AMENDMENT # 3 TO: KALAMAZOO COLLEGE, G-1013

# AMENDMENT TO THE HEALTH BENEFIT PLAN

IT IS UNDERSTOOD AND AGREED THAT THE FOLLOWING MODIFICATIONS SHALL BE MADE:

1. The first paragraph under the **BENEFITS** section of the Plan document will be deleted in its entirety and replaced with the following:

Black Plan (Michigan) and Orange Plan (Michigan): Benefits are described and are subject to the terms and conditions set forth in the pages that follow. Tier 1 and Tier 2 are based on network-contracted rates, and Tier 3 benefits are based on Usual and Customary charges.

Black Plan (Non-Michigan) and Orange Plan (Non-Michigan): Benefits are described and are subject to the terms and conditions set forth in the pages that follow. In-Network benefits are based on network-contracted rates, and Out-of-Network benefits are based on Usual and Customary charges.

1. The following changes will be made to the **SCHEDULE OF MEDICAL BENEFITS – BLACK PLAN**:
   1. The **SCHEDULE OF MEDICAL BENEFITS – BLACK PLAN** will be renamed as the **SCHEDULE OF MEDICAL BENEFITS – BLACK PLAN (NON- MICHIGAN)** and all associated references will be updated accordingly.
   2. The Urgent Care Center Visits benefit will be revised to read as follows:

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| **Benefit Description** | **In-Network** | **Out-of-Network** |
| Urgent Care Center Visits Physician’s Fee for an Examination | $40 co-payment per visit, then 100% (Deductible waived) | 70% 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 |

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* 1. The Emergency Room Treatment benefit will be revised to read as follows:

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| **Benefit Description** | **In-Network** | **Out-of-Network** |
| Emergency Room Treatment Physician’s Fee for an Examination in the Emergency Room | $150 co-payment\* per visit, then 100% (Deductible waived) | Paid as In-Network |
|  | \*may waive if admitted Inpatient from the emergency room |  |
| All Other Charges Billed by the Hospital, Physician, or Any Other Provider in Connection with the Emergency Room Visit | 100%; Deductible waived | Paid as In-Network |
| **Special Note about the Emergency Room Treatment Benefit:** The Plan does not require certification for emergency services. | | |

1. The **SCHEDULE OF PRESCRIPTION DRUG BENEFITS – BLACK PLAN** will be renamed as the **SCHEDULE OF PRESCRIPTION DRUG BENEFITS – BLACK PLAN (NON-MICHIGAN)** and all associated references will be updated accordingly.
2. The **SCHEDULE OF MEDICAL BENEFITS – ORANGE PLAN** will be renamed as the **SCHEDULE OF MEDICAL BENEFITS – ORANGE PLAN (NON-MICHIGAN)** and all associated references will be updated accordingly.
3. The **SCHEDULE OF PRESCRIPTION DRUG BENEFITS – ORANGE PLAN** will be renamed as the **SCHEDULE OF PRESCRIPTION DRUG BENEFITS – ORANGE PLAN (NON-MICHIGAN)** and all associated references will be updated accordingly.
4. The following four schedules will be added to the **BENEFITS** section of the Plan document:

# SCHEDULE OF MEDICAL BENEFITS – BLACK PLAN (MICHIGAN)

1. As used throughout the Schedule of Benefits, the following terminology shall mean:

Tier 1: Charges billed by providers that participate in the Nomi Health Network. Nomi Health Network offers most covered healthcare services at zero cost to Covered Persons. There is no co-payment or Deductible requirement when using Nomi Health Network Providers, except for the services listed otherwise. To learn more about Nomi Health Network and how to reduce out-of-pocket costs when obtaining healthcare services, visit [www.nomihealth.com/provider-](http://www.nomihealth.com/provider-) search, or call (855) 601-1900.

**Important Notes – Black Plan (Michigan)**

**Important Notes – Black Plan (Michigan)**

Tier 2: Charges billed by providers that participate with any network used by the Plan, except for the Nomi Health Network as identified elsewhere in this provision.

Tier 3: Charges billed by providers that do not participate with any network used by the Plan.

1. As required by the No Surprises Act, if a Covered Person receives services in the following situations, the services will be paid at the Tier 1 Network benefit level (regardless of the network status of the billing provider): (1) emergency care; (2) transportation by air ambulance; or (3) nonemergency care at a Tier 1 facility provided by a Tier 2 or Tier 3 Physician or laboratory, unless the Covered Person provides informed consent.

Additionally, if a Covered Person receives eligible treatment from a Tier 1 Provider, any charges for the following will be paid at the Tier 1 benefit level, even if provided by a Tier 2 or Tier 3 Provider: (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 a Tier 2 or Tier 3 Provider if there was no Tier 1 Provider that could provide the item or service at the Tier 1 facility or office where the treatment was performed. If a Covered Person receives eligible treatment at a Tier 2 Network facility, any charges for the following will be paid at the Tier 2 benefit level, even if provided by a Tier 3 Physician or laboratory (if such charges are billed by Tier 1 providers, the Tier 1 Network benefit level will apply): (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 a Tier 3 Physician or laboratory if there was no Tier 2 Physician or laboratory that could provide the item or service at the Tier 2 facility.

1. If a Covered Person receives eligible treatment at a Tier 1 or Tier 2 facility and the Plan Administrator determines that the Covered Person had no choice over the Physician that provides treatment, the claim may be adjusted. In this situation, claims from a Tier 2 or Tier 3 Provider may be adjusted to yield Tier 1-level or Tier 2-level benefits depending on the facility where treatment was received.

If a Covered Person receives treatment from a Tier 3 Provider and the Plan Administrator determines that treatment was not provided by a Tier 1 Provider or Tier 2 Provider for one of the reasons specified below, the claim may be adjusted to yield Tier 2-level benefits (unless specifically stated otherwise below):

* 1. There was not access to a Qualified Tier 1 Provider or Qualified Tier 2 Provider located within a Reasonable Distance from the Covered Person’s residence.
  2. It was not reasonable for the Covered Person to seek care from a Tier 1 Provider or Tier 2 Provider because of a Medical Emergency.
  3. A Covered Person either traveled to a place where he or she could not reasonably be expected to know the location of the nearest Tier 1 Provider or Tier 2 Provider or traveled to a place where no Tier 1 Provider or Tier 2 Providers are available.
  4. A Dependent child received Tier 3 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.

1. The Deductible and Coinsurance Maximum Out-of-Pocket amounts below are intended to limit the amount of Deductible and Coinsurance that has been designated as the Covered Person’s or Family’s responsibility; however, in certain cases, the total amount that is paid in co-payments may decrease the amount of Coinsurance or Deductible that a Covered Person or Family has to pay. That is, once the Plan’s Total Maximum Out-of-Pocket has been satisfied by any combination of Deductible, Coinsurance, and co-payments paid by the Covered Person or Family, the Plan will no longer charge such amounts for the remainder of the Plan Year.
2. Certification is required for all Inpatient Hospital admissions, select surgical procedures, and some Outpatient procedures. Please see the “Utilization Review Program” subsection for specific information regarding requirements and deadlines.

