ABATEMENT WORKERS NATIONAL

HEALTH & WELFARE PLAN

Summary Plan Description
January 1, 2025

ABATEMENT WORKERS NATIONAL HEALTH & WELFARE PLAN

SUMMARY PLAN DESCRIPTION

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PART ONE:
GENERAL INFORMATION

WHY AM I RECEIVING THIS SUMMARY PLAN DESCRIPTION?

The Abatement Workers National Health and Welfare Fund is furnishing this Summary Plan Description ("SPD") to you so that you have a summary of your benefits. Additionally, Federal law requires that you, as a participant under the Plan (the "Participant") periodically be provided with an SPD. This SPD incorporates all the amendments and benefit updates. **This SPD will supersede and replace all prior Plan SPDs, as well as any Summary of Material Modifications that you may have received since that time. This SPD is effective as of January 1, 2025.** You are advised to read this SPD in its entirety and keep it for your records.

As a reminder, this is only a summary of your benefits and rights. The legal rules that govern those benefits and rights are contained in the actual Plan Document. If you wish to view the Plan Document or obtain a copy of it, you can do so by contacting the Benefits Office, whose contact information is listed within this SPD. **In the event of any discrepancy or conflict between this SPD and the provisions of the Plan Document, the Plan Document controls.**

Also, if certain provisions in this SPD are amended or are changed after you receive this document, you will be sent a Summary of Material Modifications ("SMM"), which will explain those changes to you.

WHAT IS THE PURPOSE OF THIS SPD?

The SPD provides a general description of the benefits that are available to both you and your Dependents, including the answers to questions such as:

- → How do you or your Dependents become eligible to participate?
- → How do you or your Dependents stay eligible?
- → What benefits the Plan does and does not pay for?
- → How much your cost-sharing is, including your co-insurance and deductibles?
- → How do you file a claim or appeal a claim that has been denied?

DEFINED TERMS

Certain terms will be used in this SPD that have a specific meaning. These terms are defined below and will be capitalized when they appear throughout the SPD. Those defined terms are listed in the attached Appendix A.

ARE THE BENEFITS THIS PLAN PROVIDES GUARANTEED TO ME?

No. The benefits provided by this Plan are not vested, guaranteed, or considered lifetime benefits. The Board of Trustees may modify or discontinue benefits at any time. If the Plan is terminated, any claim for benefits pending at the time of such termination will be considered a priority claim against the remaining assets of the Plan, to the extent permitted by law.

WHO IS RESPONSIBLE FOR THE ADMINISTRATION OF THE PLAN?

As required by federal law, your Plan is operated by the Board of Trustees made up of an equal number of representatives from the sponsoring Union, the International Association of Heat and Frost Insulators and Allied Workers Regional Local Union No. 207, and from Employers as well as various Employer associations who contribute to the Fund as required by a Collective Bargaining Agreement. The Plan Trustees are known as the "named fiduciaries," are subject to the Employee Retirement Income Security Act of 1974 ("ERISA"), and, as such, will have the maximum possible discretionary authority to administer all aspects of the Plan's operations, including but not limited to, the exclusive right and discretion to interpret all terms and provisions of the Plan's Governing Documents, such as this Plan, the Trust Agreement, Summary Plan Description, Summary of Material Modifications, policies and procedures, resolutions, directives, or any document, instrument, or record used in the administration of the Plan, as well as any amendments or modifications thereof and to apply the same as they deem appropriate.

The Board of Trustees' original intent is and continues to be the ability to exercise their discretionary authority to the fullest extent permitted by the law, and all Trustee determinations made pursuant to this authority, whether prospectively or retroactively, will be entitled to the highest possible deference allowed by law, in case of review by any court or governmental authority of competent jurisdiction. Unless otherwise expressly provided by applicable law, the Board of Trustees' determination on all matters pertaining to the Plan will be final and binding on all concerned parties to the extent permitted by law.

WHO ARE THE MEMBERS OF THE BOARD OF TRUSTEES?

Union Trustees

Robert (Doug) Ripple
6550 Poe Ave.
Dayton, OH 45414
(877) 207-9968

Employer Trustees

Neil J. Stamp
National Environmental Contracting
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Organizer
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P.O. Box 629
New Haven, WV 25265
(304) 882-2162

George Lesko (alternate)
Rand Environmental Services Inc.
35555 Genron Ct.
Romulus, MI 48174
(989) 345-1180

WHAT IF I HAVE QUESTIONS?

Throughout this SPD you will be referred to the Plan Administrator for questions and assistance. The Plan Administrator keeps the Plan's records, is responsible for its day-to-day operations, and has representatives who can assist you with any questions you may have. The Plan Administrator is BeneSys, and can be reached at (248) 641-4907 or Toll Free at (800) 772-0459. Notices, payments, and other documents that you may be required to send will almost always be sent to the Plan Administrator, so make special note of its address and contact information.

WHAT IF I WANT TO REVIEW ANY GOVERNING DOCUMENTS?

If you want to review a copy of the Plan Document (and its amendments), Trust Agreement (and its amendments), or the latest annual report, please notify the Benefits Office in writing of your request. You may be subject to a fee where permitted by law not to exceed the lesser of (a) the actual cost of production or (b) $0.25 per page.

GENERAL INFORMATION ABOUT YOUR PLAN

The name of your Plan is the Abatement Workers National Health and Welfare Fund (the "Plan"). The Plan's tax identification number is 38-3024918. The Plan number is 501. The provisions of your Plan became effective January 1, 2025 (known as the Effective Date of the Plan), even though you may have participated in a predecessor plan before that date. This Plan provides some benefits on a self-funded basis, meaning that the Plan pays claims out of its general assets, while others are provided by purchasing contracts of insurance. The assets of the Plan come from Employer Contributions and investment earnings on these contributions. The Board of Trustees reserves the right to modify which part of the benefits schedule is insured, if any, through an insurance carrier and which part will be self-funded.

WHO IS THE PLAN'S LEGAL COUNSEL?

The Plan's legal counsel is Novara Tesija & Catenacci PLLC. Their address is 888 West Big Beaver Road, Suite 870, Troy, Michigan 48084, and their phone number is (248) 354-0380. The Plan's attorneys are responsible for handling all legal matters that affect the Plan and its operation.

HOW ARE LEGAL DOCUMENTS SERVED ON THE PLAN?

If you wish to serve legal documents on the Plan, the documents should be delivered to the Benefits Office and/or the Plan's legal counsel.

SPECIAL NOTICES

Federal law requires that the Plan inform you about certain benefits. The Benefits Office also will provide the following notices on an annual basis, or with certain benefit statements when required by law:

→ **Rights under the Women's Health and Cancer Rights Act.** The Plan, as required by the Women's Health and Cancer Rights Act of 1998 ("WHCRA"), provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema. Please contact the Benefits Office for more information.

→ **Rights under the Newborns' and Mothers' Health Protection Act.** Under the Newborn's and Mothers' Health Protection Act ("Newborns' Act"), group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours

following a vaginal delivery, or less than ninety-six (96) hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than forty-eight (48) hours (or ninety-six (96) hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of forty-eight (48) hours (or ninety-six (96) hours).

→ **Non-Discrimination.** The Plan complies with all applicable civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. The Plan further provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters, written information in other formats (large print, audio, accessible electronic formats, other formats), and provides free language services to people whose primary language is not English, such as qualified interpreters, and information written in other languages. If you need these services, please contact the Benefits Office. If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F HHH Building
Washington, D.C. 20201
Toll Free: 1-800-368-1019
800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

→ **Provider Non-Discrimination.** The Plan will not discriminate with respect to participation under the Plan against any Medical Provider or other health care provider who is acting within the scope of his/her licensee or certification under applicable state law.

→ **Notice of Privacy Practices.** The Plan maintains a Notice of Privacy Practices for Protected Health Information which informs you about your rights and the Fund's legal duties and privacy practices concerning your protected health information. This Notice has previously been provided to all participants. A copy of this Notice can be obtained by contacting the Benefits Office.

RECIPROCITY FOR WORK IN OTHER UNION JURISDICTIONS

The Trustees have entered into reciprocity agreements with other health and welfare funds covering related crafts throughout the country. Pursuant to these reciprocity agreements, contributions made on your behalf may be transferred from one fund to another, upon your request and authorization. The contributions that may be transferred may enable you to meet the Continuing Eligibility requirements of the "home fund." Note that contributions are prorated and may not count hour-for-hour, depending on the rates of each respective jurisdiction. This means that if you work in another jurisdiction and have Employer Contributions made to another fund on your behalf, you may request that such contributions be transferred to this Plan via a reciprocity agreement.

PART TWO:
ESTABLISHING AND CONTINUING ELIGIBILITY FOR BENEFITS

ELIGIBILITY IN GENERAL

You become eligible for benefits as a Participant in this Plan by satisfying the conditions that apply to you, depending on what type of employee you are. For example, if you are an Office Employee of an Employer, your eligibility requirements are different from a person who is working in the field.

The Benefits Office will automatically determine Initial Eligibility. All classes of Participants must complete all requested enrollment forms to begin receiving benefits.

If you make a false statement, material misrepresentation, or commit an act of fraud, coverage for you and your Dependents may be retroactively rescinded.

Also, please note eligibility for coverage does not automatically make you eligible for all benefits offered by the Plan. Furthermore, some benefits also require you, in addition to satisfying the eligibility requirements, to meet certain deductibles, co-pays, and/or other requirements before you can receive those benefits. You also, as a condition of receiving benefits, agree to complete any required enrollment forms and comply with requests for documentation, such as birth certificates, marriage certificates, proof of custodial arrangements, evidence of other coverage, etc.

