B E N E F I T S

P R O G R A M S U M M A R Y

ANDREWS UNIVERSITY

Group Number: G-773

ANDREWS UNIVERSITY HAS ESTABLISHED A PROGRAM

OF BENEFITS AND PROVISIONS CONSTITUTING AN

"EMPLOYEE BENEFITS PLAN"

NOTE:

THIS BROCHURE REPRESENTS ONLY A SUMMARY OF YOUR GROUP HEALTH BENEFITS PLAN AS IT APPLIES TO ALL ELIGIBLE EMPLOYEES AND DEPENDENTS. THIS BROCHURE IS NOT THE PLAN DOCUMENT OR THE SUMMARY PLAN DESCRIPTION AND SHALL NOT BE RELIED UPON TO ESTABLISH OR DETERMINE ELIGIBILITY, BENEFITS, PROCEDURES, OR THE CONTENT OR VALIDITY OF ANY SECTION OR PROVISION OF THE HEALTH BENEFITS PLAN. PLEASE REFER TO THE HEALTH BENEFITS PLAN DOCUMENT FOR SPECIFIC INFORMATION REGARDING PLAN PROVISIONS.

HOW TO FILE A MEDICAL OR VISION CLAIM

Please submit itemized copies of any bills that have been incurred to our Claim Administrator, ADMINISTRATION SYSTEMS RESEARCH CORPORATION INTERNATIONAL (ASR), at the following address:

P.O. Box 6392
Grand Rapids, Michigan 49516-6392
(616) 957-1751, or (800) 968-2449

If the claim is for an Injury, additional information will be required in order to proceed with processing. When submitting the initial bills, please attach a written statement detailing how, when, and where the Injury was received. Failure to provide this information may delay the timely processing of the claim.

CLAIMS HANDLING

Complete and proper claims for benefits made by Covered Persons will be promptly processed but in the event there are delays in processing claims, Covered Persons shall have no greater rights to interest or other remedies against the Claim Administrator than as otherwise afforded by law.

All information will be reviewed promptly. The Plan Administrator or ASR may request missing or additional data if needed. The Plan Administrator or ASR reserves the right to require an original claim form or billing statement.

In order for any bill to be considered, the bill must be complete. Make sure that the bill shows the patient's full name, the date that services were rendered or purchases made, the diagnosis, the type of care or supply received, and the cost per item.

Generally, the provider of service (Hospital, Physician, laboratory, etc.) will be automatically reimbursed unless proof of prior payment is submitted when the claim is filed. Once a claim is processed, ASR will, acting on behalf of the Plan Administrator, send the Employer or the Participant a check for the amount due and/or an "Explanation of Benefits" that is issued to others on behalf of the Covered Person. The Plan Administrator reserves the right to pay the approved portion directly to the Participant. Be sure to check for amounts that the Covered Person may be responsible for paying.

Try to keep copies of all bills and to submit expense claims to ASR as soon as each bill is received, even if the Deductible has not yet been met. Please read this booklet before a claim occurs, because certain expenses are not covered under the Plan. If you have any questions, be sure to ask the Employer or ASR.

COORDINATION WITH OTHER COVERAGE FOR INJURIES ARISING OUT OF AUTOMOBILE ACCIDENTS

The following special coordination rule applies regarding automobile insurance. If a Covered Person has automobile insurance (including, but not limited to no-fault) that provides health benefits, the automobile insurance shall be the primary plan and this Plan shall be the secondary plan for purposes of paying benefits.

BENEFITS

Benefits are described and are subject to the terms and conditions set forth in the pages that follow. In-Network benefits are based on Network-contracted rates. Out-of-Network benefits are based on Usual and Customary charges.

IMPORTANT!! **CERTIFICATION IS REQUIRED FOR ALL INPATIENT HOSPITAL ADMISSIONS AND FOR SOME OUTPATIENT PROCEDURES. PLEASE SEE "UTILIZATION REVIEW PROGRAM" FOR SPECIFIC INFORMATION REGARDING REQUIREMENTS, DEADLINES, AND PENALTIES FOR NON-COMPLIANCE.**

