

**PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION**

FOR THE

**CITY OF GRAND RAPIDS
UNIFIED HEALTH CARE PLAN**

(MEDICAL, PRESCRIPTION DRUG, DENTAL AND VISION)

**EFFECTIVE AS OF:
January 1, 2014**

Amendment #5 added Schedule of Benefits - Plan A to this plan.

Amendment #5 added Schedule of Prescription Benefits - Plan A to this plan.

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Amendment #5 added Schedule of Benefits - High Deductible Health Plan to this plan.

Amendment #5 added Schedule of Prescription Benefits - High Deductible Health Plan to this plan.

INTRODUCTION

This document is a description of the City of Grand Rapids Unified Health Care Plan (Plan). No oral interpretations can change this Plan. The Plan described is designed to:

1. Clarify Plan requirements.
2. To ensure proper utilization of Plan Benefit coverages.
3. To mitigate against improper unwarranted charges/costs to the Plan.
4. To be in compliance with the law.

Members' and Providers' responsibility is to provide all information regarding services being provided. If Employee or Provider does not provide accurate and/or complete information, the Employee may be held responsible for any charges.

To update the Plan, certain changes have been made which are incorporated in this restatement of the Plan Document. Topics covered include:

1. The Plan has been updated to comply with certain provisions of the Patient Protection and Affordable Care Act (the "Affordable Care Act").
2. The Plan has been updated to comply with the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). See page 19.
3. The Plan has been updated to comply with the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996, as amended, entitled "Security Standards." See page 87.
4. The Plan has been updated to comply with the provisions of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("MHPA of 2008").
5. The Physician Office Visit copay is \$20.00. This applies to visits in the Physician's Office and Urgent Care Center, Consultations, Chiropractic, and Mental Disorders & Substance Use Disorders Outpatient Office Visits. See the Schedule of Benefits page 32.
6. The Prescription Drug benefit includes a \$600 calendar year maximum for Proton Pump Inhibitors (PPIs). Once this maximum is met, the Employee's copay shall increase to \$20 generic and \$40 brand name. (PPIs dispensed under the OTC program do not count toward the \$600 maximum.)
7. The Prescription Drug benefit includes an OTC Step Therapy provision for the following OTC drug classifications: Proton Pump Inhibitors, Antihistamines and NSAIDs.

8. As specified in the applicable union contract, bargaining unit members who retire prior to age 65 will continue to be covered with the same health benefits as active employees, including any future changes applied to the active employee Plan.

Coverage under the Plan will take effect for an eligible Employee and designated Dependents when the Employee and such Dependents satisfy all the eligibility requirements of the Plan.

You are reminded that Medical Necessity is the standard which governs the City's Plan.

The City of Grand Rapids fully intends to maintain this Plan. However, it continues to reserve the right to terminate, suspend, discontinue, or amend the Plan at any time and for any reason subject to the collective bargaining agreements.

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, maximums, co-payments, exclusions, limitations, definitions, eligibility, and the like subject to the collective bargaining agreements.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, lack of Medical Necessity, lack of timely filing of claims, or lack of coverage. These provisions are explained in summary fashion in this document; additional information is available from the Plan Administrator at no extra cost.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated. An expense for service or supply is incurred on the date the service or supply is furnished.

If the Plan is terminated, amended, or benefits are eliminated, the rights of Covered Persons are limited to Covered Charges incurred before termination, amendment, or elimination.

DEFINED TERMS

The following terms have special meaning:

Active Employee is an Employee on the regular payroll of the Employer who is scheduled to perform the duties of his or her job with the Employer on a permanent full-time basis or qualifying permanent part-time basis.

Accidental Injury shall mean physical damage caused by an action, object, or substance outside the body. This includes strains, sprains, cuts and bruises; allergic reactions, frostbite, sunburn, and sunstroke; swallowing poison and medication overdosing; and inhaling smoke, carbon monoxide, or fumes.

Acute Care Facility shall mean a facility that offers a wide range of medical, surgical, obstetric, and pediatric services. These facilities primarily treat patients with conditions that require a hospital stay of less than 30 days. The facility is not primarily for:

1. Custodial, convalescent, or rest care
2. Care of the aged
3. Skilled nursing care or nursing home care
4. Substance use disorder treatment

Amendment #2 added Administrative Period, Full-Time Employee, Hour(s) of Service, Initial Measurement Period, Initial Stability Period, Measurement Period, New Employee, Part-Time Employee, Seasonal Employee, Stability Period, Standard Measurement Period, Standard Stability Period, Variable Hour Employee to this section.

Administrator or Plan Administrator shall mean the person responsible for the day-to-day functions and management of the Plan. The Administrator may employ persons or firms to process claims and perform other Plan related services. The Administrator is the Employer.

Allogeneic (Allogenic) Transplant shall mean a procedure using another person's bone marrow or peripheral blood stem cells to transplant into the patient (including syngeneic transplants when the donor is the identical twin of the patient.)

Ambulatory Surgical Center is a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s), and does not provide for overnight stays.

Autologous Transplant shall mean a procedure using the patient's own bone marrow or peripheral blood stem cells for transplantation back into the patient.

Baseline shall mean the initial test results to which future results will be compared in order to detect abnormalities.

Benefit means coverage for health care services available in accordance with the terms of this Plan.

Birth Center means any freestanding health facility, place, professional office, or institution which is not a Hospital or in a Hospital, where births occur in a home-like

atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

Calendar Year means January 1st through December 31st of the same year.

Claims Administrator shall mean the entity providing the services delegated to it by the employer in connection with the operation of the Plan including processing and payment of claims. The Claims Administrator is Meritain Health, 2370 Science Parkway, Okemos, MI 48854.

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

Co-insurance percentage means the amount the Plan pays.

Coordination of Benefits (COB) means the coordination of your health benefits when you have coverage under more than one group health plan.

Co-pay is the portion of the medical expense that is your responsibility, as shown in the Schedule of Benefits. A Copay is applied for each occurrence of such covered medical service and is not applied toward satisfaction of the Deductible. Co-pays are applied toward satisfaction of the calendar year maximum out-of-pocket.

Cosmetic Dentistry means unnecessary dental procedures.

Covered Person or Covered Participant is an Employee or Dependent who is covered under this Plan.

Creditable Coverage means coverage of an individual under a qualified health plan as follows:

1. a group health plan;
2. health insurance coverage;
3. Medicare;
4. Medicaid;
5. TRICARE;
6. an Indian Health Service plan or tribal organization plan;
7. a state risk pool coverage;
8. a federal employees health insurance coverage;

9. a public health plan (this includes plans established or maintained by a state, the U.S. government, a foreign country, a state or federal penitentiary, U.S. Veterans Administration, or any political subdivision of a state, the U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in the Plan);
10. a Peace Corps plan;
11. the State Children's Health Insurance Program.

To the extent that further clarification is needed with respect to the sources of Creditable Coverage listed in the prior sentence, please see the complete definition of Creditable Coverage that is set forth in 45 C.F.R. § 146.113(a), which is incorporated by reference.

Custodial Care is care (including room and board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can be performed by persons who have no medical training according to generally accepted medical standards. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, and feeding; or supervision over medication which could normally be self-administered.

Dentist is a person who is properly trained and licensed to practice dentistry and who is practicing within the scope of such license.

Dependent child is defined in the "Eligibility, Effective Date, and Termination Provisions" section of this document.

Designated Cancer Center shall mean a site approved by the National Cancer Institute (NCI) as a comprehensive cancer center, clinical cancer center, consortium cancer center, or an affiliate of one of these centers.

Designated Health Care Provider shall mean a physician, group of physicians, hospitals, or service providers who have contracted for the provision of professional health services to Covered Employees and Covered Dependents. The physician, group of physicians, hospitals, or service providers may be organized as a Preferred Provider Organization (including a hospital), sole proprietorship, partnership, or professional service corporation. This is alternately referred to as a Network, Panel, or PPO.

Durable Medical Equipment means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury, and (d) is appropriate for use in the home.

Effective Date is the first day of coverage.

Emergency First Aid means the initial exam and treatment of conditions resulting from accidental injury.

Employee means a person who is an Active Permanent Employee of the Employer who is regularly scheduled to work for the Employer in an Employee/Employer relationship.

Employer is the City of Grand Rapids.

Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

Emergency Services means with respect to an Emergency Medical Condition:

- A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and
- Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3)) to Stabilize the individual.

End Stage Renal Disease (ESRD) means permanent and irreversible kidney failure that can no longer be controlled by medication or fluid and dietary restriction. Therefore, it requires a regular course of dialysis or a kidney transplant to maintain the patient's life.

Enrollment Date for purposes of complying with HIPAA regulations only means the first day of the waiting period, if any.

Essential Health Benefit has the same meaning found in section 1302(b) of the Affordable Care Act and in applicable federal regulations or other guidance, if any. Essential Health Benefits include the following general categories and the items and services covered within such categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services (including behavioral health treatment); prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Experimental and/or Investigational means services, supplies, care, and treatment which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical or dental community or government oversight agencies at the time services were rendered.

The Plan Administrator must make an independent evaluation of the experimental or non-experimental standings of specific technologies. The Plan Administrator shall be

guided by a reasonable interpretation of the Plan's provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Plan Administrator will be final and binding on the Plan. The Plan Administrator will be guided by the following principles:

1. if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
2. if the drug, device, medical treatment, procedure, or the patient informed consent document utilized with the drug, device, treatment, or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or
3. if Reliable Evidence (see definition in paragraph below) shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials; is the research, experimental, study or Investigational arm of on-going phase III clinical trials; or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its, or its efficacy as compared with a standard means of treatment or diagnosis; or
4. if Reliable Evidence (see definition in paragraph below) shows that the prevailing opinion among experts regarding the drug, device, medical treatment, or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable Evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocols(s) of another facility studying substantially the same drug, device, medical treatment, or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment, or procedure.

Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use.

Explanation of Benefits (EOB) means a form you will receive each time a claim is processed for you. The EOB shows you what services have been paid and what you may owe.

Family Unit is the covered Employee and the his/her family members who are covered as Dependents under the Plan.

Formulary means a list of prescription medications compiled by a third party payer of safe, effective therapeutic drugs specifically covered by this Plan.

Freestanding Facility means a facility separate from a hospital that provides outpatient services such as substance use disorder treatment, rehabilitation, skilled nursing care, or physical therapy.

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

Genetic Information means information about genes, gene products, and inherited characteristics that may derive from an individual or a family patient. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories, and direct analysis of genes or chromosomes. Genetic Information will not be taken into account for purposes of (1) determining eligibility for benefits under the Plan (including initial enrollment and continued eligibility), and (2) establishing contribution or premium accounts for coverage under the Plan.

High-Dose Chemotherapy (HDC) means a procedure that involves giving a patient cell destroying drugs in doses higher than approved by the FDA for therapy.

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

Home Health Care Agency is an organization that meets all of these tests: its main function is to provide Home Health Care Services and Supplies; it is federally certified as a Home Health Care Agency; and it is licensed by the state in which it is located, if licensing is required.

Home Health Care Plan must meet these tests: it must be a formal written plan made by the patient's attending Physician which is reviewed at least every 30 days; it must state the diagnosis; it must certify that the Home Health Care is in place of Hospital confinement; and it must specify the type and extent of Home Health Care required for the treatment of the patient.

Home Health Care Services and Supplies include part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and speech therapy; medical supplies; and laboratory services provided by or on behalf of the Hospital.

Hospice Agency is an organization whose main function is to provide Hospice Care Services and Supplies. It is licensed by the state in which it is located if licensing is required.

Hospice Care Plan is a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

Hospice Care Services and Supplies are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, home care, and family counseling during the bereavement period.

Hospice Unit is a facility or separate Hospital Unit that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

Hospital is an institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets these tests: it is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations; it is approved by Medicare as a Hospital; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians; it continuously provides on-site 24-hour-a-day nursing services by or under the supervision of registered nurses (R.N.s); and it is operated continuously with organized facilities for operative surgery on the premises.

The definition of "Hospital" shall be expanded to include the following:

1. A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.
2. A facility operating primarily for the treatment of Substance Use Disorders if it meets these tests: maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; has a Physician in regular attendance; continuously provides on-site 24-hour-a-day nursing service by a registered nurse (R.N.); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Use Disorders.

Illness means a non-occupational bodily disorder, disease, physical sickness, Pregnancy, childbirth, miscarriage, Complications of Pregnancy, Mental Disorders or Substance Use Disorders.

Injury means an accidental physical injury to the body caused by unexpected external means.

Inpatient Services means hospital services that include a room/bed charge for an overnight stay.

Intensive Care Unit is defined as a separate, clearly designated service area that is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has facilities for special nursing care not available in regular rooms and wards of the Hospital; special life saving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

Late Enrollee means a Plan Participant who enrolls under the Plan other than during the first 31-day period in which the individual is eligible to enroll under the Plan, during an Open Enrollment Period, or during a Special Enrollment Period.

Lifetime is a word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean while covered under this Plan. Under no circumstances does Lifetime mean during the lifetime of the Covered Person.

Medical Care Facility means a Hospital, a facility that treats one or more specific ailments, or any type of Skilled Nursing Facility.

Medically Necessary means services you receive from a medical provider must be medically necessary, unless stated otherwise, in order to be payable under the Plan. Medical necessity definitions for hospital services and medical services are as follows:

Medical necessity for payment of **hospital services** requires that **all** of the following conditions be met:

1. The covered services are for the treatment, diagnosis, or symptoms of an injury, condition, or disease.
2. The service, treatment or supply is **appropriate** for the symptoms and is consistent with the diagnosis.
 - A. Appropriate means that the type, level and length of care, treatment, or supply and setting are needed to provide safe, adequate care and treatment
 - B. For inpatient hospital stays, acute care as an inpatient must be necessitated by the patient's condition because safe and adequate care cannot be received as an outpatient or in a less intensified medical setting.
3. The services are not mainly for the convenience of the patient or health care provider.
4. The treatment is not generally regarded as experimental or investigative.
5. The treatment is determined to be medically appropriate by an independent professional review.

Medical necessity for payment of **physician and dental services** is determined by physicians or dentist acting for their respective provider types and/or medical specialty and is based on criteria and guidelines developed by physicians and professional providers. It requires that:

1. The covered service is generally accepted as necessary and appropriate for the patient's condition in consideration of the symptoms. The covered service is consistent with the diagnosis.

2. The covered service is essential or relevant to the evaluation or treatment of the disease, injury, condition, or illness. It is not mainly for the convenience of the patient or physician.
3. The covered service is reasonably expected to improve the patient's condition or level of functioning. In the case of diagnostic testing, the results are used in the diagnosis and management of the patient's care.
4. In the absence of established criteria, medical necessity will be determined by physician or professional review according to generally accepted standards and practices.
5. Determination of medical necessity for payment purposes is based on standards of practice established by physicians.

Medicare is the Health Insurance for the Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Mental Disorder means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of the International Classification of Diseases, published by the U.S. Department of Health and Human Services.

Morbid Obesity is a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight in the most recent Metropolitan Life Insurance Co. tables (or similar actuarial tables) for a person of the same height, age, and mobility as the Covered Person.

Named Fiduciary shall mean the person who has the authority to control and manage the operation and administration of the Plan. The Named Fiduciary for the Plan is the employer unless otherwise designated by the employer.

Non-Occupational shall mean, with respect to Injury or Disease, an Injury or Disease for which the person is entitled to no benefits under any worker's compensation law or similar legislation, or does not arise out of or in the course of any employment or occupation for compensation or profit.

Non-Participating Provider means a health care practitioner or health care facility that has not contracted directly with the Plan or an entity contracting on behalf of the Plan to provide health care services to Plan enrollees.

Occupational Therapy means treatment consisting of specifically designed therapeutic tasks or activities that:

1. Improve or restore a patient's functional level when illness or injury has affected muscles or joints.
2. Helps the patient apply the restored or improved function to daily living.

Office Visit means all services, **billed by the physician**, are covered by one co-pay including lab, x-ray, and other services.

Outpatient Care and/or Services is treatment including services, supplies, and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Ambulatory Surgical Center, or the patient's home.

Pain Management is considered an integral part of a complete disease treatment plan. The Plan will provide coverage for the comprehensive evaluation and treatment of diseases including the management of symptoms such as intractable pain that may be associated with these diseases. Your health care benefits provide for such coverage and are subject to Plan limitations along with the assistance of the Nurse Advocate.

Participating Provider means a health care practitioner or health care facility that has contracted directly with the Plan or an entity contracting on behalf of the Plan to provide health care services to Plan enrollees.

Pharmacy means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he/she practices.

Physical Therapy means treatment that is intended to restore or improve the patient's use of specific muscles or joints, usually through exercise and therapy. The treatment is designed to improve muscle strength, joint motion, coordination, and general mobility.

Reminder: Physical therapy is not covered when services are principally for the general good and welfare of the patient (e.g., developmental therapy or activities to provide general motivation).

Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Doctor of Medical Dentistry (DMD), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Midwife, Occupational Therapist, Optometrist (O.D.), Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist, and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

Plan means the City of Grand Rapids Unified Health Care Plan which is a benefits plan for certain employees of City of Grand Rapids.

Plan Maximum are the words that appear in this Plan in reference to benefit maximums and limitations. Plan Maximum is understood to mean the dollar amount paid to a Plan participant while covered under this Plan.

Plan Participant is any Employee or Dependent who is covered under this Plan.

Plan Year is the 12-month period beginning on either the effective date of the Plan or on the day following the end of the first Plan Year which may be a short Plan Year.

Pregnancy is childbirth and conditions associated with Pregnancy, including complications.

Prescription Drug means any of the following: a Food and Drug Administration-approved drug or medicine which is required under federal law to bear the legend of "Caution: federal law prohibits dispensing without prescription"; injectable insulin; or hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of a Sickness or Injury.

Qualified Clinical Trial is defined as a Phase I, Phase II, Phase III or Phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life threatening condition and is described in (1), (2) or (3) below:

1. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
 - A. The National Institutes of Health;
 - B. The Centers for Disease Control and Prevention;
 - C. The Agency for Health Care Research and Quality;
 - D. The Centers for Medicare & Medicaid Services;
 - E. A cooperative group or center of one of the entities described in (a) through (d) above;
 - F. A qualified non-governmental research entity identified in guidelines issued by the National Institutes of Health for center support grants; or
 - G. The Department of Veteran Affairs; the Department of Defense or the Department of Energy, if (i) the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health; and (ii) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
2. The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.
3. The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

Quantity Limits

Quantity Limits (QL) ensure that you receive the medication that you need in a quantity considered safe, and are based upon U.S. Food and Drug Administration (FDA) recommendations and clinical studies.

Rescission or “to rescind” means a cancellation or discontinuance of coverage retroactively, but does not include a retroactive cancellation for non-payment of premiums.

Regular Business Hours means Monday through Friday, 8:00 AM – 5:00 PM EST.

Routine Care is well adult and well child care by a Physician that is not for an Illness or Injury.

Sickness is a person’s illness, disease, or pregnancy (including complications).

Skilled Nursing Facility is a facility that fully meets all of these tests:

1. It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.
2. Its services are provided for compensation and under the full-time supervision of a Physician.
3. It provides 24 hour per day nursing services by licensed nurses under the direction of a full-time registered nurse.
4. It maintains a complete medical record on each patient.
5. It has an effective utilization review plan.
6. It is not, other than incidentally, a place for rest, the aged, Custodial or educational care.
7. It is approved and licensed by Medicare.

This term also applies to charges incurred in a facility referring to itself as an **extended care facility, convalescent nursing home, rehabilitation hospital, or any other similar nomenclature.**

Speech Therapy means active treatment of speech, language or voice impairment due to illness, injury, or as a result of surgery.

Specialty Drugs are used to treat chronic conditions and include oral and injectable medications. Specialty drugs include a broad range of chronic conditions such as cancer, multiple sclerosis, rheumatoid arthritis, HIV/AIDS and many more.

Specialty Pharmacy services are offered by 4D Pharmacy’s partnerships with Prescription Solutions and Diplomat Pharmacy. Specialty Pharmacy services provide comprehensive patient management services, including clinical case management programs, counseling, education and social services. Prescriptions dispensed by a 4D

Pharmacy specialty pharmacy partner will include all your needed supplies – needles, syringes, alcohol swabs and sharps containers, at no additional cost to you.

Spinal Manipulation/Chiropractic Care means skeletal adjustments, manipulation, or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from or related to distortion, misalignment, or subluxation of or in the vertebral column.

Spouse is defined in the “Eligibility, Effective Date, and Termination Provisions” section of this document.

Stabilize means, with respect to an Emergency Medical Condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility; or with respect to an Emergency Medical Condition of a pregnant woman who is having contractions and (1) there is inadequate time to effect a safe transfer to another hospital before delivery, or (2) transfer may pose a threat to the health or safety of the woman or her unborn child, to deliver (including the placenta).

Stem Cells means primitive blood cells originating in the marrow that are also found in small quantities in the blood. These cells develop into mature blood elements including red cells, white cells, and platelets.

Step Therapy programs are well-planned paths to ensure the most appropriate and cost effective drug therapy. Step Therapy requires that you have tried an alternative therapy first or that your doctor has clinically documented why you cannot take the alternative therapy. Step therapy may include select covered over-the-counter products.

Substance Use Disorder means any disease or condition that is classified as a Substance Use Disorder in the current edition of the International Classification of Diseases, published by the U.S. Department of Health and Human Services.

Temporomandibular Joint (TMJ) syndrome is the treatment of jaw joint disorders including conditions of structures linking the jawbone and skull and complex of muscles, nerves, and other tissues related to the temporomandibular joint. Care and treatment shall include but are not limited to orthodontics, crowns, inlays, physical therapy, and any appliance that is attached to or rests on the teeth.

Total Disability (Totally Disabled) means in the case of an Active Employee, the complete inability to perform as a result of Injury of Sickness any and every duty of his or her occupation or of a similar occupation for which the person is reasonably capable due to education and training. In the case of a Dependent, this means the complete inability as a result of Injury or Sickness to perform the normal activities of a person of like age and gender in good health.

Urgent Care Center means a freestanding facility which is primarily engaged in providing minor emergency and episodic medical care. A legally qualified Physician, a registered nurse, and a registered technician must be in attendance at all times.

CITY OF GRAND RAPIDS UNIFIED HEALTH CARE PLAN

General Information

Follow these simple steps and you'll get the most out of the City of Grand Rapids Unified Health Care Plan:

Show your ID card at the physician's office, hospital, pharmacy, dental, or vision offices where you receive services.

Call your physician first when you have a health concern. Your physician can guide you or give you advice over the phone. Non-emergency care is less costly if you receive care in an **urgent care** center or your **physician's** office.

Go to the nearest emergency facility for emergency care treatment. Emergency room services for an Emergency Medical Condition and accidental injuries are covered when the lack of immediate medical attention could result in serious jeopardy to your health. The emergency room should not be used for colds, headaches, slight fever and back pains since these conditions may not require emergency care. Also, follow-up care is not considered emergency care.

Use the Nurse Advocate to complement your physician's services. Call **1-800-423-1028** and ask for the **Nurse Advocate** for confidential assistance with healthcare questions, help in choosing a provider, or assistance with arranging services. Hours are Monday through Friday 8:00 AM to 5:00 PM EST.

How to reach Meritain Health

1. Call 1-800-423-1028. Our customer service hours are Monday through Friday from 8:00 AM to 5:00 PM EST
2. Please send all correspondence to:
Meritain Health
P.O. Box 30126
Lansing, MI 48909
3. Walk-in Service - You may visit the Meritain Health office at 15 Ionia Ave SW, #540, in Grand Rapids, MI to have us assist you with any questions you may have regarding your health plan. Meritain Health hours are Monday through Friday from 8:00 AM to 5:00 PM EST.

Your Identification Card (ID)

The Plan's ID card is issued once you enroll for coverage. It provides important information regarding your medical, prescription drug, dental and vision coverages to your Providers. Only the employee's name and identification number will appear on the ID cards. However, the cards are for use by all covered patients.

1. Carry your ID card with you at all times to help avoid delays when you need medical attention.

2. If you or anyone in your family needs an ID card, please call us at 1-800-423-1028.
3. Only you and your eligible dependents may use the issued ID cards. Lending your ID card to anyone not eligible to use it is illegal and subject to possible fraud investigation.
4. Call Meritain Health (1-800-423-1028) or the City's Human Resources Department (616-456-3300) for replacement cards if your card is lost or stolen.
5. Providers may call 1-800-423-1028 to verify benefits during replacement card period.

Customer Service

You are important. You can call Meritain Health's office anytime during regular business hours if you have a question about your Plan.

Meritain Health also has the Interactive Voice Response System (IVR) available 24 hours per day, 7 days per week. This number is 1-800-423-1028. You can check on the status of medical and dental bills anytime of the day.

To help serve you better, here are some important tips to remember:

1. Have the covered persons' member ID number located on your ID card ready.
2. If you are questioning a service, please provide:
 - A. Patient's and provider's name
 - B. Date the patient was treated
3. When corresponding, please make sure the covered person's member ID or social security number is on each page and keep a copy of the correspondence for your records.
4. When visiting the Meritain Health office, please bring a copy of any bills, forms, or other materials related to your inquiry.

4D Pharmacy has provided multiple methods by which you can receive answers to your questions anytime and from anywhere. First, 4D Pharmacy's Member Services Help Desk is available 24 hours a day, 7 days per week at 1-877-647-4026. Additionally, you may access a broad range of tools and information through the Member link at www.4dpharmacy.com including:

1. A pharmacy locator
2. A co-pay finder
3. Drug Information

4. Your claims history
5. Mail Order Information
6. Reimbursement Forms (if necessary)

Explanation of Benefits

You will receive an **Explanation of Benefits (EOB)** form each time a claim is processed for you. This form is not a bill. The EOB shows you what services have been paid and what you may owe. If a service is denied, the EOB will explain why all or part of the charge was not covered. You will receive a letter detailing information. This will be needed to reconsider the bill for payment.

Please check your EOB carefully. It is very important that you notify Meritain Health if you did not receive the services or there are any discrepancies stated on your EOB.

ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION PROVISIONS

Coverage Starts

The Plan determines when you are eligible for coverage. You will be given an enrollment form to complete and return to the City of Grand Rapids Human Resources Department. You must be an active employee on the day your coverage becomes effective. If you are not actively at work on the date you become eligible for coverage, your coverage will begin on the date you report to work.

Newly Hired Employees

Newly hired full-time permanent employees are eligible for health care coverage on the first day of your active employment.

Retired Bargaining Unit Members

As specified in the applicable union contract, Bargaining Unit Members who retire prior to age 65 will continue to be covered with the same health benefits as active Employees, including any future changes applied to the active Employee Plan.

Special Enrollment Periods

If written application for participation is not made within 30 days after the Employee and/or Dependent meet the eligibility requirements and complete the Waiting Period, the Employee and/or Dependent may enroll as a late Enrollee unless the Employee and/or Dependent has special enrollment rights to enroll during a Special Enrollment Period. An Employee and/or Dependent has special enrollment rights to enroll during a Special Enrollment Period in the following circumstances:

1. Where the Employee and/or Dependent declined coverage when initially eligible because the Employee and/or Dependent had other coverage and the other coverage is lost as follows:
 - A. Where the other coverage is COBRA continuation coverage and it has been exhausted;
 - B. Where the other coverage is lost due to the ineligibility of Employee and/or Dependent (i.e., as a result of a legal separation, reduction in hours of employment, or a Change in Family Status); or
 - C. Where coverage is lost because Employer contributions for the coverage has been terminated.
2. The Employee and/or Dependent have a new Dependent by marriage, birth, adoption, or placement for adoption.

An Employee and/or Dependent with the above stated special enrollment rights must request enrollment during a Special Enrollment Period which is during the first 30 days after the loss of other coverage or due to marriage, birth, adoption, or placement for adoption (whichever is applicable). Enrollment will be effective on the date of the loss of coverage or the date of the marriage, birth, adoption, or placement for adoption (for all eligible individuals enrolling as a result of the new Dependent).

3. Special Enrollment due to coverage under Medicaid or under a State Children's Health Insurance Program (CHIP). If an Employee or eligible Dependent did not enroll in the Plan when initially eligible, but were otherwise eligible to enroll, he or she will be permitted to later enroll in the Plan under one of the following circumstances:
 - a. The Employee or eligible Dependent was covered under Medicaid or CHIP at the time of initial enrollment and such coverage subsequently terminates; or
 - b. The Employee or eligible Dependent become eligible for a premium assistance subsidy under Medicaid or CHIP subsequent to the time they were initially eligible.

The Employee or eligible Dependent must request enrollment in the Plan within 60 days after coverage under Medicaid or CHIP terminates or within 60 days after his or her eligibility for a premium assistance subsidy under Medicaid or CHIP is determined, whichever is applicable. Enrollment will be effective on the date of the loss of coverage.

4. Special Enrollment for Children Up to Age 26. A Dependent Child described in this paragraph (and the Employee, if the Employee is not enrolled) is eligible to enroll in the Plan during a one-time Special Enrollment Period. This Special Enrollment Period is available for any Dependent Child under age 26 whose coverage ended or who was denied coverage or who was not eligible for coverage under the Plan before January 1, 2011. The Special Enrollment Period will begin no later than the date described in the previous sentence and no earlier than the date written notice of this Special Enrollment Period is provided to such dependent or the Employee and will last for a period of thirty days. Enrollment that is properly requested during that Special Enrollment Period will become effective on January 1, 2011.
5. Special Enrollment for Individuals Who Previously Reached a Lifetime Maximum. An individual described in this Paragraph (and the Employee, if the Employee is not enrolled) is eligible to enroll in the Plan during a one-time Special Enrollment Period. This Special Enrollment Period is available for any person who is as an eligible Employee or Dependent during the Special Enrollment Period whose coverage under the Plan previously ended because he or she reached a lifetime limit on benefits that applied under the Plan. The Special Enrollment Period for purposes of this paragraph begins no later than January 1, 2011, and no earlier than the date written notice of this Special Enrollment Period is provided to the Dependent or the Employee and will last for a period of thirty days. Enrollment that is properly requested during that Special Enrollment Period will become effective on January 1, 2011.

Dependents. A Dependent is any one of the following persons:

1. A covered Employee's Spouse, unless legally separated.

2. A covered Employee's Dependent Child until the end of the month in which the child attains age 26.

Remember: You must notify the City's Human Resources Department and complete a change form when there are any dependent status changes (e.g., birth of a child, adoption, etc.)

3. A covered Employee's Dependent Child age 26 or older, who is unable to be self-supporting by reason of mental or physical handicap and is incapacitated, provided the child suffered such incapacity prior to the end of the month in which he/she attained age 26. The child must be unmarried and dependent upon the Employee for support and maintenance. The Plan Sponsor may require subsequent proof of the child's disability and dependency, including a Physician's statement certifying the child's physical or mental incapacity.

Remember: You must notify us in writing of the condition before the end of the calendar month in which the dependent turns 26. You may be required to provide verification of a dependent's total and permanent disability.

4. A child for whom the covered Employee is required to provide health coverage due to a Qualified Medical Child Support Order (QMCSO). Procedures for determining a QMCSO may be obtained from the Plan Sponsor at no cost.

The term "Spouse" shall mean the person of the opposite sex recognized as the covered Employee's husband or wife under the laws of the state where the covered Employee lives. The Plan Administrator may require documentation proving a legal marital relationship.

The term "Dependent Child" shall mean a covered Employee's natural born son, daughter, stepson, stepdaughter, legally adopted child or a child placed with the covered Employee in anticipation of adoption, or eligible child for whom the Employee is legal guardian. Coverage for an eligible child for whom the Employee is legal guardian will remain in effect until such child no longer meets the age requirements of an eligible Dependent under the terms of the Plan, regardless of whether or not such child has attained age 18 (or any other applicable age of emancipation of minors).

Important: A child is eligible for coverage as of the date of placement. Placement occurs when you become legally obligated for the total or partial support of the child in anticipation of adoption. A sworn statement with the date of placement or a court order verifying placement is required.

For purposes of this section, the term "legal guardian" means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of an individual that is placed with such person by judgment, decree, or other order of any court of competent jurisdiction.

The Plan Administrator may require documentation proving dependency, including birth certificates, tax records or initiation of legal proceedings severing parental rights.

The following are excluded as Dependents: any Spouse who is on active duty in any military service of any country; or any person who is covered under the Plan as an Employee.

If a person covered under the Plan changes status from Employee to Dependent or Dependent to Employee and the person is covered continuously under the Plan during and after the change in status, credit will be given toward deductibles and all amounts applied to Plan maximums.

Important: If you have a dependent that is no longer eligible for health coverage, the Plan has benefit options available to continue his/her coverage. Please see page 24 for COBRA information. Contact the City's Human Resources Department for information.

Changing Your Records

You need to immediately inform the City's Human Resources Department of any change in your enrollment status or address. You will need to fill out a change form. Changes you should report include marriage, divorce, childbirth, adoption, death, or change of address. It is important that your records be kept up-to-date so claims can be processed quickly and accurately.

Here's what you need to do to report a change:

1. Notify the Plan within 30 days of any event that changes the status of a Dependent.
2. Complete, sign, and return the change form to the City's Human Resources Department. Be sure to fill in the names, dates, and reason for the change.

Reminder: If the change is not reported within 30 days, no claims will be paid until required notification is received by the City's Human Resources Department.

Eligibility for Active Employees over Age 65 and/or Their Dependents

Persons affected by this section are:

1. Employees age 65 and older; and
2. Employee's Spouses age 65 and older.

All health benefits as described above to which a participating Employee or Spouse is entitled under the Plan will be paid before and without regard to any payments available under Medicare unless and until the Employee or Spouse rejects in writing health coverage under the Plan.