The coverage of Spouses and Dependent Children is tied to the eligibility of the primary Participant (meaning the person who is the Active, Retiree, or Disabled Participant). If the Primary Participant loses coverage, so do his or her Spouse and Dependent Children.

ELIGIBILITY FOR ACTIVE PARTICIPANTS/EMPLOYEES WORKING IN THE FIELD

How do I become eligible for benefits?

As an Active Employee (meaning you are working and not retired or Disabled) you establish Initial Eligibility for benefits on the first day of the month following the month in which the Plan receives at least 435 hours of Employer Contributions within a consecutive four-month period. In the alternative, you may also establish Initial Eligibility on the first day of the month following the month in which the Plan receives at least 520 hours of Employer Contributions within a consecutive six-month period. You must also complete the required enrollment forms. Your Employer has a one (1) month "bookkeeping" period to remit the fringe benefit contributions. For example, this means that contributions for January would not be due until the 15th of February.

Example: You worked 435 hours between January, February, March and April. Your coverage will begin June 1st and you will also be provided coverage for July.

The contributions from your Employer for the hours you worked must be received by the Plan before those hours will be considered Employer Contributions for establishing eligibility. You cannot self-pay to establish Initial Eligibility.

The Plan also includes special rules for expedited eligibility for newly hired Employees who can establish immediate eligibility through their employer making a lump sum contribution payment equal to the amount of the 435 Employer contribution hours needed to establish eligibility. Other special eligibility rules apply to newly organized Employees.

How do I stay eligible for benefits?

You stay eligible by either working enough hours or by making a self-payment if you do not work enough hours or are not working at all. The monthly requirement for staying eligible is 145 hours of Employer Contributions. These requirements are subject to change at the discretion of the Board of Trustees. If there is a change, you will receive a notice from the Plan Administrator. If you do not work any hours in a particular month or do not work enough hours in the month to remain eligible, you can make a self-payment. If you are not working in Covered Employment, the maximum number of **full** self-payments you can make in a year is three (3). While you are making self-payments, you must be available for work and register on the Union's out-of-work list. Partial self-payments will not count toward the three (3) payment maximum.

If you work more hours than are needed to stay eligible, all excess hours will go to your Hour Bank until the maximum number of hours is reached (currently equivalent to four months of coverage). In the event you do not work enough hours to stay eligible, you can draw hours from your Hour Bank to stay covered or to offset the cost of self-payments, as long as you are available for work. If you change your classification and go from working as an Active Participant to an Office Employee, you will forfeit your bank the first day of the month that you become eligible as an office worker.

Continuing Coverage by Making Self-Payments

A self-payment is made when you have not worked any hours or you have not worked enough hours to remain eligible. Self-payments may be "full" meaning you pay the full premium set by the Board of Trustees, or "partial" meaning you pay a portion of that rate offset by Employer Contributions for hours worked, or hours drawn from your Hour Bank. The self-payment rate is calculated by multiplying the current contribution rate by the number of hours you are short of meeting the requirement to Continue Eligibility. When a self-payment is due to Continue Eligibility, you will receive a notice from the Plan Administrator. If you elect COBRA coverage, you will also receive certain notices required by law.

To be eligible to make self-payments, you must be available for work from a Contributing Employer to the Plan. You demonstrate availability for work by registering on the Union's out of work list. If you fail to register, or drop your book with the Union, it will be presumed you are no longer available for work. This requirement will not apply if you are disabled or on a leave of absence, such as a medical or military leave. Participants who are not eligible to continue coverage through self-payments will be offered coverage under COBRA if eligible.

How do I lose eligibility for benefits?

You will lose coverage if you did not work enough hours to continue eligibility and you did not make a self-payment. The Plan utilizes a two-month bookkeeping period. Therefore, as an example, if you do not work enough hours in June, your coverage will end two months later, on September 1.

If I lose eligibility for benefits, how can I reinstate my coverage?

If you lose coverage, meaning you did not work enough hours to continue eligibility and you did not make a self-payment, you can only reinstate coverage by meeting the Initial Eligibility requirements as noted above. Additionally, if you have a balance in your Hour Bank prior to reinstating coverage, you may use your Hour Bank to reinstate coverage.

Can I opt out of coverage?

Yes. If you have the availability of health care coverage through a Spouse or other source, you may choose to opt-out of the Plan and return at a later date. You can also opt-out of Plan Vision and Dental coverage, although this will not change what you must work or pay to stay eligible. However, you will be required to pay a $50 per month "opt-out fee" for the duration of the time you have chosen to completely opt out of the Plan to later be eligible to reinstate coverage. You will not be eligible for reinstatement if you fail to remit any required opt-out fees.

SUMMARY OF ELIGIBILITY REQUIREMENTS FOR ACTIVE PARTICIPANTS				
Initial Eligibility	**Continuing Eligibility**	**Excess Hours (Hour Bank)**	**Self-Payments**	**Reinstate**
435 hours within four months or 520 hours within six months.	145 hours per month.	Deposited into Hour Bank up to Maximum of 580 hours, or 4-months of coverage. Note: Any new Participant or Participant who has not had any work hours in the previous 12 months, may only bank up to 80 hours in the first year.	Up to three (3) consecutive months, then COBRA coverage is offered.	Must meet initial eligibility rules. Contribution Hours that are earned in the month prior to the termination of coverage are credited for a period of up to two years.

ELIGIBILITY FOR OFFICE EMPLOYEES (CLASS O)

How do I become eligible?

A Class O Employee (Office Employees working for an Employer at least 32 hours per week) or Campus Class O Employee (full-time Office Employees of the Union or a sponsoring association) will establish Initial Eligibility for benefits on the first day of the second month following the month in which the Plan receives at least 173 hours of Employer Contributions at the then applicable contract contribution rate. Your Employer must have executed a Participation Agreement and you must also complete any required enrollment forms. Your Employer has a one (1) month "bookkeeping" period to remit the fringe benefit contributions. For example, this means that contributions for January would not be due until the 15th of February. The contributions from your Employer for the hours you worked must be received by the Plan before those hours will be considered Employer Contributions for establishing eligibility. No one can self-pay to establish Initial Eligibility as a Class O or Campus Class O employee.

How do I stay eligible?

You will stay eligible for coverage as long as the Plan receives at least 173 hours in Employer Contributions per month. No Hour Bank or self-pay option is available to Class O or Campus Class O Participants. If you previously built an hour bank as an Active Participant, that hour bank was forfeited on the first day of the month that you became eligible as an office worker. These requirements are subject to change at the discretion of the Board of Trustees. If there is a change, you will receive a notice from the Plan Administrator.

How do I reinstate coverage?

Class O or Campus Class O participants who lose coverage must, once again, satisfy the initial eligibility requirements that apply to Class O or Campus Class O employees.

SUMMARY OF ELIGIBILITY REQUIREMENTS FOR ACTIVE PARTICIPANTS				
Initial Eligibility	**Continuing Eligibility**	**Excess Hours (Hour Bank)**	**Self-Payments**	**Reinstate**
173 hours in a month	173 hours per month.	N/A	N/A	Must meet initial eligibility rules.

ELIGIBILITY FOR RETIRED PARTICIPANTS

The eligibility requirements for Retired Participants are discussed below.

How do I become eligible for benefits if I retire?

To qualify for coverage as a Retiree, you must meet the following criteria:

- → Have been eligible as an Active or Class O or Campus Class O Participant for at least 10 years before the date of retirement and for 12 of the previous 24 months immediately preceding the date of retirement and accrued at least 5,000 hours;
- → Retire from Covered Employment while an Active or Class O or Campus Class O Participant and apply for retirement benefits from a Union sponsored pension plan or retire from employment while an eligible Class O or Campus Class O Participant;
- → Attain the age of 55;
- → Apply for coverage by completing the required enrollment forms; and
- → Maintain continuity of coverage with this Plan through the date of retirement.

The Plan provides Medicare-eligible retired Participants and their Medicare-eligible Dependents with medical, surgical and prescription drug coverage through the Humana Medicare Advantage and Prescription Drug Plan, ("MAPD").

How do I stay eligible for benefits?

Retirees will maintain coverage provided they timely remit the required self-payments to the Plan Administrator. If, on your application for retiree coverage, you signal that you do not intend to return to work, you may use your Hour Bank to make self-payments. Retirees will receive the following discount from the then applicable Active or Class O Participant self-pay rates (whichever are applicable, based on the Participant's status at retirement) and based upon the number of Credited Years the Retiree has with the Plan:

Non-Medicare "Early" Retirees:

Number of Credited Years *	Discount Rate
25 or More	40%
20-24	30%
15-19	20%
10-14	10%

Medicare Retirees:

Number of Credited Years *	Discount Rate
25 or More	50%
20-24	40%
15-19	30%
10-14	20%

**Class A - One Credited Year is earned for every 1,600 Contribution Hours received by the Plan during the Participant's lifetime.*

**Class O – One Credited Year is earned for every 1,900 Contribution Hours received by the Plan during the Participant's lifetime.*

What if my eligibility terminates, can I reinstate my coverage?

If you fail to maintain continuous coverage, your benefits and eligibility will not be reinstated.

What if I return to work while I am retired?

If, on your retiree coverage application, you signal your intent to return to work post-retirement, your Hour Bank will be frozen. You will need to requalify as an Active Participant to regain access to your Hour Bank. During this period, you will self-pay as a retiree. Please note that if you fail to maintain eligibility by missing a self-payment during this requalification period, the balance of your Hour Bank will be forfeited.