SCHEDULE OF MEDICAL BENEFITS

Benefit Year: July 1 through June 30

BENEFITS	PREMIER PLAN		STANDARD PLAN		HIGH DEDUCTIBLE HEALTH PLAN	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Benefit Year Deductible	$100 per Covered Person $200 per Family	$1,000 per Covered Person $2,000 per Family	$250 per Covered Person $500 per Family	$500 per Covered Person $1,000 per Family	$1,050 (Employee-Only Coverage) $2,100 (Family Coverage)	$2,100 (Employee-Only Coverage) $4,200 (Family Coverage)
General Benefit Percentage	Plan pays 95% unless specifically stated otherwise	Plan pays 75% unless specifically stated otherwise	Plan pays 90% unless specifically stated otherwise	Plan pays 70% unless specifically stated otherwise	Plan pays 80% unless specifically stated otherwise	Plan pays 60% unless specifically stated otherwise
Benefit Year Out-of-Pocket Maximum	$2,500* per Covered Person $5,000* per Family	$4,000* per Covered Person $8,000* per Family	$3,000* per Covered Person $6,000* per Family	$4,000* per Covered Person $8,000* per Family	$2,500* (Employee-Only Coverage) $5,000*(Family Coverage)	$4,000* (Employee-Only Coverage) $8,000* (Family Coverage)
	*Includes Deductible and benefit percentage only. Does not include co-pays of any type or expenses that constitute a penalty for noncompliance, exceed the Usual and Customary charge allowed by the Plan, exceed the limits in the Schedule of Benefits, are subject to the Pre-Existing Conditions limitation, or are otherwise excluded under the provisions of the Plan. Only charges billed by In-Network Providers will accrue toward the Deductible and Out-of-Pocket Maximum for In-Network services, and only charges billed by Out-of-Network Providers will accrue toward the Deductible and Out-of-Pocket Maximum for Out-of-Network services.					

BENEFITS	PREMIER PLAN		STANDARD PLAN		HIGH DEDUCTIBLE HEALTH PLAN	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK

BENEFITS	PREMIER PLAN		STANDARD PLAN		HIGH DEDUCTIBLE HEALTH PLAN	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
<u>Physician Services</u>						
Office Visits	$15 co-pay per visit, then 100% (Deductible waived)	75% after Deductible	$25 co-pay per visit, then 100% (Deductible waived)	70% after Deductible	80% after Deductible	60% after Deductible
Allergy Injections and Serum	95% after Deductible	75% after Deductible	90% after Deductible	70% after Deductible	80% after Deductible	60% after Deductible
Office Surgical Procedures	95% after Deductible	75% after Deductible	90% after Deductible	70% after Deductible	80% after Deductible	60% after Deductible
Diagnostic X-rays	100%; Deductible waived	75% after Deductible	100%; Deductible waived	70% after Deductible	80% after Deductible	60% after Deductible
Diagnostic Labwork, including Allergy Testing	100%; Deductible waived	75% after Deductible	100%; Deductible waived	70% after Deductible	80% after Deductible	60% after Deductible
Chemotherapy	95% after Deductible; Certification required; $250 penalty for noncompliance	75% after Deductible; Certification required; $250 penalty for noncompliance	90% after Deductible; Certification required; $250 penalty for noncompliance	70% after Deductible; Certification required; $250 penalty for noncompliance	80% after Deductible; Certification required; $250 penalty for noncompliance	60% after Deductible; Certification required; $250 penalty for noncompliance
Physical, Speech, and Occupational Therapies	95% after Deductible; Certification required; $250 penalty for noncompliance	75% after Deductible; Certification required; $250 penalty for noncompliance	90% after Deductible; Certification required; $250 penalty for noncompliance	70% after Deductible; Certification required; $250 penalty for noncompliance	80% after Deductible; Certification required; $250 penalty for noncompliance	60% after Deductible; Certification required; $250 penalty for noncompliance
Chiropractic Care	Covered	Covered	Covered	Covered	Covered	Covered
Max Benefit Paid per Covered Person per Year for all Chiropractic Care	$500 (In- & Out-of-Network services combined)	$500 (In- & Out-of-Network services combined)	$500 (In- & Out-of-Network services combined)	$500 (In- & Out-of-Network services combined)	$500 (In- & Out-of-Network services combined)	$500 (In- & Out-of-Network services combined)