If the Employee rejects health coverage under the Plan, the Employee and all of his/her Dependents will no longer be eligible for any health coverage under the Plan. Coverage is then terminated. If the Employee's Spouse rejects health coverage under the Plan, the Spouse will not be eligible for any health coverage under the Plan. Coverage is then terminated.

Eligibility for benefits for the Employee and Spouse, as described above, is in effect from the first day of the month in which each of them respectively attains age 65, provided the Employee remains in an employment relationship with the Employer as determined by Employer.

This section incorporates the requirements of Medicare. If the working age requirements of Medicare are changed, this section will be automatically revised accordingly.

Continuation of Benefits

When You Are Totally Disabled

If your coverage ends because you are no longer employed, the Plan will continue to pay for covered services if:

1. You are totally disabled before this coverage ends, **and**
2. The services treat the condition which caused your total disability and the condition is continuous.

If you meet these conditions:

1. The Plan will pay benefits through December 31 of the year following the year in which your coverage under this certificate ended.

Example: If coverage ended October 15, 1991, we would continue to pay benefits until December 31, 1992.

2. The Plan will pay up to the approved amounts, limited by the lifetime maximum, after you pay your co-payment.

Employees on Military Leave. Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act (USERRA). These rights apply only to Employees and their Dependents that were covered under the Plan at the time of leaving for military service.

1. The maximum period of coverage of an Employee and the Employee's Dependents under such an election shall be the lesser of:
 - a. The 24 month period beginning the date on which the Employee's absence begins; or
 - b. The period beginning on the day the Employee's military service absence begins and ending on the day after the date on which the Employee returns to employment with the employer or fails to apply for or return to a position of employment with the Employer within the time limit that applies under USERRA.

2. An Employee who elects to continue health plan coverage may be required to pay up to 102% of the full contribution under the Plan, except an Employee on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.
3. Continuation coverage provided under USERRA counts as COBRA continuation coverage as long as the notice requirements of COBRA are satisfied in connection with the USERRA leave.
4. An Employee returning from USERRA-covered military leave who participated in the Plan immediately before going on USERRA leave has the right to resume coverage under the Plan upon return from USERRA leave, as long as the Employee resumes employment within the time limit that applies under USERRA. No waiting period will apply to an Employee returning from USERRA leave (within the applicable time period) unless the waiting period would have applied to the Employee if the Employee had remained continuously employed during the period of military leave.

Continuation During Family and Medical Leave (FMLA)

The Plan shall at all times comply with the Family and Medical Leave Act of 1993, as amended (FMLA), and as promulgated in regulations issued by the Department of Labor.

During any leave taken under the FMLA, the Employee may maintain coverage under the Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the leave period.

If the Employee fails to return to work after the FMLA leave, the Employer has the right to recover its contributions toward the cost of coverage during the FMLA leave.

If coverage under the Plan terminates during the FMLA leave, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work at the end of the FMLA leave.

Retroactive Termination of Coverage

Except in cases where an Employee or other Covered Person fails to pay any required contribution to the cost of coverage, the Plan will not retroactively terminate coverage under the Plan for any Covered Person unless the Covered Person (or a person seeking coverage on behalf of that person) performs an act, practice, or omission that constitutes fraud with respect to the Plan, or unless the individual makes an intentional misrepresentation of material fact. In such cases, the Plan will provide at least thirty days advance written notice to each Participant or Dependent who would be affected before coverage will be retroactively terminated. As provided above, coverage may be retroactively terminated in cases where required employee contributions have not been paid by the applicable deadline. In those cases, no advance written notice is required.

CONTINUATION OF COVERAGE WHEN YOU OR A DEPENDENT ARE NO LONGER ELIGIBLE UNDER THE UNIFIED PLAN

A federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), requires that most employers sponsoring a group health plan offer covered Employees and their covered spouses and dependent children the opportunity for a temporary extension of health coverage (called "COBRA continuation coverage") in certain instances where coverage under the Plan would otherwise end. This section is intended to inform you, in summary fashion, of the rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in regulations issued by the Department of the Treasury and the Department of Labor. This section is intended to reflect the law and does not grant or take away any rights that apply under applicable law. Instructions on COBRA rights and procedures, as well as election forms and other information, will be provided by the Plan Administrator to Covered Persons who become Qualified Beneficiaries under COBRA.

What is COBRA continuation coverage? COBRA continuation coverage is group health plan coverage that an employer must offer to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at specific rates for up to a statutory-mandated maximum period of time or until they become ineligible for COBRA continuation coverage, whichever occurs first. The right to COBRA continuation coverage is triggered by the occurrence of one of certain enumerated events that result in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The continuation coverage is identical to the coverage under the Plan that the Qualified Beneficiary had immediately before the Qualifying Event, or, if the coverage has been changed, the coverage is identical to the coverage provided to similarly situated Active Employees who have not experienced a Qualifying Event.

Who is a Qualified Beneficiary? In general, a Qualified Beneficiary is:

- (i) Any individual who, on the day before a Qualifying Event, is covered under the Plan as either a covered Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee, and who loses coverage under the Plan because of the Qualifying Event.
- (ii) Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage.

In addition, if the Qualifying Event is a bankruptcy proceeding under Title 11 of the U.S. Code with respect to an Employer, a covered retired Employee (who retired from employment with that Employer) and any individual who is covered under the Plan as the Spouse, surviving Spouse or Dependent child of such a retired Employee may also be Qualified Beneficiaries. Those individuals are qualified beneficiaries only if (1) for the Employee, he or she retired on or before the date of substantial elimination of coverage and (2) for any other individuals, they were beneficiaries under the Plan on the day before the bankruptcy proceeding commenced.

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who

received from the individual's Employer no earned income that constituted income from sources within the United States. If, for the reason described in the preceding sentence, an individual is not a Qualified Beneficiary, then a Spouse or Dependent child of the individual is not a Qualified Beneficiary by virtue of the relationship to the individual. **A Domestic Partner and his/her children, if applicable, are not Qualified Beneficiaries.**

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) is offered the opportunity to make an independent election to receive COBRA continuation coverage.

What is a Qualifying Event? A Qualifying Event is any of the following if an Employee, a Spouse or a Dependent child would lose coverage (i.e., would cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage.

For a covered Employee, the following may be a Qualifying Event:

- (i) The termination (other than because of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment.

For a covered Spouse, in addition to (i), the following may be Qualifying Events:

- (ii) The death of a covered Employee.
- (iii) The divorce or legal separation of a covered Employee from the Employee's Spouse.
- (iv) A covered Employee's entitlement to Medicare.

For a covered Dependent child, in addition to events (i)-(iv) above, the following may be a Qualifying Event:

- (v) A Dependent child's ceasing to satisfy the Plan's requirements for coverage as a Dependent child (e.g., attainment of the maximum age for dependency under the Plan).

Finally, for a covered retired Employee (or a Spouse, surviving Spouse, or Dependent who has coverage as the Spouse, surviving Spouse or Dependent of a retired Employee), the following may also be a Qualifying Event:

- (vi) A proceeding in bankruptcy under Title 11 of the U.S. Code with respect to an Employer from whose employment a covered retired Employee retired at any time.

If the Qualifying Event causes the Employee, or the Spouse or a Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event the persons losing such coverage become Qualified Beneficiaries under COBRA. In addition, if a bankruptcy

Qualifying Event causes a former Employee (who retired on or before the date of a substantial elimination of coverage), or such a former Employee's Spouse, surviving Spouse or Dependent child to experience a substantial elimination of coverage under the Plan occurring within 12 months before or after the date the bankruptcy proceeding commences, that former Employee, Spouse, surviving Spouse or Dependent child becomes a Qualified Beneficiary under COBRA. Any increase in contribution that must be paid by a covered Employee, former Employee or the Spouse, surviving Spouse or a Dependent child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event occurs, however, if a covered Employee does not return to employment at the end of the FMLA leave. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date. Note that the covered Employee and covered Family members will be entitled to COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the Plan during the FMLA leave.

What is the election period and how long must it last? An election period is the time period within which the Qualified Beneficiary can elect COBRA continuation coverage under the Plan. Availability of COBRA continuation coverage is conditioned upon the timely election of such coverage. The election period begins on the date of the Qualifying Event and ends 60 days after the later of (1) the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or (2) the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage.

Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event? Yes, in some cases. Each covered Employee or Qualified Beneficiary is responsible for notifying the Plan Administrator of the occurrence of a Qualifying Event that is:

- (i) A Dependent child's ceasing to be a Dependent child under the Plan.
- (ii) The divorce or legal separation of the covered Employee.

A Qualified Beneficiary (or the covered Employee or Spouse) must notify the Plan Administrator within 60 days after the later of the date one of these Qualifying Events occurs.

This notice must be provided, along with any required documentation to:

**Plan Administrator
COBRA Qualifying Event**
City of Grand Rapids
300 Monroe Avenue, Suite 801
Grand Rapids, Michigan 49503
616-456-3300

The notice must be provided in writing in a letter addressed to the Plan Administrator. The notice must include:

- (i) The covered Employee's name, address, phone number and health plan ID number.
- (ii) The name, address, phone number and health plan ID number for any Dependent child or Spouse whose eligibility is affected by the qualifying event.
- (iii) A description of the Qualifying Event (or a notice of a disability determination or termination of disability status, as described below) and the date on which it occurred.
- (iv) The following statement: "By signing this letter, I certify that the Qualifying Event described in this letter occurred on the date described in this letter." If the notice concerns a disability determination or a change in disability status, as described below, this statement is not required.
- (v) The signature of the person sending the letter.

The Qualified Beneficiary (or the covered Employee or Spouse) must also provide, along with the letter, documentation of the event that occurred, such as a photocopy of a divorce order or legal separation order showing the date of the divorce or the date the legal separation began. If a Qualified Beneficiary or anyone else has a question about what type of documentation is required, he or she should contact the Plan Administrator.

In addition to accepting a letter with the information described above, the Plan Administrator, in its discretion, may develop and make available a form, which may then be completed to provide the required notice. If such a form is available, a covered Employee or a covered Spouse or Dependent child may obtain a copy by requesting it from the Plan Administrator at the address provided in this notice.

The Plan is not required to offer the Qualified Beneficiary an opportunity to elect COBRA continuation coverage if the notice is not provided to the Plan Administrator within 60 days after the later of (1) the date of the Qualifying Event or (2) the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event.

Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights? If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Employer or Plan Administrator, as applicable.

When may a Qualified Beneficiary's COBRA continuation coverage be terminated? COBRA continuation coverage ends on the earliest of the following dates:

- (i) The last day of the applicable maximum coverage period.
- (ii) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.
- (iii) The date upon which the Employer ceases to provide any group health plan (including successor plans) to any Employee.
- (iv) The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other group health plan.
- (v) The date, after the date of the election, that the Qualified Beneficiary is first entitled to Medicare. This date does not apply for anyone who became a Qualified Beneficiary because of a bankruptcy proceeding.
- (vi) For a Qualified Beneficiary who is entitled to a disability extension, the later of:
 - (a) (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the first month that is later than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or
 - (b) the last day of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA participants, (i.e., fraud.)

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

What are the maximum coverage periods for COBRA continuation coverage? The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below.

- (i) If the Qualifying Event is a termination of employment or reduction of hours of employment, except as provided in paragraphs (ii) and (iii) below, the maximum coverage period ends 18 months after the Qualifying Event.

- (ii) If the Qualifying Event is a termination of employment or reduction of hours of employment and the Qualified Beneficiary is entitled to a disability extension, the maximum coverage period ends 29 months after the Qualifying Event if there is a disability extension (unless the disability ends before the end of that 29- month period).
- (iii) If a covered Employee becomes entitled to Medicare before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Employee ends on the later of:
 - (a) 36 months after the date the covered Employee becomes entitled to Medicare; or
 - (b) 18 months (or up to 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.
- (iv) For a bankruptcy Qualifying Event, the maximum coverage period for a Qualified Beneficiary who is a retired covered Employee (or a surviving Spouse who was participating in the Plan as a surviving Spouse on the day before the bankruptcy Qualifying Event) ends on the date of the covered retired Employee's (or surviving Spouse's) death. The maximum coverage period for a Qualified Beneficiary who is the Spouse or Dependent child of the covered retired Employee ends 36 months after the death of the covered retired Employee.
- (v) For a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.
- (vi) For any Qualifying Event other than those described above, the maximum coverage period ends 36 months after the Qualifying Event.

Under what circumstances can the maximum coverage period be expanded? If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-month maximum coverage period, the maximum coverage period may be expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to last longer than 36 months after the date of the first Qualifying Event.

However, no event is a second Qualifying Event unless that event would have been an initial Qualifying Event if it had occurred for an active covered Employee. For example, an Employee's entitlement to Medicare cannot be a second Qualifying Event for a Spouse or a Dependent child unless an active Employee's entitlement to Medicare

would have been an initial Qualifying Event, i.e., unless an Employee's entitlement to Medicare would have resulted in a loss of coverage for the Spouse or Dependent child.

A Qualified Beneficiary (or a covered Employee or Spouse) must notify the Plan Administrator of a second Qualifying Event within 60 days after the later of the date of the Qualifying Event or the date the Qualified Beneficiary would lose coverage because of the Qualifying Event. To submit this notice, the Qualified Beneficiary must follow the procedures described above under **"Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event?"**

How does a Qualified Beneficiary become entitled to a disability extension? A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary (or a covered Employee or Spouse) must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. To submit this notice, the Qualified Beneficiary must follow the procedures described above under **"Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event?"**

If a Qualified Beneficiary becomes entitled to a disability extension and then there is a final determination by the Social Security Administration, under title II or XVI of the Social Security Act, that the Qualified Beneficiary is no longer disabled, the Qualified Beneficiary (or the covered Employee or someone else) must notify the Plan Administrator of that determination within 30 days after the date of the final determination. The notice should take the form of a letter as described above under **"Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event?"**

Can a Plan require payment for COBRA continuation coverage? Yes. For any period of COBRA continuation coverage, the Plan will require the payment of an amount equal to 102% of the actual cost of coverage except the Plan will require the payment of an amount equal to 150% of the actual cost of coverage for any period of COBRA continuation coverage covering a disabled qualified beneficiary that would not be required to be made available in the absence of a disability extension.

Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments? Yes.

What is Timely Payment for payment for COBRA continuation coverage? For regular monthly payments, Timely Payment means a payment made by the first day of the month in question (the "due date") or within a 30 day grace period beginning on that due date.

Notwithstanding the above paragraph, the Plan will not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is sent to the Plan.

Special Additional Continuation Coverage Election Period for "TAA-Eligible Individuals". In addition to the other COBRA rules described in the Plan, there are some special rules that apply if an individual is classified as a "TAA-eligible individual" by the U.S. Department of Labor. (This applies only if the individual qualifies for assistance under the Trade Adjustment Assistance Reform Act 2002 because he or she became unemployed as a result of increased imports or the shifting of production to other countries.)

If an individual who is classified by the Department of Labor as a TAA-eligible individual does not elect continuation coverage when he or she first loses coverage, he or she may qualify for an election period that begins on the first day of the month in which the individual becomes a TAA-eligible individual and lasts up to 60 days. However, in no event does this election period last later than 6 months after the date of the individual's TAA-related loss of coverage. If a TAA eligible individual elects continuation coverage during this special election period, continuation coverage would begin at the beginning of that election period, but, for purposes of determining the maximum required COBRA coverage period, the coverage period will be measured from the date of the original Qualifying Event, i.e., the TAA-related loss of coverage.

The Trade Adjustment Assistance Act also provides for a tax credit that may apply to some expenses for continuation coverage. An affected individual should consult with a financial advisor if he or she has questions about the tax credit.

SCHEDULE OF BENEFITS

MEDICAL BENEFITS

All benefits described in this Schedule are subject to the exclusions and limitations described more fully herein including but not limited to the Plan Administrator's determination that care and treatment are Medically Necessary; services, supplies, and care are not Experimental and/or Investigational. The meanings of the capitalized terms are in the Defined Terms section beginning on page 3 of this document.

The City of Grand Rapids Unified Health Plan contains a Preferred Provider Organization (PPO) that has entered into agreements with many Hospitals, Physicians, and other health care related providers who are called PPO Providers. The name of the PPO is Cofinity.

Non-participating Providers

Non-participating providers have **not** signed agreements with Cofinity. If you receive services from a non-participating provider, they will submit the claim directly to Meritain Health for payment. The address is located on the back of your ID card.

Co-payments Payable by Plan Participants

Co-payments are dollar amounts that the Covered Person must pay before the Plan pays.

Co-insurance Percentage Payable by the Plan

Co-insurance percentage is the amount the Plan pays.

Out-of-Pocket Payable by Plan Participants

If a Participant or family meets the Co-insurance Maximum Out-Of-Pocket amount, as described below (10% co-insurance), Eligible Expenses will then be payable at 100% for the remainder of the Calendar Year.

If a Participant or family meets the Calendar Year Maximum Out-Of-Pocket amount, as described below (10% co-insurance and medical co-pays), Eligible Expenses will then be payable at 100% for the remainder of the Calendar Year.

The Maximum Out-of-Pocket amounts do **not** include prescription drug co-pays, or expenses that exceed the Plan limits or are excluded under the provisions of the Plan.

**ACTIVE EMPLOYEES AND RETIREES WHOSE
PLANS RATIFIED IN 2008/2009**

	PPO PROVIDER	NON-PPO PROVIDER
THE PLAN'S MAXIMUM BENEFIT AMOUNT	Unlimited	
CO-PAYMENTS (The dollar amount the Participant pays for the following services)		
Office visits (Includes all services administered Physician Office)	\$20 co-payment then 100%	\$20 co-payment then 100%
Urgent Care Center	\$20 co-payment then 100%	\$20 co-payment then 100%
Emergency Services (Co-payment waived if admitted to hospital, Inpatient Co-insurance will apply)	\$150 co-payment then 100%	\$150 co-payment then 100%
Consultations	\$20 co-payment then 100%	\$20 co-payment then 100%
Chiropractic	\$20 co-payment then 100%	\$20 co-payment then 100%
Mental Disorders & Substance Use Disorders Outpatient Office Visits	\$20 co-payment then 100%	\$20 co-payment then 100%

CO-INSURANCE PERCENTAGE (The percentage the Plan pays after the Participant pays 10%)		
Hospital Services		
Inpatient	90%	90%
Outpatient	90%	90%
Emergency Services (Co-payment waived if admitted to hospital, Inpatient Co-insurance will apply)	\$150 co-payment then 100%	\$150 co-payment then 100%
Outpatient Surgical Center	90%	90%
Mental Disorders & Substance Use Disorders		
Inpatient	90%	90%
Outpatient	\$20 co-payment then 100%	\$20 co-payment then 100%
Emergency Care (Emergency Services) (Co-payment waived if admitted to hospital, Inpatient Co-insurance will apply)	\$150 co-payment then 100%	\$150 co-payment then 100%
Calendar Year Co-Insurance Maximum Out-of-Pocket		
Out-of-Pocket Maximum (10% Co-insurance)		
Individual	\$500	\$500
Family	\$500	\$500
Calendar Year Maximum Out-of-Pocket		
Out-of-Pocket Maximum (10% coinsurance and medical co-pays)		
Individual	\$6,350	\$6,350
Family	\$12,700	\$12,700

If a Participant or family meets the Co-insurance Maximum Out-Of-Pocket amount, as described (10% co-insurance), Eligible Expenses will then be payable at 100% for the remainder of the Calendar Year.

If a Participant or family meets the Calendar Year Maximum Out-Of-Pocket amount, as described (10% co-insurance and medical co-pays), Eligible Expenses will then be payable at 100% remainder of the Calendar Year.

The Maximum Out-of-Pocket amounts do **not** include prescription drug copays or expenses that exceed the Plan limits or are excluded under the provisions of the Plan.

Other Medical Services	PPO Provider	Non-PPO Provider
Ambulance	100%	100%
Extended Care	100%	100%
Home Health Care	100%	100%
Hospice	100%	100%
Physician Services		
Hospital Visits	100%	100%
Emergency Services	100%	100%
Surgeon/Assistant Surgeon	100%	100%
Anesthesiologist	100%	100%
Maternity (Professional Fees)*/Employee, Spouse And Dependents		
Preventive prenatal and breastfeeding support (other than lactation consultations)	100%	100%
Lactation Consultations	100%	100%
All Other Prenatal, Delivery and Postnatal Care	100%	100%
*See Eligible Medical Expenses for limitations.		
Chiropractic Services		
Exam/Manipulation	\$20 co-payment then 100%	\$20 co-payment then 100%
X-rays	100%	100%
Temporomandibular Joint Dysfunction (TMJ)	100%	100%
Organ Transplant	100%	100%
Diagnostic X-ray and Lab	100%	100%
Radiation/Chemotherapy	100%	100%
Occupational Therapy	100%	100%
Speech Therapy	100%	100%
Physical Therapy	100%	100%
Medical Supplies	100%	100%
Durable Medical Equipment	100%	100%
Prosthetics	100%	100%
Orthotics	100%	100%
Preventive Services and Routine Care		
<i>Preventive Services</i> This benefit includes office visit associated with Preventive Services	100%	100%

and any other eligible item or service received and billed at the same time as any preventive service. Any office visit or other item or service billed separately will be paid under the Routine Care provision of the Plan.		
Other Medical Services	PPO Provider	Non-PPO Provider
Preventive Services and Routine Care (continued)		
<i>Routine Care</i>	\$20 co-payment then 100%	\$20 co-payment then 100%
<p>This benefit only includes items and services that are not otherwise covered under the Preventive Services provision Plan such as:</p> <ul style="list-style-type: none"> • Office visits (associated with Preventive Services (but billed separately) or Routine Care) • Routine Physical/Gynecological exam: limit of 1 physical or 1 gynecological exam per calendar year, and the following services once per calendar year: chemical profile, complete blood count, fecal occult blood screening, urinalysis, EKG test • Pap smear, limited to 1 routine pap smear per calendar year • Mammogram, limited to 1 per woman age 35 to 40, and 1 per calendar year at age 40 and older • Prostate Specific Antigen (PSA) screening, limited to 1 per calendar year beginning at age 40 • Routine colonoscopy, limited to 1 procedure from age 40 to age 50, and 1 procedure per calendar year age 51 and older 		
Diagnosis of Infertility Benefits Limited to: supplies and services for the diagnosis of infertility.	100%	100%
Other Eligible Expenses	100%	100%

MEDICAL BENEFITS

Medical Benefits apply when Covered Charges are incurred by a Covered Person for care of an Injury or Sickness during the time the person is covered for these benefits under the Plan. Please read each section carefully for a complete explanation of your benefits.

Hospital Benefits – Inpatient Care

Your coverage includes the following hospital services:

Room and Board

Your benefits include the cost of a semi-private room; the use of special units such as intensive, burn, or cardiac care; meals and special diets; and general nursing care. **If you request a private room, your coverage will pay the cost of a semi-private room and you will be required to pay the difference.**

Inpatient Hospital Care

You have unlimited number of inpatient hospital care days available for the diagnosis and treatment of general medical conditions which cannot be treated as outpatient and are subject to the Plan maximums.

The following types of admissions also are considered general medical care:

1. **Maternity and nursery care** – includes delivery room costs and routine nursery care for a newborn during an eligible mother's hospital stay. After the hospital stay, the newborn is covered as a dependent child, but **only if you add the child to your coverage by completing an enrollment form. See Dependent section beginning on page 19 for dependent enrollment provisions.**

Remember: If a change form is not received adding the child, claims for this dependent may be delayed or denied.

Note: Under federal law, the Plan generally will not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or 96 hours following a cesarean section. However, the attending physician may discharge the mother or the newborn earlier after consulting with the mother. The Plan may not require a provider to obtain authorization for prescribing a length of stay not in excess of the 48/96-hour minimum.

2. **Cosmetic surgery** – includes correction of birth defects, conditions resulting from accidental injuries or traumatic scars, and the correction of deformities resulting from certain surgeries such as breast reconstruction following mastectomies.
3. **Dental surgery** – includes removal of impacted teeth or multiple extractions **only** when a concurrent hazardous medical condition, such as a heart condition exists. The inpatient stay must be considered medically necessary to safeguard the life of the patient during the dental surgery.

Mental Disorder and Substance Use Disorder Treatment

The Plan provides for unlimited number of days for **inpatient** mental disorder or substance use disorder treatment. Benefits are payable when services are medically necessary and approved by the treating physician.

A mental disorder or substance use disorder treatment admission can include individual and group therapy sessions and family counseling.

Physicians can be directly reimbursed for the following inpatient services:

1. Psychological testing
2. Individual psychotherapeutic treatment
3. Family counseling for members of a patient's family
4. Group psychotherapeutic treatment
5. Inpatient consultations when your physician requires assistance of a consulting psychologist in diagnosing or treating your mental disorder.

Hospital Services and Supplies

The following services and supplies are covered when they are needed during a hospital admission:

1. **Anesthesia** – includes administration, cost of equipment, supplies, and the services of a hospital anesthesiologist when billed as a hospital service.
2. **Blood services** – includes whole blood, blood derivatives, blood plasma, packed red blood cells, and supplies used for administering the services.
3. **Laboratory and pathology tests** – includes laboratory tests and procedures required to diagnose a condition or injury when billed as a hospital service.
4. **Drugs** – includes medicines prescribed and given during a hospital admission.
5. **Durable medical equipment** - includes items such as oxygen tents, wheelchairs, and other hospital equipment used during a hospital stay.
6. **Medical and surgical supplies** – includes gauze, cotton, fabrics, plaster, and other materials used in dressings and casts plus solutions used during the hospital admission.
7. **Prosthetic or orthotic appliances** – includes items that are surgically implanted in the body such as heart valves or those used externally as part of regular hospital equipment while you are in the hospital.
8. **External prosthetic and orthotic devices prescribed by a physician for use outside of the hospital.**
9. **Special treatment rooms** – includes operating, delivery, and recovery rooms.

10. **Cost of obtaining, preserving and storing human skin, bone, blood, and bone marrow to be used for medically necessary covered services.**
11. **Oxygen and other therapeutic gases and their administration**
12. **Services provided in a special care unit, such as intensive care**
13. **Inhalation therapy**
14. **Electroshock therapy**
15. **Sterilization when medically necessary**

The Plan coverage includes the following diagnostic and radiology services:

1. **CAT and MRI scans** - covers scans of the head and body when required for eligible diagnoses
2. **Diagnostic tests** - includes but not limited to EKG's, EMG's, EEG's, thyroid function tests, and nerve conduction studies required in the diagnosis of an illness or injury.
3. **Therapeutic Radiology** – includes radiological treatment by X-ray, isotopes, or cobalt for a malignancy.
4. **Diagnostic Radiology** – includes but not limited to ultrasound and X-rays required for the diagnosis of an illness or injury.

Hospital Benefits - Outpatient Care

The following services are covered when performed in the outpatient department of a hospital or a freestanding facility such as an Urgent Care facility:

1. **Pre-Admission Testing**
Testing **must** be performed within seven days before a scheduled hospital admission or surgery. These tests must be valid at the time of admission and must not be duplicated during the hospital stay.
2. **Physical, Occupational, and Speech Therapy**
Your physical, occupational, and speech therapy when medical necessary are payable under the following criteria:

Important: If you are not sure that the criteria will be met, please have your physician call the Nurse Advocate at 1-800-423-1028.

A. Physical therapy by a licensed physical therapist. The therapy must be in accordance with a Physician's exact orders as to type, frequency, and duration for the improvement of a body function. Cardiac Rehabilitation

Therapy Phases I, II, and III are included when ordered by a physician and supervised by a licensed therapist.

B. Occupational therapy by a licensed occupational therapist. Therapy must be ordered by a Physician for the improvement of a body function that was affected by an Injury or Sickness.

C. Speech Therapy by a licensed speech therapist. Therapy must be ordered by a Physician and follow either (1) surgery for correction of a congenital condition of the oral cavity, throat, or nasal complex (other than a frenectomy) of a person; (2) an Injury; or (3) a Sickness that is other than a learning disorder.

Examples of covered medical expenses are:

1. Physical therapy prescribed to restore the musculoskeletal functioning of legs.
2. Physical therapy used in conjunction with a treatment program to accelerate the healing of an acute injury or illness involving the muscles or joints

Examples of **not** covered expenses:

1. Long-standing, chronic conditions such as arthritis
2. Health club membership or spa membership
3. Developmental conditions or learning disabilities
4. Congenital or inherited speech abnormalities
5. Inpatient hospital admissions principally for speech or language therapy

Emergency Care Services

Benefits include the initial exam and treatment of accidental injuries or a sudden onset of a condition with acute symptoms requiring immediate medical care. This includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions, or other such medical conditions. Call your physician and/or access an Urgent Care facility.

Important: Routine care for minor medical problems such as headaches, colds, slight fever, and back pains may not be considered emergency care. Also, follow-up care is not considered emergency care. You should use your Physician's office or Urgent Care facility in these circumstances.

Emergency Services. The Plan shall pay the greater of the following amounts for Emergency Services received from Non-Participating Providers:

1. The amount negotiated with Participating Providers for Emergency Services provided, excluding any copay or coinsurance that would be imposed if the service had been received from a Participating Provider. If there is more than one amount negotiated with Participating Providers for the Emergency Services provided, the amount paid shall be the median of the negotiated amounts,

excluding any copay or coinsurance that would be imposed if the service had been received from a Participating Provider;

2. The amount for the Emergency Service calculated using the same method the Plan generally uses to determine payments for services provided by a Non-Participating Provider (such as usual, customary and reasonable amount), excluding any copay or coinsurance that would be imposed if the service had been received from a Participating Provider; or
3. The amount that would be paid under Medicare (part A or Part B of title XVIII of the Social Security Act, 42 U.S.C. §1395 et seq.) for the Emergency Service, excluding any copay or coinsurance that would be imposed if the service had been received from a Participating Provider.

Professional Ambulance Services

Ambulance services are covered to transport a patient up to 25 miles unless the destination is the nearest medical facility capable of treating the patient's condition. The service must be medically necessary, prescribed by a physician (when used for transferring a patient), and provided in a vehicle qualified as an ambulance and part of a licensed ambulance operation. Air ambulance is also covered when no other means of transport is available or the patient's condition requires air transport rather than ground ambulance. For air ambulance, the provider must be licensed as an air ambulance service and is not a commercial air carrier. If you need assistance, please contact the Nurse Advocate.

The Plan **does not** pay for:

1. Transportation for the convenience of the patient or the patient's family or for the preference of the physician.
2. Ambulance services provided by a fire department, rescue squad, or other carrier whose fee is a voluntary donation.

Outpatient Mental Disorder Care

Your coverage includes psychological testing, individual and group therapy sessions, and family counseling. These services must be medically necessary and provided by or under the direction of a physician. If you need assistance, please contact the Nurse Advocate at 1-800-423-1028.

Examples of covered expenses:

1. Ancillary services for patients who are admitted and discharged on the same day of treatment.
2. Prescribed drugs given by the facility in connection with treatment.
3. Electroshock therapy when administered by or under the supervision of a physician.
4. Anesthesia for electroshock therapy when administered by or under the supervision of a physician, other than the physician giving the electroshock therapy.

Outpatient Substance Use Disorder Treatment

Treatment is covered when medically necessary and provided by or under the direction of a physician.

Chemotherapy

Treatment is payable in a hospital, in the outpatient department of a hospital, or in a physician's office. Your benefits include the administration and cost of drugs when ordered by a physician for the treatment of a specific type of malignant disease, approved by the Food and Drug Administration for use in chemotherapy, and provided as part of a chemotherapy program. (Your benefits also include three [3] follow-up visits within 30 days of your last chemotherapy treatment to monitor the effects of chemotherapy). These treatments may be coordinated with the Nurse Advocate.

NOTE

If the FDA has not approved the drug for the specific disease being treated, a review by the Nurse Advocate determines the appropriateness of the drug for that disease by using the following criteria:

1. Current medical literature must confirm that the drug is effective for the disease being treated;
2. Recognized oncology organizations must generally accept the drug as treatment for the specific disease; and
3. The physician must obtain informed consent from the patient for the treatment.

Hemodialysis

Hemodialysis services are covered to treat acute kidney failure and end stage renal disease (ESRD). You can receive treatment in the outpatient department of a hospital, in a licensed facility, or in your home. Your physician must arrange for home hemodialysis and all services must be billed by a facility licensed for hemodialysis. Benefits include cost of the equipment, installation, training, and necessary hemodialysis supplies. Services may be coordinated with the Nurse Advocate.

Important: Dialysis services for the treatment of ESRD are coordinated with Medicare. It is important that individuals with ESRD apply for Medicare coverage regardless of age. The Plan is the primary payer for up to 30 months if the patient is under 65 and is eligible for Medicare solely because of ESRD.

Home Hemophilia Program

The Plan includes all medications and medical supplies needed for in-home treatment of hemophilia including syringes, needles, and the antihemophilic factor. Your physician must prescribe all services and all services and supplies must be billed by a licensed provider. Your benefits also include training the patient or a family member on how to inject the antihemophilic factor when the training is provided through a licensed facility. Services should be coordinated with the Nurse Advocate.

Home Health Care

To receive benefits under the Home Health Care benefit, the following criteria must apply:

1. It must be medically necessary;
2. A physician who certifies that the patient is confined to the home due to illness or accident must prescribe and submit a detailed treatment plan to a licensed health care provider and a copy must be sent to the Nurse Advocate.

Once the home health care provider accepts the patient and treatment has been coordinated with the Nurse Advocate, the following services are covered when billed by the agency:

1. Part-time health aide services if the patient is receiving skilled nursing care or physical or speech therapy, and the health care provider has identified a need for the patient to have these services.
2. Social services and nutritional guidance when requested by the patient's physician.
3. Physical, speech, and occupational therapy (up to a combined maximum of 60 visits per patient per calendar year; this benefit maximum renews each calendar year).
4. Nursing care when given by a registered nurse or licensed practical nurse (LPN) employed by the home health care provider.
5. The care is medically necessary and required on a 24 hour basis.
6. The nurse is not related to or living with the patient.
7. Home Health Care is limited to 40 visits per patient per calendar year.