If you go back to work, you will be eligible for coverage as an Active Participant, provided that you qualify. Medicare-eligible participants who are eligible on account of employment hours are covered under the Plan's HAP PPO Group medical, surgical and prescription drug policy, not the Humana Medicare Advantage and Prescription Drug Plan.

SUMMARY OF ELIGIBILITY REQUIREMENTS FOR RETIRED PARTICIPANTS		
Initial	**Continuing**	**Reinstate**
• 5,000 hours • 10 years as an active **Employee**, including 12 of the previous 24 months. • Retire from **Covered Employment**. • Attain age 55. • Maintain continuity of coverage through retirement date.	Remit applicable self-payment rate.	N/A

ELIGIBILITY FOR DISABLED PARTICIPANTS

How do I establish eligibility as a Disabled Participant?

If you are an Active Participant or Campus Class O Participant who becomes totally and permanently Disabled, you will be eligible for disability coverage if you satisfy the following requirements:

- → You must be eligible as an Active Participant or Campus Class O Participant at the time the disability occurs;
- → You must have accrued at least 5,000 hours during the 10 years immediately preceding the disability or accrued at least 5 full years of credited service under a pension or annuity plan sponsored by the Union;
- → You must be Disabled;
- → You must apply for disability coverage and submit evidence of your disability to the Plan office within 30 days of its commencement;
- → You must agree to submit to an examination by an independent Medical Provider selected by the Trustees to confirm your disability status; and

→ You cannot be eligible for coverage from the Plan as a Retiree or by being an Active Participant receiving coverage from your Hour Bank.

How do I continue eligibility?

After the weekly disability payments end, coverage can be maintained by using any remaining hours in your Hour Bank. Once the balance in your Hour Bank is exhausted, you may continue Eligibility by making self-payments with a 30% discount off of the applicable self-payment rate.

The Trustees retain the right to, at their discretion, verify that you continue to meet the Plan's definition of Disabled. As a condition of coverage as a Disabled Participant, you agree to submit to an Independent Medical Examination if requested by the Board of Trustees, and upon reasonable notice and terms based upon your medical condition.

How do I reinstate coverage?

Disabled Participants who have failed to maintain continuous coverage cannot have their benefits or eligibility reinstated.

SUMMARY OF ELIGIBILITY REQUIREMENTS FOR DISABLED PARTICIPANTS		
Initial Eligibility	**Continuing Eligibility**	**Reinstate**
• Eligible Active Participant at the time of disability. • At least 5,000 work hours in the previous 10 years or at least 5 years of credited service through a Union pension/annuity plan. • Be Disabled. • Apply for coverage within 30 days of disability. • Submit to an exam by a Medical Provider.	If you had applied for the weekly disability benefit prior to the Permanent and Total Disability Program, you will have had coverage for up to 26 weeks. After disability credits end, you must exhaust any hours in your Hour Bank. After Hour Bank is exhausted, to continue coverage, you must make self-payments.	N/A

ELIGIBILITY FOR SURVIVING SPOUSES AND DEPENDENTS

How does a Surviving Spouse become eligible?

The Surviving Spouse of a deceased Active Participant, Retiree or Disabled Participant may continue coverage provided both the deceased Active or Retired Participant and the Surviving Spouse were covered at the time of death. Coverage of a Surviving Spouse will begin on the first day of the month following the month in which the Hour Bank of the deceased Participant or Retiree is exhausted. The coverage provided will depend on whether the Surviving Spouse and any eligible Dependents are Medicare-eligible.

How do I continue coverage as a Surviving Spouse?

Surviving Spouses and their Dependents remain eligible by making self-payments at the rates established by the Board of Trustees. A Surviving Spouse may use any balance in the Hour Bank to continue coverage before self-payments are required. If the Participant was Disabled, any disability credits may also be exhausted before self-payments are required. Self-payments will be required from the Surviving Spouse as of the first day of the later of:

- → The month following the month in which the death of the Active Participant, Retiree or Disabled Participant occurs; or
- → In the case of an Active Participant, the month in which the Hour Bank is exhausted; or
- → In the case of a Disabled Participant, when extended eligibility and any balance in the Hour Bank are exhausted.

Self-payment rates will be established by the Trustees from time to time, which may be modified at any time, at their sole discretion.

How does a Dependent become eligible?

The eligibility of Dependents is linked to the eligibility of the Active or Class O or Campus Class O Participant, Disabled Participant, Retiree, or Surviving Spouse. An eligible Dependent includes the following: (1) a person's Spouse; (2) son, daughter, stepchild, adopted child, child lawfully placed for adoption, or foster child that is lawfully placed with the Participant, who is less than 26 years of age (coverage will terminate in this instance on the last day of the month in which the Dependent child turns 26); or (3) a handicapped child, who is incapable of self-sustaining employment because of mental or physical handicap, and who is dependent on you for support and maintenance. A handicapped child can remain as your Dependent and eligible for coverage so long as (1) you remain eligible for benefits as a Participant, and (2) the incapacity of your child began before the date the child's coverage would otherwise terminate under the Plan (for example, the disability began before the child was already age

26 or older). You must notify the Plan of the disability at least 31 days before the Dependent's coverage under the Plan would end.

How does a Dependent stay eligible?

A Dependent remains eligible so long as the Active or Class O or Campus Class O Participant, Disabled Participant, Retiree or Surviving Spouse remains eligible, and the child continues to meet the definition of Dependent.

Dependents of Surviving Spouse.

Dependents of Surviving Spouses must self-pay to maintain eligibility at rates set periodically by the Trustees. The Dependent may use any balance in the Hour Bank to continue coverage before self-payments are required. The deceased Participant and the Surviving Spouse must have been eligible for coverage under this Plan on the date of death for the Dependent to be eligible. The Board of Trustees, to the extent permitted by law, may limit Dependent coverage.

When does coverage terminate?

Your coverage will terminate on the first day of the month following the occurrence of any of the events listed below. Once terminated, coverage cannot be reinstated.

→ If you are a Surviving Spouse and you remarry.
→ You become eligible for group coverage as an employee of any employer.
→ If you are a Dependent Child, upon your 26th birthday.
→ If you fail to make a timely self-payment.

How do I reinstate coverage?

Coverage for a Surviving Spouse and Dependents will not be reinstated. If you fail to make a timely self-payment, coverage will be offered under COBRA

SUMMARY OF ELIGIBILITY REQUIREMENTS FOR SURVIVING SPOUSES AND THEIR DEPENDENTS			
Initial Eligibility	**Continuing Eligibility**	**Termination of Eligibility**	**Reinstate**
Must be the Spouse of a deceased active Participant or Retiree and be covered under the Plan at the time of death.	Must exhaust Hour Bank of deceased Participant. After Hour Bank is exhausted, must make self-payments.	• Spouse remarries • Spouse receives coverage from other group health plans. • Cease making self-payments. • Dependent child turns 26.	N/A

OTHER COVERAGE SITUATIONS

How does the Plan treat court-ordered coverage for minor children?

Coverage will be provided in accordance with any valid order of a court, determined by the Board of Trustees to be a Qualified Medical Child Support Order under applicable law, which creates or recognizes the right of an alternate recipient to benefits as an eligible Dependent under the Plan. A QMCSO must create or recognize an alternative recipient's right to receive benefits for which an eligible Dependent is eligible to receive under this Plan, provide a reasonable description of the benefits of this Plan, and the period to which the QMCSO applies.

The Benefits Office will establish reasonable methods to notify individuals affected by the order, segregate any amounts payable under the order, determine whether the order is qualified and distribute the benefits under the QMCSO. Any payment made by the Plan under a QMCSO or reimbursement for expenses paid by the Dependent Child or the Dependent Child's custodial parent or legal guardian will be made in accordance with applicable law. A request for coverage under a QMCSO must be submitted to the Plan Administrator within 30 days of the entry of the QMCSO.

What coverage is available under the Family Medical Leave Act?

An Employer which is a "covered employer" as that term is defined by the Family Medical Leave Act ("FMLA"), is required to notify the Plan when an eligible Participant has been granted family or medical leave. Both the Employer and the Participant are required to provide the notices, information, and documentation as may be required by the Board of Trustees and by law. The Plan will continue coverage during the period of any leave for which you are eligible under the provisions of the FMLA provided the Employer remits the required contributions and fully complies with all requirements established by the Board of Trustees. If you have questions about ensuring you and your Employer are complying with FMLA leave, contact the Benefits Office.

What if I go out on military leave?

Under the Uniformed Services Employment and Reemployment Rights Act ("USERRA"), if you leave Covered Employment to enter service in the Armed Forces, or other uniformed services of the United States, you may continue coverage under the Plan. The contributions accrued in your Hour Bank can be used to continue coverage, or frozen for use upon your return. You may elect to continue coverage for medical, surgical, and prescription drug benefits under the Plan for a period which is the lesser of the 24 months beginning on the last day of Covered Employment, or the day the Participant fails to apply for or return to Covered Employment.

If you elect to continue coverage, you may use your Hour Bank to continue coverage. Beyond that, you will be charged either: (1) the monthly COBRA premium rate or (2) the active Participant

rate, whichever is less. If your period of service is fewer than 31 days, coverage shall be provided at no additional cost to you.

Upon discharge from uniformed services under honorable conditions, you must return to work, apply for reemployment, or register on the Union's out-of-work list within the following time frames:

- → For periods of service of 1-30 days, time is allotted to travel home, plus eight (8) hours of rest, then upon the beginning of the next working day.
- → For periods of service of 31-180 days, within 14 days after completing service.
- → For periods of service over 180 days, within 90 days after completing service.

