 Kalamazoo College, G-1013

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|  | 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  General Benefit Percentage  Coinsurance Maximum Out-of-Pocket per Benefit Year  Total Maximum Out-of-Pocket per Benefit Year (Includes Deductible, Coinsurance, Medical Copayments, and Prescription Drug Co-payments) | | $1,000/person$1,500/person  $2,000/family$3,000/family  90% after deductible70% after deductible  (10% coinsurance)(30% coinsurance)  $1,000/person$1,500/person  $2,000/family$3,000/family  $6,000/personNot applicable  $12,000/family | | $0/person$500/person  $0/family$1,000/family  100%80% after deductible  (0% coinsurance)(20% coinsurance)  Not applicable$1,500/person $3,000/family  $7,150/personNot applicable  $14,300/family | |
| 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-cable 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.   1. 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. 2. 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) | | *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 | *Telemedicine E-Visits Billed by Amwell*:  Not applicable | *Telemedicine E-Visits Billed by Amwell*:  $-0- co-payment per visit, then 100%  Contact Amwell at  (844) 733-3627 or www.amwell.com | *Telemedicine E-Visits Billed by Amwell*:  Not applicable |
|  | | *Primary Care Provider Office and Other Telemedicine E-Visits:*  $25 co-payment per visit, then  100% (deductible waived) | *Primary Care Provider Office Visits and Other Telemedicine E-Visits:* 70% after deductible | *Primary Care Provider Office Visits and Other Telemedicine E-Visits:*  $10 co-payment per visit, then 100% | *Primary Care Provider Office Visits and Other Telemedicine E-Visits:* 80% after deductible |
|  | | *Specialist Office and Telemedicine E-Visits:*  $40 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 |

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|  | 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: provides Medical Care in family practice, general practice, internal medicine, obstetrics and gynecology, or pediatrics. For the purposes of this benefit, t n and training in a recognized medical specialty who is not a Primary Care Provider as defined above. Specialists are often licensed or certified in their medical specialty. | | | | | |
| Routine Preventive Care  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   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 A. | | | | | |
| 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 diabetesmanagement 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 diabetesmanagement 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. | |

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|  | Benefit Description | Black Plan | | | Orange Plan | | | |
| In-Network | Out-of-Network | | In-Network | | Out-of-Network | |
| Urgent Care Center Visits | | $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  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 certificatio | | | n 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 in | patient hospital admissions, observational stays at the hospital, sele | | | ct | surgical procedures, and certain | |
|  | | outpatient services listed at the e | nd 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 illnes sharing provisions such as deduct may apply depending upon the typ | s; annual frequency limits and costibles, coinsurance, or co-payments e of service rendered | | Paid the same as any other illnes sharing provisions such as deduct may apply depending upon the typ | | s; annual frequency limits and cost-  ibles, coinsurance, or co-payments e of service rendered | |
| Outpatient Surgery and Surgery-Related Services  Charges Billed by an Ambulatory Surgery Center  Charges Billed by Other Outpatient Providers | | 90%; deductible waived  90% after deductible | 70% after deductible 70% after deductible | | 100%  100% | | 80% after deductible 80% after deductible | |
| Other Outpatient Services  Chemotherapy  Radiation Therapy  Hemodialysis | | 90% after deductible | 70% after deductible | | 100% | | 80% after deductible | |

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| 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*  *Office):*  90%; deductible waived | *Services Performed in a*  *Freestanding Outpatient Imaging*  *Office):*  70% after deductible | 100% | 80% after deductible |
|  | | *Services Performed in a*  *Hospital Facility:*  90% after deductible | *Services Performed in a*  *Hospital Facility:*  70% 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 costsharing 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 costsharing 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 A covered person can call the Certification telephone number on the health plan identification card to determine if a s 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 | | $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  30 Visits\* Allowed per Covered Person per Benefit Year for All Chiropractic Care (In-Network and Outof-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. | | 90% after deductible | 70% after deductible | 100% | 80% after deductible |
| Durable Medical Equipment, Prosthetics, and Orthotics | | 90% after deductible | 50% after deductible | 100% | 50% after deductible |