Important: The Plan **does not** pay for general housekeeping services, transportation to or from a hospital or other facility, elastic stockings, sheepskin, or comfort items (such as lotion, mouthwash, body powder, etc.), physician services, and custodial or non-skilled care.

Skilled Nursing Care

Care in an approved skilled nursing facility is covered when the patient is suffering from or gradually recovering from an illness or injury and is expected to improve. In addition, the Plan will require written confirmation of the need for skilled care from the patient's physician. Physician's benefits for medical care are limited to two (2) visits per week. All services must be provided at a licensed skilled nursing facility and medically necessary. If you need assistance, please call the Nurse Advocate at 1-800-423-1028.

The Plan does **not** pay for:

1. Custodial care
2. Care for senility or mental retardation

ALTERNATIVE CARE PROVISION

In addition to the benefits specified in this Plan, the alternative care provision allows for the expansion of these benefits to include services and/or facilities, which are not outlined in the Plan (e.g., acupuncture if medically necessary). This enhancement is intended to provide the most appropriate level of care for the patient in lieu of hospitalization.

These alternative care benefits are recommended by the Nurse Advocate after review and consultation with the patient's attending Physician. The Nurse Advocate also monitors care to insure that the most appropriate level of care is maintained. However the Nurse Advocate **cannot** require a change in a patient's level of care without the full approval and cooperation of the attending Physician.

Each situation will be reviewed and recommendations made on an individual basis, keeping in mind that what may be appropriate for one individual may not be appropriate for another.

This provision will not increase any stated Plan maximums.

Hospice Care

A hospice is a provider or facility that is primarily involved in providing care to terminally ill individuals and can be an alternative to hospitalization. A patient is considered terminally ill when the attending physician has certified in writing that life expectancy is six months or less.

You may elect for hospice care benefits only after discussion with and referral by your attending physician. Your statement must be in writing to the Hospice provider, and **all hospice services must be arranged through a hospice provider. Please contact the Nurse Advocate for assistance at 1-800-423-1028.**

1. **Electing Hospice benefits** – The hospice benefits will be more specific to the patient's needs and may include alternative services that provide more appropriate care. However, services for medical conditions **unrelated** to the terminal illness will be covered in accordance with the Plan.

The patient may cancel, in writing, all hospice benefits at any time. When services are cancelled, the patient's regular coverage resumes.

2. **Level of Care** – The Hospice benefit provides four levels of care:
 - A. Routine home care that consists of services provided to patients who are living at home and are not receiving continuous home care (see next item). Benefits include counseling, home health care, and physical therapy; such care must not exceed eight hours per day.

- B. Continuous home care that consists of nursing care services provided to patients during crisis periods to enable them to stay in their homes; such care is covered up to 24 hours per day during periods of crisis.
 - C. Inpatient respite care that consists of short-term inpatient services to allow home care providers short periods of relief. Such care must be provided in a licensed facility on a non-routine or occasional basis and in increments of five days or less in any 30-day period.
 - D. General inpatient care that consists of services for pain control and acute and/or chronic symptom management that cannot be provided in other less intensive settings.
3. **Hospice Services** – The following benefits are payable under the Hospice benefit:
- A. **Nursing Care** when provided by or under the supervision of a registered nurse.
 - B. **Medical social services** by a qualified social worker when provided under the supervision of a physician.
 - C. **Counseling services** for the patient and caregivers when care is provided in the home and for family bereavement after the patient's death.
 - D. **Medical appliances and supplies** to provide comfort to the patient and when approved by the Plan.
 - E. **Durable medical equipment** when furnished by the hospice provider for use in the patient's home.
 - F. **Physical, speech, and occupational therapy** when provided to control symptoms and maintain the patient's daily activities and basic functional skills.

Important: There is a separate dollar maximum for services provided by a physician who is not part of the hospice team.

Human Organ Transplant

The following types of human organ transplants are covered when received at a hospital or, where noted, designated transplant facility or designated cancer center.

Organ and Tissue Transplants

Benefits are payable for services and expenses for transplanting organs and tissues to an eligible recipient. Coverage includes evaluation and surgical removal of the donated part (including skin, cornea, and kidney) from a living or non-living donor. These transplants are subject to the same guidelines as for other basic benefits.

Bone Marrow Transplants

Benefits for **allogeneic** bone marrow transplants are payable only when the bone marrow of another person is transplanted into the patient to treat the following conditions and is not considered experimental or investigational.

1. Acute lymphocytic leukemia
2. Acute non-lymphocytic leukemia
3. Aplastic anemia
4. Beta Thalassemia, major
5. Chronic myeloid leukemia
6. Hodgkin's disease (relapsed and stage III or IV)
7. Hurler's syndrome
8. Myelodysplastic syndromes
9. Myelofibrosis
10. Neuroblastoma (stage III or IV)
11. Non-Hodgkin's lymphoma (intermediate or high grade)
12. Osteopetrosis
13. Severe combined immune deficiency disease (SCID)
14. Sickle cell disease (when complicated by stroke)
15. Wiskott-Aldrich syndrome

Allogeneic bone marrow transplants are payable when the donor is an immediate relative (mother, father, sister, or brother) and has four of the six important HLA genetic markers as the patient. **Donors outside of the immediate family must have five of six important HLA genetic markers as the patient.**

Note: HLA (human leukocyte antigens) genetic markers are specific chemical groupings of many body cells, including white blood cells that are used to detect the constitutional similarity of one person to another.

Your coverage also includes transplants of the patient's own bone marrow (**autologous**) and/or transplanting the patient's own peripheral blood stem cells when used to rescue a patient after receiving high doses of chemotherapy. The transplant cannot be considered experimental or investigational.

Only the following conditions are covered:

1. Acute lymphocytic leukemia
2. Acute non-lymphocytic leukemia
3. Ewing's sarcoma
4. Germ cell tumor of the ovary, testis, mediastinum, & retroperitoneum

5. Hodgkin's disease (Stage III or IV)
6. Medulloblastoma
7. Metastatic breast cancer (Stage IV)
8. Multiple myeloma
9. Neuroblastoma (Stage III or IV)
10. Non-Hodgkin's lymphoma (intermediate or high grade)
11. Primitive neuroectodermal tumors
12. Wilms' Tumor

Payable benefits for bone marrow transplants include:

1. High-dose chemotherapy and/or total body radiation
2. Blood tests on immediate relatives for evaluation as donors (if tests are not covered by the potential donor's health plan)
3. Harvesting the marrow and/or peripheral blood stem cells if the donor meets specific genetic marker requirements for allogeneic bone marrow transplants; harvesting and storing the marrow and/or peripheral blood stem cells for a transplant intended to be performed within one year for autologous bone marrow transplants
4. Search of the National Bone Marrow Donor Program Registry for a donor (a search will begin only when the need for a donor is established)
5. Infusion of colony simulating growth factors
6. Hospitalization in an intensive care unit, special care unit, or private room
7. Services you receive as a donor of bone marrow and/or peripheral blood stem cells (e.g., infusion of growth stimulating factors, hospitalization, blood tests and harvesting as indicated above)

Note: The Plan also will pay for similar services related to or for high-dose chemotherapy, total body radiation, allogeneic or autologous bone marrow, and/or peripheral blood stem cell transplants to treat conditions other than those listed above if the services are not otherwise **excluded from coverage as experimental or investigational**. This benefit does not limit or preclude coverage of antieoplastic drugs when Michigan law requires that these drugs and the reasonable cost of their administration be covered.

The Plan does **not** pay for:

1. Any services related to or for allogeneic bone marrow transplants and/or peripheral blood stem cell transplants when the donor does not meet the HLA genetic marker matching requirements

2. Purging of and/or positive stem cell selection of bone marrow stem cells or peripheral blood stem cells
3. Harvesting and storage costs of bone marrow and/or peripheral blood stem cells if not intended for transplant within one year
4. Health care services provided by persons who are not legally qualified or licensed to provide such services
5. Services that are not medically necessary (See **Defined Terms** for definition of medically necessary)
6. Any facility, physician, or associated services related to any of the above exclusions

Specified Oncology Clinical Trials

Covers antineoplastic drugs to treat stages II and III breast cancer and all stages of ovarian cancer when they are provided pursuant to an approved phase II or III clinical trial. This benefit does not limit or preclude coverage of antineoplastic drugs when Michigan law requires that these drugs and the reasonable cost of their administration be covered.

In order for services to be payable as eligible benefits:

1. The inpatient admission and length of stay **must** be medically necessary and prearranged (NO retroactive approvals will be granted);
2. The services **must** be performed at a National Cancer Institute (NCI) designated cancer center (see **Defined Terms** for definition of designated cancer center) or an affiliate of an NCI designated center;
3. The treatment plan, also called protocol, **must** meet the guidelines of the February 19, 1993, American Society of Clinical Oncology (ASCO) statement for clinical trials; and
4. The patient must be covered under this Plan

Important: If the above requirements are not met, the services will not be a covered benefit and **you will be responsible for all charges.**

Covered Services

Covered services are payable when directly related to a bone marrow transplant, peripheral blood stem cell transplant, high-dose chemotherapy, or total body radiation. When prearranged by the Nurse Advocate, the following services are covered:

1. Allogeneic transplants (including syngeneic transplants when the donor is the identical twin of the patient)

- A. Blood tests to evaluate the donors (if not covered by the potential donor's health plan)
 - B. Search of the National Bone Marrow Donor Program Registry for a donor (a search will begin only when the need for a donor is established). The registry's bill must be submitted to the Plan by the designated cancer center.
 - C. Infusion of colony stimulating growth factors
 - D. Harvesting (including peripheral blood stem cell phereses) and storage of the donor's bone marrow and/or peripheral blood stem cells for a transplant intended to be performed within one year (if not covered by the donor's health plan)
 - E. Purging of or positive stem cell selection of bone marrow or peripheral blood stem cells
 - F. High-dose chemotherapy and/or total body radiation
 - G. Infusion of bone marrow and/or peripheral blood stem cells
2. Autologous transplants
- A. Infusion of colony stimulating growth factors
 - B. Harvesting (including peripheral blood stem cell phereses) and storage of the donor's bone marrow and/or peripheral blood stem cells for a transplant intended to be performed within one year (if not covered by the donor's health plan)
 - C. Purging of or positive stem cell selection of bone marrow or peripheral blood stem cells
 - D. High-dose chemotherapy and/or total body radiation
 - E. Infusion of bone marrow and/or peripheral blood stem cells
3. Prearranged hospitalization in an intensive care unit, special care unit, or private room.
4. Up to a total of \$5,000 for travel, meals, and lodging expenses directly related to prearranged services rendered during an approved clinical trial. The expenses must be incurred during the period that begins on the date the approval was given and ends 180 days after the transplant. The Plan will pay the expenses of an adult patient and one companion (or two companions if the patient is under age 18). Within the \$5,000, the following amounts apply to the **combined** expenses of the patient and eligible companion(s):

- A. Up to \$60 per day for travel
- B. Up to \$50 per day for lodging
- C. Up to \$40 per day for meals

The Plan does **not** pay for:

1. Services performed at a center that is not an NCI designated center or affiliate of an NCI designated center.
2. A hospital admission, a length of stay at a hospital, or any service that has not been **prearranged**.
3. Harvesting (including phereses) and storage costs of bone marrow and/or peripheral blood stem cells if not intended for transplantation within one year.
4. Any other services related to any of the above exclusions.
5. Items or services, such as investigational drugs, non-health care services, and/or research management (such as administrative costs) that are normally covered by other funding sources (e.g., investigational drugs funded by a drug company).
6. Services rendered as part of a protocol that do not meet the February 19, 1993 ASCO guidelines.
7. Items that are not considered directly related to travel, meals, and lodging expenses. They include **but are not limited to** dry cleaning/clothing/laundry services, kennel fees, entertainment (cable, movie rentals, televisions, books magazines), car maintenance, toiletries, security deposits, toys, alcoholic beverages, flowers/cards/stationary/stamps, household products, household utilities including cell phone charges, or maid/baby-sitter/day care services.

Specified Human Organ Transplants

Hospital care for specified human organ transplants performed during the transplant benefit period is covered in full when the transplant is **prearranged** by the Nurse Advocate and received at a **transplant facility**. (See **Defined Terms** for a definition of transplant facility).

1. Benefits apply only to transplants of the:
 - A. Liver
 - B. Partial liver (a portion of the liver taken from a brain dead or living donor)
 - C. Heart
 - D. Lung(s)
 - E. Lobar lung (transplantation of a portion of a lung from a brain dead or living donor)

- F. Heart-lung(s)
 - G. Pancreas
 - H. Simultaneous pancreas-kidney
 - I. Small intestine (small bowel)
 - J. Combined small intestine-liver
2. All payable human organ transplant services, except anti-rejection drugs, must be provided during the **benefit period** that begins five days before the transplant surgery and ends one year after the surgery.
 3. The transplant facility or your physician **must prearrange** services and coordinate services **with** the Nurse Advocate before surgery. Authorization for the transplant surgery will be sent to you and the transplant facility or your physician (whoever requests the preauthorization).

When **prearranged** and directly related to the transplant, the Plan will pay for the following services. Benefits are limited to a \$1 million per human organ transplant.

1. Facility and professional services.
2. Anti-rejection drugs and other transplant-related prescription drugs as needed. Payment will be based on the amount we determine to be reasonable and necessary. Payment for the drugs is limited only by the \$1 million per human organ transplant.
3. Medically necessary services needed to treat a condition arising out of the organ transplant surgery if the condition occurs during the benefit period and is a direct result of the organ transplant surgery. The Plan will pay for any medically necessary service needed to treat a condition as a result of the organ transplant surgery.
4. Up to \$10,000 per transplant for travel, meals, and lodging directly related to prearranged services. The Plan will pay the cost of transportation to and from the designated transplant facility for an adult patient and one companion eligible to accompany the patient (or two companions if the patient is under age 18 or if the transplant involves a living related donor). Within the \$10,000 we will pay the reasonable and necessary costs of meals (up to \$30 per day) and lodging for the companion(s) eligible to accompany the patient.
5. Reasonable and necessary cost of acquiring the organ which includes surgery to obtain the organ, storage of the organ, and transportation of the organ. The total payment for all services combined for each organ transplant will not be more than the \$1 million per human organ transplant maximum.

The Plan **does not** pay for:

1. Living donor transplants other than partial liver and lobar lung transplants

2. Pancreatic islet cell transplants (pancreatic cells that manufacture and secrete insulin)
3. Anti-rejection drugs that do not have Food and Drug Administration marketing approval
4. Transplant procedures and related services that are not prearranged.
5. Transplant surgery that is not performed in a transplant facility
6. Transportation, meals, and lodging costs under circumstances other than those related to the initial prearranged transplant surgery
7. Any expenses incurred for transportation, meals, and lodging after the initial transplant surgery and hospitalization
8. Items not considered directly related to travel, meals, and lodging expenses. They include, but are not limited to, dry cleaning/clothing/laundry services, kennel fees, entertainment (cable, movie rentals, televisions, books, magazines), car maintenance, toiletries, security deposits, toys, alcoholic beverages, flowers/cards/stationary/stamps, household products, household utilities including cell phone charges, or maid/baby-sitter/day care services.
9. Services prior to your organ transplant surgery such as expenses for evaluation and testing if not covered by your hospital/medical/surgical coverage.

Physician Benefits

The Plan coverage provides the following benefits:

Preventive Services and Routine Care

The Plan coverage includes the following preventive services and routine care:

1. **Preventive Services:** The following preventive services are paid as shown in the Medical Schedule of Benefits:
 - A. Evidence-Based Preventive Services

Evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force (the “Task Force”) with respect to the individual involved, except that with respect to breast cancer screening, mammography and prevention of breast cancer, the recommendations of the Task Force issued in 2002 will be considered the current recommendations until further guidance is issued by the Task Force or the Health Resources and Services Administration.
 - B. Routine Vaccines

Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved.

C. Prevention for Children

With Respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

D. Prevention for Women

With respect to women, such additional preventive care and screenings, not otherwise addressed by the Task Force, as provided for in comprehensive guidelines supported by the Health Resources and Services Administration and published on August 1, 2011 (or any applicable subsequent guidelines or guidance requiring any additional women's preventive services). Those guidelines generally include the following:

- (i) Well-woman visits. Well-woman preventive care visits annually for adult women to obtain the recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care. The inclusion of a well-woman visit is not meant to limit the coverage for any other preventive service described elsewhere in this Plan document that might be administered as part of the well-woman visit.

Coverage for prenatal care is limited to pregnancy-related Physician office visits including the initial and subsequent history and physical exams of the pregnant woman. In the event a provider bills a "maternity global rate", the portion of the claim that will be considered for prenatal visits and therefore, preventive care, is 40% of the "maternity global rate". As a result, 60% of the "maternity global rate" will be considered for delivery and postnatal care and the normal cost-sharing provisions would apply. Items not considered preventive (and therefore subject to normal cost-sharing provisions) include inpatient admissions, high risk specialist units, ultrasounds, amniocentesis, fetal stress tests, delivery including anesthesia and certain pregnancy diagnostic lab tests.

- (ii) Screening for gestational diabetes. A maximum of five (5) screenings for gestational diabetes shall be covered in pregnant women.
- (iii) Human papillomavirus (HPV) testing. High-risk HPV DNA testing in women with normal cytology results. Screening is limited to women age 30 or older and is limited to 1 screening every 3 Calendar Years.
- (iv) Counseling annually for sexually transmitted infections for all sexually active women. Limited to two (2) counseling sessions per Calendar Year.
- (v) Screening and counseling annually for human-immune-deficiency virus (HIV) for all sexually active women.
- (vi) Screening and counseling annually for interpersonal and domestic violence.

- (vii) Contraceptive methods and counseling, as prescribed by your Physician. All FDA approved contraceptive methods (see Preventive Drugs section below), sterilization procedures and patient education and counseling for women with reproductive capacity. Contraceptive counseling is limited to 2 visits per 12-month period.

For purposes of the above, the sterilization procedures to be considered preventive include sterilization implant (Essure) and surgical sterilization (Sterilization) either abdominally, vaginally or laparoscopically. Eligible charges for a sterilization procedure and all ancillary services will be covered when sterilization is the primary purpose of the services provided and/or if it is performed as a standalone procedure and billed as such. However, complications arising following a sterilization procedure are not covered as preventive services. Covered Expenses do not include charges for a sterilization procedure to the extent the procedure was not billed separately by the provider or because it was not the primary purpose of the procedure. To the extent sterilization is part of another procedure and/or is not a separate line on the bill, the sterilization procedure is not a Covered Expense.

- (viii) Breastfeeding support, supplies and counseling in conjunction with each birth, including the following:
 - 1. Comprehensive lactation support and counseling by a trained provider during pregnancy and/or in the postnatal period (60 days from baby's date of birth). Lactation consultation is limited to 6 cumulative visits per 12-month period.
 - 2. Breastfeeding equipment will be covered, subject to the following:
 - a. Rental of a Hospital grade electric pump while the baby is Hospital confined; and
 - b. Purchase of a standard (non-Hospital grade) electric breast pump or manual breast pump if requested within 60 days (electric) or 12 months (manual) from the baby's date of birth, provided the Covered Person has not received either a standard electric breast pump or a manual breast pump within the last 3 Calendar Years.
 - 3. For women using a breast pump from a prior pregnancy, 1 new set of breast pump supplies will be covered at 100% with each subsequent pregnancy for initiation or continuation of breastfeeding within the first 12 months from the baby's date of birth

For a detailed listing of women's preventive services, please visit the U.S. Department of Health and Human Services website at: <http://www.hrsa.gov/womensguidelines>. For a paper copy, please contact the Plan Administrator. To the extent the above does not cover any

preventive service required to be covered under the guidelines published by the Health Resources and Services Administration on August 1, 2011 (or any applicable subsequent guidelines or guidance requiring any additional women's preventive services), the above shall be deemed to be amended to cover such preventive services to the extent required by such guidelines.

E. Preventive Drugs

Preventive Drugs that are not covered under the Prescription Drug Card Program. Please contact the Prescription Drug Card Program Administrator for a list of medications.

For a detailed listing of preventive services, please visit the U.S. Department of Health and Human Services website at:

<https://www.healthcare.gov/what-are-my-preventive-care-benefits>

For a paper copy, please contact the Plan Administrator. To the extent the above does not cover any preventive service required to be covered by the U.S. Department of Health and Human Services (HHS) the above shall be deemed to be amended to cover such preventive service to the extent required by the HHS.

2. **Routine Care.** This benefit only includes items and services that are not otherwise covered under the Preventive Services provision of the Plan such as: **Office Visits** (associated with Preventive Services (but billed separately) or Routine Care).

Routine Physical/Gynecological Exam – covers one annual physical or gynecological examination and the following services once per calendar year:

- A. Chemical profile
- B. Complete blood count
- C. Fecal occult blood screening
- D. Urinalysis
- E. EKG Tests

Pap Smear – covers laboratory services for one routine pap smear every calendar year. More frequent pap smears covered for the following conditions:

- A. Previous surgery for vaginal, cervical, or uterine malignancy
- B. Presence of a suspected lesion in the vaginal, cervical, or uterine areas
- C. Post-surgery

Well-Baby Care Visits – covers routine visits to a physician to monitor the development and well being of children.

Mammograms – covers one mammogram (breast X-ray) for a woman from the age of 35 to 40. At 40 and older, one mammogram per calendar year is covered. More frequent mammograms are covered if requested by your physician because of the suspected or actual presence of a disease or when required as a post-operative procedure.

Prostate Specific Antigen (PSA) Screening – covers one PSA screening laboratory test per member, per calendar year beginning at age 40.

Routine colonoscopy – including all related expenses, limited to 1 procedure from age 40 to age 50, and 1 procedure per calendar year age 51 and older.

Office Visits

The exam, diagnosis, and treatment of illness or injury by a physician is payable when you are seen in the physician's office, outpatient clinic, or outpatient department of a hospital; including when necessary for the prescription of anti-depressants. Diagnosis includes Laboratory Blood Test and X-rays. Injections are covered including Tetanus, Flu, and Hepatitis B Vaccines.

IUDs and the related physician administration expenses are eligible as a covered benefit.

Contact the Nurse Advocate at 1-800-423-1028 if you have any questions.

Allergy Services

The Plan pays for allergy testing, survey, and therapeutic injections when performed by or under the supervision of a physician. Benefits are **not** payable for fungal or bacterial skin tests (such as those given for tuberculosis or diphtheria), self-administered or over-the-counter medications, psychological testing, evaluation or therapy for allergies, environmental studies, evaluation, or control.

Chiropractic Services

The Plan benefits include the following chiropractic services:

1. **New Patient Office Calls** – covers one every 36 months. A new patient is one who has not seen by the same provider in 36 months.
2. **Office Calls** – covers one every calendar year for established patients.
3. **Chiropractic Traction** – number of payable visits is determined by your physical therapy benefit.
4. **Chiropractic Manipulation** – limited to one per day, up to 38 **medically necessary** visits per condition per calendar year.
5. **Benefits are provided for acute conditions for a maximum of 20 visits within a 90 consecutive day period.**

Maternity Care

You have coverage for obstetrical services including delivery and pre- and post-natal care visits, and preventive prenatal and breastfeeding support as identified under the Preventive Services and Routine Care section. Two routine ultrasound tests per pregnancy will be covered. Additional ultrasound tests will be covered only if medically necessary. (Ultrasound tests for the sole purpose of determining the gender of the fetus is not considered medically necessary.)

The initial inpatient examination of the newborn is a benefit when performed by a physician other than the anesthesiologist or the delivering provider.

Important: Maternity care benefits also are payable when provided by a Certified Nurse Midwife. Delivery must be in a hospital or birthing center.

Surgery

Surgical benefits include the surgical fee and pre- and post-operative medical care given by the surgeon. Surgery is covered inpatient and outpatient, in the physician's office, or in an ambulatory surgical facility.

1. **Cosmetic or reconstructive surgery** is covered only for the correction of birth defects from conditions resulting from accidental injuries or traumatic scars, correction of abnormal congenital conditions, and correction of deformities resulting from certain surgeries such as reconstructive mammoplasties. This reconstructive mammoplasty coverage will include reimbursement for the following:
 - A. Reconstruction of the breast on which a mastectomy has been performed
 - B. Surgery and reconstruction of the other breast to produce a symmetrical appearance, and
 - C. Coverage of prostheses and physical complications during all stages of mastectomy including lymphedemas in a manner determined in consultation with the attending Physician and the patient.
2. **Dental surgery** is covered only for the removal of impacted teeth or multiple extractions. The patient must be hospitalized for the surgery because a concurrent medical condition exists such as a heart condition. The inpatient admission for the dental surgery must be considered medically necessary to safeguard the life of the patient.
3. **Voluntary sterilization** for both male and female patients is covered regardless of medical necessity. Voluntary sterilization procedures are covered in addition to and to the extent they are not otherwise included for coverage under the Preventive Services and Routine Care section of the Plan.

Technical Surgical Assistance (TSA)

TSA is a covered benefit for certain major surgeries that require surgical assistance by another physician. TSA is covered inpatient and outpatient and in an ambulatory surgery facility.

Anesthesia

Services for giving anesthesia are payable to a physician other than the operating or assisting physician and to certified registered nurse anesthetists.

Temporomandibular Joint Syndrome (TMJ)

Benefits for TMJ or jaw-joint disorder are primarily limited to surgery directly to the jaw joint, X-rays (including MRIs), and arthrocentesis (injection procedures). However, some symptom-management services are covered such as office visits, reversible appliance therapy, physical medicine (diathermy, hot and cold applications), and medications.

Other than the exceptions noted, benefits are **not** payable for reversible or irreversible medical or dental treatment of the mouth, teeth, jaw, jaw joint, skull, and the muscles/nerves/tissue related to the jaw joint. These exclusions include but are not limited to crowns, inlays, caps, restorations, grinding, orthodontics, dentures, partial dentures, or bridges.

If you are not sure that your prescribed treatment will be covered, ask your physician to contact Meritain Health at 1-800-423-1028 for approval *before* treatment begins.

Note: Irreversible treatment of the mouth, teeth, or jaw is intended to bring about permanent change to a person's bite or position of the jaws. It includes but is not limited to dentures, bridges, crowns, caps, inlays, restorations, grinding, and orthodontics. **Reversible** treatment of the mouth and jaw is **not** intended to result in permanent alteration of the bite or position of the jaws; it is directed at managing the patient's symptoms.

Inpatient Medical Care

Medical supervision by a physician is payable while you are in the hospital or in a skilled nursing care for general medical conditions that are not related to surgery or maternity care. Inpatient care for mental disorders and substance use disorders include benefits for individual and group psychotherapy, electroshock therapy and related anesthesia, counseling, and psychological testing.

Inpatient and Outpatient Consultations

Medical consultations are payable when your physician requires assistance in diagnosing or treating a condition or because special skill or knowledge of the consulting physician is required.

Diagnostic and Radiation Services

Physician services are payable to diagnose disease, illness, pregnancy, or injury through:

1. **Diagnostic Radiology** – includes X-rays, ultrasound, radioactive isotopes, and Magnetic Resonance Imaging (MRI) and CAT scans of the head and body when performed for an eligible diagnosis.
2. **Laboratory and Pathology Tests**, including Pathology Tests for Cancer.
3. **Diagnostic Tests** – includes EKGs, EMGs, EEGs, thyroid functions tests, nerve conduction and pulmonary function studies.
4. **Radiation Therapy** – includes radiological treatment by X-ray, isotopes, or cobalt for a malignancy.
5. **Mammograms** – covers one mammogram (breast X-ray) for a woman from the age of 35 to 40. At 40 and older, one mammogram per calendar year is covered. More frequent mammograms are covered if requested by your physician because of the suspected or actual presence of a disease or when required as a post-operative procedure.
6. **Genetic testing** – if medically necessary (e.g., if testing is required as a result of an actual diagnosed condition).

Physician Services and Facility Charges are payable when performed at any facility licensed with the appropriate governing body to provide these services.

Other Covered Services

The Plan coverage includes the following services:

Blood Services

Whole blood for transfusions is covered.

Oxygen and Other Therapeutic Gases

Oxygen and equipment to administer the oxygen are covered when prescribed by a physician and are medically necessary.

Optical Services Following Cataract Surgery

The Plan benefits include the examination and fitting of one pair of contact lenses or eyeglasses when prescribed by a physician following cataract surgery. Cataract sunglasses are **not** covered.

Dental Services

Dental services and appliances required for the treatment of an accidental injury are covered. An external force must have caused the injury. Injuries resulting from biting or chewing are **not** covered.

Cochlear Implants

Mapping required for Cochlear Implants is covered.

Implants and two (2) sets of batteries covered per calendar year.

Durable Medical Equipment (DME)

To verify if a DME benefit prescribed is a covered benefit, please contact the Nurse Advocate at 1-800-423-1028. The prescription must include a description of the equipment and a diagnosis. For rental equipment, a new prescription must be written when the current prescription expires.

Important: The Plan does **not** pay for exercise and hygienic equipment, comfort and convenience items, self-help devices such as elevators, deluxe equipment, such as motorized wheelchairs unless medically necessary and required so the patient can operate the equipment themselves, and experimental or investigational equipment.

1. Durable Medical Equipment: The rental of oxygen, wheelchairs, walkers, special Hospital beds, iron lungs, and other Durable Medical Equipment will be payable as shown in the Schedule of Benefits, subject to the following:
 - a The equipment must be prescribed by a Physician and needed in the treatment of an Illness or Injury; and
 - b The equipment will be provided on a rental basis; however such equipment may be purchased at the Plan's option. Any amount paid to rent the equipment will be applied towards the purchase price. In no case will the rental cost of Durable Medical Equipment exceed the purchase price of the item (oxygen equipment is not limited to the purchase price); and
 - c Benefits will be limited to standard models, as determined by the Plan; and
 - d The Plan will pay benefits for only ONE of the following: a manual wheelchair, motorized wheelchair or motorized scooter, unless Medically Necessary due to growth of the person or changes to the person's medical condition require a different product, as determined by the Plan; and
 - e If the equipment is purchased, benefits will be payable for subsequent repairs, excluding batteries, necessary to restore the equipment to a serviceable condition. If such equipment cannot be restored to a serviceable condition, replacement will be considered eligible, subject to prior approval by the Plan. In all cases, repairs or replacement due to abuse or misuse, as determined by the Plan, are not covered; and
 - f Expenses for the rental or purchase of any type of air conditioner, air purifier, or any other device or appliance will not be considered eligible.

Medical Supplies

The Plan pays for medical supplies and dressings for use in the home and compression stockings (e.g., Jobst) when prescribed by a physician for the treatment of a specific medical condition.

Prosthetic and Orthotic Appliances

The Plan pays for prosthetic and orthotic appliances when they are prescribed by a physician and supplied by a licensed orthotist or prosthetist. Benefits cover temporary appliances, delivery, services, and fitting charges. Adjustment or replacement of eligible appliances is payable only when required because of wear, growth, or change in the patient's condition.

A device that replaces a limb or part of a limb must be furnished by a provider who is fully accredited by the American Board of Certification in Orthotics and Prosthetics, Inc. (ABC). Please contact the Nurse Advocate for information about a provider's status.

Important: The Plan does **not** pay for spare devices, routine maintenance, supplies such as elastic stockings (except as specified), arch supports or corsets, hearing aids or for hair prosthesis such as wigs or hair implants. Orthopedic or corrective shoes are payable **only** when required to correct a physical defect and are attached to a leg brace.

Private Duty Nursing

Private duty nursing is covered when the patient's condition requires 24-hour, continuous skilled care by a professional nurse on a one-to-one basis. Non-skilled care or care provided by a nurse who ordinarily resides in the patient's home or is related to a patient of the immediate family is **not** covered.

Services must be prescribed by a physician and provided by a registered or licensed practical nurse. The attending physician must complete a Certification Statement each month the patient is required to have private duty nursing care.

Qualified Clinical Trial Expenses

Qualified Clinical Trial Expenses are, except as excluded below, healthcare items and services for the treatment of cancer or any other life threatening condition for a qualifying individual enrolled in a Qualified Clinical Trial that are otherwise consistent with the terms of the Plan and would be covered if the Covered Person did not participate in the Qualified Clinical Trial.

For purposes of this section, a "life threatening condition" means any condition or disease from which the likelihood of death is probable unless the course of the disease or condition is interrupted; and a "qualifying individual" means any Covered Person who is eligible to participate in a Qualified Clinical Trial according to the trial protocol for treatment of cancer or any other life threatening condition that makes his or her participation in the program appropriate, as determined based on either (i) a conclusion of a referring health care professional or (ii) medical and scientific information provided by the Covered Person.

Notwithstanding the above, Qualified Clinical Trial expenses do not include any of the following:

1. Costs associated with managing the research associated with the Qualified Clinical Trial; or

2. Costs that would not be covered for non-Experimental and/or Investigational treatments; or
3. Any item or service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Exclusions

Examples of what The Plan does **not** pay:

1. Care and services available at no cost to you in a veterans' or other federal hospital or any hospital maintained by any state or governmental agency
2. Medically necessary services received on an inpatient basis that can be provided safely in an outpatient or office location
3. Custodial care, rest therapy, and care in a nursing or rest home facility
4. Dental surgery other than for the removal of impacted teeth or multiple extractions when the patient must be hospitalized for the surgery because of concurrent medical conditions exists
5. Treatment of temporomandibular joint syndrome (TMJ) and related jaw-joint problems by any method other than as specified in this SPD
6. Hospital admissions that begin **before** the effective date of coverage
7. Hospital admissions that begin **after** the coverage termination date
8. Medical services or supplies provided or furnished while coverage is not in effect (**before** the effective date of coverage or **after** the coverage termination date)
9. Health care services provided by persons who are not legally qualified or licensed to provide such service
10. Routine hospital outpatient care requiring repeated visits for the treatment of chronic conditions
11. Hospitalization principally for observation, diagnostic evaluation, physical therapy, X-ray or lab tests, reduction of weight by diet control (with or without medication), basal metabolism tests, or electrocardiography
12. Items for the personal comfort or convenience of the patient
13. Proctoscopic exams
14. Infertility care, supplies, services, and treatment for infertility, except for diagnostic services rendered for infertility evaluation NOTE: This exclusion is not intended to exclude coverage for any infertility counseling or treatment required to be covered (if any) as a preventive service under the guidelines published by the Health Resources and Services Administration on August 1, 2011 (or any applicable subsequent guidelines).