**Important Notes – Black Plan (Michigan)**

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| **Schedule of Medical Benefits – Black Plan (Michigan)** | | | |
| **Benefit Description** | **Tier 1** | **Tier 2** | **Tier 3** |
| Plan Year (benefit-based accumulators) | January 1 through December 31 | | |
| Comprehensive Medical Benefit  Deductible per Plan Year | $0/Covered Person  $0/Family  100%  (0% Coinsurance)  $0/Covered Person  $0/Family  $0/Covered Person\*  $0/Family\*  \*Charges for Tier 1 co- payments will apply toward the Plan’s Total Out-of- Pocket Maximums as described below | $1,000/Covered Person  $2,000/Family | $1,500/Covered Person |
|  |  | $3,000/Family |
| General Benefit Percentage Paid (all Covered Expenses, unless specifically stated otherwise) | 90% after Deductible  (10% Coinsurance) | 70% after Deductible  (30% Coinsurance) |
| Coinsurance Maximum Out-of-Pocket per Plan Year (includes Coinsurance only) | $1,000/Covered Person  $2,000/Family | $1,500/Covered Person  $3,000/Family |
| Total Maximum Out-of- Pocket per Plan Year (includes Deductible, Coinsurance, medical co- payments, and prescription drug co-payments) | $6,000/Covered Person  $12,000/Family | Unlimited |
| **Special Notes about the Comprehensive Medical Benefit:**   1. For Nomi Health Network Tier 1 benefits only: Covered Persons do not have to meet a Deductible and there are no co-payments, except for select services as noted in the Schedule below. 2. For Tier 2 and Tier 3 benefits only: An individual within a Family has to meet only the per-Covered Person Deductible before the Plan will begin paying benefits. Additionally, an individual within a Family has to meet only the per-Covered Person Coinsurance Maximum Out-of-Pocket before the Plan’s general benefit percentage will increase to 100% for the remainder of the Plan Year for the applicable benefit tier or the per-Covered Person Total Maximum Out-of-Pocket for Tier 2 charges before medical and prescription drug co-payments will no longer be charged for the remainder of the Plan Year. | | | |

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| **Schedule of Medical Benefits – Black Plan (Michigan)** | | | |
| **Benefit Description** | **Tier 1** | **Tier 2** | **Tier 3** |
| Comprehensive Medical Benefit, cont.   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 in the Schedule of Benefits, or are otherwise excluded under the provisions of the Plan. There is no concurrent accrual of Deductible or Coinsurance Maximum Out-of-Pocket amounts; Tier 1, Tier 2, and Tier 3 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 does not include any drug manufacturer’s assistance. Additionally, the Total Maximum Out-of-Pocket also does 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 limits in a Schedule of Benefits, or are otherwise excluded under the provisions of the Plan. Amounts applied toward the Total Maximum Out-of-Pockets for Tier 1 services will also accrue toward the Total Maximum Out-of- Pockets for Tier 2 services, and vice versa. | | | |
| Outpatient Physician Services (includes office visits, Telemedicine e-visits, and second surgical opinions) |  |  |  |
| Physician’s Fee for an Examination | *Amwell Telemedicine E-Visits:*  $0 co-payment per visit, then 100%  Contact Amwell at (844) 733-3627 or  [www.amwell.com](http://www.amwell.com/) | *Amwell Telemedicine E-Visits:*  $0 co-payment per visit, then 100% (Deductible waived)  Contact Amwell at (844) 733-3627 or  [www.amwell.com](http://www.amwell.com/) | *Amwell Telemedicine E-Visits:*  $0 co-payment per visit, then 100% (Deductible waived)  Contact Amwell at (844) 733-3627 or  [www.amwell.com](http://www.amwell.com/) |
|  | *Non-Specialist Office Visits and*  *Telemedicine E-Visits:*  $0 co-payment per visit, then 100% | *Non-Specialist Office Visits and*  *Telemedicine E-Visits:*  $25 co-payment per visit, then 100% (Deductible waived) | *Non-Specialist Office Visits and*  *Telemedicine E-Visits:*  70% after Deductible |
|  | *Specialist Office Visits and Telemedicine*  *E-Visits:*  $0 co-payment per visit, then 100% | *Specialist Office Visits and Telemedicine*  *E-Visits:*  $40 co-payment per visit, then 100% (Deductible waived) | *Specialist Office Visits and Telemedicine*  *E-Visits:*  70% after Deductible |

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| **Schedule of Medical Benefits – Black Plan (Michigan)** | | | |
| **Benefit Description** | **Tier 1** | **Tier 2** | **Tier 3** |
| 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 |
| **Special Note about the Outpatient Physician Services Benefit:** As used in this benefit, the term “Non- Specialist” means a Physician, Physician’s Assistant, Nurse Practitioner, or other eligible provider who provides Medical Care in primary care, 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 specifically addressed elsewhere in this Schedule of Benefits (e.g., chiropractic care). The term “Specialist” means a Physician with advanced education 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 | 100% | 100%; Deductible waived | 70% after Deductible |
| **Special Note about the Routine Preventive Care Benefit:** 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; 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% | 100%; Deductible waived | 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. | | | |

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| **Schedule of Medical Benefits – Black Plan (Michigan)** | | | |
| **Benefit Description** | **Tier 1** | **Tier 2** | **Tier 3** |
| Preventive Diabetes Disease Management and Support through Teladoc Health© | Items, services, and supplies provided through the Teladoc Health© program are covered at 100% and no Deductible will apply.  When diagnosed with an eligible condition, Covered Persons can register at [www.teladochealth.com](http://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](http://www.teladochealth.com/) for additional information about qualifying conditions and services available. | | |
| Urgent Care Center Visits Physician’s Fee for an Examination | $20 co-payment per visit, then 100% | $40 co-payment per visit, then 100% (Deductible waived) | 70% after Deductible |
| All Other Charges Billed in Connection with the Examination | 100% | 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 | $150 co-payment\* per visit, then 100%  \*will waive if admitted Inpatient from the emergency room | $150 co-payment\* per visit, then 100% (Deductible waived)  \*will waive if admitted Inpatient from the emergency room | Paid at Tier 2 level |
| All Other Charges Billed by the Hospital, Physician, or Any Other Provider in Connection with the Emergency Room Visit | 100% | 100%; Deductible waived | Paid at Tier 2 level |
| **Special Note about the Emergency Room Treatment Benefit:** The Plan does not require certification for emergency services. | | | |
| Ambulance Transportation (Ground or Air) | Not available | $50 co-payment per trip, then 100% (Deductible waived) | Paid at Tier 2 level |

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| **Schedule of Medical Benefits – Black Plan (Michigan)** | | | |
| **Benefit Description** | **Tier 1** | **Tier 2** | **Tier 3** |
| Certification Requirement | Certification is required for all Inpatient Hospital admissions, observational stays at the Hospital, select surgical procedures, and certain Outpatient services. See the “Utilization Review Program” subsection of the Plan document for additional information.  If a Nomi Health Network (Tier 1) Provider can safely and cost- effectively provide any of the services that require certification, the Utilization Review Firm will attempt to certify a Nomi Health Network Provider to provide the Covered Person’s treatment so that the patient can take advantage of this money-saving opportunity. | | |
| Inpatient Hospital Services Room and Board, Surgical Services, and Ancillary Services | 100% | 90% after Deductible | 70% after Deductible |
| Inpatient Physician Services Hospital Visits, Surgical Procedures, and Anesthesiology | 100% | 90% after Deductible | 70% after Deductible |
| Outpatient Surgery and Surgery-Related Services  Charges Billed by an Ambulatory Surgery Center (Place of Service Code “24”) | 100% | 90%; Deductible waived | 70% after Deductible |
| Charges Billed by Other Outpatient Providers | 100% | 90% after Deductible | 70% after Deductible |
| Other Outpatient Services Chemotherapy Radiation Therapy Hemodialysis | 100% | 90% after Deductible | 70% after Deductible |
| Outpatient Diagnostic Lab Tests and X-Rays  Advanced Types of X- Rays, Imaging Services, and Nuclear Radiology Services (includes, but not limited to: MRIs, CT/CAT scans, MRAs, nuclear cardiology studies, and PET scans) | 100% | *Services Performed in a Freestanding Outpatient Imaging Center (includes a Physician’s Office):*  90%; Deductible waived | *Services Performed in a Freestanding Outpatient Imaging Center (includes a Physician’s Office):*  70% after Deductible |
|  | 100% | *Services Performed in a Hospital Facility:* | *Services Performed in a Hospital Facility:* |
|  |  | 90% after Deductible | 70% after Deductible |
| All Other X-Rays and Lab Test Services (includes pathology tests and ultrasounds) | 100% | 90% after Deductible | 70% after Deductible |