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| 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 36Consecutive-Month Period  $500 Maximum Benefit Paid for a Hearing Aid per Covered Person per Ear in Any 36-ConsecutiveMonth 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 instead are eligible for coverage under the 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 Primary Care Provider, 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 costsharing 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 costsharing 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: Coordination with Other Coverage for Injuries Arising out of Automobile Accidents   1. Inpatient hospital confinements and observational stays In the event that a covered person is injured in an accident involving an automobile, this Plan shall be the 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) secondary.   1. Durable medical equipment if the purchase price or forecasted total rental cost is $2,500 or more 2. Home health care If a covered person receives treatment from an out-of-network provider and the Plan Administrator determines 3. Custom-made orthotic or prosthetic appliances if the purchase price is $2,500 or more that treatment was not provided by an in-network provider for one of the reasons specified below, the claim 4. Oncology treatment may be adjusted to yield in-network-level benefits: 5. Enteral and total parenteral nutrition therapy   A. There is not access to a Qualified in-network provider located within a Reasonable Distance from the 8. 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 B. It was not reasonable for the covered person to seek care from an in-network provider because of a determine if a prescribed medication is subject to the Certification Requirement. medical emergency.  C. A covered person either traveled to a place where he or she could not reasonably be expected to know As required by the No Surprises Act, if a covered person receives services in the following situations, the the location of the nearest in-network provider or traveled to a place where no in-network providers are services will be paid at the in-network benefit level: (1) Emergency care; (2) Transportation by air ambulance; available.  or (3) Nonemergency care at an in-network facility provided by an out-of-network physician or laboratory, D. A covered person receives eligible treatment at an in-network facility and he or she had no choice over unless the covered person provides informed consent. the physician that provides treatment.  Additionally, if a covered person receives eligible treatment at an in-network facility, any charges for the E. A dependent child receives out-of-network treatment while attending a secondary school, college, following will be paid at the in-network benefit level, even if provided by an out-of-network physician or university, or vocational/technical school.  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. | | | | | |

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|  | 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-  HDHP, will render that individual ineligible to contribute to an HSA for the entire plan year. | | | ccount (HSA), enrollment in this Plan, which is not an |
|  | Benefit Description | Black Plan | Orange Plan |
| Prescription Drugs  Retail Prescription Drug Co-payments (30-Day Supply)  A covered person may fill a prescription for up to and including a 30-day supply for the co-payment amounts shown. If a prescribing physician requests more than a 30-day supply of a drug, up to a 90-day supply of a covered prescribed medication can be purchased at a participating pharmacy for the applicable Mail Service Program co-payment specified below. | | $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 (90Day 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 (30Day 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 Prime Therapeutics Pharmacy LLC specialty pharmacy in order to be eligible for Plan coverage. Covered persons can contact Prime Therapeutics Pharmacy LLC specialty pharmacy 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 Prime Therapeutics Pharmacy LLC specialty pharmacy in order to be eligible for Plan coverage. Covered persons can contact Prime Therapeutics Pharmacy LLC specialty pharmacy 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: SM 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 ProductsSM Program, the covered person can contact the Select Drugs and ProductsSM Program vendor, Paydhealth, at (877) 422- ation requirements and criteria, including enrollment in the Select Drugs and ProductsSM Program when applicable, will result in a costcontainment 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. d non-preferred generic and brand- -   iption drugs that generally includes most generic drugs and may include some low-cost brandugs that includes preferred brand-name drugs and may include some high-  category of prescription drugs that generally includes all non- 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.   1. quivalent 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 Rx Formulary Tier 1 co- 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 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 brandname 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 stepprior 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. | | | |

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|  | Special Eligibility Provision for Working Spouses and Domestic Partners |
| 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 be considered his or her primary coverage, and this Plan will be the secondary coverage.  employers, a coverage election opportunity will be available because of an annual open enrollment period, time). If it is found that a spouse or domestic partner who is eligible for coverage under his or her 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 cov 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 emp  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. | |