15. Psychiatric services after determination that the patient's condition will not respond to treatment
16. Psychological tests for vocational guidance or counseling
17. Premarital or pre-employment exams
18. Services and supplies that are not medically necessary according to accepted standards of medical practice
19. Services provided through a medical clinic or similar facility provided or maintained by the Plan
20. Treatment of occupational injury or disease that the City of Grand Rapids is to furnish or otherwise fund
21. Care and services payable by government-sponsored health care programs, such as Medicare or TRICARE for which a member is eligible. These services are not payable even if you have not signed up to receive the benefits provided such programs.
22. Cosmetic surgery and related services solely for improving appearance, except as specified in the Plan
23. Treatment of a condition caused by military action or war, declared or undeclared
24. Expenses for treatment, procedures, devices, drugs or medicines which are determined to be Experimental and/or Investigational will not be considered eligible, except to the extent such expenses are Qualified Clinical Trial Expenses
25. Services for which a charge is not customarily made; services for which the patient is not obligated to pay or services without cost
26. Routine hearing exams and preparation, fitting, or procurement of hearing aids. This exclusion does not apply to Preventive Services.
27. Vision exams and eyeglasses or other corrective vision appliances except as specified in the Plan. This exclusion does not apply to Preventive Services.
28. Dental services and appliances except those specified in the Plan
29. Dialysis services after 30 months of end stage renal disease treatment
30. Services that are not included in your plan summary document
31. Transportation and travel except as specified in the Plan
32. Reversed sterilizations

33. Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation and occupational or physical therapy covered by the Plan.
34. Nutritional supplements. This exclusion does not apply to Preventive Services.
35. Routine foot care such as treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions (except open cutting operations), and treatment of corns, calluses or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease)
36. Expenses for Injuries incurred during the commission or attempted commission of any criminal act, as defined by the State, involving, but not limited to: a) involving the use of alcohol or illegal drugs, excluding minor traffic violations, b) involving violence or the threat of violence to another person, or c) in which the Covered Person uses a firearm, explosive or other weapon likely to cause physical harm or death
37. Charges for administrative costs of completing claim forms, itemized bills, medical reports or for providing records, mailing and/or shipping expenses, expenses for broken appointments or expenses for telephone calls
38. Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician
39. Reversal of any surgical treatment of Morbid Obesity
40. Any expenses resulting from losses which are due to riot or revolt
41. Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment.
42. Services for educational or vocational testing, training, care for learning disorders or behavioral problems whether or not services are rendered in a facility that also provides medical treatment, except as specified in the Medical Benefits section
43. Adoption expenses or expenses related to surrogate parenting
44. Expenses for weight loss programs, except when prescribed for Morbid Obesity
45. Expenses for diaphragms. This exclusion does not apply to Preventive Services

NURSE ADVOCATE

The Nurse Advocate is a benefit that provides a nurse who is available to answer questions you have regarding your health status, issues regarding payment of a claim, or health benefits payable under the Plan. If you have health care concerns or questions, you can voluntarily discuss them with a nurse from the privacy of your home.

The Nurse Advocate will support you and help you cope with complex medical systems and provide a confidential source of answers for health care and health plan questions.

The Nurse Advocate can help you obtain answers about health care options and even help you select a primary care physician or specialist. The Nurse Advocate is available to help you understand what your doctor has said to you, discuss a procedure that you think might benefit you, or anything health related. The Nurse Advocate is there to help you!

The Nurse Advocate is available Monday through Friday from 8 AM to 5 PM EST at 1-800-423-1028. Call and ask for the Nurse Advocate.

In the event you have any concerns or questions regarding the voluntary program implemented by the Nurse Plan Advocate, please submit the concern in writing to:

Human Resource Department, Attn: Director of Human Resources, 300 Monroe NW, Grand Rapids, MI 49503.

PRESCRIPTION

(ACTIVE EMPLOYEES AND RETIREES WHOSE PLANS RATIFIED IN 2008/2009)

NOTE: An OTC Step Therapy provision applies to the following OTC drug classifications: Proton Pump Inhibitors (PPIs), Antihistamines and NSAIDs. Refer to your OTC handout provided by Human Resources for information on Over-the-Counter (OTC) medications.

Prescription - Retail:

Generic drugs	
Co-payment.....	\$10
Percentage payable.....	100%
Brand Name drugs	
Co-payment.....	\$20
Percentage payable.....	100%
Preventive Drug	\$0 copay
Covered OTC medicines	\$0 copay

Prescription - Mail Order: (90 day supply)

Generic drugs	
Co-payment.....	\$10
Percentage payable.....	100%
Brand Name drugs	
Co-payment.....	\$20
Percentage payable.....	100%
Preventive Drug	\$0 copay

Proton Pump Inhibitor (PPI) Calendar Year Maximum

Benefit per Covered Person: \$600*

* Once the Calendar Year Maximum Benefit is met, the copay shall increase to \$20 generic equivalent drugs and \$40 brand name drugs. (PPIs dispensed under the OTC Program do not count toward the \$600 Calendar Year maximum benefit.)

When medication is a necessary part of your total health care program, the Plan includes coverage for the following prescription drug services.

What's Covered

You have coverage for:*

1. Federal legend and state-controlled drugs
2. Compound medications containing at least one federal legend drug ingredient
3. Injectable insulin
4. Needles and syringes dispensed with insulin or chemotherapeutic drugs

5. Oral or injectable contraceptive medications prescribed by a physician
6. Selected covered Over-the-Counter (OTC) medicines with a prescription
7. Anorexients and anti-obesity drugs when medically necessary
8. Growth hormones when medically necessary
9. Anaphylaxis therapy when medically necessary
10. Glucagon injectables when medically necessary
11. Prescription Hematinics when medically necessary
12. Anti-migraine drugs (including Injectable Imitrex) subject to quantity limits; contact the City's Human Resources Department for more information
13. Prescription vitamins (oral and injectable) when medically necessary
14. Sexual dysfunction drugs
15. Diaphragms

Covered drugs may be dispensed at a retail pharmacy in quantities of up to a 34-day supply or 100-unit doses for certain maintenance drugs, whichever is greater. Covered OTC drugs may be dispensed in quantities to a 90-day supply.

* This list is meant to be a summary of covered Prescription drugs; it is **not** all-inclusive. For complete information, including a list of covered Prescription drugs and quantity limits, please contact the City's Human Resource Department.

New therapies will be reviewed by the Plan as may be required.

Please note prescription drugs are subject to the cost-sharing provisions described above unless the prescription drug qualifies as a preventive drug (as defined below).

Generic Equivalent Drugs

Generic equivalent drugs can be produced by more than one manufacturer and distributed under more than one name. The Food and Drug Administration requires that these generic drugs meet the same standards for active ingredients as brand name drugs. **With the exception of insulin**, if there is a generic equivalent to a brand name drug, your **pharmacy will automatically dispense the generic equivalent unless your physician has indicated "DAW"** (dispensed as written) in his or her own handwriting on your prescription as required by State Law.

Co-Branded Drugs

Co-branded drugs are chemically equivalent drugs sold under different brand names. They are designated "preferred" and "non-preferred". When dispensing brand name drugs that are co-branded, your pharmacist must fill your prescription with the drug identified as "preferred" by 4D Pharmacy.

When your prescription is filled with a co-branded drug, we will pay our approved amount for the preferred co-branded drug less your co-pay. If your prescription is filled with a non-preferred, co-branded drug, you must pay the full cost of the drug unless the prescribing physician requests and obtains authorization for the non-preferred drug from 4D Pharmacy's Prescriber Hot Line.

Preventive Drug

A list of Prescription Drugs, FDA approved contraceptive devices and FDA approved over-the-counter medications (including over-the-counter emergency contraceptives), when prescribed by a Physician, that have been identified by the U.S. Department of Health and Human Services (HHS) as a preventive service. The term "Preventive Drug" does not include abortifacient drugs or over-the-counter contraceptives (other than FDA approved over-the-counter emergency contraceptives) regardless of whether or not such items are prescribed by a Physician. Please contact the Prescription Drug Card Program Administrator for a complete listing of the Preventive Drugs covered under this Plan and any restrictions on the available drugs. You may also view the guidelines established by HHS by visiting the website at:

<https://www.healthcare.gov/what-are-my-preventive-care-benefits>

and/or

www.healthcare.gov/law/resources/regulations/womensprevention.html

For a paper copy, please contact the Plan Administrator.

Note: Coverage for preventive contraceptives and contraceptive devices is only available for women of child bearing age.

Your Co-pay

Your co-pay is as follows:

1. **Retail**
\$10 for generic equivalent drugs and \$20 for brand name drugs even when the prescription indicates "DAW" or if there is no generic equivalent drug available.
2. **Mail Order**
\$10 for a 90-day supply of generic equivalent drugs and \$20 for brand name drugs, even when the prescription indicates "DAW" or if there is no generic equivalent available.
3. **Proton Pump Inhibitor (PPI) after Calendar Year maximum has been met**
\$20 generic equivalent drugs and \$40 brand name drugs. (PPIs dispensed under the OTC Program do not count toward the \$600 Calendar Year maximum benefit.)

Quantity Limits (QL)

Some drugs may be subject to Quantity Limits (QL). QL will determine monthly drug dosage dispensed and/or the number of months the drug usage is usually needed to treat a particular condition.

Choosing Your Pharmacy

You can have your prescriptions filled at a network or non-network pharmacy. The choice is always yours. Remember that when your prescriptions are filled through a non-network pharmacy, you have higher out-of-pocket costs.

Network Pharmacy

A network pharmacy is a pharmacy that is part of 4D Pharmacy. Network pharmacies will file claims for you and they receive payment directly from the Plan.

When your prescriptions are filled through a **network** pharmacy, the Plan will pay 100% of the approved amount less your co-pay.

Non-Network Pharmacy

Pharmacies not part of 4D Pharmacy are called *non-network*. If you go to a non-network pharmacy, you and not the pharmacy will need to file your "Direct Member Reimbursement" (DMR) form and receipts for payment. You will receive 75% of the approved amount less your co-pay.

Mail Order Prescription Drugs

Your mail order prescription drug program is available for long-term prescription drug needs through 4D Pharmacy's partnership with Prescription Solutions. If you are taking medication on a regular basis, ordering your prescriptions through the mail order plan is convenient. In addition to mailing your prescriptions to the mail order pharmacy, your physician can phone in or fax your prescription orders. Refills on your mail order prescriptions can be ordered by mail, telephone, or the Internet.

When prescribed by your physician, you can order up to a 90-day supply (three months) of medication by mail from Prescription Solutions and pay the appropriate co-pay (refer to the "Your Co-pay" section above) for each prescription or refill.

Ordering from Prescription Solutions requires an order form. No claim forms are needed. Your medication is delivered to your home, postage-paid, within 10 to 14 business days from the date you mailed your order.

If you have any questions, you can call Prescription Solutions at 1-888-225-2610 or go to the website at www.4dpharmacy.com and use the convenient automated refill system available through the Member Services link.

What's Not Covered

The Plan's Prescription Drug coverage **excludes**:

1. Drugs that cost less than your co-pay
2. Administration of drugs or any drug consumed at the time and place of the prescription order
3. Refills not authorized by a physician
4. Therapeutic devices or appliances, even if prescribed by a physician (e.g., garments regardless of their intended use)

5. More than a 34-day supply, except for specified maintenance drugs that are covered for 100-unit doses (retail pharmacy), or mail order prescriptions that are covered for a 90-day supply, and covered OTC drugs may be dispensed in quantities to a 90-day supply
6. More than 12 doses of a sexual dysfunction drug such as Viagra in a 30-day period; when using mail order, more than 36 doses in a 90-day period
7. More than 4 doses of Injectable Imitrex in a 34-day period or as may be required by State and Federal Law
8. Refills dispensed after one year from the date of the prescription or as may be required by State and Federal Law
9. Prescription drugs that are used primarily for improving appearance rather than for treating a disease
10. Any vaccine given solely to resist infectious diseases
11. Any drug 4D Pharmacy determines is experimental or investigational
12. Any drug except insulin that does not require a prescription
13. Drugs or services obtained before the effective date or after the Plan ends
14. Non-preferred co-branded drugs, unless they are preauthorized
15. Any Over-the-Counter drug that is not identified as a covered drug or medicine
16. Any drug, medication or supply not approved for coverage under the plan
17. Charges for the administrations or injection of any drugs
18. Any drug, medicine or medications labeled "Caution-Limited by Federal Law to Investigational use" or experimental drug
19. Injectable drugs (except: Insulin, anaphylaxis therapy, migraine, blood cell stimulators, glucagon and prescription vitamins)
20. Fertility Drugs
21. Biologicals such as serums, vaccines etc.
22. Dental Products, including fluoride only products
23. Nutritional and Dietary products
24. Research drugs
25. Obsolete drugs as determined by the FDA
26. Medical devices

DENTAL BENEFITS

(ACTIVE EMPLOYEES AND RETIREES WHOSE PLANS RATIFIED IN 2008/2009)

Dental Percentage Payable by the Plan

Class I Services Preventive.....	75%
Class II Services Restorative.....	75%
Class III Services Construction of Dentures and Bridges.....	75%
Class IV Services Orthodontia	50%

Maximum Benefit Amount

Per person per Calendar Year – Class I, II, & III Services.....	\$1,000
Lifetime Maximum Plan Benefit – Class IV Services.....	\$1,500

BENEFIT PAYMENT

Each Calendar Year benefits will be paid to a Covered Person for the dental charges in excess of the co-pay. Payment will be made at the rate shown under Dental Percentage Payable in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount.

MAXIMUM BENEFIT AMOUNT

The Maximum Dental Benefit Amount is shown in the Schedule of Benefits.

DENTAL CHARGES

Dental charges are charges made by a Dentist or other Physician for necessary care, appliances, or other dental material listed as a covered dental service.

A dental charge is incurred on the date the service or supply for which it is made is performed or furnished. However, there are times when one overall charge is made for all or part of a course of treatment. In this case Meritain Health will apportion that overall charge to each of the separate visits or treatments. The pro rata charge will be considered to be incurred as each visit or treatment is completed.

Predetermination of Benefits

Predetermination gives your dentist an opportunity to submit proposed treatment plans for Meritain Health's review before beginning services. This pre-review allows you and

your dentist to agree on treatment based on what the Plan will cover. Dentists usually use this procedure for non-urgent, complex or expensive procedures such as crowns and dentures.

Your coverage is subject to the annual Plan benefit maximum available and time limitations at the time services are **actually** received.

What's Covered

You have coverage for the following classes of services:

Class I – Preventive Services

Benefits include:

1. Oral exams limited to 2 per calendar year
2. Teeth cleaning limited to 2 per calendar year
3. Bitewing X-rays limited to 2 sets per calendar year
4. Full-mouth X-rays once every 3 calendar years
5. Fluoride treatment (no age limitation)
6. Emergency treatment
7. Space maintainers for patients under age 19

Class II – Restorative Services

Benefits include:

1. Fillings (amalgam, acrylic, or silicate)
2. Inlays, onlays, and crowns
3. Recementing of crowns, inlays, onlays, and bridges
4. Root canal therapy
5. Periodontal treatments
6. Oral surgery including extractions
7. General anesthesia
8. General adjustments and relining of dentures
9. Repair of removable dentures
10. Replacement of crowns after five years if unserviceable

Class III – Construction of Dentures and Bridges

Benefits include:

1. Removable dentures (complete and partial)
2. Fixed bridges including abutment crowns
3. Replacement of dentures and bridges after five years if unserviceable

Class IV – Orthodontic Services

Services are paid at 50% of the approved amount. Your co-pay is 50%. The Plan maximum per eligible patient is \$1,500. **These services must be received before the patient reaches 19. Services include:**

1. Braces
2. Monthly orthodontic treatments
3. Minor orthodontic tooth-guidance appliances

ALTERNATE TREATMENT

Many dental conditions can be treated in more than one way. This Plan has an "alternate treatment" clause that governs the amount of benefits the Plan will pay for treatments covered under the Plan. If a patient chooses a more expensive treatment than is needed to correct a dental problem according to accepted standards of dental practice, the benefit payment will be based on the cost of the treatment that provides professionally satisfactory results at the most cost-effective level.

For example, if a regular amalgam filling is sufficient to restore a tooth to health and the patient and the Dentist decide to use a gold filling, the Plan will base its reimbursement on the Usual and Reasonable Charge for an amalgam filling. The patient will pay the difference in cost. **Please contact Meritain Health at 1-800-423-1028 before major dental services are performed.**

Exclusions

The Plan's Dental Care coverage **does not** pay for:

1. Charges for missed appointments
2. Charges for completing claim forms and other charts or reports
3. Services and supplies not necessary for the diagnosis or treatment of a dental illness or injury or not recommended and approved by the attending dentist
4. Services that are experimental, investigative, substandard, or not approved by the American Dental Association
5. Charges for cleaning of teeth unless done by or under the supervision of a dentist (supervision means the dentist is available but not necessarily at chairside during the procedure)
6. Treatment given by someone other than a dentist, except for scaling or cleaning of teeth and topical application of fluoride by a licensed dental hygienist under the supervision of a dentist
7. Service for cosmetic purposes; personalized services or supplies
8. Charges for veneers placed on crowns or pontics other than the ten lower and ten upper anterior (front) teeth

9. Charges for instruction in oral hygiene, diet, and plaque control programs
10. Dental sealants
11. Gold foil restoration, implants, and periodontal splinting
12. Appliances, restorations, or services necessary to increase dimension, restore, or correct occlusion, or treat jaw-joint disorders
13. Dental services to correct congenital or developmental malformation or primarily for improving appearance
14. The most costly treatment when two or more methods are available to treat the condition. The Plan will pay the approved amount for the least costly treatment
15. Adjustments of dentures within six months after installation
16. Lost, missing, or stolen appliances; repairs and replacement of appliances
17. Charges for duplicate appliances
18. Charges for removal of impacted teeth or multiple extractions when the patient must be hospitalized for the surgery because of concurrent medical conditions exist; these expenses are covered under the Medical portion of the Plan.

VISION CARE COVERAGE

(ACTIVE EMPLOYEES AND RETIREES WHOSE PLANS RATIFIED IN 2008/2009)

The Plan's vision coverage is designed to encourage regular eye examinations and help pay the cost of corrective eyewear.

Your Dollar Maximum

The Plan's vision services are limited to an annual maximum of **\$200** per calendar year per member. Benefits renew on the first day of each new calendar year.

What's Covered

Vision care benefits include:

Examinations

1. Visual acuity tests
2. External examination of the eyes
3. Tonometry (glaucoma testing)
4. Binocular measure
5. Ophthalmoscope

Frames

Wire, plastic, or metal

Lenses

Glass or plastic-equivalent – single, bifocal, or trifocal vision

Contact Lenses

Hard, soft, or extended wear - single or bifocal vision

Exclusions

The Plan's Vision Care coverage **does not** pay for:

1. Medical or surgical treatment
2. Drugs or medications administered for a purpose other than a vision examination
3. Special procedures such as vision training or subnormal-vision aids
4. Services ordered before the effective date of your coverage or lenses and frames delivered more than 60 days after your coverage ends
5. Vision testing examinations, lenses, or frames for any condition, disease, ailment, or injury related to your employment or an act of war

HOW TO SUBMIT A CLAIM

Network Providers will submit claims to the Claims Administrator on your behalf.

When a Covered Person has a claim to submit for payment that person must:

1. For medical Plan reimbursements, attach bills for services rendered. For Dental Claims, the dentist must submit the form. ALL BILLS MUST SHOW:
 - A. Name of Employer
 - B. Employee's Name
 - C. Employee's Social Security Number
 - D. Patient's Name
 - E. Patient's Date of Birth
 - F. Name, Address, and Telephone Number of the Provider of Care
 - G. Provider Tax ID Number
 - H. Diagnosis
 - I. Type of Service(s) Rendered with Diagnosis and/or Procedure Codes
 - J. Date of Service(s)
 - K. Charges

Please note: We cannot accept "balance due" statements or Explanation of Benefit statements as an itemized bill. The statements do not contain the information that we need to accurately process your claims.

2. Send the above to the Claims Administrator at this address:

Meritain Health
P.O. Box 30126
Lansing, MI 48909
1-800-423-1028

Important: If you receive medical services out of the country, try to get all receipts itemized in English. Cash register receipts, canceled checks, or money order stubs may accompany your itemized statement, but may not substitute for an itemized statement.

WHEN CLAIMS SHOULD BE FILED

Claims should be filed with the Claims Administrator within twenty-four (24) months of the date charges for the services were incurred. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date may be declined or reduced unless:

1. It's not reasonably possible to submit the claim in that time, and
2. The claim is submitted within two (2) years from the date incurred. This two (2) year period will not apply when the person is not legally capable of submitting the claim.

The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

CLAIMS PROCEDURE

The Plan's claims procedures are intended to reflect the Department of Labor's claims procedures regulations, and should be interpreted accordingly. In the event of any conflict between the summary and those Regulations, those Regulations will control. In addition, any changes in those Regulations shall be deemed to amend this summary automatically, effective as of the date of those changes.

To receive benefits under the Plan, the claimant must follow the procedures established by the Plan Administrator and/or the insurance company which has the responsibility for making the particular benefit payments to the claimant.

Initial claims for Plan benefits are made to the Plan Administrator or, if applicable, the Insurer providing that benefit. The Plan Administrator, (or Insurer, if applicable) will review the claim itself or appoint an individual or an entity to review the claim, following these procedures:

1. **Urgent Care Claims.** If your claim is considered an urgent care claim, the Plan Administrator will notify you of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the Plan receives the claim, unless you fail to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. If you fail to provide sufficient information for the Plan to decide your claim, the Plan Administrator will notify you as soon as possible, but not later than 24 hours after the Plan receives the claim, of the specific information necessary to complete the claim. The notification may be oral unless written notification is requested by you. You will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Plan Administrator will notify you of the Plan's determination as soon as possible, but in no case later than 48 hours after the earlier of (1) the Plan's receipt of the specified additional information or (2) the end of the period afforded the claimant to provide the specified additional information.

A claim for benefits is considered an urgent care claim if the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function or, in the opinion of a Physician with knowledge of your medical condition, would subject

you to severe pain that could not be adequately managed without the care or treatment which is the subject of the claim. In determining if an initial claim for benefits should be treated as an urgent care claim, the Plan will defer to a determination, if any, by an attending provider that the claim should be treated as an urgent care claim, if that determination is timely provided to the Plan.

2. **Concurrent Care Claims.** If the Plan has approved an ongoing course of health care treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of the previously approved course of treatment (other than by Plan amendment or termination) before the approved time period or number of treatments constitutes an adverse determination. In such a case, the Plan Administrator will notify you of the adverse determination at a time sufficiently in advance of the reduction or termination to allow you claimant to appeal and obtain a determination on review of that adverse determination before reduction or termination of the benefit.

Any request by you to extend a previously approved course of urgent care treatment beyond the approved period of time or number of treatments shall be decided as soon as possible, taking into account the medical exigencies, and the Plan Administrator will notify you of the benefit determination, whether adverse or not, within 24 hours after the Plan receives the claim, provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

3. **Pre-Service Claims.** For a pre-service claim, the Plan Administrator will notify you of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after the Plan receives the claim. If, due to matters beyond the control of the Plan, the Plan Administrator needs additional time to process a claim, the Plan Administrator may extend the time to notify you of the Plan's benefit determination for up to 15 days, provided that the Plan Administrator notifies you within 15 days after the Plan receives the claim, of those special circumstances and of when the Plan Administrator expects to make its decision. However, if such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension must specifically describe the required information, and you will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A claim for benefits is considered a pre-service claim if the claim requires approval, in part or in whole, in advance of obtaining the health care in question.

4. **Post-Service Claims.** For a post-service claim, the Plan Administrator will notify you of the Plan's adverse determination within a reasonable period of time, but not later than 30 days after receipt of the claim. If, due to special circumstances, the Plan Administrator needs additional time to process a claim, the Plan Administrator may extend the time for notifying you of the Plan's benefit determination on a one-time basis for up to 15 days, provided that the Plan Administrator notifies you within 30 days after the Plan receives the claim, of those special circumstances and of the date by which the reviewer expects to

make a decision. However, if such a decision is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and you will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A claim for benefits is considered a post-service claim if it is a request for payment for services or other benefits that you have already received (or any other claim for health benefits that is not a pre-service claim or an urgent care claim).

Manner and Content of Notice of Initial Adverse Determination. If the Plan Administrator denies a claim, it must provide to you in writing or by electronic communication:

1. An explanation of the specific reasons for the denial;
2. A reference to the Plan provision or insurance contract provision upon which the denial is based;
3. A description of any additional information or material that you must provide to perfect the claim;
4. An explanation of why the additional material or information is necessary;
5. Notice that you have the right to request a review of the claim denial and information on the steps to be taken if you wish to request a review of the claim denial along with the time limits applicable to a request for review;
6. A statement describing your right to request an external review, or, if applicable, to bring an action for judicial review;
7. A copy of any rule, guideline, protocol, or other similar criterion relied upon in making the adverse determination (or a statement that the same will be provided upon your request and without charge); and
8. If the adverse determination is based on the Plan's Medical Necessity, experimental treatment or similar exclusion or limit, either: (a) an explanation of the scientific or clinical judgment applying the exclusion or limit to your medical circumstances, or (b) a statement that the same will be provided upon your request and without charge.

Any notice of adverse determination also will include the following information:

1. Information sufficient to identify the claim involved, including the date of service, the health care provider, and the claim amount (if applicable);
2. As part of the explanation of the determination, a discussion of the decision, as well as disclosure of any denial code used (and an explanation of its meaning)

and a description of the Plan's standard, if any, that was used in denying the claim;

3. A description of available internal appeals and external review processes, including information regarding how to initiate an appeal;
4. Information (including contact information) about the availability of any applicable office of health insurance consumer assistance or ombudsmen established pursuant to the Patient Protection and Affordable Care Act (PPACA) to assist individuals with internal claims and appeals and external review processes; and
5. a statement describing the availability, upon request, of any applicable diagnosis code (and an explanation of its meaning) and any applicable treatment code (and an explanation of its meaning).

NOTE: The Plan will make reasonable good faith efforts to comply with requirements (1) through (5) above. However, the Plan will not be treated as in violation of any requirement of the Plan's claims procedures because a notice fails to satisfy all of those requirements, to the extent that an enforcement grace period applies under Department of Labor Technical Release 2011-01 (or any later guidance that extends that enforcement grace period). Under Technical Release 2011-01, an enforcement grace period currently applies until the first day of the first Plan Year that begins on or after January 1, 2011 for requirements (1) through (4) above and until the first day of the first Plan Year that begins on or after July 1, 2011 for requirement (5) above.

For an adverse determination concerning an urgent care claims, the information described in this Section may be provided to you orally within the permitted time frame, provided that a written or electronic notification in accordance with this Section is furnished to you no later than 3 days after the oral notification.

Internal Review of Initially Denied Claims

If you submit a claim for Plan benefits and it is initially denied under the procedures described above, you may request a review of that denial under the following procedures:

Health Benefit Claims. You have 180 days after you receive notice of an initial adverse determination to request a review of the adverse determination.

If you request a review of an adverse determination within the applicable time period, the review will meet the following requirements:

1. The Plan will provide a review that does not afford deference to the adverse determination that is being appealed and that is conducted by an appropriate named fiduciary of the Plan who did not make the adverse determination that is the subject of the appeal, and who is not a subordinate of the individual who made that adverse determination.

2. The appropriate named fiduciary of the Plan will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment before making a decision on review of any adverse determination based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational or not Medically Necessary or appropriate. The professional engaged for purposes of a consultation in the preceding sentence will be an individual who is neither an individual who was consulted in connection with the adverse determination that is the subject of the appeal, nor a subordinate of any such individual.
3. The Plan will identify any medical or vocational experts whose advice is obtained on behalf of the Plan in connection with the Plan's review of an adverse determination, without regard to whether the advice is relied upon in making the determination on review.
4. For a requested review of a adverse determination involving an urgent care claim, the review process will meet the expedited deadlines described below. Your request for such an expedited review may be submitted orally or in writing and all necessary information, including the Plan's determination on review, will be transmitted between the Plan and you by telephone, facsimile or other available similarly expeditious method.
5. The reviewer will afford you an opportunity to review and receive, without charge, all relevant documents, information and records relating to the claim and to submit issues and comments relating to the claim in writing to the Plan. The reviewer will take into account all comments, documents, records and other information submitted by the claimant relating to the claim regardless of whether the information was submitted or considered in the initial benefit determination.
6. You will be provided, free of charge, any new or additional evidence or rationale considered, relied upon, or generated by the Plan in connection with the claim. Such evidence or rationale will be provided as soon as possible and sufficiently in advance of the Plan's deadline for providing notice of its determination on review to give you a reasonable opportunity to respond prior to such determination.
7. The Plan will ensure that all claims are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decisions.
8. The Plan will provide you with continued coverage pending the outcome of an internal appeal.

All requests for review of initially denied claims (including all relevant information) must be submitted to the following address:

Meritain Health, Inc.
Appeals Department

Deadline for Internal Review of Initially Denied Claims

1. **Urgent Care Claims.** For urgent care claims, the reviewer will notify you of the Plan's determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of your request for review of an initial adverse determination by the Plan.
2. **Pre-Service Claims.** For a pre-service claim, the reviewer will notify you of the Plan's determination on review within a reasonable period of time appropriate to the medical circumstances, but in no event later than 30 days after the Plan receives your request for review of the initial adverse determination.
3. **Post-Service Claims.** For a post-service claim, the reviewer will notify you of the Plan's benefit determination on review within a reasonable period of time, but in no event later than 60 days after the Plan receives your request for review of the initial adverse benefit determination.

Manner and Content of Notice of Decision on Internal Review of Initially Denied Claims. Upon completion of its review of an initial adverse determination, the reviewer will give you, in writing or by electronic notification, a notice of its benefit determination. For an adverse determination, the notice will include:

1. A description of the Plan's decision;
2. The specific reasons for the decision;
3. The relevant Plan provisions or insurance contract provisions on which its decision is based;
4. A statement that you are entitled to receive, upon request and without charge, reasonable access to, and copies of, all documents, records and other information in the Plan's files which is relevant to your claim for benefits;
5. A statement describing your right to request an external review, or, if applicable, to bring an action for judicial review;
6. If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination on review, a statement that a copy of the rule, guideline, protocol or other similar criterion will be provided without charge to you upon request;

7. If the adverse determination on review is based on a Medical Necessity, experimental treatment or similar exclusion or limit, either: (a) an explanation of the scientific or clinical judgment on which the determination was based, applying the terms of the Plan to the claimant's medical circumstances, or (b) a statement that such an explanation will be provided without charge upon request; and

Any notice of adverse determination will include the following information:

1. Information sufficient to identify the claim involved, including the date of service, the health care provider, and the claim amount (if applicable);
2. As part of the explanation of the determination, a discussion of the decision, as well as disclosure of any denial code used (and an explanation of its meaning) and a description of the Plan's standard, if any, that was used in denying the claim;
3. A description of available internal appeals and external review processes, including information regarding how to initiate an appeal;
4. Information (including contact information) about the availability of any applicable office of health insurance consumer assistance or ombudsmen established pursuant to the Patient Protection and Affordable Care Act to assist individuals with internal claims and appeals and external review processes; and
5. A statement describing the availability, upon request, of any applicable diagnosis code (and an explanation of its meaning) and any applicable treatment code (and an explanation of its meaning).

NOTE: The Plan will make reasonable good faith efforts to comply with requirements (1) through (5) above. However, the Plan will not be treated as in violation of any requirement of the Plan's claims procedures because a notice fails to satisfy all of those requirements, to the extent that an enforcement grace period applies under Department of Labor Technical Release 2011-01 (or any later guidance that extends that enforcement grace period). Under Technical Release 2011-01, an enforcement grace period currently applies until the first day of the first Plan Year that begins on or after January 1, 2011 for requirements (1) through (4) above and until the first day of the first Plan Year that begins on or after July 1, 2011 for requirement (5) above.

Calculation of Time Periods. For purposes of the time periods described in the Plan's claim procedures, the period of time during which a benefit determination is required to be made begins at the time a claim (or a request for review or a denied claim) is filed in accordance with the Plan procedures without regard to whether all the information necessary to make a decision accompanies the request. If a period of time is extended due to your failure to submit all information necessary for a claim for non-urgent care benefits, the period for making the determination is "frozen" from the date the notification requesting the additional information is sent to you until the date you respond or, if earlier, until 45 days from the date you receive (or were reasonably expected to receive) the notice requesting additional information.

Adverse Determination. For purposes of the Plan's claim procedures, an "adverse determination" is a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of an individual's eligibility to participate in the Plan, and including a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate. Adverse determination also includes any rescission of coverage, whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at the time of rescission.