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| **Schedule of Medical Benefits – Black Plan (Michigan)** | | | | |
| **Benefit Description** | | **Tier 1** | **Tier 2** | **Tier 3** |
| Medically Necessary Elective Abortions | and | 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, Testing | and | 100% | 100%; Deductible waived | 70% after Deductible |
| Outpatient Infusion/ Injection Therapy | | 100% | 90% after Deductible | 70% 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 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 a Nomi Health Network (Tier 1) Provider or 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 or does not use a Nomi Health Network (Tier 1) Provider. See the “Utilization Review Program” subsection of the Plan document for additional information. | | | | |
| Chiropractic Care  Spinal Manipulations, Therapy Treatments, and a Physician’s Fee for an Initial or Periodic Evaluation | | 100% | $25 co-payment per day, then 100% (Deductible waived) | 50% after Deductible |
| Diagnostic Spinal X-Rays | | 100% | 90% after Deductible | 70% after Deductible |
| 30 Visits Allowed per Covered Person per Plan Year for All Covered Chiropractic Care Services (Tier 1, Tier 2, and Tier 3 services combined) | |  |  |  |
| **Special Note about the Chiropractic Care Benefit:** For purposes of this benefit, a visit includes all 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 (DME), Prosthetics, and Orthotics | | 100% | 90% after Deductible | 50% after Deductible |
| **Special Note about the Durable Medical Equipment (DME), Prosthetics, and Orthotics Benefit:** Certain DME items are required by Health Care Reform to be covered under the Plan’s Routine Preventive Care benefit. Accordingly, when such items are received from a Tier 1 or Tier 2 Provider, | | | | |

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| **Schedule of Medical Benefits – Black Plan (Michigan)** | | | |
| **Benefit Description** | **Tier 1** | **Tier 2** | **Tier 3** |
| Durable Medical Equipment (DME), Prosthetics, and Orthotics, cont.  these charges will be processed as a Routine Preventive Care expense and subject to no cost sharing. A summary of these required preventive care items and services can be viewed by logging on to the Claim Administrator’s Website address printed on the back of the Covered Person’s identification card or by calling the Claim Administrator at the telephone number printed on the Covered Person’s identification card. | | | |
| Hearing Care  Exams, Evaluations, Conformity Tests, and Hearing Aids | 100% | 90% after Deductible | 70% 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 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 Tier 1 or Tier 2 services (cost-sharing provisions will depend on whether the provider is a Specialist or Non-Specialist, as well as the type of service rendered). Please see the Hearing Care benefit for more information about services eligible for coverage under this benefit. | | | |
| Outpatient Rehabilitative Services  Physical Therapy, Speech Therapy, and Occupational Therapy | 100% | $25 co-payment per day, then 100% (Deductible waived) | 50% after Deductible |
| 50 Outpatient Visits Allowed per Covered Person per Plan Year for Outpatient Rehabilitative Services (Any and All Eligible Diagnoses/ Conditions; Tier 1, Tier 2, and Tier 3 services combined) |  |  |  |

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| **Schedule of Medical Benefits – Black Plan (Michigan)** | | | |
| **Benefit Description** | **Tier 1** | **Tier 2** | **Tier 3** |
| Diagnosis or Treatment of Underlying Cause of Infertility | 100% (if available) | 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 | 100% | 90% after Deductible | 70% after Deductible |
| Hospice | 100% | 90% after Deductible | 70% after Deductible |

# SCHEDULE OF PRESCRIPTION DRUG BENEFITS – BLACK PLAN (MICHIGAN)

**Important Notes for Eligible Prescription Drugs – Black Plan (Michigan)**

1. As stated in the Schedule of Benefits, the annual Total Maximum Out-of-Pocket amounts include charges paid by the Covered Person for prescription drug co-payments. However, these amounts do not include any financial assistance from a drug manufacturer or any other third-party sponsored program, nor any medical- and prescription drug-related expenses that constitute a penalty for noncompliance, exceed the Usual and Customary charge allowed by the Plan, exceed limits in a Schedule of Benefits, or are otherwise excluded under the provisions of the Plan. Amounts paid by a Covered Person for such penalties do not accumulate toward the Covered Person’s or Family’s medical Deductible or Total Maximum Out-of-Pocket amounts.

Once the applicable Tier 2 annual Total Maximum Out-of-Pocket amount has been met, the Plan pays 100% of the purchase price and no separate prescription drug co-payment applies for the remainder of the Plan Year.

1. As used in this Schedule of Benefits, the term “Rx Formulary Tier 1” generally means a category of prescription drugs that 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. For additional information about the coverage status and Rx Formulary Tier category of a drug, as well as any quantity/age limits or prior authorization requirements that may apply, the Covered Person can contact the Pharmacy Benefits Manager (PBM) at the telephone number 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.

**Important Notes for Eligible Prescription Drugs – Black Plan (Michigan)**

1. Certain over-the-counter drugs will be covered under the Plan and shall be subject to the Rx Formulary Tier 1 co-payments shown below. A Physician’s prescription for these products is required.
2. In accordance with the requirements of Health Care Reform, the Plan provides coverage for certain preventive care medications without any cost-sharing provisions such as medical Deductibles or prescription drug co-payments. Preventive care medications include, but are not limited to, certain FDA-approved contraceptive agents, certain smoking cessation intervention products when prescribed by a Physician, and breast cancer medications that lower the risk of cancer or slow its development. For more information about eligible preventive care medications, Covered Persons can contact the PBM at the telephone number on the health plan identification card.
3. Certain immunizations administered at a pharmacy within the designated network, including any injection/administration fees charged by the pharmacy, will be covered by the Plan through the Prescription Drug Card Program at 100% (no prescription drug co-payment will be applied). Covered Persons can contact the PBM for more information on how to find a pharmacy within the designated network that administers these immunizations.
4. 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.

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| **Schedule of Prescription Drug Benefits – Black Plan (Michigan)** | |
| Prescription Drug Co-Payments  Retail Prescription Drug Card Program 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 |

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| **Schedule of Prescription Drug Benefits – Black Plan (Michigan)** | |
| Prescription Drug Co-Payments, cont. Mail Service Program Co-Payments (90-Day Supply)  Specialty Pharmacy Program Co- Payment (30-Day Supply) | $20/Rx Formulary Tier 1 drug,  $50/Rx Formulary Tier 2 drug,  $100/Rx Formulary Tier 3 drug  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 Management LLC Pharmacy, LLC specialty pharmacy in order to be eligible for Plan coverage. Covered Persons can contact Prime Therapeutics Management LLC 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 ProductsSM 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) 422-1776. Failure to meet the Plan’s prior authorization requirements and criteria, including enrollment in the Select Drugs and ProductsSM 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). | |

# SCHEDULE OF MEDICAL BENEFITS – ORANGE PLAN (MICHIGAN)

1. As used throughout the Schedule of Benefits, the following terminology shall mean:

Tier 1: Charges billed by providers that participate in the Nomi Health Network. Nomi Health Network offers most covered healthcare services at zero cost to Covered Persons. There is no co-payment or Deductible requirement when using Nomi Health Network Providers, except for the services listed otherwise. To learn more about Nomi Health Network and how to reduce out-of-pocket costs when obtaining healthcare services, visit [www.nomihealth.com/provider-](http://www.nomihealth.com/provider-) search, or call (855) 601-1900.