The period in which you must return to work, apply for reemployment, or register on the Union's out-of-work list is extended to two (2) years after completion of service if you are recovering from an illness or injury incurred or aggravated during the performance of service.

Upon return to Covered Employment or registration on the Union's out-of-work list, you will be eligible for coverage without having to reestablish eligibility. However, if the period of military service exceeds five (5) years, you must again establish Initial Eligibility before your coverage will be reinstated. You will also need to submit copies of your induction and discharge papers to the Benefits Office.

CONTINUATION OF COVERAGE UNDER COBRA

The Consolidated Omnibus Budget Reconciliation Act ("COBRA") offers Participants and their Dependents the opportunity to temporarily extend their health care coverage at group rates, in certain instances, after coverage under the Plan would normally end. The Board of Trustees sets the cost of COBRA coverage; however, it is subject to maximums imposed by law.

How do you become eligible to receive COBRA coverage?

To be eligible for coverage under COBRA, you must experience a Qualifying Event. Persons who experience a qualifying event are called qualified beneficiaries under COBRA and can elect COBRA coverage provided they comply with the Plan's notice requirements.

When will I receive information regarding COBRA?

The Benefits Office will provide COBRA information in the following two (2) instances:

- → Within the first ninety (90) days of you and your Dependents receiving coverage under this Plan, you will receive a general notice that describes your rights under COBRA; and;

→ If a qualifying event occurs, you and your Dependents will receive an election notice within fourteen (14) days of receiving notice that the qualifying event has occurred. Such election notice will describe your COBRA rights and how to elect COBRA coverage.

What are Qualifying Events for COBRA?

If you are an Active Participant:

→ Reduction in your hours of employment.
→ Termination of your employment for reasons other than gross misconduct.
→ Your former Employer files a Chapter 11 petition for bankruptcy.
→ You are determined to be disabled by the Social Security Administration.

If you are a Spouse or Dependent Child:

→ The death of your Active Participant parent or Spouse.
→ Divorce or legal separation.
→ Eligibility for Medicare.
→ Loss of status as a Dependent Child (i.e., turning age 26).

What are the notice requirements if I experience a qualifying event?

When you experience a qualifying event, written notice is required to the Benefits Office. The requirements for this notice are summarized below.

→ **If the qualifying event is due to divorce, marital separation, or loss of dependency status:** You (NOT YOUR EMPLOYER) must notify the Benefits Office within sixty (60) days starting from the latest of (1) the date the qualifying event occurred; (2) the date the Participant or Dependent would lose coverage under the Plan as a result of the qualifying event; or (3) the date the Participant or Dependent is informed (through the furnishing of the SPD or COBRA general notice) of the responsibility to notify the Plan. In the case of divorce or legal separation, the Participant or Dependent must provide the Plan with a copy of the decree of divorce or legal separation to qualify for COBRA continuation coverage.

→ **For all other qualifying events:** your Employer or former Employer must notify the Benefits Office within thirty (30) days starting from the latest of (a) the date the qualifying event occurred; (b) the date the Participant or Dependent would lose coverage under the Plan as a result of the qualifying event; or (c) the date the Participant or Dependent is informed (through furnishing of the SPD or COBRA general notice) of the responsibility to notify the Plan.

Failure to provide timely notice to the Plan of a Qualifying Event will result in the immediate termination of coverage and the denial of any incurred but yet to be paid claims. In addition, the Plan may take legal action to recoup the amount of claims paid or the COBRA premiums that should have been paid to the Plan had the required notice been provided to the Plan.

How long does COBRA coverage last?

The length of coverage available is summarized in the chart below.

Qualifying Event	Maximum Continuation Period		
	Employee	Spouse	Child
Reduction in work hours	18 months	18 months	18 months
Termination (other than for misconduct)	18 months	18 months	18 months
You are determined to be disabled by the SSA	29 months	29 months	29 months
You die	N/A	36 months	36 months
You and your Spouse divorce	N/A	36 months	36 months
Your child no longer qualifies as a Dependent	N/A	N/A	36 months

Under what circumstances can COBRA coverage be extended after the initial Qualifying Event?

The initial period of COBRA coverage can be extended if you experience a second qualifying event and provide the required notice to the Plan.

→ **If you become Disabled:** if the initial Qualifying Event was due to a reduction in work hours or the termination of your employment, your COBRA coverage can be extended for a total period of twenty-nine (29) months for the following reasons; (1) you are found to be disabled as determined by the Social Security Administration ("SSA"); and (2) there is a second and independent qualifying event during the first eighteen (18) months of coverage under COBRA.

To be eligible for the extension, you must notify the Benefits Office in writing of the Social Security Disability award within the first eighteen (18) months of your COBRA coverage and within sixty (60) days of the last of the following events to occur:

1. The date the SSA determined you were disabled.

2. The date on which coverage was lost due to a reduction in hours or termination of employment (i.e., the qualifying event),

3. The date on which a qualified beneficiary (such as your Spouse or Child) would lose coverage because of your loss of coverage due to your termination or reduction in hours (i.e., the qualifying event).

4. The date the qualified beneficiary is informed (by provision of the SPD or COBRA general notice) of the responsibility to notify the Plan and the procedures for doing so.

If you fail to timely provide the required notice of your Social Security Disability Award you will NOT be eligible for the extension of your coverage.

Also, if you lose your SSD status, you must notify the Benefits Office within 30 days of the date the Social Security Administration notifies you of its position and provide a copy of the notice to the Benefits Office.

Can I extend my COBRA coverage again after a second qualifying event?

→ **If a second Qualifying Event occurs:** If you and your family are on COBRA due to your termination or reduction in hours (i.e. the first qualifying event), you and your Dependents may be entitled to an additional eighteen (18) months of coverage under COBRA, for a total coverage period of thirty-six (36) months, in the event of (1) your death, (2) due to divorce, (3) becoming eligible for Medicare, or (4) your Dependent Child turns age 26 or otherwise ceases to meet the Plan's definition of a Dependent. The second qualifying event must cause a loss of coverage as if the first qualifying event had not occurred in order for the extension to be offered.

You must provide the Benefits Office with written notice of the second qualifying event within sixty (60) days of the later of (a) the date of the second qualifying event; (b) the date that your Spouse or Child would lose coverage under the Plan due to the second qualifying event (such as turning age 26); or (c) the date you or your Spouse or Child is informed (by provision of the SPD or COBRA general notice) of the responsibility to notify the Plan.

If you fail to timely provide the required notice you will NOT be eligible for the extension of your coverage. If you are unsure on how or when to provide this notice, please contact the Benefits Office for assistance.

PART THREE:
BENEFITS UNDER THIS PLAN

WHAT BENEFITS ARE AVAILABLE UNDER THIS PLAN?

The Schedules of Benefits for this Plan are incorporated in this SPD within the following Appendices to this SPD:

- → Appendix B for the HAP Schedule of Benefits, Exclusions and Claims Procedure
- → Appendix C for the Humana Schedule of Benefits, Exclusions and Medicare Rx Program
- → Appendix D for the Delta Dental Schedule of Benefits
- → Appendix E for the Vision Service Plan ("VSP") Schedule of Benefits

Medical, Surgical and Prescription Drug Benefits

The Plan provides eligible Active Participants, Retirees and Dependents with comprehensive medical, surgical and prescription drug benefits which include, but are not limited to, hospital, surgical, in-hospital physician, diagnostic services, psychiatric, hospice, ambulance, prescription drug and related services. Coverage for Active Participants and their eligible Dependents is governed by the HAP Insurance Contract, which includes the HAP PPO and the AETNA PPO network. A summary of HAP Insurance Contract Benefits and the procedures to claim them is provided in Appendix B.

Medical, surgical and prescription drug benefits for Medicare-eligible Retirees and disabled Participants and their Medicare-eligible Dependents are governed by the Humana Medicare Advantage and Prescription Drug Plan. A summary of Humana benefits and the procedures to claim them is provided in Appendix C.

Dental Coverage

The Plan provides eligible Participants, Retirees and Dependents with basic dental benefits, and orthodontic coverage up to age 19, according to the schedule of covered benefits. Dental coverage is provided by Delta Dental and described in Appendix D.

Vision Coverage

The Plan provides eligible Participants, Retirees and Dependents with vision benefits up to age 19, according to the schedule of covered benefits. Vision coverage is provided by Vision Service Plan ("VSP"), as described in Appendix E.

CT Scan Reimbursement

The Plan provides a reimbursement of $150 toward the cost of a low-dose CT scan, up to one time per year. Please contact the Plan Administrator for more information about this benefit.

DEATH BENEFITS

The Plan purchases group insurance from an insurance company, covering its Active Participants, Class O and Campus Class O Participants and their Spouses and Dependents, in case of death or dismemberment. The Plan also provides certain death benefits to Retirees. Written notice of the death of an eligible Participant must be given to the Plan Administrator within one year of the date of death of the eligible Participant, Retiree or Dependent; otherwise, no death benefit will be paid hereunder.

In the event of death or disability of an Active Participant, Class O or Campus Class O Participant, or their Spouses and Dependents, the Plan will provide the following benefits to the Active Participant or his designated beneficiaries.