Plan's Failure to Follow Procedures

If the Plan fails to follow the claim procedures described above, you will be deemed to have exhausted the Plan internal claim procedures and you will be entitled to pursue any available remedy under State or Federal law on the basis that the Plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

However, the Plan will not be treated as failing to follow its claim procedures and you will not be deemed to have exhausted the Plan's administrative remedies merely because of a failure by the Plan that would be considered (based on applicable regulations) a "de minimis violation" that does not cause and is not likely to cause prejudice or harm to you as long as the Plan can demonstrate that the violation was for good cause or due to matters beyond the control of the Plan and that the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and you. You may request a written explanation of any violation by the Plan of these procedures. If you request such an explanation, the Plan will provide it within 10 days and, if applicable, the explanation will include a specific description of the Plan's reasons for asserting that the violation does not cause the Plan's internal claim procedures to be exhausted. If a court or external review rejects your request for an immediate review (based on a claim that you should be deemed to have exhausted the Plan's internal claim procedures), because the court or external reviewer determines that the "de minimis violation" exception applies, the Plan will provide to you a notice of your right to resubmit your internal appeal with a reasonable time (no longer than 10 days) after the court or external reviewer makes such a determination. Any applicable time limit for you to re-file your claim will begin to run when you receive that notice from the Plan.

External Review of Denied Claims

NOTE: This provision does not apply to dental and vision benefits.

If you have exhausted the Plan's internal appeal process (or if you are eligible to request an external review for any other reason under the above procedures), you may request an external review of the Plan's final adverse determination for certain health benefit claims.

The Plan will provide for an external review process in accordance with applicable State law (if any). If no external review process exists under applicable State law or, effective after December 31, 2011, if the State law external review process does not meet certain minimum standards of the NAIC Uniform Health Carrier External Review Model Act (or the temporary "NAIC-similar" standards described in Department of Labor Technical Release 2011-02), the Plan will provide for an external review process that meets Federal law requirements. Governmental plans that are not eligible to participate in a qualifying State process must elect to participate in a federal process administered by HHS or in the federal external review process that applies to ERISA-governed, self-funded Plans. If the Plan elects to participate in the federal external review process that applies to an ERISA self-funded plan, the external review procedures described below will apply.

For any adverse determination for which external review is available, the state external review requirements are as follows:

1. You have 60 days following the date you receive notice of the Plan's final internal adverse determination within which to request an external review. The request for an external review must be submitted in writing to the following address:

By mail:

DIFS – Office of the General Counsel – Appeals Section
P.O. Box 30220
Lansing, MI 48909-7720
Fax: (517) 241-4168

By courier / delivery:

DIFS – Office of the General Counsel – Appeals Section
611 W. Ottawa Street, 3rd Floor
Lansing, MI 48933-1070
Phone: (877) 999-6442

2. Within 5 business days following the date the commissioner receives your external review request the commissioner will complete a preliminary review. The commissioner will notify you in writing within one business day after it completes the preliminary review whether the claim is eligible for the external review process:
 - A. If the request is complete, but the claim is not eligible for external review, the notice will describe the reasons it is not eligible.
 - B. If the request is not complete, the notice will describe information or materials needed to make the request complete.
3. Following the commissioner's preliminary review, if the request is eligible for external review and appears to involve issues of Medical Necessity or clinical review criteria, the commissioner will assign an independent review organization (IRO) at the time the request is accepted for external review to make a recommendation on the request for external review. Within 7 business days

following assignment of the IRO, the Plan will forward to the IRO all information and materials relevant to the final internal adverse determination.

If the request is eligible for external review and does not appear to involve issues of Medical Necessity or clinical review criteria, and appears to only involve contractual issues of the Plan, the commissioner may either keep the request and conduct his own external review or assign an independent review organization (IRO) at the time the request is accepted for external review to make a recommendation on the request for external review. Within 7 business days following assignment of the IRO, the Plan will forward to the reviewing entity all information and materials relevant to the final internal adverse determination.

4. The assigned reviewing entity will notify you in writing immediately of the request's eligibility and acceptance for external review. The notice will include a statement regarding your right to submit any additional information, within 7 business days from the date of receipt of the notice, for the reviewing entity to consider as part of the external review process. Any such additional information received by the reviewing entity will be forwarded on and shared with the Plan. The Plan, based upon any new information received, may reconsider its final internal adverse determination. Reconsideration by the Plan will not delay the external review process. If the Plan does not reconsider its final internal adverse benefits determination, the reviewing entity will continue to proceed with the external review process.
5. Within 14 days after assignment of the external review request to the IRO, the IRO must provide written notice of its external review recommendation to the commissioner. The IRO's recommendation is required to contain the following:
 - A. A general description of the reason for the request for external review, including information sufficient to identify the claim, the diagnosis code and treatment code and the corresponding meaning for each and the reason for the previous denial;
 - B. The date the IRO received the assignment to conduct the external review, the date the external review was conducted, and the date of the IRO recommendation;
 - C. References to the evidence or documentation, including practice guidelines, the specific coverage provisions, and evidence based standards considered in reaching its recommendation;
 - D. A discussion of the principal reason or reasons for its recommendation, including the rationale for its recommendation and any evidence-based standards that were relied on in making its recommendation.
6. No later than 7 days after receipt of the IRO's recommendation, the commissioner shall provide written notice to you and the Plan of the decision to uphold or reverse the final adverse determination. If the commissioner has kept a request to review, the commissioner shall provide notice to you and Plan of his or her decision no later than 14 days after the decision to keep the request. The commissioner's notice shall include the following:

- A. The principal reason or reasons for the decision;
- B. If appropriate, the principal reason or reasons why the commissioner did not follow the assigned IRO's recommendation.

Expedited External Review

NOTE: This provision does not apply to dental and vision benefits.

You may request an expedited external review if you have received:

1. An initial internal adverse determination if the adverse determination involves a medical condition for which the time frame for completion of an expedited internal appeal under the Plan's internal claim procedures would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or
2. A final internal adverse determination, if you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function or if the final internal adverse determination concerns an admission, availability of care, continued stay or health care item or service for which you received emergency services but have not been discharged from a facility.

The following requirements apply to an expedited external review:

1. Immediately following the date the commissioner receives the external review request the commissioner will complete a preliminary review. The commissioner will notify you in writing immediately after completion of the preliminary review whether the request is eligible for the external review process.
 - A. If the request is complete, but the claim is not eligible for external review, the notice will describe the reasons it is not eligible.
 - B. If the request is not complete, the notice will describe any information or materials needed to make the request complete. If the request is not complete and additional information or materials is needed to complete the preliminary review, you will have until the later of (i) 48 hours following the date of receipt of the notification or (ii) the end of the 60 day deadline described in (1) above to provide the necessary additional information or materials.
2. Following the commissioner's preliminary review, if the request is eligible for external review, the commissioner will assign an independent review organization (IRO) to make a recommendation on the request for external review. No later than 12 hours after receiving notice that the expedited external review has been granted, the Plan will forward to the IRO, by any available expeditious method (e.g. telephone, facsimile, etc.), all information and materials relevant to the internal adverse determination.
3. If you have not completed the Plan's expedited internal review process, the IRO will determine immediately after receiving the assignment whether you must first complete the Plan's expedited internal review process. If the IRO does determine

you must complete the Plan's expedited internal review process, it will notify you immediately upon making this determination and suspend the expedited external review.

4. The IRO must provide its recommendation to the commissioner (either in writing or orally) as expeditiously as the claimant's medical condition or circumstance require and no later than 36 hours after the date the commissioner received the request for expedited external review.
5. As expeditiously as the claimant's medical condition or circumstance require and no later than 24 hours after the date the commissioner received the IRO's recommendation, the commissioner shall provide written notice to you and the Plan of the decision to uphold or reverse the adverse determination. If notice is not provided in writing, the commissioner must provide written notice to you and the Plan as confirmation of the decision within 48 hours after the date of the notice. The commissioner's notice is required to contain the following information:
 - A. The principal reason or reasons for the decision;
 - B. If appropriate, the principal reason or reasons why the commissioner did not follow the assigned IRO's recommendation.

NOTE: An expedited external review will not be provided for retrospective adverse determinations.

Effect of External Review Determination

A determination on external review is binding on the Plan and the claimant, except to the extent that other remedies are available under applicable State or Federal law. However, a decision by the external reviewer does not preclude the Plan from making payment or providing benefits on a claim at any time, including after a decision that denies the claim. When an external review decision requires the Plan to provide benefits or payment on a claim, the Plan will provide benefits or payment pursuant to the decision without unreasonable delay regardless of whether the Plan intends to seek judicial review of the decision, unless and until there is a judicial decision that provides otherwise.

Insured Benefits and State Insurance Laws

For any insured benefit under the Plan, nothing in the Plan's claims procedures will be construed to supersede any provision of any applicable State law that regulates insurance, except to the extent that such law prevents application of the Plan's claims procedures.

Statute of Limitations for Plan Claims

Please note that no legal action may be commenced or maintained to recover benefits under the Plan more than 12 months after the final review/appeal decision by the Plan Administrator has been rendered (or deemed rendered).

COORDINATION OF BENEFITS

Coordination of the benefit plans. Coordination of benefits sets out rules for the order of payment of Covered Charges when two or more plans -- including Medicare -- are paying. The plans will coordinate benefits when a claim is received in the following situations:

1. When a Covered Person is covered by this Plan and another plan; or
2. The Covered Person's Spouse is covered by this Plan and by another plan or the couple's Covered children are covered under two or more plans, the plans will coordinate benefits when a claim is received.

How COB Works

When a patient has double coverage, the Plan first determines who should pay first **before** processing your claim. If primary, full benefits will be paid under this Plan. If the Plan is secondary, the Plan will provide payment towards the balance of the cost of covered services – up to the **total** allowable amount determined by both payers.

Benefit plan. This provision will coordinate the medical and dental benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans:

1. Group or group-type plans, including franchise or blanket benefit plans.
2. Blue Cross and Blue Shield group plans.
3. Group practice and other group prepayment plans.
4. Federal government plans or programs. This includes Medicare.
5. Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.

Allowable Charge. For a charge to be allowable, it must be a Usual and Reasonable Charge and at least part of it must be covered under this Plan.

In the case of an HMO (Health Maintenance Organization) or other in-network only plans, this Plan will not consider any charges in excess of what an HMO or network provider has agreed to accept as payment in full. Also, when an HMO or network only plan is primary and the Covered Person does not use an HMO or network provider, this Plan will not consider as an allowable charge any charge that would have been covered by the HMO or network only Plan had the Covered Person used the services of an HMO or network provider.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the allowable charge.

Benefit Plan Payment Order. When two or more plans provide benefits for the same allowable charge, benefit payment will follow these rules.

1. Plans that do not have a coordination provision or one like it will pay first. Plans with such a provision will be considered after those without one.
2. Plans with a coordination provision will pay their benefits by the following rules, up to the Allowable Charge:

- A. The benefits of the plan which covers the person directly (that is, as an employee, patient, or subscriber - "Plan A") are determined before those of the plan which covers the person as a dependent ("Plan B").

Special Rule. If: (i) the person covered directly is a Medicare beneficiary, and (ii) Medicare is secondary to Plan B, and (iii) Medicare is primary to Plan A (for example, if the person is retired), THEN Plan B will pay before Plan A.

- B. The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired are determined before those of a benefit plan that covers that person as a laid-off or Retired Employee. The benefits of a benefit plan which covers a person as a Dependent of an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a Dependent of a laid off or Retired Employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

- C. The benefits of a medical plan which covers a person as an Employee who is neither laid off nor retired or a Dependent of an Employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary. Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.

- D. When a child is covered as a Dependent and the parents are not legally separated or divorced, these rules will apply:

- i. The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;
- ii. If both parents have the same birthday, the benefits of the benefit plan that has covered the patient for the longer time are determined before those of the benefit plan that covers the other parent.

- E. When a child's parents are divorced or legally separated, these rules will apply:

- i. This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.

- ii. This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a Dependent will be considered next. The benefit plan of the parent without custody will be considered last.
 - iii. This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent.
 - iv. If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are not separated or divorced.
- F. If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of allowable charges when paying secondary.
- 3. Medicare will pay primary, secondary, or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts.
 - 4. If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

Claims Determination Period. Benefits will be coordinated on a Calendar Year basis. This is called the claims determination period.

Right to Receive or Release Necessary Information. To make this provision work, this Plan may give or obtain needed information from an insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Covered Person will give this Plan the information it asks for about other plans and their payment of allowable charges.

Facility of Payment. This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

Right of Recovery. This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Covered Person. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the allowable charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

THIRD PARTY RECOVERY PROVISION

RIGHT OF SUBROGATION AND REFUND

When this provision applies. The Covered Person may incur medical or dental charges due to injuries that may be caused by the act or omission of a Third Party or a Third Party may be responsible for payment. In such circumstances, the Covered Person may have a claim against that Third Party or insurer for payment of the medical or dental charges. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any rights the Covered Person may have to Recover payments from any Third Party or insurer. This Subrogation right allows the Plan to pursue any claim which the Covered Person has against any Third Party or insurer, whether or not the Covered Person chooses to pursue that claim. The Plan may make a claim directly against the Third Party or insurer; but, in any event, the Plan has a lien on any amount recovered by the Covered Person whether or not it is designated as payment for medical or dental expenses. This lien shall remain in effect until the Plan is repaid in full.

The Covered Person

1. Automatically assigns to the Plan his or her rights against any Third Party or insurer when this provision applies; and
2. Must repay to the Plan the benefits paid on his or her behalf out of the Recovery made from the third party or insurer.

Amount subject to subrogation or refund. The Covered Person agrees to recognize the Plan's right to Subrogation and reimbursement. These rights provide the Plan with a 100% first dollar priority over any and all Recoveries and funds paid by a Third Party to a Covered Person relative to the Injury or Sickness. This includes a priority over any claim for non-medical or dental charges, attorney fees, or other costs and expenses. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any and all rights the Covered Person may have to recover payments from any Responsible Third Party. Further, accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan the Covered Person's Third Party Claims.

Notwithstanding its priority to funds, the Plan's Subrogation and Refund rights, as well as the rights assigned to it, are limited to the extent to which the Plan has made or will make payments for medical or dental charges in addition to any costs and fees associated with the enforcement of its rights under the Plan. The Plan reserves the right to be reimbursed for its court costs and attorney's fees if the Plan needs to file suit in order to Recover payment for medical or dental expenses from the Covered Person. Also, the Plan's right to Subrogation still applies if the Recovery received by the Covered Person is less than the claimed damage, and, as a result, the claimant is not made whole.

When a right of recovery exists, the Covered Person will execute and deliver all required instruments and papers as well as doing whatever else is needed to secure the Plan's right of subrogation as a condition to having the Plan make payments. In addition, the Covered Person will do nothing to prejudice the right of the Plan to Subrogate.

Conditions Precedent to Coverage. The Plan shall have no obligation whatsoever to pay medical or dental benefits to a Covered Person if a Covered Person refuses to cooperate with the Plan's reimbursement and Subrogation rights or refuses to execute and deliver such papers as the Plan may require in furtherance of its reimbursement and Subrogation rights. Further, in the event the Covered Person is a minor, the Plan shall have no obligation to pay any medical or dental benefits incurred on account of Injury or Sickness caused by a Responsible Third Party until after the Covered Person or his authorized legal representative obtains valid Court recognition and approval of the Plan's 100%, first dollar reimbursement and Subrogation rights on all Recoveries, as well as approval for the execution of any papers necessary for the enforcement thereof, as described herein.

Defined terms

"Covered Person" means anyone covered under the Plan including minor dependents.

"Recoveries" means all monies paid to the Covered Person by way of judgment, settlement, or otherwise to compensate for all losses caused by the Injury or Sickness, whether or not said losses reflect medical or dental charges covered by the Plan.

"Recoveries" further includes, but is not limited to, recoveries for medical or dental expenses, attorney's fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, lost wages, and any other recovery of any form of damages or compensation whatsoever.

"Refund" means repayment to the Plan for medical or dental benefits that it has paid toward care and treatment of the Injury or Sickness.

"Subrogation" means the Plan's right to pursue and lien upon the Covered Person's claims for medical or dental charges against the other person.

Recovery from another plan under which the Covered Person is covered. This right of Refund also applies when a Covered Person recovers under an uninsured or underinsured motorist plan (which will be treated as Third Party coverage when reimbursement or Subrogation is in order), homeowner's plan, renter's plan, medical malpractice plan, or any liability plan.

Rights of Plan Administrator. The Plan Administrator has a right to request reports on and approve of all settlements.

HIPAA PRIVACY PRACTICES

The following is a description of certain rules that apply to the Plan Sponsor regarding uses and disclosures of your health information.

Disclosure of Summary Health Information to the Plan Sponsor

In accordance with HIPAA's standards for privacy of individually identifiable health information (the "privacy standards"), the Plan may disclose summary health information to the Plan Sponsor, if the Plan Sponsor requests the summary health information for the purpose of:

1. Obtaining premium bids from health plans for providing health insurance coverage under this Plan; or
2. Modifying, amending or terminating the Plan.

"Summary health information" is information, which may include individually identifiable health information, that summarizes the claims history, claims expenses or the type of claims experienced by individuals in the Plan, but that excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by a five-digit zip code.

Disclosure of Protected Health Information ("PHI") to the Plan Sponsor for Plan Administration Purposes

Except as described under "Disclosure of Summary Health Information to the Plan Sponsor" above or under "Disclosure of Certain Enrollment Information to the Plan Sponsor" below or under the terms of an applicable individual authorization, the Plan may disclose PHI to the Plan Sponsor and may permit the disclosure of PHI by a health insurance issuer or HMO with respect to the Plan to the Plan Sponsor only if the Plan Sponsor requires the PHI to administer the Plan. The Plan Sponsor by formally adopting this Plan document, certifies that it agrees to:

1. Not use or further disclose PHI other than as permitted or required by the Plan or as required by law;
2. Ensure that any agents, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
3. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;
4. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;
5. Make available PHI in accordance with section 164.524 of the privacy standards;
6. Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the privacy standards;

7. Make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the privacy standards;
8. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the U.S. Department of Health and Human Services ("HHS"), for purposes of determining compliance by the Plan with part 164, subpart E, of the privacy standards;
9. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and
10. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the privacy standards, is established as follows:
 - A. The Plan Sponsor shall only allow certain named employees or classes of employees or other persons under control of the Plan Sponsor who have been designated to carry out plan administration functions, access to PHI. The Plan Sponsor will maintain a list of those persons and that list is incorporated into this document by this reference. The access to and use of PHI by any such individuals shall be restricted to plan administration functions that the Plan Sponsor performs for the Plan.
 - B. In the event any of the individuals described in (a) above do not comply with the provisions of the Plan documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate and shall be imposed so that they are commensurate with the severity of the violation.

"Plan administration" activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Plan or solicit bids from prospective issuers. "Plan administration" functions include quality assurance, claims processing, auditing, monitoring and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

The Plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that:

1. The Plan documents have been amended to incorporate the above provisions; and
2. The Plan Sponsor agrees to comply with such provisions.

Disclosure of Enrollment Information to the Plan Sponsor

Pursuant to section 164.504(f)(1)(iii) of the privacy standards, the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered under the Plan.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage; Disclosures of Genetic Information

Except as otherwise provided below, the Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator or the Third Party Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters (“MGUs”) for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the privacy standards.

The Plan will not use or disclose genetic information, including information about genetic testing and family medical history, for underwriting purposes. The Plan may use or disclose PHI for underwriting purposes, assuming the use or disclosure is otherwise permitted under the privacy standards and other applicable law, but any PHI that is used or disclosed for underwriting purposes will not include genetic information.

“Underwriting purposes” is defined for this purpose under federal law and generally includes any Plan rules relating to (1) eligibility for benefits under the Plan (including changes in deductibles or other cost-sharing requirements in return for activities such as completing a health risk assessment or participating in a wellness program); (2) the computation of premium or contribution amounts under the Plan (including discounts or payments or differences in premiums based on activities such as completing a health risk assessment or participating in a wellness program); (3) the application of any preexisting condition exclusion under the Plan; and (4) other activities related to the creation, renewal, or replacement of a contract for health insurance or health benefits. However, “underwriting purposes” does not include rules relating to the determination of whether a particular expense or claim is medically appropriate.

HIPAA SECURITY PRACTICES

Disclosure of Electronic Protected Health Information (“Electronic PHI”) to the Plan Sponsor for Plan Administration Functions

In accordance with HIPAA’s standards for security (the “security standards”), to enable the Plan Sponsor to receive and use Electronic PHI for Plan administration functions (as defined in 45 CFR § 164.504(a)), the Plan Sponsor agrees to:

1. Implement and maintain administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains or transmits on behalf of the Plan.
2. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures.
3. Ensure that any agent, including any business associate or subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate Security Measures to protect the Electronic PHI.
4. Report to the Plan any Security Incident of which it becomes aware.
5. The Plan Sponsor will promptly report to the Plan any breach of unsecured Protected Health Information of which it becomes aware in a manner that will facilitate the Plan’s compliance with the breach reporting requirements of the HITECH Act, based on regulations or other applicable guidance issued by the Department of Health and Human Services.

Any terms not otherwise defined in this section shall have the meanings set forth in the security standards.

RESPONSIBILITIES FOR PLAN ADMINISTRATOR

Plan Administrator

The City of Grand Rapids Unified Health Care Plan is the benefit Plan of the City of Grand Rapids. The Plan Administrator is also called the Plan Sponsor. An individual may be appointed by City of Grand Rapids to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator resigns, dies, or is otherwise removed from the position, the City of Grand Rapids shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan; to make determinations regarding issues which relate to eligibility for benefits; to decide disputes which may arise relative to a Plan Participant's rights; and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties subject to the Collective Bargaining Agreements.

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

Duties of the Plan Administrator

1. Administer the Plan in accordance with its terms.
2. Interpret the Plan, including the right to remedy possible ambiguities, inconsistencies, or omissions.
3. Decide disputes which may arise relative to a Plan Participant's rights.
4. Prescribe procedures for filing a claim for benefits and to review claim denials.
5. Keep and maintain the Plan documents and all other records pertaining to the Plan.
6. Appoint a Claims Administrator to pay claims.
7. Delegate to any person or entity such powers, duties, and responsibilities as it deems appropriate.

Plan Administrator Compensation

The Plan Administrator serves **without** compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows: Funding is derived from the funds of the Employer **for Employee and Dependent Coverage**.

Benefits are paid directly from the Plan through the Claims Administrator.

THE TRUST AGREEMENT

If this Plan is established under a Trust agreement, that agreement is made a part of the Plan. If applicable, a copy of the appropriate agreement is available for examination by Employees and their Dependent (s) at the office of the Plan Administrator during normal business hours. Also, upon written request, the following items will be furnished to an Employee, Retiree, or Dependent:

1. A copy of the Trust agreement.
2. A complete list of employers and employee organizations sponsoring the Plan.

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan is not to be construed as a contract for or of employment.

CLERICAL ERROR

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, if it is requested, the amount of overpayment will be deducted from future benefits payable.

AMENDING AND TERMINATING THE PLAN

If the Plan is terminated, the rights of the Plan Participants are limited to expenses incurred before termination.

The Employer intends to maintain this Plan indefinitely; however, it reserves the right, at any time, to amend, suspend, or terminate the Plan in whole or in part subject to the Collective Bargaining Agreements. This includes amending the benefits under the Plan or the Trust agreement (if any)

CERTIFICATES OF CREDITABLE COVERAGE

The Plan will automatically provide a Certificate of Creditable Coverage to anyone who loses coverage under the Plan before December 31, 2014. In addition, until December 31, 2014 (or later, to the extent required under applicable law), a Certificate of Creditable Coverage will be provided upon request at any time while the individual is covered under the Plan and up to 24 months after the individual loses coverage under the Plan.

The Plan will make reasonable efforts to collect information about any Dependents and to include that information on the Certificate of Creditable Coverage, but the Plan will not issue an automatic Certificate of Creditable Coverage for Dependents until the Plan has reason to know that a Dependent has lost coverage under the Plan prior to December 31, 2014.

All questions about the Certificate of Creditable Coverage may be directed to the Plan Administrator. Refer to the Plan Information page.

PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded group health, dental, and disability plan and the administration is provided through a Third Party Claims Administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees. The Plan is not insured.

PLAN NAME

City of Grand Rapids Unified Health Care Plan

PLAN NUMBER

501

TAX ID NUMBER

38-6004689

PLAN EFFECTIVE DATE

July 1, 1999

PLAN REVISED AND RESTATED DATE

January 1, 2014

PLAN YEAR ENDS

December 31st

EMPLOYER INFORMATION

City of Grand Rapids
300 Monroe Avenue NW
Grand Rapids MI 49503

PLAN ADMINISTRATOR

Director of Human Resources

AGENT FOR SERVICE OF LEGAL PROCESS

City Attorney

CLAIMS ADMINISTRATOR

Meritain Health
2370 Science Parkway
Okemos, MI 48854
(517)-349-7010
1-800-423-1028

CITY OF GRAND RAPIDS
EMPLOYEE BENEFIT PLAN ADOPTION AGREEMENT

BY THIS AGREEMENT, the Grand Rapids Unified Health Care Plan is hereby adopted as shown. The Provisions set forth herein are hereby made a part of this Plan.

SCHEDULE OF BENEFITS RET-65 FIRE (IAFF) 6/22/09

MEDICAL BENEFITS

All benefits described in this Schedule are subject to the exclusions and limitations described more fully herein including but not limited to the Plan Administrator's determination that care and treatment are Medically Necessary; services, supplies, and care are not Experimental and/or Investigational. The meanings of the capitalized terms are in the Defined Terms section.

The City of Grand Rapids Unified Health Plan contains a Preferred Provider Organization (PPO) that has entered into agreements with many Hospitals, Physicians, and other health care related providers who are called PPO Providers. The name of the PPO is Cofinity.

Non-participating Providers

Non-participating providers have **not** signed agreements with Cofinity. If you receive services from a non-participating provider, they will submit the claim directly to Meritain Health for payment. The address is located on the back of your ID card.

Co-payments Payable by Plan Participants

Co-payments are dollar amounts that the Covered Person must pay before the Plan pays.

Co-insurance Percentage Payable by the Plan

Co-insurance percentage is the amount the Plan pays.

Out-of-Pocket Payable by Plan Participants

If a Participant or family meets the Co-insurance Maximum Out-Of-Pocket amount, as described below (10% co-insurance), Eligible Expenses will then be payable at 100% for the remainder of the Calendar Year.

If a Participant or family meets the Calendar Year Maximum Out-Of-Pocket amount, as described below (10% co-insurance and medical co-pays), Eligible Expenses will then be payable at 100% for the remainder of the Calendar Year.

The Maximum Out-of-Pocket amounts do **not** include prescription drug co-pays, or expenses that exceed the Plan limits or are excluded under the provisions of the Plan.

RET-65 FIRE (IAFF) 6/22/09

	PPO PROVIDER	NON-PPO PROVIDER
THE PLAN'S MAXIMUM BENEFIT AMOUNT	Unlimited	
CO-PAYMENTS (The dollar amount the Participant pays for the following services)		
Office visits	\$20 co-payment then 100%	\$20 co-payment then 100%
NOTE: Copay applies to the Physician office visit component only. All other services are paid subject to any Deductible and Coinsurance percentages.		
Urgent Care Center	\$20 co-payment then 100%	\$20 co-payment then 100%
Emergency Services (Co-payment waived if admitted to hospital, Inpatient Co-insurance will apply)	\$150 co-payment then 100%	\$150 co-payment then 100%
Consultations	\$20 co-payment then 100%	\$20 co-payment then 100%
Chiropractic	\$20 co-payment then 100%	\$20 co-payment then 100%
Mental Disorders & Substance Use Disorders Outpatient Office Visits	\$20 co-payment then 100%	\$20 co-payment then 100%

CO-INSURANCE PERCENTAGE (The percentage the Plan pays after the Participant pays 10%)		
Hospital Services		
Inpatient	90%	90%
Outpatient	90%	90%
Emergency Services (Co-payment waived if admitted to hospital, Inpatient Co-insurance will apply)	\$150 co-payment then 100%	\$150 co-payment then 100%
Outpatient Surgical Center	90%	90%
Mental Disorders & Substance Use Disorders		
Inpatient	90%	90%
Outpatient	\$20 co-payment then 100%	\$20 co-payment then 100%
Emergency Services (Co-payment waived if admitted to hospital, Inpatient Co-insurance will apply)	\$150 co-payment then 100%	\$150 co-payment then 100%

CALENDAR YEAR CO-INSURANCE MAXIMUM OUT-OF-POCKET		
Out-of-Pocket Maximum (10% Co-insurance)		
Individual	\$500	\$500
Family	\$500	\$500
CALENDAR YEAR MAXIMUM OUT-OF-POCKET		
Out-of-Pocket Maximum (10% coinsurance and medical co-pays)		
Individual	\$6,350	\$6,350
Family	\$12,700	\$12,700

If a Participant or family meets the Co-insurance Maximum Out-Of-Pocket amount, as described (10% co-insurance), Eligible Expenses will then be payable at 100% for the remainder of the Calendar Year.

If a Participant or family meets the Calendar Year Maximum Out-Of-Pocket amount, as described (10% co-insurance and medical co-pays), Eligible Expenses will then be payable at 100% for the remainder of the Calendar Year.

The Maximum Out-of-Pocket amounts do **not** include prescription drug copays or expenses that exceed the Plan limits or are excluded under the provisions of the Plan.

Other Medical Services	PPO Provider	Non-PPO Provider
Ambulance	100%	100%
Extended Care	100%	100%
Home Health Care	100%	100%
Hospice	100%	100%
Physician Services		
Hospital Visits	100%	100%
Emergency Services	100%	100%
Surgeon/Assistant Surgeon	100%	100%
Anesthesiologist	100%	100%
Maternity (Professional Fees)*/Employee, Spouse And Dependents		
Preventive prenatal and breastfeeding support (other than lactation consultations)	100%	100%
Lactation Consultations	100%	100%
All Other Prenatal, Delivery and Postnatal Care	100%	100%
*See Eligible Medical Expenses for limitations.		
Chiropractic Services		
Exam/Manipulation	\$20 co-payment then 100%	\$20 co-payment then 100%
X-rays	100%	100%
Temporomandibular Joint Dysfunction (TMJ)	100%	100%
Organ Transplant	100%	100%
Diagnostic X-ray and Lab	100%	100%
Radiation/Chemotherapy	100%	100%
Occupational Therapy	100%	100%
Speech Therapy	100%	100%
Physical Therapy	100%	100%
Medical Supplies	100%	100%
Durable Medical Equipment	100%	100%
Prosthetics	100%	100%
Orthotics	100%	100%

	PPO Provider	Non-PPO Provider
Preventive Services and Routine Care		
<i>Preventive Services</i> This benefit includes office visit associated with Preventive Services and any other eligible item or service received and billed at the same time as any preventive service. Any office visit or other item or service billed separately will be paid under the Routine Care provision of the Plan.	100%	100%
<i>Routine Care</i>	\$20 co-payment then 100%	\$20 co-payment then 100%
<p>This benefit only includes items and services that are not otherwise covered under the Preventive Services provision of the Plan such as:</p> <ul style="list-style-type: none"> • Office visits (associated with Preventive Services (but billed separately) or Routine Care) • Routine Physical/Gynecological exam: limit of 1 physical or 1 gynecological exam per calendar year, and the following services once per calendar year: chemical profile, complete blood count, fecal occult blood screening, urinalysis, EKG test • Pap smear, limited to 1 routine pap smear per calendar year • Mammogram, limited to 1 per woman age 35 to 40, and 1 per calendar year at age 40 and older • Prostate Specific Antigen (PSA) screening, limited to 1 per calendar year beginning at age 40 • Routine colonoscopy, limited to 1 procedure from age 40 to age 50, and 1 procedure per calendar year age 51 and older 		
Diagnosis of Infertility Benefits Limited to supplies and services for the diagnosis of infertility.	100%	100%
Other Eligible Expenses	100%	100%

PRESCRIPTION

RET-65 FIRE (IAFF) 6/22/09

NOTE: An OTC Step Therapy provision applies to the following OTC drug classifications: Proton Pump Inhibitors (PPIs), Antihistamines and NSAIDs. Refer to your OTC handout provided by Human Resources for information on Over-the-Counter (OTC) medications.

Prescription - Retail:

Generic drugs	
Co-payment.....	\$10
Percentage payable.....	100%
Brand Name drugs	
Co-payment.....	\$20
Percentage payable.....	100%
Preventive Drug	\$0 copay
Covered OTC medicines	\$0 copay

Prescription - Mail Order: (90 day supply)

Generic drugs	
Co-payment.....	\$10
Percentage payable.....	100%
Brand Name drugs	
Co-payment.....	\$20
Percentage payable.....	100%
Preventive Drug	\$0 copay

Proton Pump Inhibitor (PPI) Calendar Year Maximum

Benefit per Covered Person: \$600*

* Once the Calendar Year Maximum Benefit is met, the copay shall increase to \$20 generic equivalent drugs and \$40 brand name drugs. (PPIs dispensed under the OTC Program do not count toward the \$600 Calendar Year maximum benefit.)

**SUMMARY OF MATERIAL MODIFICATION
AND
AMENDMENT #6
TO THE
CITY OF GRAND RAPIDS
UNIFIED HEALTH CARE PLAN
GROUP NO. 15364**

This Summary of Material Modification and Amendment describes changes to the City of Grand Rapids Unified Healthcare Plan effective January 1, 2014. These changes are effective as of **January 1, 2018** and will remain in effect until amended in writing by the Plan Administrator.

This document should be read carefully and attached to the Plan Document and Summary Plan Description. Please contact the Plan Administrator identified in the Summary Plan Description if you have any questions regarding the changes described in this Summary of Material Modification.

City of Grand Rapids (the "Plan Sponsor") is amending the City of Grand Rapids Unified Healthcare Plan (the "Plan") as follows:

1. **Claims Administrator** under **Defined Terms** section is hereby deleted and replaced as follows:

DEFINED TERMS

Claims Administrator shall mean the entity providing the services delegated to it by the employer in connection with the operation of the Plan including processing and payment of claims. The Claims Administrator is Meritain Health, Inc., P. O. Box 27810, Minneapolis, MN 55427-0810.