Tier 2: Charges billed by providers that participate with any network used by the Plan, except for the Nomi Health Network as identified elsewhere in this provision.

Tier 3: Charges billed by providers that do not participate with any network used by the Plan.

**Important Notes – Orange Plan (Michigan)**

**Important Notes – Orange Plan (Michigan)**

1. As required by the No Surprises Act, if a Covered Person receives services in the following situations, the services will be paid at the Tier 1 Network benefit level (regardless of the network status of the billing provider): (1) emergency care; (2) transportation by air ambulance; or (3) nonemergency care at a Tier 1 facility provided by a Tier 2 or Tier 3 Physician or laboratory, unless the Covered Person provides informed consent.

Additionally, if a Covered Person receives eligible treatment from a Tier 1 Provider, any charges for the following will be paid at the Tier 1 benefit level, even if provided by a Tier 2 or Tier 3 Provider: (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 a Tier 2 or Tier 3 Provider if there was no Tier 1 Provider that could provide the item or service at the Tier 1 facility or office where the treatment was performed. If a Covered Person receives eligible treatment at a Tier 2 Network facility, any charges for the following will be paid at the Tier 2 benefit level, even if provided by a Tier 3 Physician or laboratory (if such charges are billed by Tier 1 providers, the Tier 1 Network benefit level will apply): (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 a Tier 3 Physician or laboratory if there was no Tier 2 Physician or laboratory that could provide the item or service at the Tier 2 facility.

1. If a Covered Person receives eligible treatment at a Tier 1 or Tier 2 facility and the Plan Administrator determines that the Covered Person had no choice over the Physician that provides treatment, the claim may be adjusted. In this situation, claims from a Tier 2 or Tier 3 Provider may be adjusted to yield Tier 1-level or Tier 2-level benefits depending on the facility where treatment was received.

If a Covered Person receives treatment from a Tier 3 Provider and the Plan Administrator determines that treatment was not provided by a Tier 1 Provider or Tier 2 Provider for one of the reasons specified below, the claim may be adjusted to yield Tier 2-level benefits (unless specifically stated otherwise below):

* 1. There was not access to a Qualified Tier 1 Provider or Qualified Tier 2 Provider located within a Reasonable Distance from the Covered Person’s residence.
  2. It was not reasonable for the Covered Person to seek care from a Tier 1 Provider or Tier 2 Provider because of a Medical Emergency.
  3. A Covered Person either traveled to a place where he or she could not reasonably be expected to know the location of the nearest Tier 1 Provider or Tier 2 Provider or traveled to a place where no Tier 1 Provider or Tier 2 Providers are available.
  4. A Dependent child received Tier 3 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.

1. The Deductible and Coinsurance Maximum Out-of-Pocket amounts below are intended to limit the amount of Deductible and Coinsurance that has been designated as the Covered Person’s or Family’s responsibility; however, in certain cases, the total amount that is paid in co-payments may decrease the amount of Coinsurance or Deductible that a Covered Person or Family has to pay. That is, once the Plan’s Total Maximum Out-of-Pocket has been satisfied by any combination of Deductible, Coinsurance, and co-payments paid by the Covered Person or Family, the Plan will no longer charge such amounts for the remainder of the Plan Year.
2. Certification is required for all Inpatient Hospital admissions, select surgical procedures, and some Outpatient procedures. Please see the “Utilization Review Program” subsection for specific information regarding requirements and deadlines.

**Important Notes – Orange Plan (Michigan)**

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| **Schedule of Medical Benefits – Orange Plan (Michigan)** | | | |
| **Benefit Description** | **Tier 1** | **Tier 2** | **Tier 3** |
| Plan Year (benefit-based accumulators) | January 1 through December 31 | | |
| Comprehensive Medical Benefit  Deductible per Plan Year | $0/Covered Person  $0/Family  100%  (0% Coinsurance)  $0/Covered Person  $0/Family  $0/Covered Person\*  $0/Family\*  \*Charges for Tier 1 co- payments will apply toward the Plan’s Total Out-of- Pocket Maximums as described below | $0/Covered Person | $500/Covered Person |
|  | $0/Family | $1,000/Family |
| General Benefit Percentage Paid (all Covered Expenses, unless specifically stated otherwise) | 100%  (10% Coinsurance) | 80% after Deductible  (20% Coinsurance) |
| Coinsurance Maximum Out-of-Pocket per Plan Year (includes Coinsurance only) | $0/Covered Person  $0/Family | $1,500/Covered Person  $3,000/Family |
| Total Maximum Out-of- Pocket per Plan Year (includes Deductible, Coinsurance, medical co- payments, and prescription drug co- payments) | $7,150/Covered Person  $14,300/Family | Unlimited |
| **Special Notes about the Comprehensive Medical Benefit:**   1. For Nomi Health Network Tier 1 benefits only: Covered Persons do not have to meet a Deductible and there are no co-payments, except for select services as noted in the Schedule below. 2. For Tier 2 and Tier 3 benefits only: An individual within a Family has to meet only the per-Covered Person Deductible before the Plan will begin paying benefits. Additionally, an individual within a Family has to meet only the per-Covered Person Coinsurance Maximum Out-of-Pocket before the Plan’s general benefit percentage will increase to 100% for the remainder of the Plan Year for the applicable benefit tier or the per-Covered Person Total Maximum Out-of-Pocket for Tier 2 charges before medical and prescription drug co-payments will no longer be charged for the remainder of the Plan Year. | | | |

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| **Schedule of Medical Benefits – Orange Plan (Michigan)** | | | |
| **Benefit Description** | **Tier 1** | **Tier 2** | **Tier 3** |
| Comprehensive Medical Benefit, cont.   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 in the Schedule of Benefits, or are otherwise excluded under the provisions of the Plan. There is no concurrent accrual of Deductible or Coinsurance Maximum Out-of-Pocket amounts; Tier 1, Tier 2, and Tier 3 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 does not include any drug manufacturer’s assistance. Additionally, the Total Maximum Out-of-Pocket also does 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 limits in a Schedule of Benefits, or are otherwise excluded under the provisions of the Plan. Amounts applied toward the Total Maximum Out-of-Pockets for Tier 1 services will also accrue toward the Total Maximum Out-of- Pockets for Tier 2 services, and vice versa. | | | |
| Outpatient Physician Services (includes office visits, Telemedicine e-visits, and second surgical opinions)  Physician’s Fee for an Examination | *Amwell Telemedicine E-Visits:*  $0 co-payment per visit, then 100%  Contact Amwell at (844) 733-3627 or  [www.amwell.com](http://www.amwell.com/) | *Amwell Telemedicine E-Visits:*  $0 co-payment per visit, then 100%  Contact Amwell at (844) 733-3627 or  [www.amwell.com](http://www.amwell.com/) | *Amwell Telemedicine E-Visits:*  $0 co-payment per visit, then 100% (Deductible waived)  Contact Amwell at (844) 733-3627 or  [www.amwell.com](http://www.amwell.com/) |
|  | *Non-Specialist Office Visits and*  *Telemedicine E-Visits:*  $0 co-payment per visit, then 100% | *Non-Specialist Office Visits and*  *Telemedicine E-Visits:*  $10 co-payment per visit, then 100% | *Non-Specialist Office Visits and*  *Telemedicine E-Visits:*  80% after Deductible |
|  | *Specialist Office Visits and Telemedicine*  *E-Visits:*  $0 co-payment per visit, then 100% | *Specialist Office Visits and Telemedicine*  *E-Visits:*  $10 co-payment per visit, then 100% | *Specialist Office Visits 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 |