Type of Loss	Total Payout Amount
Death	Active: $50,000 Class O: $50,000 Spouse: $25,000 Dependent Child: $12,500 (age 6 months to 23 years). Retiree and Early Retiree: $25,000
Accidental Death and Dismemberment	Active: $100,000
Accidental Death at the Workplace	$150,000 ($100,000 Accidental Death benefit plus and additional $50,000)
Both hands or both feet, one hand and one foot, vision in both eyes, one hand/foot and vision in one eye	$100,000
One hand/foot, or vision in one eye	$50,000

WEEKLY DISABILITY BENEFITS AND LOSS OF TIME

Weekly disability benefits (loss of time benefits) are payable to eligible Active and Campus Class O Participants and in the amount of $350.00 per week for up to twenty-six (26) consecutive weeks. Benefits are not available to Active or Campus Class O Participants who, at the time he or she becomes wholly and continuously disabled, the Plan has not received Employer Contributions from an Employer made on your behalf within thirty (30) days of the disability. An eligible Active or Campus Class O Participant who becomes wholly and continuously disabled by a non-occupational accidental bodily injury or sickness or disease that prevents him from working at his occupation, provided he is under the regular care of a Medical Provider, and provided that such disability occurs while the Participant is eligible for benefits under this Plan, shall be qualified to apply for weekly disability benefits. No benefits are payable for any day during which the Participant performs any work, whether for pay or profit, even if during such period the Participant is under the care of a Medical Provider.

How do I become eligible?

You must be an eligible Active or Campus Class O Participant at the time you become disabled and must fill out and submit any forms required by the Plan Administrator to be eligible for weekly disability benefits within thirty (30) days of the day your disability begins.

How do I stay eligible?

If you become disabled while currently eligible, and unemployable as a result of an illness or an injury, regardless if your disability is related to your job, an auto accident or otherwise, the Fund will continue your eligibility, at no cost to you, up to a maximum period of twenty-six (26) weeks. The Fund will credit you with 36.25 hours for every week you are disabled, up to a maximum of four (4) weeks per month. At the end of the twenty-six (26) week period, any hours in your Hour Bank will be used to continue your eligibility until exhausted. To continue receiving credit hours during your disability, you must continue to be disabled and be under the care of a Medical Provider. You may also be required to provide the Plan Administrator with proof you continue to meet the eligibility requirements from time to time.

Payment of Loss of Time Benefit

Benefit payments will be made during the period of disability, beginning: (1) with the 1st day of disability if you are admitted to a hospital or your disability results from an accident or injury; or (2) with the 8th day of disability for all other instances.

Disability Period

A new disability related to the same cause as a previous disability must be separated by at least five (5) days of employment, while a new disability due to unrelated causes must be separated from a previous disability by at least fifteen (15) days of employment.

What if I return to work?

You must notify the Plan Administrator of your active status on the date you return to work. If weekly disability benefits are paid based on a certification of disability by the attending Medical Provider, you return to Covered Employment without notifying the Plan Administrator and benefits are paid in error, you must refund such benefits to the Plan within ten (10) days of returning to Covered Employment.

Weekly Disability benefits are NOT payable under the following conditions:

→ For any period of disability during which you are not under the direct care of a Medical Provider.

→ For a disability due to accidental bodily injuries arising out of and in the course of your employment.

→ For a disability due to occupational disease. Occupational disease means a disease for which the Participant submitting the claim is entitled to receive workers' compensation or other benefits provided by law.

→ For a disability because of an automobile accident.

→ For a disability resulting from alcoholism or drug abuse.

→ For any disability caused by or related to engaging in a criminal act.

Absences you have resulting from a disability within eight (8) weeks of active employment will be treated as within a single disability period unless the new disability is a result of a different cause from any prior disability. In addition, no disability will be considered as starting more than three (3) days before your first visit to a Medical Provider.

For some of the above scenarios, i.e., if you are disabled from an automobile accident, hours may be credited to you in order to continue coverage under the Plan. The Plan may provide up to six (6) months of eligibility credit. If you would like more information, please contact the Administrator.

When will Weekly Disability benefits be paid?

Disability payments will be made to you beginning:

- → With the first (1st) day of disability due to the accident or injury.
- → The first (1st) day of hospitalization.
- → The first (1st) day of a surgical procedure performed in an outpatient facility.
- → With the eight (8th) day of disability due to an illness.

Any balance of benefits that has not been paid by the end of the disability period will be paid only if your Medical Provider provides the Benefits Office with the required medical evidence or certification of disability.

Weekly Disability benefits are NOT payable during period in which you work, whether in Covered Employment or otherwise. IF YOU RETURN TO WORK, YOU MUST NOTIFY THE BENEFITS OFFICE IMMEDIATELY. If you fail to notify the Plan of your return to work, you will be required to refund any benefits that were improperly paid to you. The Plan reserves the right to offset against any of your current or future benefits to recoup improperly paid benefits.

WHAT BENEFITS AM I ELIGIBLE FOR?

The chart below summarizes the types of benefits which are available to each class of Participant. The benefits are explained in more detail within the subsequent sections of this SPD, as well as within the Appendices.

BENEFITS TYPE	PARTICIPANT CLASS				
	Active	Class O	Campus Class O	Early Retirees – not on Medicare	Retirees eligible for Medicare
Medical, Surgical, & RX	√	√	√	√	√
Dental & Vision	√	√	√	√	√
Death / AD&D Benefit	√	√	√	√	√
Weekly Disability and Loss of Time Benefits	√		√		
Low-Dose CT Scan	√				

PART FOUR:
RESTRICTIONS ON YOUR COVERAGE

ARE ANY SERVICES EXCLUDED UNDER THIS PLAN?

Yes, comprehensive lists of exclusions for medical, surgical and prescription drug, dental, and vision benefits can be obtained by contacting HAP, Delta Dental and/or VSP, or you can contact the Benefits Office for more information.

COORDINATION OF BENEFITS WITH OTHER POLICIES AND INSURANCE

Coordination of Benefits ("COB") is a set of rules for the order of payment of covered charges when two (2) or more plans (not including a motor vehicle policy where the Participant or Dependent has not signed a subrogation agreement) cover the same individual to avoid duplicate or overlapping payments. The COB rules apply generally to all medical, surgical, as well as dental and vision benefits provided by this Plan. The COB rules do not apply to death benefits.

The plan that pays first (primary) according to the rules will pay as if there were no other plans involved. The other plans (secondary) will pay the balance due up to one hundred percent (100%) of the allowable expenses under the terms of that plan. When this Plan pays secondary, it will not make payments until the other insurance has fully paid up to its policy limits.

What happens if I, my Spouse, or my Dependent Children are covered under more than one Plan?

COB rules are in effect whenever any individual has coverage under this Plan and or any other health and welfare plan, or plan providing dental or vision coverage. The COB rules are generally summarized in the chart below:

COVERAGE TYPE	PRIMARY	SECONDARY
Policy that has no coordination provisions	Plan without coordination provision	Plan with coordination provision
Employer-provided coverage	Plan covering individual as an Employee	Plan covering individual as Spouse or Child
Coverage for a Child	Plan covering parent whose birthday is earlier in the year***	Plan covering the parent whose birthday is later in the year***
Coverage for a Child with divorced parents with a court order	Plan of the parent as specified as primary insurer under Judgement of Divorce	Other parent's plan

Coverage for a Child with divorced parents without a court order	Plan covering parent with physical custody	Plan of Spouse with physical custody
Motor vehicle coverage	Motor vehicle plan	N/A

***If the parents have the same birthday, the plan and coverage in effect for the longest will be primary.

If one of the policies or plans is issued in another state that does not use birthdays for coordination of benefits and each policy or plan by its terms is secondary, then the out-of-state policy or plan will be secondary. Each policy or plan will then be responsible for a maximum of fifty percent (50%) of his or her allowed expense or benefit.

COORDINATION WITH MEDICARE

The rules for coordination with Medicare are summarized below: When Medicare is primary, you must file any medical claims with Medicare first. After Medicare makes payment, the Plan will coordinate benefits with Medicare. In general, if you remain working then this Plan is primary, and Medicare will be secondary. The Plan will cover the Medicare Part A deductible and Part B deductible and twenty percent (20%) of the Medicare-approved charges, otherwise covered by the Plan.

SUMMARY OF COORDINATION OF BENEFITS WITH MEDICARE

COVERAGE	PRIMARY	SECONDARY
You are age 65 or older, but do not retire and continue to work as an Active Participant.	This Plan	Medicare
You retire, but later return to work as an Active Participant and you work sufficient hours to meet the requirements for Active Participant Coverage.	This Plan	Medicare
You are age 65 or older and are a Retired Participant.	Medicare	This Plan
You are age 65 or older but have coverage through your Spouse based on their current employment and eligibility for benefits from this Plan.	This Plan	Medicare
If you are Disabled, Retired, and UNDER age 65.	This Plan	Medicare
If you are Disabled, Retired, and age 65 or over.	Medicare	This Plan
You turn age 65 while continuing coverage through COBRA, and do NOT have End Stage Renal Disease (ESRD).	Medicare	This Plan/COBRA
You have ESRD and have coverage through this Plan through any option.	This Plan for the first 30 months of Medicare eligibility.	In month 31, this Plan will be secondary.

The above table is representative of some common scenarios, but not all possible scenarios. You should always keep the Plan informed of any other coverage that you or your Spouse maintains. If you have specific questions on coordination with Medicare, please contact the Benefits Office.

COVERAGE FOR AUTOMOBILE AND MOTORCYCLE ACCIDENTS

If you are in an automobile accident and are insured under an automobile insurance policy, the following rules will apply:

- → Payments for claims are based on Michigan law and the type of auto insurance that everyone involved in the accident has.
- → Generally speaking, if your auto insurance has what's called full – or uncoordinated – medical coverage, the auto insurance company will be billed first. This means that it would be expected to make payments on claims as your primary insurance. This Plan would be second in line to pay after your no-fault auto carrier.
- → If your auto insurance has coordinated medical benefits, this Plan pays related claims first. The auto insurance company would only review any claims that this Plan would reject.
- → Regardless of the type of auto insurance you have, it is important to remember that you must follow all of the requirements of your HAP contract when seeking services.