2. **Item (2) - How to reach Meritain Health** under **City of Grand Rapids Unified Health Care Plan** is hereby deleted and replaced as follows:

CITY OF GRAND RAPIDS UNIFIED HEALTH CARE PLAN

How to reach Meritain Health

2. Please send all correspondence to:

Meritain Health, Inc.
P.O. Box 27810
Minneapolis, MN 55427-0810

3. *The Maternity (Professional Fees)*/Employee, Spouse and Dependents listed under the Schedule of Medical Benefits Plan A (Under 65 Retirees after 2004/2005 Union Ratifications) is hereby deleted and replaced as follows:*

**SCHEDULE OF MEDICAL BENEFITS
PLAN A
(UNDER 65 RETIREES AFTER 2004/2005 UNION RATIFICATIONS)**

	PARTICIPATING PROVIDER	NON- PARTICIPATING PROVIDER (Subject to Usual, Customary & Reasonable Charges)
Maternity (Professional Fees)*/Employee, Spouse And Dependents		
Preventive prenatal and breastfeeding support (other than lactation consultations)	100%	100%
Lactation Consultations	100%	100%
All Other Prenatal, Delivery and Postnatal Care	100%	100%
*See Eligible Medical Expenses for limitations.		

4. *The Calendar Year Maximum Out-of-Pocket section in the Schedule of Benefits and the Prescription section for Active Employees and Retirees Whose Plans Ratified in 2008/2009 are hereby deleted and replaced as follows:*

**SCHEDULE OF BENEFITS
ACTIVE EMPLOYEES AND RETIREES WHOSE
PLANS RATIFIED IN 2008/2009**

	PARTICIPATING PROVIDER	NON- PARTICIPATING PROVIDER (Subject to Usual, Customary & Reasonable Charges)
Calendar Year Maximum Out-of-Pocket (20% coinsurance, deductible and medical and prescription drug co-pays)		
Single	\$7,350	\$7,350
Family	\$14,700	\$14,700

**PRESCRIPTION
(ACTIVE EMPLOYEES AND RETIREES WHOSE PLANS RATIFIED IN 2008/2009)**

Calendar Year Maximum Out-of-Pocket (prescription drug co-pays – included with major medical)	
Single	\$7,350
Family	\$14,700

5. The **Calendar Year Maximum Out-of-Pocket** section in the **Schedule of Benefits (Ret-65 Fire (IAFF) 6/22/09)** (previously amended in Amendment #5) is hereby deleted and replaced as follows:

RET-65 FIRE (IAFF) 6/22/09

	PPO PROVIDER	NON- PPO PROVIDER
CALENDAR YEAR MAXIMUM OUT-OF-POCKET		
Out-of-Pocket Maximum (10% coinsurance and medical co-pays)		
Single	\$7,350	\$7,350
Family	\$14,700	\$14,700

6. The **Calendar Year Deductible** and **Calendar Year Maximum Out-of-Pocket** sections in the **Schedule of Benefits High Deductible Health Plan Option** and **Schedule of Prescription Benefits High Deductible Health Plan** are hereby deleted and replaced as follows:

**SCHEDULE OF BENEFITS
HIGH DEDUCTIBLE HEALTH PLAN OPTION**

	PARTICIPATING PROVIDER	NON- PARTICIPATING PROVIDER (Subject to Usual, Customary & Reasonable Charges)
Calendar Year Deductible (combined with prescription)		
Single	\$6,650	No Coverage
Family	\$13,300	No Coverage
Calendar Year Maximum Out-of-Pocket (Includes Deductible – combined with prescription)		
Single	\$6,650	No Coverage
Family	\$13,300	No Coverage

**SCHEDULE OF PRESCRIPTION BENEFITS
HIGH DEDUCTIBLE HEALTH PLAN**

Calendar Year Deductible (combined with major medical)	
Single	\$6,650
Family	\$13,300
Calendar Year Maximum Out-of-Pocket (includes Deductible – combined with major medical)	
Single	\$6,650
Family	\$13,300

7. *The Plan will no longer offer Teladoc benefit. As such the **Teladoc** benefit (as stated in Amendment #5) under **Physician Services** section to the **Active Employees and Retirees Whose Plans Ratified in 2008/2009** and the **RET-65 Fire (IAFF) 6/22/09** under the **Schedule of Benefits** is hereby deleted and not replaced.*
8. ***Telemedicine** (as stated in Amendment #5) under the **Medical Benefits** section of the Plan is hereby deleted and not replaced.*
9. *Number **(37)** under the **Exclusions** subsection in **Medical Benefits** section of the Plan is hereby deleted and replaced with the following:*

MEDICAL BENEFITS

Exclusions

Examples of what The Plan does **not** pay:

37. Charges for administrative costs of completing claim forms, itemized bills, medical reports or for providing records, mailing and/or shipping expenses, expenses for broken appointments or expenses for telephone calls.
10. *The **How to Submit a Claim** section is hereby deleted and replaced as shown in **Exhibit A**.*
11. *The **Claims Administrator** section under **General Plan Information** is hereby deleted and replaced as follows:*

PLAN INFORMATION

CLAIMS ADMINISTRATOR

P. O. Box 27810
Minneapolis, MN 55427-0810
1-800-423-1028

All other provisions of this Plan shall remain unchanged.

EXHIBIT A

HOW TO SUBMIT A CLAIM

You will receive an Employee identification card which will contain important information, including claim filing directions and contact information. The Employee identification card will show your Participating Provider Network and the Medical Management Administrator.

At the time you receive treatment, show the Employee identification card to your provider of service. In most cases, your provider will file your claim for you. You may file the claim yourself by sending it to the address listed on the Employee identification card. Other general information or inquiries should be sent to:

Meritain Health, Inc.
P.O. Box 27810
Minneapolis, MN 55427-0810
(800) 925-2272

Most claims under the Plan will be “post service claims.” A “post service claim” is a claim for a benefit under the Plan after the services have been rendered. Post service claims must include the following information in order to be considered filed with the Plan:

1. The date of service;
2. The name, address, telephone number and tax identification number of the provider of the services or supplies;
3. The place where the services were rendered;
4. The diagnosis and procedure codes;
5. The amount of charges (including Network repricing information);
6. The name of the Plan;
7. The name of the covered Employee; and
8. The name of the patient.

A call from a provider who wants to know if an individual is covered under the Plan or if a certain procedure or treatment is a Covered Expense before the treatment is rendered, is not a “claim” since an actual written claim for benefits is not being filed with the Plan. Likewise, presentation of a prescription to a pharmacy does not constitute a claim.

When Claims Should be Filed

Claims should be filed with the Claims Administrator within 24 months of the date charges for the services were incurred. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date may be declined or reduced unless:

1. It's not reasonably possible to submit the claim in that time, and

2. The claim is submitted within 2 years from the date incurred. This 2 year period will not apply when the person is not legally capable of submitting the claim.

The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

Procedures for all Claims

The Plan's claim procedures are intended to reflect the Department of Labor's claims procedures regulations and should be interpreted accordingly. In the event of any conflict between this Plan and those Regulations, those Regulations will control. In addition, any changes in those Regulations shall be deemed to amend this Plan automatically, effective as of the date of those changes.

To receive benefits under the Plan, the claimant (i.e. you and your covered Dependents) must follow the procedures outlined in this section. There are 4 different types of claims: (1) Urgent Care Claims; (2) Concurrent Care Claims; (3) Pre-Service Claims; and (4) Post-Service Claims. The procedures for each type of claim are more fully described below:

1. **Urgent Care Claims.** If your claim is considered an urgent care claim, the Plan Administrator will notify you of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the Plan receives the claim, unless you fail to provide sufficient information to determine whether or to what extent, benefits are covered or payable under the Plan. If you fail to provide sufficient information for the Plan to decide your claim, the Plan Administrator will notify you as soon as possible, but not later than 24 hours after the Plan receives the claim, of the specific information necessary to complete the claim. The notification may be oral unless written notification is requested by you. You will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Plan Administrator will notify you of the Plan's determination as soon as possible, but in no case later than 48 hours after the earlier of (1) the Plan's receipt of the specified additional information or (2) the end of the period afforded the claimant to provide the specified additional information.

A claim for benefits is considered an urgent care claim if the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function or, in the opinion of a Physician with knowledge of your medical condition, would subject you to severe pain that could not be adequately managed without the care or treatment which is the subject of the claim. In determining if the initial claim for benefits should be treated as an urgent care claim, the Plan will defer to a determination, if any, by an attending provider that the claim should be treated as an urgent care claim, if that determination is timely provided to the Plan.

2. **Concurrent Care Claims.** If the Plan has approved an ongoing course of health care treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of the previously approved course of treatment (other than by Plan amendment or termination) before the approved time period or number of treatments constitutes an adverse determination. In such a case, the Plan Administrator will notify you of the adverse determination at a time sufficiently in advance of the reduction or termination to allow you, the claimant, to appeal and obtain a determination on review of that adverse determination before reduction or termination of the benefit.

Any request by you to extend a previously approved course of urgent care treatment beyond the approved period of time or number of treatments shall be decided as soon as possible, taking into account the medical exigencies and the Plan Administrator will notify you of the benefit determination, whether adverse or not, within 24 hours after the Plan receives the claim provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

3. **Pre-Service Claims.** For a pre-service claim, the Plan Administrator will notify you of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after the Plan receives the claim. If, due to matters beyond the control of the Plan, the Plan Administrator needs additional time to process a claim, the Plan Administrator may extend the time to notify you of the Plan's benefit determination for up to 15 days provided that the Plan Administrator notifies you within 15 days after the Plan receives the claim, of those special circumstances and of when the Plan Administrator expects to make its decision. However, if such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension must specifically describe the required information and you will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A claim for benefits is considered a pre-service claim if the claim requires approval, in part or in whole, in advance of obtaining the health care in question.

4. **Post-Service Claims.** For a post-service claim, the Plan Administrator will notify you of the Plan's adverse determination within a reasonable period of time, but not later than 30 days after receipt of the claim. If, due to special circumstances, the Plan Administrator needs additional time to process a claim, the Plan Administrator may extend the time for notifying you of the Plan's benefit determination on a one-time basis for up to 15 days provided that the Plan Administrator notifies you within 30 days after the Plan receives the claim, of those special circumstances and of the date by which the reviewer expects to make a decision. However, if such a decision is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information and you will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A claim for benefits is considered a post-service claim if it is a request for payment for services or other benefits that you have already received (or any other claim for health benefits that is not a pre-service claim or an urgent care claim).

Manner and Content of Notice of Initial Adverse Determination

If the Plan Administrator denies a claim, it must provide to you in writing or by electronic communication:

1. An explanation of the specific reasons for the denial;
2. A reference to the Plan provision or insurance contract provision upon which the denial is based;
3. A description of any additional information or material that you must provide in order to perfect the claim;
4. An explanation of why the additional material or information is necessary;

5. Notice that you have the right to request a review of the claim denial and information on the steps to be taken if you wish to request a review of the claim denial along with the time limits applicable to a request for review;
6. A statement describing your right to request an external review or, if applicable, to bring an action for judicial review;
7. A copy of any rule, guideline, protocol or other similar criterion relied upon in making the adverse determination (or a statement that the same will be provided upon your request and without charge); and
8. If the adverse determination is based on the Plan's Medical Necessity, Experimental treatment or similar exclusion or limit, either: (a) an explanation of the scientific or clinical judgment applying the exclusion or limit to your medical circumstances or (b) a statement that the same will be provided upon your request and without charge.

Any notice of adverse determination also will include the following information:

1. Information sufficient to identify the claim involved, including the date of service, the health care provider and the claim amount (if applicable);
2. As part of the explanation of the determination, a discussion of the decision, as well as disclosure of any denial code used (and an explanation of its meaning) and a description of the Plan's standard, if any, that was used in denying the claim;
3. A description of available internal appeals and external review processes, including information regarding how to initiate an appeal;
4. Information (including contact information) about the availability of any applicable office of health insurance consumer assistance or ombudsmen established pursuant to the Patient Protection and Affordable Care Act (PPACA) to assist individuals with internal claims and appeals and external review processes; and
5. A statement describing the availability, upon request, of any applicable diagnosis code (and an explanation of its meaning) and any applicable treatment code (and an explanation of its meaning).

For an adverse determination concerning an urgent care claim, the information described in this Section may be provided to you orally within the permitted time frame provided that a written or electronic notification in accordance with this section is furnished to you no later than 3 days after the oral notification.

Internal Review of Initial Adverse Benefit Determination

If you submit a claim for Plan benefits and it is initially denied under the procedures described above, you may request a review of that denial under the procedures described below.

You have 180 days after you receive notice of an initial adverse determination within which to request a review of the adverse determination.

If you request a review of an adverse determination within the applicable time period, the review will meet the following requirements:

1. The Plan will provide a review that does not afford deference to the adverse determination that is being appealed and that is conducted by an appropriate named fiduciary of the Plan who did not make the adverse determination that is the subject of the appeal and who is not a subordinate of the individual who made that adverse determination.
2. The appropriate named fiduciary of the Plan will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment before making a decision on review of any adverse determination based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is Experimental and/or Investigational or not Medically Necessary or appropriate. The professional engaged for purposes of a consultation in the preceding sentence will be an individual who is neither an individual who was consulted in connection with the adverse determination that is the subject of the appeal, nor a subordinate of any such individual.
3. The Plan will identify any medical or vocational experts whose advice is obtained on behalf of the Plan in connection with the Plan's review of an adverse determination, without regard to whether the advice is relied upon in making the adverse determination on review.
4. For a requested review of an adverse determination involving an urgent care claim, the review process will meet the expedited deadlines described below. Your request for such an expedited review may be submitted orally or in writing and all necessary information, including the Plan's determination on review, will be transmitted between the Plan and you by telephone, facsimile or other available similarly expeditious method.
5. The reviewer will afford you an opportunity to review and receive, without charge, all relevant documents, information and records relating to the claim and to submit issues and comments relating to the claim in writing to the Plan. The reviewer will take into account all comments, documents, records and other information submitted by the claimant relating to the claim regardless of whether the information was submitted or considered in the initial benefit determination.
6. You will be provided, free of charge, any new or additional evidence or rationale considered, relied upon or generated by the Plan in connection with the claim. Such evidence or rationale will be provided as soon as possible and sufficiently in advance of the Plan's deadline for providing notice of its determination on review to give you a reasonable opportunity to respond prior to such determination.
7. The Plan will ensure that all claims are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decisions.
8. The Plan will provide you with continued coverage pending the outcome of an internal appeal.

All requests for review of initial adverse benefit determinations (including all relevant information) must be submitted to the following address:

Meritain Health, Inc.
Appeals Department
P. O. Box 41980
Plymouth, MN 55441-0970

Deadline for Internal Review of Initial Adverse Benefit Determinations

1. **Urgent Care Claims.** For urgent care claims, the reviewer will notify you of the Plan's determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the Plan receives your request for review of an initial adverse determination by the Plan.
2. **Pre-Service Claims.** For a pre-service claim, the reviewer will notify you of the Plan's determination on review within a reasonable period of time appropriate to the medical circumstances, but in no event later than 30 days after the Plan receives your request for review of the initial adverse determination.
3. **Post-Service Claims.** For a post-service claim, the reviewer will notify you of the Plan's benefit determination on review within a reasonable period of time, but in no event later than 60 days after the Plan receives your request for review of the initial adverse determination.

Manner and Content of Notice of Decision on Internal Review of Initial Adverse Benefit Determinations

Upon completion of its review of an initial adverse determination, the reviewer will give you, in writing or by electronic notification, a notice of its benefit determination. For an adverse determination, the notice will include:

1. A description of the Plan's decision;
2. The specific reasons for the decision;
3. The relevant Plan provisions or insurance contract provisions on which its decision is based;
4. A statement that you are entitled to receive, upon request and without charge, reasonable access to and copies of, all documents, records and other information in the Plan's files which is relevant to your claim for benefits;
5. A statement describing your right to request an external review, or, if applicable, to bring an action for judicial review;
6. If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination on review, a statement that a copy of the rule, guideline, protocol or other similar criterion will be provided without charge to you upon request;
7. If the adverse determination on review is based on a Medical Necessity, Experimental treatment or similar exclusion or limit, either: (a) an explanation of the scientific or clinical judgment on which the determination was based, applying the terms of the Plan to the claimant's medical circumstances or (b) a statement that such an explanation will be provided without charge upon request.

Any notice of adverse determination will include the following information:

1. Information sufficient to identify the claim involved, including the date of service, the health care provider and the claim amount (if applicable);
2. As part of the explanation of the determination, a discussion of the decision, as well as disclosure of any denial code used (and an explanation of its meaning) and a description of the Plan's standard, if any, that was used in denying the claim;
3. A description of available internal appeals and external review processes, including information regarding how to initiate an appeal;
4. Information (including contact information) about the availability of any applicable office of health insurance consumer assistance or ombudsmen established pursuant to the Patient Protection and Affordable Care Act (PPACA) to assist individuals with internal claims and appeals and external review processes; and
5. A statement describing the availability, upon request, of any applicable diagnosis code (and an explanation of its meaning) and any applicable treatment code (and an explanation of its meaning).

Calculation of Time Periods

For purposes of the time periods described in the Plan's claim procedures, the period of time during which a benefit determination is required to be made begins at the time a claim (or a request for review of an adverse benefit determination) is filed in accordance with the Plan procedures without regard to whether all the information necessary to make a decision accompanies the request. If a period of time is extended due to your failure to submit all information necessary for a claim for non-urgent care benefits, the period for making the determination is "frozen" from the date the notification requesting the additional information is sent to you until the date you respond or, if earlier, until 45 days from the date you receive (or were reasonably expected to receive) the notice requesting additional information.

Adverse Determination

For purposes of the Plan's claim procedures, an "adverse determination" is a denial, reduction or termination of or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination or failure to provide or make payment that is based on a determination of an individual's eligibility to participate in the Plan and including a denial, reduction or termination of or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental and/or Investigational or not Medically Necessary or appropriate. Adverse determination also includes any rescission of coverage, whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at the time of rescission.

Plan's Failure to Follow Procedures

If the Plan fails to follow the claim procedures described above, you will be deemed to have exhausted the Plan internal claim procedures and you will be entitled to pursue any available remedy (including any available external review process) under state or federal law on the basis that the Plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

However, the Plan will not be treated as failing to follow its claim procedures and you will not be deemed to have exhausted the Plan's administrative remedies merely because of a failure by the Plan that would be considered (based on applicable regulations) a "*de minimis* violation" that does not cause and is not likely to cause prejudice or harm to you as long as the Plan can demonstrate that the violation was for good cause or due to matters beyond the control of the Plan and that the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and you. You may request a written explanation of any violation by the Plan of these procedures. If you request such an explanation, the Plan will provide it within 10 days and, if applicable, the explanation will include a specific description of the Plan's reasons for asserting that the violation does not cause the Plan's internal claim procedures to be exhausted. If a court or external review rejects your request for an immediate review (based on a claim that you should be deemed to have exhausted the Plan's internal claim procedures), because the court or external reviewer determines that the "*de minimis* violation" exception applies, the Plan will provide to you a notice of your right to resubmit your internal appeal with a reasonable time (no longer than 10 days) after the court or external reviewer makes such a determination. Any applicable time limit for you to re-file your claim will begin to run when you receive that notice from the Plan.

External Review of Adverse Benefit Determinations

NOTE: This provision does not apply to dental and vision benefits.

If you have exhausted the Plan's internal appeal process (or if you are eligible to request an external review for any other reason under the above procedures), you may request an external review of the Plan's final adverse determination for certain health benefit claims.

The Plan will provide for an external review process in accordance with applicable state law (if any). If no external review process exists under applicable state law or if the state law external review process does not meet certain minimum standards of the NAIC Uniform Health Carrier External Review Model Act (or the temporary "NAIC-similar" standards described in Department of Labor Technical Release 2011-02), the Plan will provide for an external review process that meets federal law requirements. Governmental plans that are not eligible to participate in a qualifying state process must elect to participate in a federal process administered by HHS or in the federal external review process that applies to ERISA-governed, self-funded Plans. If the Plan elects to participate in the federal external review process that applies to an ERISA self-funded plan, the external review procedures described below will apply.

Note that the federal external review process (including the expedited external review process described later in these procedures) is not available for review of all internal adverse determinations. Specifically, federal external review is not available for review of an internal adverse determination that is based on a determination that a claimant fails to meet the eligibility requirements under the terms of the Plan. Also, the federal external review process is available only for:

1. An adverse determination that involves medical judgment (including, but not limited to determinations based on the Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit; or the Plan's determination that a treatment is Experimental or Investigational), as determined by the external reviewer; and
2. A rescission of coverage.

For any adverse determination for which external review is available, the federal external review requirements are as follows:

1. You have 4 months following the date you receive notice of the Plan's final internal adverse determination within which to request an external review. The request for an external review must be submitted to the following address:

Meritain Health, Inc.
Appeals Department
P. O. Box 41980
Plymouth, MN 55441-0970

2. Within 5 business days following the date the Plan receives your external review request the Plan will complete a preliminary review. The Plan will notify you in writing within one business day after it completes the preliminary review whether the claim is eligible for the external review process:
 - A. If the request is complete, but the claim is not eligible for external review, the notice will describe the reasons it is not eligible and will provide contact information for the U.S. Department of Health and Human Services Health Insurance Assistance Team (HIAT).
 - B. If the request is not complete, the notice will describe information or materials needed to make the request complete. If the request is not complete and additional information or materials are needed to complete the preliminary review, you will have until the later of (i) 48 hours following the date of receipt of the notification or (ii) the end of the 4-month deadline described in (1) above to provide the necessary additional information or materials.
3. Following the Plan's preliminary review, if the request is eligible for external review, the Plan will assign an independent review organization (IRO) (as soon as administratively feasible) to make a determination on the request for external review. Within 5 business days following assignment of the IRO, the Plan will forward to the IRO all information and materials relevant to the final internal adverse determination.
4. The assigned IRO will notify you in writing (within a reasonable period of time) of the request's eligibility and acceptance for external review. The notice will include a statement regarding your right to submit any additional information, within 10 business days from the date of receipt of the notice, for the IRO to consider as part of the external review process. Any such additional information received by the IRO will be forwarded on and shared with the Plan. The Plan, based upon any new information received, may reconsider its final internal adverse determination. Reconsideration by the Plan will not delay the external review process. If the Plan does not reconsider its final internal adverse benefits determination, the IRO will continue or proceed with the external review process.
5. Within 45 days after the IRO receives the external review request from the Plan, the IRO must provide written notice of its external review determination to you and the Plan. The IRO's notice is required to contain the following:
 - A. A general description of the reason for the request for external review, including information sufficient to identify the claim, the diagnosis code and treatment code and the corresponding meaning for each and the reason for the previous denial;

- B. The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
- C. References to the evidence or documentation, including the specific coverage provisions and evidence based standards, considered in reaching its decision;
- D. A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
- E. A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the group health plan or to you;
- F. A statement that judicial review may be available to you; and
- G. Current contact information, including telephone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act Section 2793.

Expedited External Review

NOTE: This provision does not apply to dental and vision benefits.

You may request an expedited external review if you have received:

1. An initial internal adverse determination if the adverse determination involves a medical condition for which the time frame for completion of an expedited internal appeal under the Plan's internal claim procedures would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or
2. A final internal adverse determination, if you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function or if the final internal adverse determination concerns an admission, availability of care, continued stay or health care item or service for which you received Emergency Services but have not been discharged from a facility.

The following requirements apply to an expedited external review:

3. Immediately following the date the Plan receives the external review request the Plan will complete a preliminary review. The Plan will notify you in writing immediately after completion of the preliminary review whether the request is eligible for the external review process.
 - A. If the request is complete, but the claim is not eligible for external review, the notice will describe the reasons it is not eligible and will include contact information for the Employee Benefits Security Administration.
 - B. If the request is not complete, the notice will describe any information or materials needed to make the request complete. If the request is not complete and additional information or materials is needed to complete the preliminary review, you will have until the later of (i) 48 hours following the date of receipt of the notification or (ii) the end of the 4-month deadline described in (1) above to provide the necessary additional information or materials.

4. Following the Plan's preliminary review, if the request is eligible for external review, the Plan will assign an independent review organization (IRO) to make a determination on the request for external review. The Plan will promptly forward to the IRO, by any available expeditious method (e.g. telephone, facsimile, etc.), all information and materials relevant to the final internal adverse determination.
5. The IRO must provide notice to the claimant and the Plan (either in writing or orally) as expeditiously as the claimant's medical condition or circumstance require and no later than 72 hours after it receives the expedited external review request from the Plan. If notice is not provided in writing, the IRO must provide written notice to you and the Plan as confirmation of the decision within 48 hours after the date of the notice. The IRO's notice is required to contain the following information:
 - A. A general description of the reason for the request for external review, including information sufficient to identify the claim, the diagnosis code and treatment code and the corresponding meaning for each and the reason for the previous denial;
 - B. The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
 - C. References to the evidence or documentation, including the specific coverage provisions and evidence based standards, considered in reaching its decision;
 - D. A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
 - E. A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to either the group health plan or to you;
 - F. A statement that judicial review may be available to you; and
 - G. Current contact information, including telephone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act Section 2793.

Effect of External Review Determination

A determination on external review is binding on the Plan and the claimant, except to the extent that other remedies are available under applicable state or federal law. However, a decision by the external reviewer does not preclude the Plan from making payment or providing benefits on a claim at any time, including after a decision that denies the claim. When an external review decision requires the Plan to provide benefits or payment on a claim, the Plan will provide benefits or payment pursuant to the decision without unreasonable delay regardless of whether the Plan intends to seek judicial review of the decision, unless and until there is a judicial decision that provides otherwise.

State Insurance Laws

Nothing in the Plan's claims procedures will be construed to supersede any provision of any applicable state law.

Statute of Limitations for Plan Claims

Please note that no legal action may be commenced or maintained to recover benefits under the Plan more than 12 months after the final review/appeal decision by the Plan Administrator has been rendered (or deemed rendered).

Appointment of Authorized Representative

A Covered Person is permitted to appoint an authorized representative to act on his or her behalf with respect to a benefit claim or appeal of a denial. An assignment of benefits by a Covered Person to a provider will not constitute appointment of that provider as an authorized representative. To appoint such a representative, the Covered Person must complete a form which can be obtained from the Plan Administrator or the Third Party Administrator. However, in connection with a claim involving urgent care, the Plan will permit a health care professional with knowledge of the Covered Person's medical condition to act as the Covered Person's authorized representative without completion of this form. In the event a Covered Person designates an authorized representative, all future communications from the Plan will be with the representative, rather than the Covered Person, unless the Covered Person directs the Plan Administrator, in writing, to the contrary.

Physical Examinations

The Plan reserves the right to have a Physician of its own choosing examine any Covered Person whose Illness or Injury is the basis of a claim. All such examinations will be at the expense of the Plan. This right may be exercised when and as often as the Plan Administrator may reasonably require during the pendency of a claim. The Covered Person must comply with this requirement as a necessary condition for coverage.

**SUMMARY OF MATERIAL MODIFICATION
AND
AMENDMENT #5
TO THE
CITY OF GRAND RAPIDS
UNIFIED HEALTH CARE PLAN
GROUP NO. 15364**

This Summary of Material Modification and Amendment describes changes to the City of Grand Rapids Unified Healthcare Plan effective January 1, 2014. These changes are effective as of **January 1, 2017** and will remain in effect until amended in writing by the Plan Administrator.

This document should be read carefully and attached to the Plan Document and Summary Plan Description. Please contact the Plan Administrator identified in the Summary Plan Description if you have any questions regarding the changes described in this Summary of Material Modification.

City of Grand Rapids (the "Plan Sponsor") is amending the City of Grand Rapids Unified Healthcare Plan (the "Plan") as follows:

1. *City of Grand Rapids is hereby adding **Schedule of Benefits Plan A, Schedule of Prescription Benefits Plan A, Schedule of Benefits High Deductible Health Plan and Schedule of Prescription Benefits High Deductible Health Plan** as shown in **Exhibit's A, B, C, and D.***
2. *The Plan will no longer offer dental coverage, as such the **Dental Benefits** section in the Plan is hereby removed in its entirety and not replaced.*
3. *The **Calendar Year Maximum Out-of-Pocket** section in the **Schedule of Benefits** (previously amended in Amendment #4) and **RET-65 Fire (IAFF) 6/22/09** are hereby deleted and replaced as follows:*

SCHEDULE OF BENEFITS

**ACTIVE EMPLOYEES AND RETIREES WHOSE
PLANS RATIFIED IN 2008/2009**

	PARTICIPATING PROVIDER	NON- PARTICIPATING PROVIDER (Subject to Usual, Customary & Reasonable Charges)
Calendar Year Maximum Out-of-Pocket (20% coinsurance, deductible and medical and prescription drug co-pays)		
Single	\$7,150	\$7,150
Family	\$14,300	\$14,300

If a Participant or family meets the Co-insurance Maximum Out-of-Pocket amount, as described (20% co-insurance), eligible expenses will then be payable at 100% for the remainder of the Calendar Year.

If a Participant or family meets the Calendar Year Maximum Out-of-Pocket amount, as described (deductible, medical and prescription drug co-pays and 20% co-insurance), eligible expenses will then be payable at 100% for the remainder of the Calendar Year. However each individual in a family is not required to contribute more than the single Out-of-Pocket amount to the family Out-of-Pocket Maximum before the Plan will pay 100% of covered expenses for any Covered Person in the family during the remainder of that Calendar Year.

The Maximum Out-of-Pocket amounts do **not** include expenses that exceed the Plan limits, are in excess of Usual, Customary and Reasonable, or are excluded under the provisions of the Plan.

RET-65 FIRE (IAFF) 6/22/09

	PPO PROVIDER	NON- PPO PROVIDER
CALENDAR YEAR MAXIMUM OUT-OF-POCKET		
Out-of-Pocket Maximum (10% coinsurance and medical co-pays)		
Single	\$7,150	\$7,150
Family	\$14,300	\$14,300

If a Participant or family meets the Co-insurance Maximum Out-of-Pocket amount, as described (10% co-insurance), eligible expenses will then be payable at 100% for the remainder of the Calendar Year.

If a Participant or family meets the Calendar Year Maximum Out-of-Pocket amount, as described (10% co-insurance and medical co-pays), eligible expenses will then be payable at 100% for the remainder of the Calendar Year.

The Maximum Out-of-Pocket amounts do **not** include prescription drug co-pays or expenses that exceed the Plan limits or are excluded under the provisions of the Plan.

4. *The following **Teladoc** benefit is hereby added to the **Active Employees And Retirees Whose Plans Ratified In 2008/2009** and the **RET-65 Fire (IAFF) 6/22/09** under the **Schedule of Benefits** as follows:*

SCHEDULE OF BENEFITS

ACTIVE EMPLOYEES AND RETIREES WHOSE PLANS RATIFIED IN 2008/2009

	PPO PROVIDER	NON-PPO PROVIDER (Subject to Usual, Customary & Reasonable Charges)
Physician Services		
Teladoc	100% Deductible waived	N/A

RET-65 FIRE (IAFF) 6/22/09

	PPO PROVIDER	NON-PPO PROVIDER
Physician Services		
Teladoc	100%	N/A

5. The **Calendar Year Maximum Out-of-Pocket** under the **Prescription** section (previously amended in Amendment #4) is hereby deleted and replaced as follows:

PRESCRIPTION (ACTIVE EMPLOYEES AND RETIREES WHOSE PLANS RATIFIED IN 2008/2009)

Calendar Year Maximum Out-of-Pocket (prescription drug co-pays – included with major medical)	
Single	\$7,150
Family	\$14,300

- 6 **Telemedicine** is hereby added alphabetically under the **Medical Benefits** section of the Plan as follows:

MEDICAL BENEFITS

Telemedicine

Telemedicine programs provide 24/7/365 access to a national network of U.S. board-certified Physicians who can resolve many of your medical issues. For any questions with respect to the Telemedicine benefit, please contact the Plan Administrator. Coverage under this benefit does not include consults from your regular Physician; it only includes coverage for consults to the extent the Physician who is consulted participates in a Telemedicine program as shown in the General Plan Information section.

Telemedicine benefits include:

- (i) 24/7/365 access to a Physician online or by phone.
- (ii) Fast treatment. Telemedicine Physicians respond within 22 minutes, on average.
- (iii) Talk to a Telemedicine Physician from anywhere: at home, work, or while traveling.
- (iv) Save money by avoiding expensive urgent care or emergency room visits.

Call your Telemedicine provider:

- When you need care now.
- If you're considering the emergency room or urgent care center for non-emergency issues.
- On vacation, on a business trip, or away from home.
- For short-term prescription refills.

Telemedicine providers treat conditions such as:

- Cold and flu
- Bronchitis
- Respiratory infection
- Sinus problems
- Allergies
- Urinary tract infection
- Pediatric care
- Poison ivy
- Pink eye
- Ear infections

7. *Number (37) under the **Exclusions** subsection in **Medical Benefits** section of the Plan is hereby deleted and replaced with the following:*

MEDICAL BENEFITS

Exclusions

Examples of what The Plan does **not** pay:

37. Charges for administrative costs of completing claim forms, itemized bills, medical reports or for providing records, mailing and/or shipping expenses, expenses for broken appointments or expenses for telephone calls (except Teladoc services).
8. *The **Third-Party Provision** section of the Plan is hereby deleted and replaced as shown in **Exhibit E**.*

All other provisions of this Plan shall remain unchanged.