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| **Schedule of Medical Benefits – Orange Plan (Michigan)** | | | |
| **Benefit Description** | **Tier 1** | **Tier 2** | **Tier 3** |
| Outpatient Physician Services, cont.  **Special Note about the Outpatient Physician Services Benefit:** As used in this benefit, the term “Non- Specialist” means a Physician, Physician’s Assistant, Nurse Practitioner, or other eligible provider who provides Medical Care in primary care, 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 specifically addressed elsewhere in this Schedule of Benefits (e.g., chiropractic care). The term “Specialist” means a Physician with advanced education 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 | 100% | 100% | 80% after Deductible |
| **Special Note about the Routine Preventive Care Benefit:** 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; 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% | 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© | Items, services, and supplies provided through the Teladoc Health© program are covered at 100% and no Deductible will apply.  When diagnosed with an eligible condition, Covered Persons can register at [www.teladochealth.com](http://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](http://www.teladochealth.com/) for additional information about qualifying conditions and services available. | | |

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| **Schedule of Medical Benefits – Orange Plan (Michigan)** | | | |
| **Benefit Description** | **Tier 1** | **Tier 2** | **Tier 3** |
| Urgent Care Center Visits Physician’s Fee for an Examination  All Other Charges Billed in Connection with the Examination | $20 co-payment per visit, then 100%  100% | $20 co-payment per visit, then 100%  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 | 80% after Deductible  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  All Other Charges Billed by the Hospital, Physician, or Any Other Provider in Connection with the Emergency Room Visit | $150 co-payment\* per visit, then 100%  \*will waive if admitted Inpatient from the emergency room  100% | $150 co-payment\* per visit, then 100%  \*will waive if admitted Inpatient from the emergency room  100% | Paid at Tier 2 level  Paid at Tier 2 level |
| **Special Note about the Emergency Room Treatment Benefit:** The Plan does not require certification for emergency services. | | | |
| Ambulance Transportation (Ground or Air) | Not available | 100% | Paid at Tier 2 level |
| Certification Requirement | Certification is required for all Inpatient Hospital admissions, observational stays at the Hospital, select surgical procedures, and certain Outpatient services. See the “Utilization Review Program” subsection of the Plan document for additional information.  If a Nomi Health Network (Tier 1) Provider can safely and cost- effectively provide any of the services that require certification, the Utilization Review Firm will attempt to certify a Nomi Health Network Provider to provide the Covered Person’s treatment so that the patient can take advantage of this money-saving opportunity. | | |
| Inpatient Hospital Services Room and Board, Surgical Services, and Ancillary Services | 100% | 100% | 80% after Deductible |

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| **Schedule of Medical Benefits – Orange Plan (Michigan)** | | | |
| **Benefit Description** | **Tier 1** | **Tier 2** | **Tier 3** |
| Inpatient Physician Services Hospital Visits, Surgical Procedures, and Anesthesiology | 100% | 100% | 80% after Deductible |
| Outpatient Surgery and Surgery-Related Services | 100% | 100% | 80% after Deductible |
| Other Outpatient Services Chemotherapy Radiation Therapy Hemodialysis | 100% | 100% | 80% after Deductible |
| Outpatient Diagnostic Lab Tests and X-Rays | 100% | 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 | | |
| Allergy Services  Injections, Serum, and Testing | 100% | 100% | 80% after Deductible |
| Outpatient Infusion/ Injection Therapy | 100% | 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 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 a Nomi Health Network (Tier 1) Provider or 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 or does not use a Nomi Health Network (Tier 1) Provider. See the “Utilization Review Program” subsection of the Plan document for additional information. | | | |
| Chiropractic Care  Spinal Manipulations, Therapy Treatments, and a Physician’s Fee for an Initial or Periodic Evaluation  Diagnostic Spinal X-Rays | 100%  100% | $10 co-payment per day, then 100%  100% | 50% after Deductible  80% after Deductible |

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| **Schedule of Medical Benefits – Orange Plan (Michigan)** | | | |
| **Benefit Description** | **Tier 1** | **Tier 2** | **Tier 3** |
| Chiropractic Care, cont.  30 Visits Allowed per Covered Person per Plan Year for All Covered Chiropractic Care Services (Tier 1, Tier 2, and Tier 3 services combined) |  |  |  |
| **Special Note about the Chiropractic Care Benefit:** For purposes of this benefit, a visit includes all 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 (DME), Prosthetics, and Orthotics | 100% | 100% | 50% after Deductible |
| **Special Note about the Durable Medical Equipment (DME), Prosthetics, and Orthotics Benefit:** Certain DME items are required by Health Care Reform to be covered under the Plan’s Routine Preventive Care benefit. Accordingly, when such items are received from a Tier 1 or Tier 2 Provider, these charges will be processed as a Routine Preventive Care expense and subject to no cost sharing. A summary of these required preventive care items and services can be viewed by logging on to the Claim Administrator’s Website address printed on the back of the Covered Person’s identification card or by calling the Claim Administrator at the telephone number printed on the Covered Person’s identification card. | | | |
| 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 | 100% | 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 Plan’s Outpatient Physician Visits benefit. In such instances, an office visit co-payment may be charged for Tier 1 or Tier 2 services (cost-sharing provisions will depend on whether the provider is a Specialist or Non-Specialist, as well as the type of service rendered). Please see the Hearing Care benefit for more information about services eligible for coverage under this benefit. | | | |

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| **Schedule of Medical Benefits – Orange Plan (Michigan)** | | | |
| **Benefit Description** | **Tier 1** | **Tier 2** | **Tier 3** |
| Outpatient Rehabilitative Services  Physical Therapy, Speech Therapy, and Occupational Therapy | 100% | $10 co-payment per day, then 100% | 50% after Deductible |
| 50 Outpatient Visits Allowed per Covered Person per Plan Year for Outpatient Rehabilitative Services (Any and All Eligible Diagnoses/ Conditions; Tier 1, Tier 2, and Tier 3 services combined) |  |  |  |
| Diagnosis or Treatment of Underlying Cause of Infertility | 100% (if available) | 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 | 100% | 100% | 80% after Deductible |
| Hospice | 100% | 100% | 80% after Deductible |

# SCHEDULE OF PRESCRIPTION DRUG BENEFITS – ORANGE PLAN (MICHIGAN)

1. As stated in the Schedule of Benefits, the annual Total Maximum Out-of-Pocket amounts include charges paid by the Covered Person for prescription drug co-payments. However, these amounts do not include any financial assistance from a drug manufacturer or any other third-party sponsored program, nor any medical- and prescription drug-related expenses that constitute a penalty for noncompliance, exceed the Usual and Customary charge allowed by the Plan, exceed limits in a Schedule of Benefits, or are otherwise excluded under the provisions of the Plan. Amounts paid by a Covered Person for such penalties do not accumulate toward the Covered Person’s or Family’s medical Deductible or Total Maximum Out-of-Pocket amounts.

