prescription Drug may be covered by the Plan and may be exempted from the step-therapy provision if the covered person's physician contacts the PBM and provides evidence of the prior utilization or proof of failed therapy and the PBM authorizes the brand-name medication. For more information, covered persons can contact the PBM at the telephone number on the health plan identification card.

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. Once the spouse has elected coverage under his or her own group health plan as required by this provision, coverage under the spouse's own group health plan will be considered his or her primary coverage, and this Plan will be the secondary coverage.

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, a coverage election opportunity will be available because of an annual open enrollment period, 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 enrolled (or has remained enrolled) in this Plan for sole coverage as otherwise prohibited by this provision, benefits for the spouse or domestic partner will be terminated. Coverage may not be retroactively rescinded except as permitted by law (e.g., in cases of fraud or intentional misrepresentation of a material fact). 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.
- This provision will not apply to a spouse until the next available coverage enrollment opportunity provided by his or her employer coincident with or following the employee's initial coverage effective date under this Plan. Depending on the terms of the spouse's own employer group health plan, he or she may be eligible to immediately enroll in his or her own employer's group health plan, or the spouse may be required to wait to enroll until the next annual open enrollment period for that group health plan. The spouse should contact his or her employer to learn what group health plan enrollment opportunities apply.