EXHIBIT A

SCHEDULE OF MEDICAL BENEFITS

PLAN A

(UNDER 65 RETIREES AFTER 2004/2005 UNION RATIFICATIONS)

	PARTICIPATING PROVIDER	NON- PARTICIPATING PROVIDER (Subject to Usual, Customary & Reasonable Charges)
THE PLAN'S MAXIMUM BENEFIT AMOUNT	Unlimited	
New Benefits Due to PPACA & Mental Health Parity		
Preventive Services and Routine Care		
Preventive Services This benefit includes office visit (preventive visits only) and any other eligible item or service received and billed at the same time as any preventive service. Any office visit or other item or service billed separately will be paid under the Routine Care provision of the Plan.	100%	100%
Routine Care	\$10 co-payment then 100%	\$10 co-payment then 100%
<p>This benefit only includes items and services that are not otherwise covered under the Preventive Services provision Plan such as:</p> <ul style="list-style-type: none"> • Office visits – billed separate from Preventive services, • Routine Physical/Gynecological exam: limit of 1 physical or 1 gynecological exam per calendar year, and the following services once per calendar year: chemical profile, complete blood count, fecal occult blood screening, urinalysis, EKG test • Pap smear, limited to 1 routine pap smear per calendar year • Mammogram, limited to 1 per woman age 35 to 40, and 1 per calendar year at age 40 and older • Prostate Specific Antigen (PSA) screening, limited to 1 per calendar year beginning at age 40 • Routine colonoscopy, limited to one procedure from age 40 to age 50, and 1 procedure per calendar year age 51 and older 		
Mental Disorders & Substance Use Disorders* (Substance Abuse)		
*Note: Mental Health Benefits are being reviewed in accordance with the Mental Health Parity regulations and may be subject to change based on the review.		
Inpatient	90%	90%
Outpatient	\$10 co-payment then 100%	\$10 co-payment then 100%
NOTE: Emergency care (Ambulance and Emergency Services) will be paid the same as the benefits for Ambulance services and Emergency Services listed above in the Medical Schedule of Benefits, however, the Participating Provider level of benefits will always apply regardless of the provider utilized.		

Current Benefits		
CO-PAYMENTS (The dollar amount the Participant pays for the following services)		
	PARTICIPATING PROVIDER	NON- PARTICIPATING PROVIDER (Subject to Usual, Customary & Reasonable Charges)
Office visits (Includes all services administered Physician Office)	\$10 co-payment then 100%*	\$10 co-payment then 100%*
Urgent Care Center	\$10 co-payment then 100%*	\$10 co-payment then 100%*
*Copay applies to the Physician office visit component only. All other services are paid subject to any Coinsurance percentages.		
Emergency Services (Co-payment waived if admitted to hospital, Inpatient Co-insurance will apply)	\$150 co-payment then 100%*	\$150 co-payment then 100%*
*Copay applies to the Physician office visit component only. All other services are paid subject to any Coinsurance percentages.		
Consultations	\$10 co-payment then 100%	\$10 co-payment then 100%
Chiropractic	\$10 co-payment then 100%	\$10 co-payment then 100%
Mental Disorders & Substance Use Disorders Outpatient Office Visits	\$10 co-payment then 100%	\$10 co-payment then 100%
CO-INSURANCE PERCENTAGE (The percentage the Plan pays after the Participant pays 10%)		
	PARTICIPATING PROVIDER	NON- PARTICIPATING PROVIDER (Subject to Usual, Customary & Reasonable Charges)
Hospital Services		
Inpatient	90%	90%
Outpatient	90%	90%
Emergency Services (Co-payment waived if admitted to hospital, Inpatient Co-insurance will apply)	\$150 co-payment then 100%	\$150 co-payment then 100%
Outpatient Surgical Center	90%	90%
Calendar Year Deductible		
Individual	\$0	\$0
Family	\$0	\$0
Maximum Co-Insurance Out-of-Pocket		
Out-of-Pocket		
Individual	\$500	\$500
Family	\$500	\$500

Other Medical Services	PARTICIPATING PROVIDER	NON- PARTICIPATING PROVIDER (Subject to Usual, Customary & Reasonable Charges)
Ambulance	100%	100%
Extended Care	100%	100%
Home Health Care	100%	100%
Hospice	100%	100%
Physician Services		
Hospital Visits	100%	100%
Emergency Services	100%	100%
Surgeon/Assistant Surgeon	100%	100%
Anesthesiologist	100%	100%
Maternity (Professional Fees)*/Employee, Spouse And Dependents		
Preventive prenatal and breastfeeding support (other than lactation consultations)	100%	100%
Lactation Consultations	100%	100%
All Other Prenatal, Delivery and Postnatal Care	90%	90%
*See Eligible Medical Expenses for limitations.		
Chiropractic Services		
Exam/Manipulation	\$10 co-payment then 100%	\$10 co-payment then 100%
X-rays	100%	100%
Temporomandibular Joint Dysfunction (TMJ)	100%	100%
Organ Transplant	100%	100%
Diagnostic X-ray and Lab	100%	100%
Radiation/Chemotherapy	100%	100%
Occupational Therapy	100%	100%
Speech Therapy	100%	100%
Physical Therapy	100%	100%
Medical Supplies	100%	100%
Durable Medical Equipment	100%	100%
Prosthetics	100%	100%
Orthotics	100%	100%
Diagnosis of Infertility Benefits Limited to: supplies and services for the diagnosis of infertility.	100%	100%
Other Eligible Expenses	100%	100%

EXHIBIT B

SCHEDULE OF PRESCRIPTION BENEFITS PLAN A (UNDER 65 RETIREES AFTER 2004/2005 UNION RATIFICATIONS)

Prescription - Retail:

Preventive	
Co-payment	\$0
Percentage payable.....	100%
Generic drugs	
Co-payment	\$10
Percentage payable.....	100%
Brand Name drugs	
Co-payment	\$20
Percentage payable.....	100%

Prescription - Mail Order: (90 day supply)

Preventive	
Co-payment	\$0
Percentage payable.....	100%
Generic drugs	
Co-payment	\$10
Percentage payable.....	100%
Brand Name drugs	
Co-payment	\$20
Percentage payable.....	100%

EXHIBIT C

SCHEDULE OF BENEFITS HIGH DEDUCTIBLE HEALTH PLAN OPTION

	PARTICIPATING PROVIDER	NON- PARTICIPATING PROVIDER (Subject to Usual, Customary & Reasonable Charges)
Calendar Year Deductible (combined with prescription)		
Single	\$6,550	No Coverage
Family	\$13,100	No Coverage
Calendar Year Maximum Out-of-Pocket (Includes Deductible – combined with prescription)		
Single	\$6,550	No Coverage
Family	\$13,100	No Coverage
Lifetime Maximum per Family Member	Unlimited	No Coverage
<p>Each individual in a family is not required to contribute more than the single Out-of-Pocket amount to the family Out-of-Pocket Maximum before the Plan will pay 100% of covered expenses for any Covered Person in the family during the remainder of that Calendar Year.</p> <p>The Maximum Out-of-Pocket amounts do not include expenses that exceed the Plan limits, are in excess of Usual, Customary and Reasonable, or are excluded under the provisions of the Plan.</p>		
THE PLAN'S LIFETIME OR CALENDAR YEAR MAXIMUM BENEFIT AMOUNT	Unlimited	
CO-INSURANCE PERCENTAGE (The percentage the Plan pays after the Participant pays the Deductible)		
Hospital Services		
Inpatient	100% after Deductible	No Coverage
Outpatient	100% after Deductible	No Coverage
Emergency Services /Emergency Room Services	100% after Deductible	100% after Deductible
Outpatient Surgical Center	100% after Deductible	No Coverage
Mental Disorders & Substance Use Disorders		
Inpatient	100% after Deductible	No Coverage
Outpatient	100% after Deductible	No Coverage
<p>NOTE: Emergency care (Ambulance and Emergency Services) will be paid the same as the benefits for Ambulance services and Emergency Services listed above in the Medical Schedule of Benefits, however, the Participating Provider level of benefits will always apply regardless of the provider utilized.</p>		
Ambulance	100% after Deductible	100% after Deductible
Extended Care	100% after Deductible	No Coverage
Home Health Care	100% after Deductible	No Coverage
Hospice	100% after Deductible	No Coverage

	PARTICIPATING PROVIDER	NON- PARTICIPATING PROVIDER (Subject to Usual, Customary & Reasonable Charges)
Physician Services		
Hospital Visits	100% after Deductible	No Coverage
Emergency Room Services	100% after Deductible	100% after Deductible
Surgeon/Assistant Surgeon	100% after Deductible	No Coverage
Anesthesiologist	100% after Deductible	No Coverage
Teladoc	\$40 copay after Deductible	N/A
Maternity (Professional Fees)*/Employee, Spouse And Dependents		
Preventive prenatal and breastfeeding support (other than lactation consultations)	100%; Deductible waived	No Coverage
Lactation Consultations	100%; Deductible waived	No Coverage
All Other Prenatal, Delivery and Postnatal Care	100% after Deductible	No Coverage
*See Eligible Medical Expenses for limitations.		
Chiropractic Services		
Exam/Manipulation	100% after Deductible	No Coverage
X-rays	100% after Deductible	No Coverage
Temporomandibular Joint Dysfunction (TMJ)	100% after Deductible	No Coverage
Organ Transplant	100% after Deductible	No Coverage
Diagnostic X-ray and Lab	100% after Deductible	No Coverage
Radiation/Chemotherapy	100% after Deductible	No Coverage
Occupational Therapy	100% after Deductible	No Coverage
Speech Therapy	100% after Deductible	No Coverage
Physical Therapy	100% after Deductible	No Coverage
Medical Supplies	100% after Deductible	No Coverage
Durable Medical Equipment	100% after Deductible	No Coverage
Prosthetics	100% after Deductible	No Coverage
Orthotics	100% after Deductible	No Coverage
Preventive Services and Routine Care		
<i>Preventive Services</i> This benefit includes office visits associated with Preventive Services and any other eligible item or service received and billed at the same time as any preventive service. Any office visit or other item or service billed separately will be paid under the Routine Care provision of the Plan.	100%; Deductible waived	No Coverage

	PARTICIPATING PROVIDER	NON- PARTICIPATING PROVIDER (Subject to Usual, Customary & Reasonable Charges)
Preventive Services and Routine Care (continued)		
<i>Routine Care</i>	100%; Deductible waived	No Coverage
This benefit only includes items and services that are not otherwise covered under the Preventive Services provision of the Plan such as:		
<ul style="list-style-type: none"> • Office visits (associated with Preventive Services (but billed separately) or Routine Care) • Routine Physical/Gynecological exam: limit of 1 physical or 1 gynecological exam per calendar year, and the following services once per calendar year: chemical profile, complete blood count, fecal occult blood screening, urinalysis, EKG test • Pap smear, limited to 1 routine pap smear per calendar year 	<ul style="list-style-type: none"> • Mammogram, limited to 1 per woman age 35 to 40, and 1 per calendar year at age 40 and older • Prostate Specific Antigen (PSA) screening, limited to 1 per calendar year beginning at age 40 • Routine colonoscopy, limited to 1 procedure from age 40 to age 50, and 1 procedure per calendar year age 51 and older 	
Diagnosis of Infertility Benefits Limited to supplies and services for the diagnosis of infertility.	100% after Deductible	No Coverage
Other Eligible Expenses	100% after Deductible	No Coverage

EXHIBIT D

SCHEDULE OF PRESCRIPTION BENEFITS HIGH DEDUCTIBLE HEALTH PLAN

NOTE: An OTC Step Therapy provision applies to the following OTC drug classifications: Proton Pump Inhibitors (PPIs), Antihistamines and NSAIDs. Refer to your OTC handout provided by Human Resources for information on Over-the-Counter (OTC) medications.

Calendar Year Deductible (combined with major medical)	
Single	\$6,550
Family	\$13,100
Calendar Year Maximum Out-of-Pocket (includes Deductible – combined with major medical)	
Single	\$6,550
Family	\$13,100

Prescription - Retail:

Generic drugs	
Percentage payable after deductible.....	100%
Brand Name drugs	
Percentage payable after deductible.....	100%
Preventive Drugs	100%
Covered OTC medicines after deductible.....	100%

Prescription – Retail (90 day supply)

Generic drugs	
Percentage payable after deductible.....	100%
Preventive Drugs	100%

Prescription – Mail Order (90 day supply)

Generic drugs.....		N/A
Brand Name drugs		
Percentage payable after deductible.....		100%
Preventive Drugs.....		100%

EXHIBIT E

THIRD-PARTY RECOVERY AND PROVISION

Payment Condition

- (1) The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, Illness, disease or disability is caused in whole or in part by, or results from the acts or omissions of you and/or your Dependents, plan beneficiaries and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Covered Person") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other insurance or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party (collectively "Coverage").
- (2) The Covered Person, his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. By accepting benefits the Covered Person agrees the Plan shall have an equitable lien on any funds received by the Covered Person and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Covered Person agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Covered Person understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Covered Person shall be a trustee over those Plan assets.
- (3) In the event a Covered Person settles, recovers or is reimbursed by any Coverage, the Covered Person agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Covered Person. If the Covered Person fails to reimburse the Plan out of any judgment or settlement received, the Covered Person will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.
- (4) If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Covered Person is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the Plan may seek reimbursement.

Subrogation

- (1) As a condition to participating in and receiving benefits under this Plan, the Covered Person agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation or entity and to any Coverage to which the Covered Person is entitled, regardless of how classified or characterized, at the Plan's discretion, if the Covered Person fails to so pursue such rights or action.

- (2) If a Covered Person receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Covered Person may have against any Coverage and/or party causing the Illness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Covered Person is obligated to notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Covered Person is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.
- (3) The Plan may, at its discretion, in its own name or in the name of the Covered Person, commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.
- (4) The Covered Person authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Covered Persons and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims if the Covered Person fails to file a claim or pursue damages against:
 - (a) The responsible party, its insurer or any other source on behalf of that party;
 - (b) Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
 - (c) Any policy of insurance from any insurance company or guarantor of a third party;
 - (d) Workers' Compensation or other liability insurance company; or
 - (e) Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments and school insurance coverage.

The Covered Person assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

Right of Reimbursement

- (1) The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Covered Person is fully compensated by his or her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Covered Persons' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Covered Person are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Covered Person's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Covered Person is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

- (2) No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, express written consent of the Plan.
- (3) The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Covered Person, whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.
- (4) These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Covered Person.
- (5) This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Illness, Injury, Disease or disability.

Covered Person is a Trustee Over Plan Assets

- (1) Any Covered Person who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any Injury or Accident. By virtue of this status, the Covered Person understands that he/she is required to:
 - (a) Notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds;
 - (b) Instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts;
 - (c) In circumstances where the Covered Person is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Person obtains a settlement, judgment or other source of Coverage to include the Plan or its authorized representative as a payee on the settlement draft; and,
 - (d) Hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.
- (2) To the extent the Covered Person disputes this obligation to the Plan under this section, the Covered Person or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorneys' fees, for which he/she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.
- (3) No Covered Person, beneficiary, or the agents or representatives thereof, exercising control over plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

Excess Insurance

If at the time of Injury, Illness, disease or disability, there is available or potentially available any coverage (including but not limited to coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of coverage, except as otherwise provided for under the Plan's "Coordination of Benefits" section.

The Plan's benefits shall be excess to any of the following:

- (1) The responsible party, its insurer or any other source on behalf of that party;
- (2) Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
- (3) Any policy of insurance from any insurance company or guarantor of a third party;
- (4) Workers' Compensation or other liability insurance company; or
- (5) Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments and school insurance coverage.

Separation of Funds

Benefits paid by the Plan, funds recovered by the Covered Person and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Covered Person, such that the death of the Covered Person or filing of bankruptcy by the Covered Person, will not affect the Plan's equitable lien, the funds over which the Plan has a lien or the Plan's right to subrogation and reimbursement.

Wrongful Death

In the event that the Covered Person dies as a result of his or her Injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Covered Person(s) and all others that benefit from such payment.

Obligations

- (1) It is the Covered Person's obligation at all times, both prior to and after payment of medical benefits by the Plan:
 - (a) To cooperate with the Plan or any representatives of the Plan, in protecting its rights, including discovery, attending depositions and cooperating in trial to preserve the Plan's rights;
 - (b) To provide the Plan with pertinent information regarding the Illness, disease, disability or Injury, including Accident reports, settlement information and any other requested additional information;
 - (c) To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
 - (d) To do nothing to prejudice the Plan's rights of subrogation and reimbursement;

- (e) To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received;
 - (f) To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement;
 - (g) To not settle or release, without the prior consent of the Plan, any claim to the extent that the Covered Person may have against any responsible party or coverage;
 - (h) To instruct his/her attorney to ensure that the Plan or its authorized representative is included as a payee on any settlement draft;
 - (i) In circumstances where the Covered Person is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Person obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft; and
 - (j) To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Covered Person over settlement funds is resolved.
- (2) If the Covered Person and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the Covered Person will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Covered Person.
- (3) The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Covered Persons' cooperation or adherence to these terms.

Offset

If timely repayment is not made, or the Covered Person and/or his or her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Covered Person's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Covered Person in an amount equivalent to any outstanding amounts owed by the Covered Person to the Plan. This provision applies even if the Covered Person has disbursed settlement funds.

Minor Status

- (1) In the event the Covered Person is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.
- (2) If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

Language Interpretation

The Plan Sponsor retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision and to administer the Plan's subrogation and reimbursement rights.

Severability

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

Notwithstanding anything contained herein to the contrary, to the extent this Plan is not governed by ERISA, the Plan's right to subrogation and reimbursement may be subject to applicable State subrogation laws.

**SUMMARY OF MATERIAL MODIFICATION
AND
AMENDMENT #4
TO THE
CITY OF GRAND RAPIDS
UNIFIED HEALTH CARE PLAN (HANDBOOK 2)
GROUP NO. 140160**

This Summary of Material Modification and Amendment describes changes to the City of Grand Rapids Unified Health Care Plan (Handbook 2) effective January 1, 2014. These changes are effective as of **January 1, 2016** and will remain in effect until amended in writing by the Plan Administrator.

This document should be read carefully and attached to the Plan Document and Summary Plan Description. Please contact the Plan Administrator identified in the Summary Plan Description if you have any questions regarding the changes described in this Summary of Material Modification.

City of Grand Rapids (the "Plan Sponsor") is amending the City of Grand Rapids Unified Health Care Plan (Handbook 2) (the "Plan") as follows:

1. *The **Calendar Year Maximum Out-of-Pocket** section in the **Schedule of Benefits** is hereby deleted and replaced as follows:*

SCHEDULE OF BENEFITS

**ACTIVE EMPLOYEES AND RETIREES WHOSE
PLANS RATIFIED IN 2008/2009**

	PARTICIPATING PROVIDER	NON- PARTICIPATING PROVIDER (Subject to Usual, Customary & Reasonable Charges)
Calendar Year Maximum Out-of-Pocket (20% coinsurance, deductible and medical and prescription drug co-pays)		
Single	\$6,850	\$6,850
Family	\$13,700	\$13,700
<p>If a Participant or family meets the Co-insurance Maximum Out-of-Pocket amount, as described (20% co-insurance), eligible expenses will then be payable at 100% for the remainder of the Calendar Year.</p> <p>If a Participant or family meets the Calendar Year Maximum Out-of-Pocket amount, as described (deductible, medical and prescription drug co-pays and 20% co-insurance), eligible expenses will then be payable at 100% for the remainder of the Calendar Year. However each individual in a family is not required to contribute more than the single Out-of-Pocket amount to the family Out-of-Pocket Maximum before the Plan will pay 100% of covered expenses for any Covered Person in the family during the remainder of that Calendar Year.</p> <p>The Maximum Out-of-Pocket amounts do not include expenses that exceed the Plan limits, are in excess of Usual, Customary and Reasonable, or are excluded under the provisions of the Plan.</p>		

2. The **Calendar Year Maximum Out-of-Pocket** under the **Prescription** section is hereby deleted and replaced as follows:

PRESCRIPTION
(ACTIVE EMPLOYEES AND RETIREES WHOSE PLANS RATIFIED IN 2008/2009)

Calendar Year Maximum Out-of-Pocket (prescription drug co-pays – included with major medical)	
Single	\$6,850
Family	\$13,700

All other provisions of this Plan shall remain unchanged.

**SUMMARY OF MATERIAL MODIFICATION
AND
AMENDMENT #3
TO THE
CITY OF GRAND RAPIDS
UNIFIED HEALTH CARE PLAN (HANDBOOK 2)
GROUP NO. 140160**

This Summary of Material Modification and Amendment describes changes to the City of Grand Rapids Unified Health Care Plan (Handbook 2) effective January 1, 2014. These changes are effective as of **October 1, 2015** and will remain in effect until amended in writing by the Plan Administrator.

This document should be read carefully and attached to the Plan Document and Summary Plan Description. Please contact the Plan Administrator identified in the Summary Plan Description if you have any questions regarding the changes described in this Summary of Material Modification.

City of Grand Rapids (the "Plan Sponsor") is amending the City of Grand Rapids Unified Health Care Plan (Handbook 2) (the "Plan") as follows:

1. *The second paragraph of the **Medical Benefits** section under the **Schedule of Benefits** is hereby deleted and replaced as follows:*

SCHEDULE OF BENEFITS

MEDICAL BENEFITS

The City of Grand Rapids Unified Health Plan has entered into agreements with a network of Hospitals, Physicians, and other health care related providers which are called Participating Providers. The name of the network is Cofinity for active Employees and Aetna Choice® POS II for pre-65 Retirees.

2. *The **Non-participating Providers** section under the **Schedule of Benefits** is hereby deleted and replaced with the following:*

Non-participating Providers

Non-participating providers have **not** signed agreements with Cofinity for active Employees and Aetna Choice® POS II for pre-65 Retirees. If you receive services from a non-participating provider, they will submit the claim directly to Meritain Health for payment. The address is located on the back of your ID card.

3. *The **Schedule of Benefits - Active Employees and Retirees Whose Plan Ratified in 2008/2009** is hereby deleted and replaced as shown in **Exhibit A**.*

All other provisions of this Plan shall remain unchanged.

EXHIBIT A

SCHEDULE OF BENEFITS

ACTIVE EMPLOYEES AND RETIREES WHOSE PLANS RATIFIED IN 2008/2009

	PARTICIPATING PROVIDER	NON- PARTICIPATING PROVIDER (Subject to Usual, Customary & Reasonable Charges)
Calendar Year Deductible		
Single	\$150	\$150
Family	\$150	\$150
Calendar Year Co-Insurance Maximum Out-of-Pocket (20% coinsurance)		
Single	\$850	\$850
Family	\$850	\$850
Calendar Year Maximum Out-of-Pocket (20% coinsurance, deductible and medical and prescription drug co-pays)		
Single	\$6,600	\$6,600
Family	\$13,200	\$13,200
<p>If a Participant or family meets the Co-insurance Maximum Out-of-Pocket amount, as described (20% co-insurance), eligible expenses will then be payable at 100% for the remainder of the Calendar Year.</p> <p>If a Participant or family meets the Calendar Year Maximum Out-of-Pocket amount, as described (deductible, medical and prescription drug co-pays and 20% co-insurance), eligible expenses will then be payable at 100% for the remainder of the Calendar Year.</p> <p>The Maximum Out-of-Pocket amounts do not include expenses that exceed the Plan limits, are in excess of Usual, Customary and Reasonable, or are excluded under the provisions of the Plan.</p>		
THE PLAN'S LIFETIME OR CALENDAR YEAR MAXIMUM BENEFIT AMOUNT	Unlimited	
CO-PAYMENTS (The dollar amount the Participant pays for the following services)		
Office visits	\$20 co-payment*	\$20 co-payment*
Urgent Care Center	\$20 co-payment*	\$20 co-payment*
*Copay applies to the Physician office visit component only. All other services are paid subject to any Deductible and Coinsurance percentages.		
Emergency Services (Co-payment waived if admitted to hospital, Inpatient Co-insurance will apply)	\$100 co-payment*	\$100 co-payment*
*Copay applies to the Emergency Visit component only. All other services are paid subject to any Deductible and Coinsurance percentages		
Consultations	\$20 co-payment	\$20 co-payment
Chiropractic	\$20 co-payment	\$20 co-payment
Mental Disorders & Substance Use Disorders (office visits)	\$20 co-payment	\$20 co-payment

CO-INSURANCE PERCENTAGE (The percentage the Plan pays after the Participant pays 20%)		
	PARTICIPATING PROVIDER	NON- PARTICIPATING PROVIDER (Subject to Usual, Customary & Reasonable Charges)
Hospital Services		
Inpatient	80% after Deductible	80% after Deductible
Outpatient	80% after Deductible	80% after Deductible
Emergency Services (Co-payment waived if admitted to hospital, Inpatient Co-insurance will apply)	\$100 co-payment	\$100 co-payment
Outpatient Surgical Center	80% after Deductible	80% after Deductible
Mental Disorders & Substance Use Disorders		
Inpatient	80% after Deductible	80% after Deductible
Outpatient	\$20 co-payment	\$20 co-payment
NOTE: Emergency care (Ambulance and Emergency Services) will be paid the same as the benefits for Ambulance services and Emergency Services listed above in the Medical Schedule of Benefits, however, the Participating Provider level of benefits will always apply regardless of the provider utilized.		
Ambulance	80% after Deductible	80% after Deductible
Extended Care	80% after Deductible	80% after Deductible
Home Health Care	80% after Deductible	80% after Deductible
Hospice	80% after Deductible	80% after Deductible
Physician Services		
Hospital Visits	80% after Deductible	80% after Deductible
Emergency Services	80% after Deductible	80% after Deductible
Surgeon/Assistant Surgeon	80% after Deductible	80% after Deductible
Anesthesiologist	80% after Deductible	80% after Deductible
Maternity (Professional Fees)*/Employee, Spouse And Dependents		
Preventive prenatal and breastfeeding support (other than lactation consultations)	100% Deductible waived	100% Deductible waived
Lactation Consultations	100% Deductible waived	100% Deductible waived
All Other Prenatal, Delivery and Postnatal Care	80% after Deductible	80% after Deductible
*See Eligible Medical Expenses for limitations.		
Chiropractic Services		
Exam/Manipulation	\$20 co-payment	\$20 co-payment
X-rays	80% after Deductible	80% after Deductible
Temporomandibular Joint Dysfunction (TMJ)	80% after Deductible	80% after Deductible
Organ Transplant	80% after Deductible	80% after Deductible
Diagnostic X-ray and Lab	80% after Deductible	80% after Deductible

	PARTICIPATING PROVIDER	NON- PARTICIPATING PROVIDER (Subject to Usual, Customary & Reasonable Charges)
Radiation/Chemotherapy	80% after Deductible	80% after Deductible
Occupational Therapy	80% after Deductible	80% after Deductible
Speech Therapy	80% after Deductible	80% after Deductible
Physical Therapy	80% after Deductible	80% after Deductible
Medical Supplies	80% after Deductible	80% after Deductible
Durable Medical Equipment	80% after Deductible	80% after Deductible
Prosthetics	80% after Deductible	80% after Deductible
Orthotics	80% after Deductible	80% after Deductible
Preventive Services and Routine Care		
<i>Preventive Services</i> This benefit includes office visits associated with Preventive Services and any other eligible item or service received and billed at the same time as any preventive service. Any office visit or other item or service billed separately will be paid under the Routine Care provision of the Plan.	100% Deductible waived	100% Deductible waived
Other Medical Services		
Preventive Services and Routine Care (continued)		
<i>Routine Care</i>	\$20 co-payment*	\$20 co-payment*
*Copay applies to the Physician office visit component only. All other services are paid subject to any Deductible and Coinsurance percentages.		
This benefit only includes items and services that are not otherwise covered under the Preventive Services provision of the Plan such as:		
<ul style="list-style-type: none"> • Office visits (associated with Preventive Services (but billed separately) or Routine Care) • Routine Physical/Gynecological exam: limit of 1 physical or 1 gynecological exam per calendar year, and the following services once per calendar year: chemical profile, complete blood count, fecal occult blood screening, urinalysis, EKG test • Pap smear, limited to 1 routine pap smear per calendar year 	<ul style="list-style-type: none"> • Mammogram, limited to 1 per woman age 35 to 40, and 1 per calendar year at age 40 and older • Prostate Specific Antigen (PSA) screening, limited to 1 per calendar year beginning at age 40 • Routine colonoscopy, limited to 1 procedure from age 40 to age 50, and 1 procedure per calendar year age 51 and older 	
Diagnosis of Infertility Benefits Limited to supplies and services for the diagnosis of infertility.	80% after Deductible	80% after Deductible
Other Eligible Expenses	80% after Deductible	80% after Deductible

**CITY OF GRAND RAPIDS UNIFIED HEALTH CARE PLAN
SUMMARY OF MATERIAL MODIFICATION
AND
AMENDMENT #2
TO THE
CITY OF GRAND RAPIDS
UNIFIED HEALTH CARE PLAN**

This Summary of Material Modification and Amendment describes changes to the City of Grand Rapids Unified Health Care Plan effective January 1, 2014. These changes are effective as of **the dates specified below** and will remain in effect until amended in writing by the Plan Administrator.

This document should be read carefully and attached to the Plan Document and Summary Plan Description. Please contact the Plan Administrator identified in the Summary Plan Description if you have any questions regarding the changes described in this Summary of Material Modification.

City of Grand Rapids (the "Plan Sponsor") is amending the City of Grand Rapids Unified Health Care Plan (the "Plan") as follows:

EFFECTIVE JANUARY 1, 2015:

Patient Protection and Affordable Care Act (the "Affordable Care Act")

This Summary of Material Modification and Amendment to the City of Grand Rapids Unified Health Care Plan (the "Plan") is adopted to comply with certain provisions of the Patient Protection and Affordable Care Act (the "Affordable Care Act").

1: Definitions

The following definitions are added alphabetically to the Plan:

DEFINED TERMS

Administrative Period means the optional period, during which an Employer can determine which Employees are Full-Time Employees, notify and enroll eligible Employees in coverage, etc. (similar to an open enrollment period). This period cannot be longer than 90 days and cannot be used to reduce or lengthen the Measurement or Stability Periods. The Administrative Period includes all periods, other than the Initial Measurement Period, between the day he or she completes at least one Hour of Service with the Employer of a New Employee who is a Part-Time, Seasonal, Temporary or Variable Hour Employee and the first day of the Employee's Initial Stability Period.

Full-Time Employee means for a New Employee, an Employee who upon hiring is reasonably expected to work, on average, at least 30 Hours of Service per week and who is not a Part-Time, Seasonal, Temporary or Variable Employee. A Full-Time Employee (and his or her eligible Dependents) must be offered coverage no later than 90 days from the day he or she completes at least one Hour of Service with the Employer (or at the end of the waiting period). For an Ongoing Employee, it is defined to mean an Employee who has been determined during the Measurement Period to average at least 30 Hours of Service per week.

Hour(s) of Service means each hour for which an Employee is paid, or entitled to payment, for the performance of duties for the Employer (or a related Employer) and each hour for which an Employee is paid, or entitled to payment by the Employer (or a related Employer) for a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty, or leave of absence, but excluding Hours of Service to the extent that the compensation for those services constitutes income from sources outside the United States or performed as (1) a bona fide volunteer (as defined in Treas. Reg. Section 54.4980H-1(a)(7)) or (2) part of a Federal or State work study program. For purposes of this definition, a related Employer is any entity that must be treated as part of the same “applicable large employer” as the Employer for purposes of Code Section 4980H, as determined at the time that the applicable Hour of Service is performed or credited.

For Employees paid on an hourly basis, an Employer must calculate actual Hours of Service from records of hours worked and hours for which payment is made or due (the “actual method”). For Employees paid on a non-hourly basis, the Employer must calculate Hours of Service based on the actual method or, provided doing so does not substantially understate the Employee’s hours, using an equivalency method where the Employee is credited with either (1) 8 Hours of Service for each day for which the Employee would be required to be credited with one Hour of Service or (2) 40 Hours of Service for each week for which the Employee would be required to be credited with at least one Hour of Service.

Initial Measurement Period means the “look back period” during which an Employer measures the Hours of Service for its New Employees in order to determine their status as a Full-Time Employee, Part-Time, Seasonal or Temporary Employee which may begin on the day the New Employee completes at least one Hour of Service with the Employer or any date up to and including the first day of the first calendar month (or, if later, the first day of the first payroll period) starting on or after the date the Employee completes at least one Hour of Service for the Employer. For purposes of this definition, an Employee who has been rehired by the Employer is treated as a New Employee for the Employer on his or her most recent reemployment date only if more than 13 consecutive weeks have passed since the Employee was last credited with an Hour of Service with the Employer (or with any affiliated company organization that is required to be treated as the same Employer for purposes of Code Section 4980H).

Initial Stability Period means the Stability Period New Employees must satisfy if a New Employee who is a Part-Time, Seasonal, Temporary or Variable Hour Employee is determined to average less than 30 Hours of Service per week during his or her Initial Measurement Period. The Initial Stability Period must not be more than one month longer than the Initial Measurement Period and must not exceed the remainder of the first entire Standard Measurement Period (plus Administrative Period) for which the Employee has been employed. If a New Employee who is a Part-Time, Seasonal, Temporary or Variable Hour Employee is determined to average at least 30 Hours of Service per week during the Initial Measurement Period, the Initial Stability Period must be a period of at least 6 consecutive calendar months and no shorter in duration than the Initial Measurement Period.

Measurement Period means the “look back period” during which an Employer measures the Hours of Service for its Employees in order to determine their status as a Full-Time Employee, Part-Time, Seasonal or Temporary Employee. This period can be between 3 and 12 consecutive calendar months.

For purposes of computing average Hours of Service for an Employee during any Measurement Period, any portion of that Measurement Period that qualifies as “special unpaid leave” will be disregarded. For purposes of this definition, “special unpaid leave” means unpaid leave for jury duty, unpaid leave that is subject to the Family and Medical Leave Act of 1993, or unpaid leave that is subject to the Uniformed Services Employment and Reemployment Rights Act of 1994.