Once the applicable Tier 2 annual Total Maximum Out-of-Pocket amount has been met, the Plan pays 100% of the purchase price and no separate prescription drug co-payment applies for the remainder of the Plan Year.

**Important Notes for Eligible Prescription Drugs – Orange Plan (Michigan)**

**Important Notes for Eligible Prescription Drugs – Orange Plan (Michigan)**

1. As used in this Schedule of Benefits, the term “Rx Formulary Tier 1” generally means a category of prescription drugs that 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. For additional information about the coverage status and Rx Formulary Tier category of a drug, as well as any quantity/age limits or prior authorization requirements that may apply, the Covered Person can contact the Pharmacy Benefits Manager (PBM) at the telephone number 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 Rx Formulary Tier 1 co-payments shown below. 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 without any cost-sharing provisions such as medical Deductibles or prescription drug co-payments. Preventive care medications include, but are not limited to, certain FDA-approved contraceptive agents, certain smoking cessation intervention products when prescribed by a Physician, and breast cancer medications that lower the risk of cancer or slow its development. For more information about eligible preventive care medications, Covered Persons can contact the PBM at the telephone number on the health plan identification card.
5. Certain immunizations administered at a pharmacy within the designated network, including any injection/administration fees charged by the pharmacy, will be covered by the Plan through the Prescription Drug Card Program at 100% (no prescription drug co-payment will be applied). Covered Persons can contact the PBM for more information on how to find a pharmacy within the designated network that administers these immunizations.
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 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.

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| **Schedule of Prescription Drug Benefits – Orange Plan (Michigan)** | |
| Prescription Drug Co-Payments  Retail Prescription Drug Card Program 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.  Mail Service Program Co-Payments (90-Day Supply)  Specialty Pharmacy Program Co- Payment (30-Day Supply) | $10/Rx Formulary Tier 1 drug,  $25/Rx Formulary Tier 2 drug,  $50/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 may be eligible for Plan coverage, but additional special coverage terms apply. These drugs must generally be filled or coordinated through the Prime Therapeutics Management LLC Pharmacy, LLC specialty pharmacy in order to be eligible for Plan coverage. Covered Persons can contact Prime Therapeutics Management LLC 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 ProductsSM 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) 422-1776. Failure to meet the Plan’s prior authorization requirements and criteria, including enrollment in the Select Drugs and ProductsSM 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). | |

1. In the **HEALTH CARE REFORM** section of the Plan document, provision F(2) will be revised to read as follows:
   1. The Plan provides certain patient protections such as:
      * If a Covered Person is required to designate a Personal Care Physician (PCP), the Covered Person may designate any participating PCP, including a Pediatrician, as the Covered Person’s PCP.
      * The Plan does not require a preauthorization for emergency services.
      * Black Plan (Michigan) and Orange Plan (Michigan) Enrollees Only: The Plan does not require a preauthorization or referral when a Covered Person seeks coverage for obstetric or gynecological care from a Tier 1 or Tier 2 OB-GYN.
      * Black Plan (Non-Michigan) and Orange Plan (Non-Michigan) Enrollees Only: The Plan does not require a preauthorization or referral when a Covered Person seeks coverage for obstetric or gynecological care from an In-Network OB-GYN.
      * Black Plan (Michigan) and Orange Plan (Michigan) Enrollees Only: With respect to certain emergency services rendered in the emergency department of a Tier 3 Hospital or an independent freestanding facility, the Plan does not impose a co-payment or Coinsurance that is greater than the co-payment or Coinsurance that would be assessed if the services had been performed in the emergency department of a Tier 1 Hospital or independent freestanding facility.
      * Black Plan (Non-Michigan) and Orange Plan (Non-Michigan) Enrollees Only: With respect to certain emergency services rendered in the emergency department of an Out-of-Network Hospital or an independent freestanding facility, the Plan does not impose a co-payment or Coinsurance that is greater than the co-payment or Coinsurance that would be assessed if the services had been performed in the emergency department of an In-Network Hospital or independent freestanding facility.
2. The existing **UTILIZATION OF IN-NETWORK PROVIDERS** section will be renamed as the **UTILIZATION OF IN-NETWORK PROVIDERS** – **BLACK PLAN (NON-MICHIGAN) AND ORANGE PLAN (NON-MICHIGAN) ONLY**, and the following section will be added to the Plan document:

# UTILIZATION OF PROVIDERS –

**BLACK PLAN (MICHIGAN) AND ORANGE PLAN (MICHIGAN) ONLY**

Medical treatment is solely a decision between a Covered Person and their Physician. While the Plan may provide different levels of benefits depending on the Covered Person’s choice of provider, neither the Plan Administrator nor the Claim Administrator endorses one licensed medical provider over another. Increased benefit levels applicable to Tier 1 or Tier 2 Providers are based solely upon negotiated fees or discounts.

## *UTILIZATION OF TIER 1 PROVIDERS*

The Plan has entered into an agreement with Nomi Health Network, a network of Physicians, Hospitals, and other medical providers (Tier 1 Providers) who have agreed to provide health care at discounted fees. Covered Persons who receive care from a facility or provider participating in the Nomi Health Network will have an opportunity to reduce their out-of-pocket expenses. The combination of these facilities and these providers shall

be known as Tier 1 Providers. If a Covered Person chooses to be treated by a Tier 1 Provider, payment of charges for eligible benefits under the Plan will be made at the corresponding percentage and will be subject to the co-payment(s) stated in the Schedule of Benefits, which will typically result in zero cost to the Covered Person (unless otherwise stated in the Schedule of Benefits). As further explained in the Schedule of Benefits, in no event will a Covered Person be charged a Tier 1 co-payment if it would cause him or her to pay more than the Plan’s established limits for the amount a Covered Person or Family must pay for all eligible Tier 2 medical expenses and prescription drug expenses combined.

## *UTILIZATION OF TIER 2 PROVIDERS*

The Plan has entered into an agreement with a network of Physicians, Hospitals, and other medical providers (Tier 2 Providers) who have agreed to provide health care at discounted fees. For Covered Persons who use Tier 2 Providers, this option works in tandem with the traditional coverage under the Plan by giving those Covered Persons the opportunity to reduce their out-of-pocket expenses. If a Covered Person chooses to be treated by a Tier 2 Provider, payment of charges for eligible benefits under the Plan will be made at the corresponding percentage stated in the Schedule of Benefits and will be subject to the co- payment(s) stated in the Schedule of Benefits (however, as further explained in the Schedule of Benefits, in no event will a Covered Person be charged a Tier 2 co-payment if it would cause him or her to pay more than the Plan’s established limits for the amount a Covered Person or Family must pay for all eligible Tier 2 medical expenses and prescription drug expenses combined).

Covered Persons will be given the names of Physicians, Hospitals, and other medical providers available in their area who have agreed to be Tier 2 Providers. The network names are printed on the Covered Person’s health plan identification card, and a complete list of Tier 2 Providers participating in these networks can be viewed by visiting the networks’ Website addresses. Covered Persons may also request a complete list of Tier 2 Providers from the Plan Administrator, which will be provided to Participants as a separate document free of charge.