BENEFITS	PREMIER PLAN		STANDARD PLAN		HIGH DEDUCTIBLE HEALTH PLAN	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Routine Preventive Care	$15 co-pay per visit, then 100% (Deductible waived)	Not Covered	$25 co-pay per visit, then 100% (Deductible waived)	Not Covered	$25 co-pay per visit, then 100% (Deductible waived)	Not Covered
Emergency Medical Care						
Immediate Care Centers	$15 co-pay per visit, then 100% (Deductible waived)	75% after Deductible	$25 co-pay per visit, then 100% (Deductible waived)	70% after Deductible	80% after Deductible	60% after Deductible
Physician's Office	$15 co-pay per visit, then 100% (Deductible waived)	75% after Deductible	$25 co-pay per visit, then 100% (Deductible waived)	70% after Deductible	80% after Deductible	60% after Deductible
Ambulance Transportation	80% after Deductible	80% after Deductible	70% after Deductible	70% after Deductible	80% after Deductible	80% after Deductible
Emergency Room -Facility Fee	$100 co-pay per visit (waived if admitted Inpatient), then 95% after Deductible	$100 co-pay per visit (waived if admitted Inpatient), then 75% after Deductible	$100 co-pay per visit (waived if admitted Inpatient), then 90% after Deductible	$100 co-pay per visit (waived if admitted Inpatient), then 70% after Deductible	80% after Deductible	60% after Deductible
-Physician Fee	95% after Deductible	75% after Deductible if treated at an out-of-network facil-ity **or** paid as in-network if treated at an in-network facil-ity	90% after Deductible	70% after Deductible if treated at an out-of-network facil-ity **or** paid as in-network if treated at an in-network facil-ity	80% after Deductible	60% after Deductible **or** paid as in-network if treated at an in-network facil-ity

BENEFITS	PREMIER PLAN		STANDARD PLAN		HIGH DEDUCTIBLE HEALTH PLAN	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Inpatient Hospital Services	Certification required; $250 penalty for noncompliance	Certification required; $250 penalty for noncompliance	Certification required; $250 penalty for noncompliance	Certification required; $250 penalty for noncompliance	Certification required; $250 penalty for noncompliance	Certification required; $250 penalty for noncompliance
Inpatient Hospital Services, cont.						
Semi-Private and ICU/CCU Rooms	95% after Deductible	75% after Deductible	90% after Deductible	70% after Deductible	80% after Deductible	60% after Deductible
Surgery and Related Services	95% after Deductible	75% after Deductible	90% after Deductible	70% after Deductible	80% after Deductible	60% after Deductible
Miscellaneous Services	95% after Deductible	75% after Deductible	90% after Deductible	70% after Deductible	80% after Deductible	60% after Deductible

BENEFITS	PREMIER PLAN		STANDARD PLAN		HIGH DEDUCTIBLE HEALTH PLAN	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Outpatient Services						
Surgery and Related Services	95% after Deductible	75% after Deductible	90% after Deductible	70% after Deductible	80% after Deductible	60% after Deductible
Pre-Admission Testing	100%; Deductible waived	100%; Deductible waived	100%; Deductible waived	100%; Deductible waived	80% after Deductible	60% after Deductible
Diagnostic X-rays and Labwork	100%; Deductible waived	75% after Deductible	100%; Deductible waived	70% after Deductible	80% after Deductible	60% after Deductible
Chemotherapy	95% after Deductible; Certification required; $250 penalty for noncompliance	75% after Deductible; Certification required; $250 penalty for noncompliance	90% after Deductible; Certification required; $250 penalty for noncompliance	70% after Deductible; Certification required; $250 penalty for noncompliance	80% after Deductible; Certification required; $250 penalty for noncompliance	60% after Deductible; Certification required; $250 penalty for noncompliance
Hemodialysis	95% after Deductible	75% after Deductible	90% after Deductible	70% after Deductible	80% after Deductible	60% after Deductible
Radiation Therapy	95% after Deductible; Certification required; $250 penalty for noncompliance	75% after Deductible; Certification required; $250 penalty for noncompliance	90% after Deductible; Certification required; $250 penalty for noncompliance	70% after Deductible; Certification required; $250 penalty for noncompliance	80% after Deductible; Certification required; $250 penalty for noncompliance	60% after Deductible; Certification required; $250 penalty for noncompliance
Outpatient Services, cont.						
Physical, Speech, and Occupational Therapies	95% after Deductible; Certification required; $250 penalty for noncompliance	75% after Deductible; Certification required; $250 penalty for noncompliance	90% after Deductible; Certification required; $250 penalty for noncompliance	70% after Deductible; Certification required; $250 penalty for noncompliance	80% after Deductible; Certification required; $250 penalty for noncompliance	60% after Deductible; Certification required; $250 penalty for noncompliance