For Employees paid on a biweekly basis, the determination of Hours of Service credited for a Measurement Period begins with the first day of the pay period that includes the first day of the Measurement Period and ends with the last day of the last pay period that ends on or before the last day of that Measurement Period.

New Employee means any Employee who has yet to be employed for a full Standard Measurement Period or who resumed employment with the Employer (or a related entity that would be considered the same Employer for purposes of Code Section 4980H) after at least 13 consecutive weeks during which the Employee was not credited with an Hour of Service for the Employer (or a related entity).

Ongoing Employee is a current Employee who has worked at least one Standard Measurement Period, as defined by this Plan.

Part-Time Employee means for any New Employee, an Employee who works no more than 25 hours in any week and up to 52 weeks per year, regardless of funding source unless explicit approval is given by the City Manager based on the needs of service.

Seasonal Employee is an Employee who works no more than 6 months in a 12 month period and not more than 40 hours in any week, regardless of funding source, without explicit approval by the City Manager, based on the needs of service.

Stability Period means the period during which Employees are considered Full-Time Employees or Part-Time Employees based on the Employee’s Hours of Service during the Measurement Period; regardless of how many hours the individual works during the Stability Period.

Standard Measurement Period means the “look back period” during which an Employer measures the Hours of Service for its Ongoing Employees in order to determine their status as a Full-Time Employee or Part-Time Employee.

Standard Stability Period for Ongoing Employees, must be at least 6 consecutive calendar months long, and must not be shorter than the Employer’s elected Standard Measurement Period. (For example, if the Employer chose a 12 month Standard Measurement Period, the Standard Stability Period would also have to be 12 months.)

Temporary Employee is an Employee hired for temporary staffing who works no more than 40 hours in any week, up to 52 weeks per year, or the allotted number of work hours authorized by its employer of record (the temporary agency) regardless of funding source.

Variable Hour Employee is an Employee who, at the time of hire, the Employer cannot reasonably determine if he or she will average at least 30 Hours of Service per week.

2: Hours of Service to be Eligible for Coverage

*The minimum number of hours an Employee is required to work per week to be eligible to enroll for coverage is 30 or more Hours of Service per week. All other waiting periods and eligibility requirements remain the same regarding when coverage will be effective. As such the following is hereby added in the **Newly Hired Employees** section under **Eligibility, Effective Date, and Termination Provisions**:*

ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION PROVISIONS

Newly Hired Employees

Newly hired full-time permanent Employees are eligible for health care coverage on the first day of your active employment. A newly hired full-time permanent Employee of the Employer who regularly works 30 or more Hours of Service per week will be eligible to enroll for coverage under this Plan. Participation in the Plan will begin as of the day he or she completes at least one Hour of Service for the Employer provided all required election and enrollment forms are properly submitted to the Plan Administrator.

You are not eligible to participate in the Plan if you are a leased employee, an independent contractor or a person performing services pursuant to a contract under which you are designated an independent contractor (regardless of whether you might later be deemed a common law employee by a court or governmental agency) or a person covered by a collective bargaining agreement that does not provide for participation in this Plan.

Determining Full-Time Employee Status for Ongoing Employees: In determining whether an Ongoing Employee is classified as a Full-Time Employee the Employer has set forth a Standard Measurement Period of 12 months followed by a Standard Stability Period of 12 months. If during the Standard Measurement Period, the Ongoing Employee is determined to be a Full-Time Employee, the Plan will have a 90-day Administrative Period to notify the Employee of his or her eligibility (and the eligibility of the Employee's eligible Dependents) to enroll in the Plan and to complete the enrollment process. An Employee who has been determined to be a Full-Time Employee during his or her Measurement Period will be offered coverage that is effective as of the first day of the Employee's Stability Period (and coverage will be added to such Full-Time Employee's eligible Dependents).

Determining Full-Time Employee Status for Part-Time, Seasonal, Temporary or New Variable Hour Employees: In determining whether a new Part-Time, Seasonal, Temporary or Variable Hour Employee will be considered as a Full-Time Employee during the Initial Stability Period, the Employer has set forth an Initial Measurement Period of 12 months followed by an Initial Stability Period of 12 months. If during the Initial Measurement Period, the Employee is determined to be a Full-Time Employee, the Plan will have a 30-day Administrative Period to notify the Employee of his or her eligibility to enroll in the plan and to complete the enrollment process (and the eligibility of the Employee's eligible Dependents).

An Employee who has been determined to be a Full-Time Employee during his or her Measurement Period will be offered coverage that is effective as of the first day of the Employee's Stability Period (and coverage will be added to such Full-Time Employee's eligible Dependents). Notwithstanding any other provision to the contrary, the combined length of the Initial Measurement Period and the Administrative Period for a New Employee who is a Part-Time, Seasonal, Temporary or Variable Hour Employee may not extend beyond the last day of the first calendar month beginning on or after the first anniversary of the date the Employee completes at least one Hour of Service with the Employer.

Material Change in Position or Employment Status for Part-Time, Seasonal, Temporary or New Variable Hour Employee: An Employee who, during his or her Initial Measurement Period, experiences a material change in position or employment status that results in the Employee becoming reasonably expected to work at least 30 Hours of Service per week for the Employer will be treated as a Full-Time Employee to whom coverage under the Plan will be offered to the Employee and his or her eligible Dependents beginning on the earlier of:

1. The fourth full calendar month following the change in employment status; or
2. The first day of the Initial Stability Period (but only if the Employee averaged at least 30 Hours of Service per week during the Initial Measurement Period).

Note: If an Employee becomes ineligible for coverage under the Plan due to a reduction in work-hours below the minimum number of hours an Employee is required to work per week to be eligible to enroll in coverage, the Employee's coverage will terminate upon the start of the next Stability Period.

3: Annual Out-of-Pocket Maximum

*The **Out-of-Pocket Payable by Plan Participants** section under **Schedule of Benefits** is hereby deleted and replaced with the following:*

SCHEDULE OF BENEFITS

Out-of-Pocket Payable by Plan Participants

If a Participant or family meets the Co-insurance Maximum Out-Of-Pocket amount, as described in the Schedule of Benefits – Active Employees and Retirees Whose Plans Ratified in 2008/2009 (20% co-insurance), Eligible Expenses will then be payable at 100% for the remainder of the Calendar Year.

If a Participant or family meets the Calendar Year Maximum Out-Of-Pocket amount, as described in the Schedule of Benefits – Active Employees and Retirees Whose Plans Ratified in 2008/2009 (deductible, medical and prescription drug co-pays and 20% co-insurance), Eligible Expenses will then be payable at 100% for the remainder of the Calendar Year.

The Maximum Out-of-Pocket amounts do **not** include expenses that exceed the Plan limits, are in excess of Usual, Customary and Reasonable, or are excluded under the provisions of the Plan.

4: Minimum Essential Coverage

*The following section is hereby added to the **Responsibilities for Plan Administrations** section of the Plan:*

RESPONSIBILITIES FOR PLAN ADMINISTRATIONS

Minimum Essential Coverage

Refer to the Employer's Summary of Benefits and Coverage (SBC) for determination as to whether the Plan provides "minimum essential coverage" within the meaning of Code Section 5000A(f) and any accompanying regulations or guidance and whether it provides "minimum value" within the meaning of Code Section 36B(c)(2)(C)(ii) and any accompanying regulations or guidance (e.g. the Plan provides at least 60% actuarial value).

EFFECTIVE JUNE 26, 2015:

*Under **Eligibility, Effective Date and Termination Provisions**, the definition of Spouse is hereby deleted and replaced with the following:*

ELIGIBILITY, EFFECTIVE DATE, AND TERMINATION PROVISIONS

"Spouse" means any person who is lawfully married to you under any state law. Specifically excluded from this definition is a spouse by reason of common law marriage, whether or not permitted in your State. The Plan Administrator may require documentation proving a legal marital relationship.

All other provisions of this Plan shall remain unchanged.

All other provisions of this Plan shall remain unchanged.

EXHIBIT A

SCHEDULE OF BENEFITS

**ACTIVE EMPLOYEES AND RETIREES WHOSE
PLANS RATIFIED IN 2008/2009**

	PARTICIPATING PROVIDER	NON- PARTICIPATING PROVIDER (Subject to Usual, Customary & Reasonable Charges)
Calendar Year Deductible		
Single	\$150	\$150
Family	\$150	\$150
Calendar Year Co-Insurance Maximum Out-of-Pocket (20% coinsurance)		
Single	\$850	\$850
Family	\$850	\$850
Calendar Year Maximum Out-of-Pocket (20% coinsurance, deductible and medical and prescription drug co-pays)		
Single	\$6,600	\$6,600
Family	\$13,200	\$13,200
<p>If a Participant or family meets the Co-insurance Maximum Out-of-Pocket amount, as described (20% co-insurance), eligible expenses will then be payable at 100% for the remainder of the Calendar Year.</p> <p>If a Participant or family meets the Calendar Year Maximum Out-of-Pocket amount, as described (deductible, medical and prescription drug co-pays and 20% co-insurance), eligible expenses will then be payable at 100% for the remainder of the Calendar Year.</p> <p>The Maximum Out-of-Pocket amounts do not include expenses that exceed the Plan limits, are in excess of Usual, Customary and Reasonable, or are excluded under the provisions of the Plan.</p>		
THE PLAN'S LIFETIME OR CALENDAR YEAR MAXIMUM BENEFIT AMOUNT	Unlimited	
CO-PAYMENTS (The dollar amount the Participant pays for the following services)		
Office visits	\$20 co-payment*	\$20 co-payment*
Urgent Care Center	\$20 co-payment*	\$20 co-payment*
*Copay applies to the Physician office visit component only. All other services are paid subject to any Deductible and Coinsurance percentages.		
Emergency Services (Co-payment waived if admitted to hospital, Inpatient Co-insurance will apply)	\$100 co-payment*	\$100 co-payment*
*Copay applies to the Emergency Visit component only. All other services are paid subject to any Deductible and Coinsurance percentages		
Consultations	\$20 co-payment	\$20 co-payment
Chiropractic	\$20 co-payment	\$20 co-payment
Mental Disorders & Substance Use Disorders (office visits)	\$20 co-payment	\$20 co-payment

CO-INSURANCE PERCENTAGE (The percentage the Plan pays after the Participant pays 20%)		
	PARTICIPATING PROVIDER	NON- PARTICIPATING PROVIDER (Subject to Usual, Customary & Reasonable Charges)
Hospital Services		
Inpatient	80% after Deductible	80% after Deductible
Outpatient	80% after Deductible	80% after Deductible
Emergency Services (Co-payment waived if admitted to hospital, Inpatient Co-insurance will apply)	\$100 co-payment	\$100 co-payment
Outpatient Surgical Center	80% after Deductible	80% after Deductible
Mental Disorders & Substance Use Disorders		
Inpatient	80% after Deductible	80% after Deductible
Outpatient	\$20 co-payment	\$20 co-payment
NOTE: Emergency care (Ambulance and Emergency Services) will be paid the same as the benefits for Ambulance services and Emergency Services listed above in the Medical Schedule of Benefits, however, the Participating Provider level of benefits will always apply regardless of the provider utilized.		
Ambulance	80% after Deductible	80% after Deductible
Extended Care	80% after Deductible	80% after Deductible
Home Health Care	80% after Deductible	80% after Deductible
Hospice	80% after Deductible	80% after Deductible
Physician Services		
Hospital Visits	80% after Deductible	80% after Deductible
Emergency Services	80% after Deductible	80% after Deductible
Surgeon/Assistant Surgeon	80% after Deductible	80% after Deductible
Anesthesiologist	80% after Deductible	80% after Deductible
Maternity (Professional Fees)*/Employee, Spouse And Dependents		
Preventive prenatal and breastfeeding support (other than lactation consultations)	100% Deductible waived	100% Deductible waived
Lactation Consultations	100% Deductible waived	100% Deductible waived
All Other Prenatal, Delivery and Postnatal Care	80% after Deductible	80% after Deductible
*See Eligible Medical Expenses for limitations.		
Chiropractic Services		
Exam/Manipulation	\$20 co-payment	\$20 co-payment
X-rays	80% after Deductible	80% after Deductible
Temporomandibular Joint Dysfunction (TMJ)	80% after Deductible	80% after Deductible
Organ Transplant	80% after Deductible	80% after Deductible
Diagnostic X-ray and Lab	80% after Deductible	80% after Deductible

	PARTICIPATING PROVIDER	NON- PARTICIPATING PROVIDER (Subject to Usual, Customary & Reasonable Charges)
Radiation/Chemotherapy	80% after Deductible	80% after Deductible
Occupational Therapy	80% after Deductible	80% after Deductible
Speech Therapy	80% after Deductible	80% after Deductible
Physical Therapy	80% after Deductible	80% after Deductible
Medical Supplies	80% after Deductible	80% after Deductible
Durable Medical Equipment	80% after Deductible	80% after Deductible
Prosthetics	80% after Deductible	80% after Deductible
Orthotics	80% after Deductible	80% after Deductible
Preventive Services and Routine Care		
<i>Preventive Services</i> This benefit includes office visits associated with Preventive Services and any other eligible item or service received and billed at the same time as any preventive service. Any office visit or other item or service billed separately will be paid under the Routine Care provision of the Plan.	100% Deductible waived	100% Deductible waived
Other Medical Services		
Preventive Services and Routine Care (continued)		
<i>Routine Care</i>	\$20 co-payment*	\$20 co-payment*
*Copay applies to the Physician office visit component only. All other services are paid subject to any Deductible and Coinsurance percentages.		
This benefit only includes items and services that are not otherwise covered under the Preventive Services provision of the Plan such as:		
<ul style="list-style-type: none"> • Office visits (associated with Preventive Services (but billed separately) or Routine Care) • Routine Physical/Gynecological exam: limit of 1 physical or 1 gynecological exam per calendar year, and the following services once per calendar year: chemical profile, complete blood count, fecal occult blood screening, urinalysis, EKG test • Pap smear, limited to 1 routine pap smear per calendar year 	<ul style="list-style-type: none"> • Mammogram, limited to 1 per woman age 35 to 40, and 1 per calendar year at age 40 and older • Prostate Specific Antigen (PSA) screening, limited to 1 per calendar year beginning at age 40 • Routine colonoscopy, limited to 1 procedure from age 40 to age 50, and 1 procedure per calendar year age 51 and older 	
Diagnosis of Infertility Benefits Limited to supplies and services for the diagnosis of infertility.	80% after Deductible	80% after Deductible
Other Eligible Expenses	80% after Deductible	80% after Deductible

**CITY OF GRAND RAPIDS UNIFIED HEALTH CARE PLAN
SUMMARY OF MATERIAL MODIFICATION
AND
AMENDMENT #1**

This Summary of Material Modification and Amendment describes changes to the City of Grand Rapids Unified Health Care Plan effective January 1, 2014. These changes are effective as of **January 1, 2015** and will remain in effect until amended in writing by the Plan Administrator.

This document should be read carefully and attached to the Plan Document and Summary Plan Description. Please contact the Plan Administrator identified in the Summary Plan Description if you have any questions regarding the changes described in this Summary of Material Modification.

City of Grand Rapids (the “Plan Sponsor”) is amending the City of Grand Rapids Unified Health Care Plan (the “Plan”) as follows:

1. *Number (3) – under **How to Reach Meritain Health** under **General Information** is hereby deleted in its entirety and not replaced.*
2. *The following definition of **Usual, Customary and Reasonable (UCR)** is hereby added alphabetically to the **Defined Terms** section:*

DEFINED TERMS

Usual, Customary, and Reasonable (UCR) shall be determined by FAIR Health Inc., or the successor industry standard. Usual, customary, and reasonable provisions will apply to non-hospital services. The 90th percentile will be used to calculate how much to pay for out-of-network services. The City agrees to work with the Union on addressing the issue of usual, customary and reasonable with members who receive services out of state and are unable to find any in-network providers in their area. In-network is already deemed to be UCR.

3. *The first paragraph of the **Medical Benefits** section under **Schedule of Benefits** is hereby deleted and replaced as follows:*

SCHEDULE OF BENEFITS

MEDICAL BENEFITS

All benefits described in this Schedule are subject to the exclusions and limitations described more fully herein including but not limited to the Plan Administrator’s determination that care and treatment are Medically Necessary; charges are Usual, Customary and Reasonable; services, supplies, and care are not Experimental and/or Investigational. The meanings of the capitalized terms are in the Defined Terms section beginning on page 3 of this document.

4. *The Schedule of Benefits - Active Employees and Retirees Whose Plan Ratified in 2008/2009 is hereby deleted and replaced as follows:*

SCHEDULE OF BENEFITS

ACTIVE EMPLOYEES AND RETIREES WHOSE PLANS RATIFIED IN 2008/2009

	PPO PROVIDER	NON-PPO PROVIDER (Subject to Usual, Customary & Reasonable Charges)
Calendar Year Deductible		
Single	\$150	\$150
Family	\$150	\$150
Calendar Year Co-Insurance Maximum Out-of-Pocket (20% coinsurance)		
Single	\$850	\$850
Family	\$850	\$850
Calendar Year Maximum Out-of-Pocket (20% coinsurance, deductible and medical and prescription drug co-pays)		
Single	\$6,600	\$6,600
Family	\$13,200	\$13,200
<p>If a Participant or family meets the Co-insurance Maximum Out-of-Pocket amount, as described (20% co-insurance), eligible expenses will then be payable at 100% for the remainder of the Calendar Year.</p> <p>If a Participant or family meets the Calendar Year Maximum Out-of-Pocket amount, as described (deductible, medical and prescription drug co-pays and 20% co-insurance), eligible expenses will then be payable at 100% for the remainder of the Calendar Year.</p> <p>The Maximum Out-of-Pocket amounts do not include expenses that exceed the Plan limits, are in excess of Usual, Customary and Reasonable, or are excluded under the provisions of the Plan.</p>		
THE PLAN'S LIFETIME OR CALENDAR YEAR MAXIMUM BENEFIT AMOUNT	Unlimited	

	PPO PROVIDER	NON-PPO PROVIDER (Subject to Usual, Customary & Reasonable Charges)
CO-PAYMENTS (The dollar amount the Participant pays for the following services)		
Office visits	\$20 co-payment*	\$20 co-payment*
Urgent Care Center	\$20 co-payment*	\$20 co-payment*
*Copay applies to the Physician office visit component only. All other services are paid subject to any Deductible and Coinsurance percentages.		
Emergency Services (Co-payment waived if admitted to hospital, Inpatient Co-insurance will apply)	\$100 co-payment*	\$100 co-payment*
*Copay applies to the Emergency Visit component only. All other services are paid subject to any Deductible and Coinsurance percentages		
Consultations	\$20 co-payment	\$20 co-payment
Chiropractic	\$20 co-payment	\$20 co-payment
Mental Disorders & Substance Use Disorders (office visits)	\$20 co-payment	\$20 co-payment
CO-INSURANCE PERCENTAGE (The percentage the Plan pays after the Participant pays 20%)		
Hospital Services		
Inpatient	80% after Deductible	80% after Deductible
Outpatient	80% after Deductible	80% after Deductible
Emergency Services (Co-payment waived if admitted to hospital, Inpatient Co-insurance will apply)	\$100 co-payment	\$100 co-payment
Outpatient Surgical Center	80% after Deductible	80% after Deductible
Mental Disorders & Substance Use Disorders		
Inpatient	80% after Deductible	80% after Deductible
Outpatient	\$20 co-payment	\$20 co-payment
NOTE: Emergency care (Ambulance and Emergency Services) will be paid the same as the benefits for Ambulance services and Emergency Services listed above in the Medical Schedule of Benefits, however, the Participating Provider level of benefits will always apply regardless of the provider utilized.		
Other Medical Services		
Ambulance	80% after Deductible	80% after Deductible
Extended Care	80% after Deductible	80% after Deductible
Home Health Care	80% after Deductible	80% after Deductible
Hospice	80% after Deductible	80% after Deductible
Physician Services		
Hospital Visits	80% after Deductible	80% after Deductible
Emergency Services	80% after Deductible	80% after Deductible
Surgeon/Assistant Surgeon	80% after Deductible	80% after Deductible
Anesthesiologist	80% after Deductible	80% after Deductible

	PPO PROVIDER	NON-PPO PROVIDER (Subject to Usual, Customary & Reasonable Charges)
Maternity (Professional Fees)*/Employee, Spouse And Dependents		
Preventive prenatal and breastfeeding support (other than lactation consultations)	100% Deductible waived	100% Deductible waived
Lactation Consultations	100% Deductible waived	100% Deductible waived
All Other Prenatal, Delivery and Postnatal Care	80% after Deductible	80% after Deductible
*See Eligible Medical Expenses for limitations.		
Chiropractic Services		
Exam/Manipulation	\$20 co-payment	\$20 co-payment
X-rays	80% after Deductible	80% after Deductible
Temporomandibular Joint Dysfunction (TMJ)	80% after Deductible	80% after Deductible
Organ Transplant	80% after Deductible	80% after Deductible
Diagnostic X-ray and Lab	80% after Deductible	80% after Deductible
Radiation/Chemotherapy	80% after Deductible	80% after Deductible
Occupational Therapy	80% after Deductible	80% after Deductible
Speech Therapy	80% after Deductible	80% after Deductible
Physical Therapy	80% after Deductible	80% after Deductible
Medical Supplies	80% after Deductible	80% after Deductible
Durable Medical Equipment	80% after Deductible	80% after Deductible
Prosthetics	80% after Deductible	80% after Deductible
Orthotics	80% after Deductible	80% after Deductible
Preventive Services and Routine Care		
<i>Preventive Services</i> This benefit includes office visits associated with Preventive Services and any other eligible item or service received and billed at the same time as any preventive service. Any office visit or other item or service billed separately will be paid under the Routine Care provision of the Plan.	100% Deductible waived	100% Deductible waived

	PPO PROVIDER	NON-PPO PROVIDER (Subject to Usual, Customary & Reasonable Charges)
Other Medical Services		
Preventive Services and Routine Care (continued)		
<i>Routine Care</i>	\$20 co-payment*	\$20 co-payment*
*Copay applies to the Physician office visit component only. All other services are paid subject to any Deductible and Coinsurance percentages.		
This benefit only includes items and services that are not otherwise covered under the Preventive Services provision of the Plan such as:		
<ul style="list-style-type: none"> • Office visits (associated with Preventive Services (but billed separately) or Routine Care) • Routine Physical/Gynecological exam: limit of 1 physical or 1 gynecological exam per calendar year, and the following services once per calendar year: chemical profile, complete blood count, fecal occult blood screening, urinalysis, EKG test • Pap smear, limited to 1 routine pap smear per calendar year 	<ul style="list-style-type: none"> • Mammogram, limited to 1 per woman age 35 to 40, and 1 per calendar year at age 40 and older • Prostate Specific Antigen (PSA) screening, limited to 1 per calendar year beginning at age 40 • Routine colonoscopy, limited to 1 procedure from age 40 to age 50, and 1 procedure per calendar year age 51 and older 	
Diagnosis of Infertility Benefits Limited to supplies and services for the diagnosis of infertility.	80% after Deductible	80% after Deductible
Other Eligible Expenses	80% after Deductible	80% after Deductible

5. The **Prescription** section is hereby deleted and replaced as follows:

PRESCRIPTION
(ACTIVE EMPLOYEES AND RETIREES WHOSE PLANS RATIFIED IN 2008/2009)

NOTE: An OTC Step Therapy provision applies to the following OTC drug classifications: Proton Pump Inhibitors (PPIs), Antihistamines and NSAIDs. Refer to your OTC handout provided by Human Resources for information on Over-the-Counter (OTC) medications.

Calendar Year Maximum Out-of-Pocket (prescription drug co-pays – included with major medical)	
Single	\$6,600
Family	\$13,200

Prescription - Retail:

Generic drugs	
Co-payment.....	\$10
Percentage payable.....	100%
Brand Name drugs	
Co-payment.....	\$20
Percentage payable.....	100%
Preventive Drugs	\$0 copay
Covered OTC medicines	\$0 copay

Prescription – Retail (90 day supply)

Generic drugs	
Co-payment.....	\$10
Percentage payable.....	100%
Preventive Drugs	\$0 copay

Prescription – Mail Order (90 day supply)

Generic drugs.....	N/A
Brand Name drugs	
Co-payment.....	\$50
Percentage payable.....	100%
Preventive Drugs.....	\$0 copay

Proton Pump Inhibitor (PPI) Calendar Year Maximum

Benefit per Covered Person: \$600*

* Once the Calendar Year Maximum Benefit is met, the copay shall increase to \$20 generic drugs and \$40 brand name drugs at retail and \$100 brand name drugs at mail. (PPIs dispensed under the OTC Program do not count toward the \$600 Calendar Year maximum benefit.)

When medication is a necessary part of your total health care program, the Plan includes coverage for the following prescription drug services.

Specialty Medication Benefits

Specialty medications are defined as biological medications and are utilized to treat complex chronic conditions. These types of drugs often require frequent dosage adjustment, special storage, a high-degree of patient education or special administration such as injection.

Specialty medications approved by the FDA prior to January 1, 2012 will follow the standard copayments listed above.

Specialty medications that were approved by the FDA on or after January 1, 2012 will now require:

1. Prior authorization

2. Limit to a 30 day supply per fill
3. Copayment of 5%, to a maximum out of pocket per prescription amount of \$100.

Use of a specialty pharmacy is recommended for these products, as specialty medications often have large side effect profiles/concerns and the medication can require specific temperature control, etc. This agreement would not apply to drugs supplied and dispensed in a hospital, clinic or doctor's office.

What's Covered

You have coverage for:*

1. Federal legend and state-controlled drugs
2. Compound medications containing at least one federal legend drug ingredient
3. Injectable insulin
4. Needles and syringes dispensed with insulin or chemotherapeutic drugs
5. Oral or injectable contraceptive medications prescribed by a physician
6. Selected covered Over-the-Counter (OTC) medicines with a prescription
7. Anorexients and anti-obesity drugs when medically necessary
8. Growth hormones when medically necessary
9. Anaphylaxis therapy when medically necessary
10. Glucagon injectables when medically necessary
11. Prescription Hematinics when medically necessary
12. Anti-migraine drugs (including Injectable Imitrex) subject to quantity limits; please contact 4D at 1-877-647-4026 or visit their website at www.4dpharmacy.com.
13. Prescription vitamins (oral and injectable) when medically necessary
14. Sexual dysfunction drugs
15. Diaphragms
16. Preventive Drugs

Covered drugs may be dispensed at a retail pharmacy in quantities of up to a 90-day supply for generic products, or up to a 34-day supply for brand products. Covered OTC drugs may be dispensed in quantities to a 90-day supply.

* This list is meant to be a summary of covered Prescription drugs; it is not all-inclusive. For detailed information on your medication, quantity limits and/or specialty drug classification, please contact 4D at 1-877-647-4026 or visit their website at www.4dpharmacy.com.

New therapies will be reviewed by the Plan as may be required.

Please note prescription drugs are subject to the cost-sharing provisions described above unless the prescription drug qualifies as a preventive drug (as defined below).

Generic Equivalent Drugs

Generic equivalent drugs can be produced by more than one manufacturer and distributed under more than one name. The Food and Drug Administration requires that these generic drugs meet the same standards for active ingredients as brand name drugs. **With the exception of insulin**, if there is a generic equivalent to a brand name drug, your **pharmacy will automatically dispense the generic equivalent unless your physician has indicated “DAW”** (dispensed as written) in his or her own handwriting on your prescription as required by State Law.

Preventive Drug

A list of Prescription Drugs, FDA approved contraceptive devices and FDA approved over-the-counter medications (including over-the-counter emergency contraceptives), when prescribed by a Physician, that have been identified by the U.S. Department of Health and Human Services (HHS) as a preventive service. The term “Preventive Drug” does not include abortifacient drugs or over-the-counter contraceptives (other than FDA approved over-the-counter emergency contraceptives) regardless of whether or not such items are prescribed by a Physician. Please contact the Prescription Drug Card Program Administrator for a complete listing of the Preventive Drugs covered under this Plan and any restrictions on the available drugs. You may also view the guidelines established by HHS by visiting the website at:

<https://www.healthcare.gov/what-are-my-preventive-care-benefits>

For a paper copy, please contact the Plan Administrator.

Note: Coverage for preventive contraceptives and contraceptive devices is only available for women of child bearing age.

Please contact the Prescription Drug Card Program Administrator for a complete listing of the Preventive Drugs covered under this Plan and any applicable restrictions. To the extent the above does not cover any Preventive Drug or contraceptive device required to be covered by the U.S. Department of Health Human Services (HHS) or under the guidelines published by the Health Resources and Services Administration on August 1, 2011 (or any applicable subsequent guidelines or guidance requiring any additional women’s preventive services), the above shall be deemed to be amended to cover such Preventive Drug or contraceptive device to the extent required by the HHS and/or such guidelines.

Your Co-pay

Your co-pay is as follows:

1. **Retail**
\$10 for generic equivalent drugs and \$20 for brand name drugs even when the prescription indicates “DAW” or if there is no generic equivalent drug available. Covered generic drugs may be dispensed only at a retail pharmacy in quantities of up to a 90-day supply for a \$10 copay. Covered brand drugs may be dispensed only at retail pharmacy for up to a 34 day supply at \$20 copay.

2. **Mail Order**

\$50 for brand name drugs, even when the prescription indicates “DAW” or if there is no generic equivalent available.

3. **Proton Pump Inhibitor (PPI) after Calendar Year maximum has been met**

\$20 copay generic equivalent drugs; \$40 copay brand name drugs; \$100 copay mail order. (PPIs dispensed under the OTC Program do not count toward the \$600 Calendar Year maximum benefit.)

Quantity Limits (QL)

Some drugs may be subject to Quantity Limits (QL). QL will determine monthly drug dosage dispensed and/or the number of months the drug usage is usually needed to treat a particular condition.

Choosing Your Pharmacy

You can have your prescriptions filled at a network or non-network pharmacy. The choice is always yours. Remember that when your prescriptions are filled through a non-network pharmacy, you have higher out-of-pocket costs.

Network Pharmacy

A network pharmacy is a pharmacy that is part of 4D Pharmacy. Network pharmacies will file claims for you and they receive payment directly from the Plan.

When your prescriptions are filled through a **network** pharmacy, the Plan will pay 100% of the approved amount less your co-pay.

Non-Network Pharmacy

Pharmacies not part of your prescription drug benefit program are called *non-network*. If you go to a non-network pharmacy, you and not the pharmacist will need to file your “Direct Member Reimbursement” (DMR) form and receipts for payment. You will receive reimbursement based on the negotiated pharmacy contractual rate, minus your applicable co-payment.

Mail Order Prescription Drugs

Your mail order prescription drug program is available for long-term prescription drug needs through 4D Pharmacy’s partnership with Welldyne Rx. If you are taking medication on a regular basis, ordering your prescriptions through the mail order plan is convenient. In addition to mailing your prescriptions to the mail order pharmacy, your physician can phone in or fax your prescription orders when allowed by federal and state prescribing laws. Refills on your mail order prescriptions can be ordered by mail, telephone, or the Internet.

When prescribed by your physician, you can order up to a 90-day supply (three months) of medication by mail from Welldyne Rx and pay the appropriate co-pay (refer to the “Your Co-pay” section above) for each prescription or refill.

Ordering from Welldyne Rx requires no claim forms. Your medication is delivered to your home, postage-paid, within 10 to 14 business days from the date you mailed your order.

If you have any questions, you can call Welldyne Rx toll free at 1-855-404-0972 or go to the website at <https://4d.welldynrx.com/> and use the convenient automated refill system available through the Member Services link.

What's Not Covered

The Plan's Prescription Drug coverage **excludes:**

1. Drugs that cost less than your co-pay.
2. Administration of drugs or any drug consumed at the time and place of the prescription order.
3. Refills not authorized by a physician.
4. Therapeutic devices or appliances, even if prescribed by a physician (e.g., garments regardless of their intended use).
5. More than a 34-day supply, except for specified maintenance drugs that are covered for 100-unit doses (retail pharmacy), or mail order prescriptions that are covered for a 90-day supply, and covered OTC drugs may be dispensed in quantities to a 90-day supply.
6. More than 12 doses of a sexual dysfunction drug such as Viagra in a 30-day period; when using mail order, more than 36 doses in a 90-day period.
7. More than 4 doses of Injectable Imitrex in a 34-day period or as may be required by State and Federal Law.
8. Refills dispensed after one year from the date of the prescription or as may be required by State and Federal Law.
9. Prescription drugs that are used primarily for improving appearance rather than for treating a disease.
10. Any vaccine given solely to resist infectious diseases.
11. Any drug 4D Pharmacy determines is experimental or investigational.
12. Any drug except insulin that does not require a prescription.
13. Drugs or services obtained before the effective date or after the Plan ends.
14. Any over-the-counter drug that is not identified as a covered drug or medicine.
15. Any drug, medication or supply not approved for coverage under the plan.
16. Charges for the administrations or injection of any drugs.
17. Any drug, medicine or medications labeled "Caution-Limited by Federal Law to Investigational use" or experimental drug.
18. Injectable medications, other than insulin, anaphylaxis, glucagon, blood cell stimulators, and specialty medications.
19. Fertility drugs.

20. Biologicals such as serums, vaccines etc.
21. Dental products, including fluoride only products.
22. Nutritional and dietary products.
23. Research drugs.
24. Obsolete drugs as determined by the FDA.
25. Medical devices.

6. *The following exclusion for **Usual, Customary and Reasonable (UCR)** is hereby added to **Exclusions** under **Medical Benefits**:*

MEDICAL BENEFITS

Exclusions

46. Charges in excess of Usual, Customary and Reasonable (UCR).

All other provisions of this Plan shall remain unchanged.