A Covered Person who is a Continuing Care Patient will receive a notice that the Covered Person may elect to receive transitional care. If the Covered Person timely notifies the Plan of the Covered Person’s need for transitional care, charges from the Tier 1 Provider that moved out of the Nomi Health Network will continue to be paid at the Tier 1-Network benefit level (and subject to the same terms and conditions that apply to the Tier 1 Network) for a period of 90 days or, if earlier, the date that the Covered Person is no longer a Continuing Care Patient. Similarly, if the Covered Person timely notifies the Plan of the Covered Person’s need for transitional care, charges from the Tier 2 Provider that moved out of the network will continue to be paid at the Tier 2-Network benefit level (and subject to the same terms and conditions that apply to the Tier 2 Network) for a period of 90 days or, if earlier, the date that the Covered Person is no longer a Continuing Care Patient (unless the provider has become an eligible Tier 1 Provider; in this case, Tier 1-level benefits can apply on the date of the provider’s new network affiliation). This 90-day period begins on the date that the Covered Person receives the notice regarding transitional care. A Covered Person who is a Continuing Care Patient is not eligible for transitional care if the Tier 1 Provider or Tier 2 Provider is removed from the network for failure to meet applicable quality standards or for fraud.

1. The **UTILIZATION REVIEW PROGRAM** section will be deleted in its entirety and replaced with the following:

# UTILIZATION REVIEW PROGRAM

**Note for Enrollees in the Black Plan (Michigan) and Orange Plan (Michigan):** The Plan has entered into an agreement with the Nomi Health Network in order to give Covered Persons the opportunity to reduce their out-of-pocket expenses when care is received from a provider participating in the Nomi Health Network (a Tier 1 Provider). If a Tier 1 Provider can safely and cost-effectively provide any of the services that require certification as outlined in the provisions below, the Utilization Review Firm will initially attempt to certify a Tier 1 Provider to provide the Covered Person’s treatment so that he or she can take advantage of this money-saving opportunity. However, the Utilization Review Firm shall ultimately certify eligible services and providers that are in the best interests of the Covered Person and the Plan, and it will exercise its discretion in a uniform and consistent manner based upon the objective criteria set forth in the Plan.

## *MANDATORY HOSPITAL ADMISSION CERTIFICATION*

If a Covered Person is scheduled for an Inpatient Hospital confinement, or is admitted to a Hospital on an observation basis, that Hospital stay should be reviewed before the admission. However, the Plan does not require certification for emergency services.

# A Covered Person must call the Certification telephone number on the health plan identification card as soon as possible before a Hospital admission, but in no event later than two business days following the admission.

## *MANDATORY SELECT SURGICAL PROCEDURE AND OUTPATIENT SERVICE* CERTIFICATION

If a Covered Person’s treatment includes any of the services listed below, the treatment should be reviewed before its inception regardless of whether or not the treatment is in lieu of hospitalization. However, the Plan does not require certification for emergency services.

1. Select surgical procedures
2. Durable Medical Equipment if the purchase price or forecasted total rental cost will be $2,500 or more
3. Home health care
4. Custom-made Orthotic or Prosthetic Appliance if the purchase price will be

$2,500 or more

1. Outpatient oncology treatment (chemotherapy or radiation therapy)
2. Enteral and total parenteral nutrition therapy
3. Outpatient infusion or injection of select products

# NOTES:

1. The list of select surgical procedures that require certification can be accessed by logging on to the Claim Administrator’s Website address printed on

the health plan identification card or by calling the Claim Administrator at the telephone number printed on the health plan identification card.

1. Equipment for administering nutrition therapy is not subject to the enteral and total parenteral nutrition therapy certification requirement; however, such products will be reviewed as part of a Covered Person’s eligible charges under the Durable Medical Equipment certification requirement included in the service list above.
2. The infusion or injection of medications that are self-administered or that are administered in most Outpatient settings generally requires certification if the per-dosage cost is $2,000 or more per 30-day supply. For purposes of this provision, the cost will be calculated using either the actual per-dosage cost of the medication or the cost of a 30-day supply of the medication, whichever cost calculation is higher. However, when otherwise eligible for Plan coverage, antibiotics, post-transplant medication regimens, spinal injections, steroid injections, or therapeutic injections for osteoarthritis of the knee will not be subject to the Plan’s certification requirement. Total parenteral nutrition (TPN) will not be subject to the Outpatient infusion or injection certification requirement; however, such products will be reviewed as part of a Covered Person’s eligible treatment under the Outpatient enteral and total parenteral nutrition therapy certification requirement included in the service list above. Additionally, medications related to an oncology diagnosis will also not be subject to the Outpatient infusion or injection certification requirement; however, such drugs will be reviewed as part of a Covered Person’s eligible treatment under the Outpatient oncology treatment certification requirement included in the service list above. 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.

In addition to the standard certification requirement for the Outpatient infusion or injection of select products as included in the service list above, the Plan will require those infusions and injections to be purchased or administered at a Tier 1 Provider (when available based on benefit design) or 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). In order to determine the most cost-effective site of service that is able to safely and appropriately provide or administer the product prescribed, the Utilization Review Firm or Plan may consider factors such as the Covered Person’s need for continuity of care during a course of treatment related to a serious or complex medical condition, the proximity of the Covered Person’s home to an available lower-cost site of service, or the use of a particular facility because of the limited distribution of a prescribed medication. 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 or does not use a Tier 1 Provider (if available) as outlined above. A Covered Person can call the Certification telephone number on the health plan identification card to find the most cost-

effective site of service that can safely and appropriately provide or administer the product prescribed.

If the Plan’s requirement to use the most cost-effective site of service will result in the disruption of an existing, Physician-approved treatment plan, the Utilization Review Firm or Plan may allow a limited number of grace fills (generally two doses) of a select product to be purchased and/or administered at a different site of service before the Plan's exclusion for failure to use the most cost-effective site of service will apply.

# A Covered Person must call the Certification telephone number on the health plan identification card as soon as possible before receiving the above-listed services, but in no event later than two business days after the services were rendered.

## *ADDITIONAL INFORMATION*

Completion of the mandatory certification requirements does not guarantee payment. Payment is subject to the Plan Administrator’s determination of eligibility and coverage. If certification is denied, the Covered Person may appeal this decision, as described in the Appeal of Denial subsection of the Claims Procedure section.

1. In the **GENERAL PLAN EXCLUSIONS AND LIMITATIONS** section of the Plan document, the *Infusion or Injection of Select Products not Performed at the Most Cost- Effective Site of Service* exclusion will be revised to read as follows:

*Infusion or Injection of Select Products not Performed at the Most Cost-Effective Site of Service*

Charges for or associated with the Outpatient infusion or injection of select products if the Covered Person did not receive services at the most cost-effective site of service that can safely and appropriately provide the treatment or does not use a Tier 1 Provider (when available based on benefit design). A medication that has been determined to be eligible for Prescription Drug Benefit coverage by the Pharmacy Benefits Manager will be eligible for coverage only under the Prescription Drug Benefit and will not be covered as a medical expense if a pharmacy (including a specialty pharmacy or similar mail-order service) has been approved by the Utilization Review Firm or Plan as the most cost-effective site of service to purchase the select product.

This exclusion will not apply to medications administered to a Covered Person while confined on an Inpatient basis, or while a Covered Person is receiving treatment at an ambulatory surgical center or an emergency room.

If the Plan’s requirement to use the most cost-effective site of service will result in the disruption of an existing, Physician-approved treatment plan, the Utilization Review Firm or Plan may allow a limited number of grace fills (generally two doses) of a select product to be purchased and/or administered at a different site of service before this exclusion will apply to those charges.

1. The **ANNUAL OPEN ENROLLMENT PERIOD** section of the Plan document will be deleted in its entirety and replaced with the following:

# ANNUAL OPEN ENROLLMENT PERIOD

The Plan will offer an Annual Open Enrollment Period in November each year for eligible individuals and their dependents to enroll or re-enroll for coverage under this Plan. For those individuals and their dependent(s), their elections will go into effect on January following the Annual Open Enrollment Period.