BENEFITS	PREMIER PLAN		STANDARD PLAN		HIGH DEDUCTIBLE HEALTH PLAN	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Behavioral Care Services (includes Mental/Nervous and Addictions Treatment)						
Inpatient and Partial Hospitalization Mental/Nervous Care	80% after Deductible	Not Covered	70% after Deductible	Not Covered	80% after Deductible	Not Covered
Inpatient and Partial Hospitalization Addictions Treatment Care	80% after Deductible	60% after Deductible	70% after Deductible	50% after Deductible	80% after Deductible	60% after Deductible
Max Number of Inpatient and Partial Hospitalization Treatment Days Allowed per Covered Person per Year for all Mental/Nervous and Addictions Treatment Care	20 days (In- & Out-of-Network services combined)	20 days (In- & Out-of-Network services combined)	20 days (In- & Out-of-Network services combined)	20 days (In- & Out-of-Network services combined)	20 days (In- & Out-of-Network services combined)	20 days (In- & Out-of-Network services combined)

Behavioral Care Services (includes Mental/Nervous and Addictions Treatment), cont.						
Outpatient and Intensive Outpatient Mental/Nervous	$15 co-pay per visit, then 100% (Deductible waived)	75% after Deductible	$25 co-pay per visit, then 100% (Deductible waived)	70% after Deductible	80% after Deductible	60% after Deductible

BENEFITS	PREMIER PLAN IN-NETWORK	PREMIER PLAN OUT-OF-NETWORK	STANDARD PLAN IN-NETWORK	STANDARD PLAN OUT-OF-NETWORK	HIGH DEDUCTIBLE HEALTH PLAN IN-NETWORK	HIGH DEDUCTIBLE HEALTH PLAN OUT-OF-NETWORK
Care						
Outpatient and Intensive Outpatient Addictions Treatment Care	$15 co-pay per visit, then 100% (Deductible waived)	60% after Deductible	$25 co-pay per visit, then 100% (Deductible waived)	50% after Deductible	80% after Deductible	60% after Deductible
Max Number of Outpatient and Intensive Outpatient Counseling Sessions Allowed per Covered Person per Year for all Mental/Nervous and Addictions Treatment Care	35 sessions (In- & Out-of-Network ser-vices combined)	35 sessions (In- & Out-of-Network services combined)	35 sessions (In- & Out-of-Network ser-vices combined)	35 sessions (In- & Out-of-Network ser-vices combined)	35 sessions (In- & Out-of-Network ser-vices combined)	35 sessions (In- & Out-of-Network ser-vices combined)
Lifetime Maximum Benefit Paid per Covered Person for All Addictions Treatment	$30,000 (In- & Out-of-Network services combined)	$30,000 (In- & Out-of-Network services combined)	$30,000 (In- & Out-of-Network services combined)	$30,000 (In- & Out-of-Network services combined)	$30,000 (In- & Out-of-Network services combined)	$30,000 (In- & Out-of-Network services combined)
	NOTE: Behavioral Care benefits will accumulate toward the Out-of-Pocket Maximum but will always be paid at the Behavioral Care benefit percentage.					

BENEFITS	PREMIER PLAN		STANDARD PLAN		HIGH DEDUCTIBLE HEALTH PLAN	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Miscellaneous						
Hospice Care	95% after Deductible	75% after Deductible	90% after Deductible	70% after Deductible	80% after Deductible	60% after Deductible
Home Health Care	95% after Deductible; Certification required; $250 penalty for noncompliance	75% after Deductible; Certification required; $250 penalty for noncompliance	90% after Deductible; Certification required; $250 penalty for noncompliance	70% after Deductible; Certification required; $250 penalty for noncompliance	80% after Deductible; Certification required; $250 penalty for noncompliance	60% after Deductible; Certification required; $250 penalty for noncompliance
Convalescent Care	95% after Deductible	75% after Deductible	90% after Deductible	70% after Deductible	80% after Deductible	60% after Deductible
Durable Medical Equipment	95% after Deductible; Certification required; $250 penalty for noncompliance	75% after Deductible; Certification required; $250 penalty for noncompliance	90% after Deductible; Certification required; $250 penalty for noncompliance	70% after Deductible; Certification required; $250 penalty for noncompliance	80% after Deductible; Certification required; $250 penalty for noncompliance	60% after Deductible; Certification required; $250 penalty for noncompliance
Prosthetics & Orthotics	95% after Deductible; Certification required if custom-made; $250 penalty for noncompliance	75% after Deductible; Certification required if custom-made; $250 penalty for noncompliance	90% after Deductible; Certification required if custom-made; $250 penalty for noncompliance	70% after Deductible; Certification required if custom-made; $250 penalty for noncompliance	80% after Deductible; Certification required if custom-made; $250 penalty for noncompliance	60% after Deductible; Certification required if custom-made; $250 penalty for noncompliance
Infertility	60% after Deductible	Not Covered	50% after Deductible	Not Covered	60% after Deductible	Not Covered
Lifetime Max Paid per Covered Person	$3,000		$3,000		$3,000	