THE PLAN'S SUBROGATION RIGHTS

The Plan, HAP and Humana have subrogation rights, which means that if it pays benefits on your behalf and you later recover money or other property from a third party to compensate you, your rights to that recovery are "subrogated" to the Plan or insurance company that paid the claim, up to the amount of benefits the Plan provided to you. The Plan also is automatically granted a lien against any settlement, judgment, or other payment that you may receive directly from the Plan. By receiving benefits, you also agree to assist the Plan in preserving its subrogation and lien rights. The Plan may require you to sign a subrogation or similar agreement before paying claims. For more information about subrogation rights, contact the Plan Administrator, or consult the Plan Document.

PART FIVE:
CLAIMS AND APPEALS UNDER HAP

GENERALLY

Benefits are paid either directly to the service provider (with your written authorization) who has agreed to accept payment from the insurance provider (e.g., HAP) or as a reimbursement to you by the insurance provider after you incur a covered expense. Before benefits can be paid to you, you may

need to obtain the appropriate claim form(s) from the insurance provider or the Plan Administrator. Medical, Surgical, and Prescription Drug claims are submitted directly to HAP. For claims for life insurance, accidental death & dismemberment, contact the Benefits Office. For Dental claims, your provider should submit your claim directly to Delta Dental, and for Vision claims, your practitioner should submit your claims directly to Vision Service Plan.

HOW TO SUBMIT A CLAIM FOR BENEFITS WITH HAP

If you receive covered services from a Medical Provider covered by the Plan, you should not have to file a Claim. Benefits are paid directly to the Medical Provider. However, you should always check with your Medical Provider to make sure that the Claim has been filed and that, if required, the services have been prior authorized.

Some non-affiliated Providers may also file Claims for You. When you receive services from a non-affiliated Provider, you are responsible for ensuring that the Pre-Service Claim, Urgent Care Claim, or Concurrent Care Claim is filed correctly and that the services have been prior authorized, even if the non-affiliated Provider offers to file the Claim for you. However, you may need to file a Claim if you see a non-affiliated Provider. Or there may be other reasons you need to file a Claim.

If you must file a Claim, follow these instructions:

- → You must send HAP your Claim within one (1) year after you receive services. HAP will not process any Claim if it receives it more than one (1) year after you receive the services. The only exception is if you were legally incapacitated and can show proof that you were incapacitated. If you can provide this proof HAP will process the Claim.
- → You may send Claims to HAP at 2850 West Grand Boulevard, Detroit, MI, 48202. Write "Attention Member Reimbursement" on the envelope.
- → Fill out the Direct Member Reimbursement form available on the HAP website. Log in at www.hap.org and click on Member Resources under Quick Links. You may also call HAP and ask for the form. All claims must include a description of the services provided and the diagnosis or other information that establishes Medical Necessity.
- → A Claim is considered filed when HAP receives it, even if HAP doesn't have all of the information HAP needs to decide the Claim. If the Claim does not have all the information needed to make a benefit determination, HAP may ask to give them additional information. If you do not provide that information in the time periods HAP describes in any notices, it may deny the Claim, in whole or in part.

HOW LONG DO I HAVE TO SUBMIT A CLAIM FOR BENEFITS?

Claims must be submitted within one (1) year of their occurrence. Claims filed later than that date may be declined/reduced unless it was not reasonably possible to submit the Claim within the one-year period.

AFTER A CLAIM IS SUBMITTED, HOW WILL I BE NOTIFIED OF A DECISION?

Regardless of the type of Claim, you will receive a written or electronic notice of any Adverse Benefit Determination.

Notice of Initial Benefit Determination

Each time a Claim is submitted and You are responsible for a portion of the Claim payment, you will receive a written or electronic notice that explains how much was paid and whether the Claim was denied, in whole or in part.

If Your Claim is denied HAP will send you a notice of Adverse Benefit Determination. The notice will do the following:

- → Explain the reason for the denial.
- → Tell you what part of the HAP Policy/Contract is the reason for the denial.
- → Describe any other information necessary to reverse the denial, or complete an incomplete Claim, and tell you when the information is necessary.
- → Explain the Appeals procedures and any rights you may have under certain laws.
- → Tell you if HAP used internal guidelines, protocols or other information. If you ask, HAP will provide, free of charge, a copy of the rule, guideline, protocol or other information, as well as reasonable access to documents, records and other information on the Claim.
- → Tell you if the Claim denial was based on a professional opinion, including a decision about whether a service is Experimental and Investigative or not Medically Necessary or appropriate. HAP will explain the scientific or clinical opinion used in the decision, if you ask, free of charge.
- → If the Claim was an Urgent Care Claim, HAP will describe the Expedited Appeal process.
- → Give you sufficient information to identify the Claim.
- → Any other information required by law.

HAP will send you the notice within certain timeframes. The notification period can depend on the type of claim you have submitted. The types of claims and the associated time periods are described below. The time periods for review begin when a Claim if filed correctly (i.e., identifies the individual and condition and is sent to the proper department), even if some additional information is needed to decide the Claim. If an extension of time is needed, the period to decide a Claim is generally

suspended until the additional information is provided, or the period given to you to provide the information expires.

- → **Urgent Care Claims.** If submitted properly, these Urgent Care Claims will be decided within seventy-two (72) hours. If more information is needed to decide on an Urgent Care Claim, you will be notified within twenty-four (24) hours of the receipt of the Claim. Such notification may be oral unless you request written notification. You will then have at least forty-eight (48) hours to provide the information needed. You will then be notified of the decision within forty-eight (48) hours of the receipt of the information, or within the forty-eight (48) hours you had to supply it. You may be notified orally of the decision, but you still will be provided a written decision on the Claim within three (3) days of the oral notification.

- → **Pre-Service Claims.** If enough information is available, Pre-Service Claims will be decided within fifteen (15) days of the receipt of the Claim. If more information is required, this period can be extended by an additional fifteen (15) days. The notice will explain the reason for the delay and provide an estimate of when the Claim will be decided. If more information is required to decide your Claim, then you will be given at least forty-five (45) days to provide that information. The Claim will then be decided within fifteen (15) days of you supplying the information, or by the end of the forty-five (45) day period you had to supply that information, whichever period expires first.

- → **Post-Service Claims.** If enough information is available, Post-Service Claims will be decided within thirty (30) days of the receipt of the Claim. If more time is needed, this period can be extended by fifteen (15) days. You will be notified prior to the expiration of the initial thirty (30) day period if an extension is needed. The notice will explain the reason for the delay and give an estimate of when the Claim will be decided. If more information is required to decide your Claim, then you will be given at least forty-five (45) days to provide that information. The Claim will then be decided within fifteen (15) days of you supplying the information, or by the end of the forty-five (45) day period you had to supply that information, whichever period expires first.

- → **Concurrent Care Claims.** If the length of treatment approved is reduced or terminated prior to the end of the period or the full number of treatments (unless the reduction or termination occurs as the result of a Plan amendment or termination), you will be provided with written notice within a sufficient amount of time prior to the reduction or termination for you to Appeal that decision. If you request to extend a course of treatment, you will be notified within twenty-four (24) hours of the receipt of your request for that extension if you requested the extension at least twenty-four (24) hours prior to the expiration of the approved length of treatment.

- → **Disability Claims.** Disability Claims will generally be decided within forty-five (45) days after the receipt of the Claim. If more time is needed to decide your Claim, this period can be extended by thirty (30) days. In such an instance, prior to the 45-day period, you will be given notice of the reasons for the extension and give an estimate of when the Claim will be decided. This period may be extended again for an additional thirty (30) days. If this occurs, you will

be given notice of this second extension prior to the end of the first thirty (30) day extension period, which will explain the reasons for the second extension and give an estimate of when the Claim will be decided. If more information is required to decide your Claim during either extension period, then you will be given at least forty-five (45) days to provide that information. The Claim will then be decided within thirty (30) days of you supplying the information, or by the end of the forty-five (45) day period you had to supply that information, whichever period expires first.

→ **Air Ambulance Claims.** A Claim also includes a request that participant cost-sharing for out-of-network emergency services and facilities, and out-of-network air ambulance services be no more expensive than for those services if they were in-network, and also that emergency procedures not be subjected to preauthorization, all in compliance with the No Surprises Act, codified at Title II of Division BB of the Consolidate Appropriations Act.

→ **All other claims:** the Claims Administrator may extend the time to reach a decision up to an additional ninety (90) days. Written notice of the extension will be furnished to you prior to the termination of the initial ninety (90) day period and will explain the circumstances requiring an extension of time, as well as identify the time and date by which the Claims Administrator expects to reach a decision.

WHAT HAPPENS IF MY CLAIM IS DENIED?

In the event your claim is denied, you will receive a notice that will explain the reasons for denying your claim and it will reference the Plan Document or Insurance Contract language upon which the denial is based. It will also explain your rights to file a civil action under ERISA, which is the federal law that regulates employee benefit plans. If applicable, the notice will also advise you of any additional information that is needed to make a further determination of your claim. The notice will also explain to you the process for filing an expedited appeal if the claim is of an urgent nature. The following is an explanation of the procedure for appealing Plan eligibility claims and claims for Plan benefits not provided through insurance. Claims for insured benefits are governed by Insurance Contract claims procedures that are summarized in the Appendix which includes the description of those insured benefits.