Additionally, the Plan will offer a one-time-only special Annual Open Enrollment Period in May/June 2025 for eligible individuals and their dependents to enroll or re-enroll for coverage under this Plan. For eligible individuals and their dependents(s) who enroll or re-enroll for coverage under this Plan during this one-time-only special Annual Open Enrollment Period, their elections will go into effect on July 1, 2025. Furthermore, unless an eligible individual completes a new election form and returns it to the Plan Administrator during this one-time-only special Annual Open Enrollment Period, an individual’s election from the previous Annual Open Enrollment Period shall automatically continue, subject to all requirements and provisions of the Plan.

An eligible individual may complete a new election form and return it to the Plan Administrator during the Annual Open Enrollment Period before the first day of the subsequent Plan Year. Further, the Plan Administrator may require an eligible individual to complete a new election form for a subsequent Plan Year. If neither one of these situations applies, an individual’s election from the previous Plan Year shall automatically continue for the subsequent Plan Year.

Employees who satisfy the Participant Eligibility Requirements for full-time Employees as described in the Participant Eligibility Requirements: Full-Time Employees section of the Plan document and who continue to be eligible for Participant Coverage may enroll or re- enroll for coverage under the Plan during the Annual Open Enrollment Period.

Any other Employee will be eligible to enroll or re-enroll for coverage under the Plan during the Annual Open Enrollment Period if he or she averaged 30 or more hours per week during the preceding 12-month Standard Measurement Period. Alternatively, an Employee who is eligible for coverage during his or her Initial Stability Period will be able to enroll or re-enroll for coverage under the Plan during the Annual Open Enrollment Period but coverage and the election will both terminate upon the expiration of the Initial Stability Period, unless the Employee maintains his or her eligibility for coverage under the terms of the Plan.

1. In the **DEFINITIONS** section of the Plan document, the *CONTINUING CARE PATIENT*

definition will be deleted in its entirety and replaced with the following two provisions:

*CONTINUING CARE PATIENT – BLACK PLAN (MICHIGAN) AND ORANGE PLAN (MICHIGAN)*

In reference to the Black Plan (Michigan) and Orange Plan (Michigan) options only, the term “Continuing Care Patient” means a Covered Person who (1) is undergoing a course of treatment for a serious and complex condition from a Tier 1- or Tier 2-Network Provider;

(2) is undergoing a course of institutional or Inpatient care from a Tier 1- or Tier 2-Network Provider; (3) is scheduled to undergo non-elective surgery from a Tier 1- or Tier 2-Network Provider, including receipt of postoperative care from the Tier 1- or Tier 2-Network Provider with respect to the non-elective surgery; (4) is pregnant and undergoing a course of treatment for the Pregnancy from the Tier 1- or Tier 2-Network Provider; or (5) is or was determined to be terminally ill and is receiving treatment for the terminal Illness from the Tier 1- or Tier 2-Network Provider.

*CONTINUING CARE PATIENT – BLACK PLAN (NON-MICHIGAN) AND ORANGE PLAN (NON-MICHIGAN)*

In reference to the Black Plan (non-Michigan) and Orange Plan (non-Michigan) options only, the term “Continuing Care Patient” means a Covered Person who (1) is undergoing a course of treatment for a serious and complex condition from an In-Network Provider;

1. is undergoing a course of institutional or Inpatient care from an In-Network Provider;
2. is scheduled to undergo non-elective surgery from an In-Network Provider, including receipt of postoperative care from the In-Network Provider with respect to the non-elective surgery; (4) is pregnant and undergoing a course of treatment for the Pregnancy from the In-Network Provider; or (5) is or was determined to be terminally ill and is receiving treatment for the terminal Illness from the In-Network Provider.
3. In the **DEFINITIONS** section of the Plan document, the *IN-NETWORK PROVIDERS* and *OUT-OF-NETWORK PROVIDERS* definitions will be deleted in their entirety and replaced with the following:

*IN-NETWORK PROVIDERS* **–** *BLACK PLAN (NON-MICHIGAN) AND ORANGE PLAN (NON-MICHIGAN) ONLY*

In reference to the Black Plan (Non-Michigan) and Orange Plan (Non-Michigan) options only, the term “In-Network Providers” means a group of Physicians, Hospitals, and other medical providers that have either agreed to provide health care at discounted fees or whose charges are subject to the Plan’s Maximum Allowable Amount limitation. This term shall also apply in accordance with the provisions detailed in the Utilization of Providers section(s).

*OUT-OF-NETWORK PROVIDERS* **–** *BLACK PLAN (NON-MICHIGAN) AND ORANGE PLAN (NON-MICHIGAN) ONLY*

In reference to the Black Plan (Non-Michigan) and Orange Plan (Non-Michigan) options only, the term “Out-of-Network Providers” means a group of Physicians, Hospitals, and

other medical providers that do not participate within a plan’s contracted network and do not provide health care at discounted fees.

*TIER 1 PROVIDERS – BLACK PLAN (MICHIGAN) AND ORANGE PLAN (MICHIGAN) ONLY*

In reference to the Black Plan (Michigan) and Orange Plan (Michigan) options only, the term “Tier 1 Providers” means facilities and providers participating in the Nomi Health Network that have agreed to provide health care at discounted fees in accordance with the Utilization of Providers section in the Plan document.

*TIER 2 PROVIDERS – BLACK PLAN (MICHIGAN) AND ORANGE PLAN (MICHIGAN) ONLY*

In reference to the Black Plan (Michigan) and Orange Plan (Michigan) options only, the term “Tier 2 Providers” means a group of Physicians, Hospitals, and other medical providers that participate with a network listed on the Covered Person’s health plan identification card (unless they are considered an eligible Tier 1 Provider) and that have agreed to provide health care at discounted fees in accordance with the Utilization of Providers section in the Plan document.

*TIER 3 PROVIDERS – BLACK PLAN (MICHIGAN) AND ORANGE PLAN (MICHIGAN) ONLY*

In reference to the Black Plan (Michigan) and Orange Plan (Michigan) options only, the term “Tier 3 Providers” means a group of Physicians, Hospitals, and other medical providers that do not participate within a plan’s contracted network and do not provide health care at discounted fees.

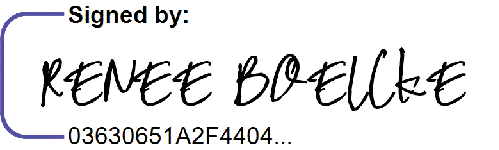
1. In the **DEFINITIONS** section of the Plan document, the note in the *USUAL AND CUSTOMARY* definition will be revised to read as follows:

**NOTE:** For claims that are subject to the No Surprises Act, the No Surprises Act governs the calculation of the payment amount by the Plan for purposes of determining both (1) the Covered Person’s cost-sharing requirement, and (2) the total payment, net of the Covered Person’s cost-sharing requirement, to the Physician or other provider. For example, these amounts may be calculated using the Qualifying Payment Amount, which is generally the median of the Plan’s contracted rate with Tier 1- or Tier 2-Network Providers (or In- Network Providers) for the same item or service in the same geographic area. The payment amount for other Tier 3 claims (or Out-of-Network Provider claims) may be calculated in this same manner, subject to the Plan Administrator’s discretion.

All other provisions of the Plan shall remain in effect and unchanged.

The undersigned has caused this amendment to be duly adopted and effective as of July 1, 2025.

9/17/2025



Date (Mandatory) KALAMAZOO COLLEGE (Authorized Representative)