BENEFITS	PREMIER PLAN		STANDARD PLAN		HIGH DEDUCTIBLE HEALTH PLAN	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Miscellaneous, cont.						
Hearing Exams	$15 co-pay per visit, then 100% (Deductible waived)	Not Covered	$25 co-pay per visit, then 100% (Deductible waived)	Not Covered	80% after Deductible	Not Covered
Hearing Tests	95% after Deductible	Not Covered	90% after Deductible	Not Covered	80% after Deductible	Not Covered
Hearing Aids	75% after Deductible	Not Covered	65% after Deductible	Not Covered	75% after Deductible	Not Covered
Temporomandibular Joint Dysfunction	Covered; $500 lifetime max paid per Covered Person for charges not related to surgery (In- & Out-of-Network ser-vices combined); the Plan will also allow charges re-lated to surgery if all other means of generally accepted treatment have been exhausted	Covered; $500 lifetime max paid per Covered Person for charges not related to surgery (In- & Out-of-Network services combined); the Plan will also allow charges related to surgery if all other means of generally accepted treatment have been exhausted	Covered; $500 lifetime max paid per Covered Person for charges not related to surgery (In- & Out-of-Network ser-vices combined); the Plan will also allow charges re-lated to surgery if all other means of generally accepted treatment have been exhausted	Covered; $500 lifetime max paid per Covered Person for charges not related to surgery (In- & Out-of-Network ser-vices combined); the Plan will also allow charges re-lated to surgery if all other means of generally accepted treatment have been exhausted	Covered; $500 lifetime max paid per Covered Person for charges not related to surgery (In- & Out-of-Network ser-vices combined); the Plan will also allow charges re-lated to surgery if all other means of generally accepted treatment have been exhausted	Covered; $500 lifetime max paid per Covered Person for charges not related to surgery (In- & Out-of-Network ser-vices combined); the Plan will also allow charges re-lated to surgery if all other means of generally accepted treatment have been exhausted

BENEFITS	PREMIER PLAN		STANDARD PLAN		HIGH DEDUCTIBLE HEALTH PLAN	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Prescription Drugs						
PharmaCare Prescription Drug Card Program						
Co-pay for Prilosec OTC or Claritin when purchased with a Physician's prescription	$-0-		$-0-		20% of purchase price after In-Network Deductible	
Prescription Drugs, cont.						
PharmaCare Prescription Drug Card Program, cont.						
Co-pay for a generic drug	20% of purchase price ($10 minimum, $40 maximum)		$10		20% of purchase price after In-Network Deductible	
Co-pay for a brand-name drug	50% of purchase price ($10 minimum, $40 maximum)		$40		20% of purchase price after In-Network Deductible	
PharmaCare Direct Pharmacy Service By Mail Program						
Co-pay for Prilosec OTC or Claritin when purchased with a Physician's prescription	$-0-		$-0-		20% of purchase price after In-Network Deductible	
Co-pay for a generic drug	20% of purchase price ($20 minimum, $80 maximum)		$20		20% of purchase price after In-Network Deductible	

BENEFITS	PREMIER PLAN		STANDARD PLAN		HIGH DEDUCTIBLE HEALTH PLAN	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Co-pay for a brand-name drug	50% of purchase price ($20 minimum, $80 maximum		$80		20% of purchase price after In-Network Deductible	
Lifetime Max Paid Per Covered Person For All Covered Medical Expenses	$1,000,000 (In- & Out-of-Network ser-vices combined)	$1,000,000 (In- & Out-of-Network ser-vices combined)	$1,000,000 (In- & Out-of-Network ser-vices combined)	$1,000,000 (In- & Out-of-Network ser-vices combined)	$1,000,000 (In- & Out-of-Network ser-vices combined)	$1,000,000 (In- & Out-of-Network ser-vices combined)