WHAT ARE MY RIGHTS TO APPEAL A DENIED CLAIM?

You, your authorized representative (who can be a relative, friend, attorney, or someone else), or your health care practitioner may start the Appeal Process by sending a request in writing to:

Alliance Health and Life Insurance Company
Attention: Manager of Appeal and Grievance Department
2850 West Grand Boulevard Detroit, MI 48202

To appoint an Authorized Representative, you must submit the following information in writing to the above address or by fax to (313) 664-5866:

→ Name and contact information of the appointed representative

→ This document should indicate that the appointed representative has the authority to discuss the member's personal health information and submit requests for appeals and grievances on the member's behalf.

→ Your signature and date

→ Representative signature and date

HAP will not be able to process the request until the documentation is received. This document is valid for one year from the date of signature.

You can also submit Appeals in person at 2850 West Grand Boulevard, Detroit, MI 48202 or 1414 E. Maple Road, Troy, MI 48083.

You may submit a level-one Appeal (Standard or Expedited) in writing within 180 calendar days from the date you receive the initial denial. You then may submit a request for your second-level Appeal within 60 calendar days from the date of the level-one Appeal decision.

You should include any extra information such as:

→ Medical evaluation report

→ Medical records

→ Your explanation of benefits

→ Other important facts to support the request.

Once HAP receives the Appeal, HAP will send a letter telling you that it accepted the Appeal. HAP has fifteen (15) calendar days for Pre-Service Appeals, and thirty (30) calendar days for Post-Service Appeals, to decide each level.

Group Plan Members have a two-step internal Appeal Process.

If you approve HAP's request for an extension of time, HAP may take up to ten (10) additional business days for review if HAP has not received necessary and requested information from a health care facility or health professional. Additional extensions are available to you upon your request. If HAP goes past the allowable time frame, you can go straight to the State for an External Review or you may bring a lawsuit under section 502(a) of ERISA.

HAP also offers an expedited Appeal Process where HAP will decide within 72 hours. You may request an Expedited Appeal in writing within 180 calendar days from the date you receive the initial denial if you believe that waiting for the routine timeframe for an internal appeal would seriously threaten you, your health or your ability to regain maximum function. HAP will ask an appropriate health care practitioner, usually a physician, to review the request and decide if your medical condition needs a decision within 72 hours. If your physician makes the request for an Expedited Appeal or indicates that you need an Expedited Appeal, HAP will provide a decision within 72 hours. When you request an Expedited Appeal, the two levels of Appeal are consolidated into one level for review by the designated appeals person.

You are allowed to have continued coverage during the Expedited Appeal Process for approved ongoing courses of treatment pending the outcome of an internal Appeal.

You or your Authorized Representative may file a request for an Expedited External Review, with the Department of Insurance and Financial Services (DIFS), at the same time you file a request for an Expedited Appeal with HAP. If this happens and DIFS accepts the external review request, you are considered to have exhausted Our Internal Appeal process.

You or your Authorized Representative may file a request for an external review with the Department of Insurance and Financial Services (DIFS) if HAP:

→ Fail to comply with the requirements of Our Internal Appeal Policy, unless the failure is based on a trivial or minor violation that does not cause prejudice or harm to You; or

→ Fail to issue a written decision to You or Your Authorized Representative within the required time, and without You requesting or agreeing to an extension; or

→ Waive Our Internal Appeal Process and the requirement for You to exhaust the process before filing a request for an external review.

If this happens and DIFS accepts your request for an external review you are considered to have exhausted AHL's internal appeal process.

When filing a request for an external review, you will be required to authorize the release of medical records that may be required to be reviewed to decide on the external review. You will not have to bear any costs for an external review, including any filing fees. You may request and receive, at no cost, copies of documents, records and other information relevant to your Appeal.

During the Internal Appeal Process, you or your Authorized Representative have the option to present the Appeal in person, by phone or using other ways of communication. As a group plan member, you may present your Appeal to an Appeals Committee at your second level Appeal. People who HAP involved in the initial denial will not be included in deciding for the Appeal.

Before your Internal Appeal may be denied based on a new or additional rationale, or any new or additional evidence considered, relied upon, or generated in connection with the Appeal, you will be provided with the new rationale and/or evidence, at no cost, within a sufficient amount of time to allow you a reasonable opportunity to respond to the new rationale and/or evidence. This information will be provided to you before you are provided with a final written determination on your Appeal providing the reasons for the decision. The final determination (of the appeal) will be written and in a culturally and linguistically appropriate manner. The written notice will also include directions on how to file a request for an external review.

If You are still not satisfied with the final decision after the internal Appeal Process or if You meet the requirements for an External Review, as described above, you can ask for an External Review under the Patient's Right to Independent Review Act. After you receive the final decision or exhaust the internal appeal process, you can request an External Review by contacting the Director of the Department of Insurance and Financial Services within one-hundred and twenty-seven (127) days, by writing to:

Department of Insurance and Financial Services Healthcare Appeals Section
Office of General Counsel
P.O. Box 30220
Lansing, MI 48909-7720

You may also call the Director toll-free at (877) 999-6442 or submit an online request at https://difs.state.mi.us/Complaints/ExternalReview.aspx.

HAP will automatically provide You with the FIS 0018 (1/18) - Health Care Request for External Review form after the final appeal decision. This form is necessary to ask for an External Review. You can also get a copy of the form anytime by going to the Department of Insurance and Financial Services website listed below. You can also call the number listed below and ask for the form.

- → Members can call Client Services at (888) 999-4347.
- → If you are deaf, hard of hearing or speech impaired, please call 711 for TTY services.
- → Call the Department of Insurance and Financial Services directly at the number listed above or visit their website at www.michigan.gov/difs.
- → For assistance, you may contact the Michigan Health Insurance Consumer Assistance, Allegan Street, 7th Floor, Lansing, MI 48933 at 877-999-6442 or email at DIFS-HICAP@Michigan.gov.

PART SIX:
YOUR RIGHTS AND RESPONSIBILITIES

WHAT ARE MY RIGHTS UNDER ERISA?

As a Participant in this Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Participants are entitled to:

→ Examine, without charge, the Governing Documents, including the Plan Document, insurance contracts, the Collective Bargaining Agreements, updated Summary Plan Description, copies of the latest annual report (Form 5500 series), and any documents filed by the Plan with the U.S. Department of Labor, such as detailed financial reports, etc. This examination may take place at the Benefits Office and other specified locations such as the work site or the union hall;

→ Obtain, upon written request to the Benefits Office, copies of documents governing the Plan, including the Plan Document, insurance contracts, the Collective Bargaining Agreement, updated Summary Plan Description, and copies of the latest annual report (Form 5500 series). The Benefits Office may make a Reasonable and Customary Charge for the copies.

→ Receive a summary of the Plan's annual financial report. The Benefits Office is required by law to furnish each Participant with a copy of this summary annual report;

→ Obtain a statement telling you what rights you have with respect to benefits offered by the Plan. This statement must be requested in writing and is not required to be given more than once a year. The Plan must provide the statement free of charge;

→ Continue health care coverage for yourself or your Dependents if there is a loss of coverage under the Plan because of a Qualifying Event. You or your Dependents may have to pay for such coverage; and

→ Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

In addition to creating rights for Participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The Board of Trustees, who operate your plan and are called "fiduciaries" of the plan, have a duty to do so prudently, and in the interest of you and other Participants and Beneficiaries. No one, including your Employer, your Union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a plan benefit or exercising your rights under ERISA. In addition:

- → If your Claim for a benefit is denied in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, within certain time schedules.

- → Under ERISA, there are steps you can take to enforce your rights. For instance, if you request materials from the Plan and do not receive them within thirty (30) days, you may file a suit in a federal court. In such a case, the court may require the Benefits Office to provide the materials and pay you up to one hundred ten dollars ($110) a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Benefits Office.

- → If you have a Claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court.

- → If you have a Claim for benefits, that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision concerning a QDRO or QMCSO, you may file suit in federal court. Furthermore, if the Plan's fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees if, for example, it finds your claim is frivolous.

If you have any questions about this statement or your rights under ERISA, you should first contact the Benefits Office and then contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor, listed in your telephone directory or the Division of Technical Assistance & Inquires, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

CIVIL ACTIONS AGAINST THE PLAN

You must file a lawsuit to challenge any denial by the Plan of your right to current or future benefits within one (1) year after your Claim for benefits (or to establish a right to future benefits) is finally denied by the Plan. Other Plan-based lawsuits must be brought within one (1) year after they accrue. How this limitation works in practice is explained below. The Board of Trustees will provide you with periodic additional notices of the limit at least annually and at other appropriate times (i.e., in letters from the Plan itself concerning your benefit claims). These requirements apply even though all Plan communications may not remind you of them.

The One (1)-Year Limit. The one (1)-year limit begins on the date your right to Plan benefits is fixed (without judicial action). For example, the one (1)-year limit will begin:

→ On the day following the date on which the Plan finally denies your Claim for benefits (or right to future benefits);

→ On the day following the last day for you to appeal a Plan denial of your Claim for benefits or future benefits (if you decide not to appeal that denial); or

→ On the day following the last date on which you could file a Claim for benefits under the Plan (if you do not file a Claim before the applicable Claim-filing deadline).

The Plan requires generally requires you to exhaust your internal remedies before filing a civil action. If you do not exhaust these remedies, you may be foreclosed from pursuing a civil action until you have done so.

If you are unsure about when or how to provide the required notice, please contact the Benefits Office.

The one (1)-year limit does not apply to Plan-related rights that you have that are not based on the Plan itself. For example, the one (1)-year limit does not apply to Claims that Plan fiduciaries have violated their ERISA fiduciary duties.