SCHEDULE OF VISION BENEFITS

BENEFITS	LIMITS
Vision Examinations	$15 co-pay, then 100%
Maximum Benefit Paid per Covered Person per Benefit Year for Vision Examinations	Unlimited
Vision Supply Expenses	
Eyeglass Frames	100%
Eyeglass Lenses	100%
Contact Lenses (All types)	100%
Maximum Benefit Paid per Covered Person per Benefit Year for Vision Supply Expenses	$220

UTILIZATION OF IN-NETWORK PROVIDERS

The Plan has entered into an agreement with a network of Physicians, Hospitals, and other medical providers (In-Network Providers) who have agreed to provide health care at discounted fees. For Covered Persons who use In-Network Providers, this option works in tandem with the traditional coverage under the Plan by giving those Covered Persons the opportunity to reduce their out-of-pocket expenses. If a Covered Person chooses to be treated by an In-Network Provider, payment of charges for eligible benefits under the Plan will be made at the corresponding percentage stated in the Schedule of Benefits and will be subject to the co-payment(s) stated in the Schedule of Benefits. The In-Network co-payment will not apply toward the Out-of-Pocket Maximum.

Covered Persons will be given the names of Physicians, Hospitals, and other medical providers available in their area who have agreed to be In-Network Providers. A complete list of In-Network Providers will be automatically furnished to Participants as a separate document, without charge, upon request. Medical treatment is solely a decision between a Covered Person and their Physician. Any Physician, Hospital, or other medical provider that has agreed to participate as an In-Network Provider is contracted and screened by the network, not the Employer, the Plan Administrator, the Claim Administrator, or the Utilization Review Firm. While the Plan may provide different levels of benefits depending on the Covered Person’s choice of provider, neither the Plan Administrator nor the Claim Administrator endorses one licensed medical provider over another. Increased benefit levels applicable to In-Network Providers are based solely upon negotiated fees or discounts.

MANDATORY HOSPITAL ADMISSION CERTIFICATION

If a Covered Person is scheduled for an Inpatient Hospital confinement, or is admitted to a Hospital on an "observation" basis, that Hospital stay should be reviewed prior to the admission. **A COVERED PERSON MUST CALL HHS, HEALTH OPTIONS, THE UTILIZATION REVIEW FIRM, AS SOON AS POSSIBLE PRIOR TO A HOSPITAL ADMISSION, BUT IN NO EVENT LATER THAN 48 HOURS FOLLOWING THE ADMISSION.**

CALL HHS, HEALTH OPTIONS AT (616) 956-9440 OR (800) 634-2712 TO CONDUCT THE "HOSPITAL ADMISSION CERTIFICATION."

MANDATORY OUTPATIENT SERVICE CERTIFICATION

If a Covered Person's treatment includes any of the following services, the treatment should be reviewed prior to its inception, regardless of whether or not the treatment is in lieu of hospitalization:

A. Outpatient Physical Therapy
B. Outpatient Occupational Therapy
C. Outpatient Speech Therapy
D. Rental or purchase of Durable Medical Equipment
E. Home Health Care
F. Purchase of a custom-made Orthotic or Prosthetic Appliance
G. Outpatient oncology treatment (chemotherapy or radiation therapy)

A COVERED PERSON MUST CALL HHS, HEALTH OPTIONS, THE UTILIZATION REVIEW FIRM, AS SOON AS POSSIBLE PRIOR TO RECEIVING THE ABOVE-LISTED SERVICES, BUT IN NO EVENT LATER THAN 48 HOURS AFTER THE SERVICES WERE RENDERED.

CALL HHS, HEALTH OPTIONS AT (616) 956-9440 OR (800) 634-2712 TO CONDUCT THE "OUTPATIENT SERVICE CERTIFICATION."

PENALTY FOR NONCOMPLIANCE

If a Covered Person fails to comply with either of these mandatory Plan provisions within the 48-hour time period, the Covered Person must pay the penalty for noncompliance specified below or, if less, the amount of Covered Expenses resulting from the Hospital confinement, procedure, or treatment.

Penalty for noncompliance: $250

The payment of this penalty for noncompliance will not be applied toward the satisfaction of the Deductible and benefit percentage maximum amount.

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