WHAT ARE MY RIGHTS UNDER HIPAA, HITECH, AND GINA?

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and The Health Information Technology for Economic and Clinical Health Act ("HITECH"), enacted as part of the American Recovery and Reinvestment Act of 2009, require that health plans protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Plan's privacy notice, which was distributed to you upon enrollment and is available from the Benefits Office. If you have questions about the privacy of your health information please contact the Plan's legal counsel, set forth above. If you wish to file a complaint under HIPAA, please contact the Benefits Office. In addition, under the Genetic Information Non-Discrimination Act ("GINA"), the Plan will not discriminate based on and cannot request genetic information when making determinations regarding your eligibility for coverage.

NOTIFICATIONS TO THE PLAN & SPECIAL ENROLLMENT RIGHTS

Under some circumstances, you will be required to notify the Benefits Office of certain events. Your failure to do so may affect your coverage. These events also qualify as Benefit Events that allow you to add individuals to coverage outside of the normal enrollment period. Accordingly, the Benefits Office must be notified in writing of any changes regarding the following:

→ **Marriage** - To add a Spouse and any eligible stepchildren to coverage, the marriage must be reported within ninety (90) days. A copy of the certificate of marriage must be filed with the Benefits Office. The Spouse and any eligible stepchildren will then be covered from the moment of marriage.

→ **New Children** - To add your newborn Child to coverage, the birth must be reported within ninety (90) days. A copy of the birth certificate must be filed with the Benefits Office. The Child will be covered from the moment of birth, as provided herein.

→ **Adoptions** - Adoption or placement of a Child must be reported within ninety (90) days to add the Child as an eligible Dependent and a copy of the legal adoption papers or court order for placement must be filed with the Benefits Office.

→ **Change of Address** - Any change of address must be reported within ninety (90) days.

→ **Name Change** - Any name change must be reported within ninety (90) days.

→ **Deaths** - Deaths must be reported immediately. A certified copy of the death certificate is required.

→ **Divorce** - Divorce must be reported immediately and a copy of the judgment of divorce must be filed in the Benefits Office. A former Spouse is no longer eligible for benefits as of the date of the divorce, except as provided under COBRA. Eligible Children will continue to be covered if they continue to qualify as Children under this Plan.

→ **26th Birthday** - Children attaining the age of twenty-six (26) are no longer eligible for coverage as of the last day of the month in which they turn age twenty-six (26). Once no longer eligible for coverage, children who age out of coverage may elect continuation of coverage under the COBRA provision of the Plan.

→ **Change of Employment Status** - If you or your Spouse switches employers, returns from a leave of absence, or moves to full or part-time employment, then you must notify the Benefits Office within ninety (90) days.

Note, you may still enroll yourself, your Spouse, and/or your Child, if you do not notify the Benefits Office within ninety (90) days. However, coverage will begin on the date of notification and will not apply retroactively back to the date of the Benefit Event.

WHAT HAPPENS WHEN CIRCUMSTANCES OR BENEFITS CHANGE?

If an amendment or termination is made to the provisions of the Plan, you will receive a notice describing the changes and how they affect you. These notices are typically referred to as a Summary of Material Modifications ("SMM").

The Plan may be terminated, in whole or in part, merged, or combined with another plan. The Board of Trustees may also terminate the Plan when a Collective Bargaining Agreement requiring Employer Contributions to the Plan no longer exists, or as otherwise permitted by law.

While the Board of Trustees has broad authority to make changes, it may not amend the Plan in a way that would: (a) authorize or permit any part of the Plan assets to be used for purposes other than the exclusive benefit of Participants or their Beneficiaries; or (b) cause any part of the Plan's assets to revert to the Employers.

PART SEVEN: APPENDICES

APPENDIX A: DEFINITIONS

→ **Active Participant: An Employee who has met the requirements established by the Board of Trustees to be eligible for benefits under this Plan.**

- **Class O:** Employees working for an Employer at least 32 hours per week.
- **Campus Class O:** Class O Participants employed by the sponsoring Union or any Association, shall be deemed Campus Class O Participants from the inception of their eligibility to participate in the Plan.

→ **Adverse Benefit Determination:** A denial, reduction, termination of, or failure to provide or make payment (in whole or in part) of a Claim, including any such denial, reduction, termination of, or failure to provide or make payment (in whole or in part) that is based upon your eligibility to participate in the Plan or 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 an Experimental or Investigational, or not Medically Necessary or appropriate. A rescission of coverage is included in this definition, irrespective of whether the rescission had an adverse effect on any particular benefit at that time. Rescissions will be treated in accordance with 45 CFR §147.128, as amended, and any person affected by a rescission will receive thirty (30) days advance written notice.

→ **Appeal:** An Appeal of an Adverse Benefit Determination that is filed in accordance with this Plan's procedures for filing an Appeal.

→ **Beneficiary(ies):** Person(s) who, because of a relationship to the Participant, may be entitled to benefits from the Plan, or who are designated by a Participant to receive benefits from the Plan in the event of his/her death, or in the absence of an effective designation, if such designated person(s) will have died, the first of the following classes of Beneficiaries, then surviving, in successive preference, the Participant's: (a) Spouse; (b) Children; (c) parents; (d) brothers and sisters; and (e) estate.

→ **Benefit Year or Calendar Year:** The twelve (12)-month period starting on January 1 of any year and ending on December 31 of that year.

→ **Child(ren):** Any Child(ren) of the Participant, including:

- A son, daughter, stepchild, adopted child, child lawfully placed for adoption, a child meeting the definition of a "foster child" under applicable law that is lawfully placed with the Participant by an authorizing placing agency or by court order, and is under the age of twenty-six (26). In case of divorce, proof of the Participant's obligation to provide coverage for a child shall be required, such as a judgment of divorce;

- Any illegitimate children under the age of twenty-six (26), so long as the Participant provides the Benefits Office with proof of paternity by presenting a registered birth certificate, naming the Participant as the father, order of filiation, or adoption order;

- Any handicapped child who is incapable of self-sustaining employment because of a mental or physical handicap; and who the Participant is required by court order to provide support and maintenance; and whose handicap began before age twenty-six (26);

- An individual named under the terms of a Qualified Medical Child Support Order; and

- Any person for whom a court has appointed the Participant as his/her legal guardian; and who is under the age of twenty-six (26).

→ **Claim:** A request for a Plan benefit made by a Claimant in accordance with this Plan's procedures for filing or appealing a Claim for benefits. A Claim must generally name a specific Claimant, identify a specific medical condition or symptom, identify a specific treatment, service, or produce for which approval is requested, and be received by a person or organizational unit of the Claims Administrator that is customarily responsible for handling benefit matters.

→ **Claimant:** A person or his/her authorized representative, who has submitted a Claim for a Plan benefit in accordance with this Plan's procedures for filing or appealing a Claim for benefits.

→ **Claims Administrator:** The entity responsible for processing and adjudicating Claims or Appeals, and for providing notices to you or your Beneficiaries of Claim determinations and adjudications, as well as Appeal determinations. The Claims Administrator is the Benefits Office in all instances.

→ **Collective Bargaining Agreement:** A contract or participation agreement between an Employer and the Union that requires fringe benefit contributions to be made to this Health and Welfare Fund.

→ **Concurrent Care Claims:** Any Claim regarding an ongoing course of treatment to be provided over a period of time or number of treatments, which has previously been approved by the Plan.

→ **Continuing Eligibility:** The requirements for a Participant to continue eligibility for benefits under the Plan after (s)he has met the requirements for Initial Eligibility.

→ **Contribution Hours:** The hours an Employee worked in Covered Employment for which an Employer has made actual contributions to this Health and Welfare Fund pursuant to a Collective Bargaining Agreement, or other written agreement. Only the hours for which contributions are actually received by the Fund (i.e., an Employer has paid the contributions to the Plan) will be deemed Contribution Hours.

→ **Covered Employment:** Employment with an Employer, for which the Employer has agreed, through a Collective Bargaining Agreement with the Union, or other written agreement, to make contributions to this Plan for work performed by an Employee covered by that Collective Bargaining Agreement.

→ **Hour Bank:** Contribution Hours above those required to meet the requirements for Continuing Eligibility.

→ **Dependent:** The Spouse and/or Child of a Participant. Your Spouse; provided, however, that a Spouse who is a full-time Employee and who is eligible to enroll in employer-sponsored coverage from his/her employer must enroll in such coverage as soon as such coverage

becomes available to the working Spouse. The Plan will apply its coordination of coverage provisions as if the working Spouse had elected the employer-sponsored coverage, unless the working Spouse has family coverage, in which case the Plan's normal coordination of benefits provisions will apply. The cost of the working Spouse's coverage may be reimbursed from the Participant's SCRA, provided however, the SCRA may not be used to reimburse the cost of individual coverage purchased on an Exchange or Marketplace.

- Your son, daughter, stepchild, adopted Child, Child lawfully placed for adoption or guardianship, or Child meeting the definition of a "foster child" under applicable law that is lawfully placed with you by an authorizing placing agency or by court order, and is under the age of twenty-six (26). A copy of the order of adoption, guardianship or placement order must be provided to the Benefits Office;

- Any illegitimate Child, so long as the Participant provides the Benefits Office with proof of paternity by presenting a registered birth certificate, naming the Participant as the father, order of filiation or adoption order;

- Each handicapped Child, who is incapable of self-sustaining employment because of a mental or physical handicap, and who is dependent on you for support and maintenance. (S)he will remain your Dependent and be eligible for coverage so long as you remain eligible for benefits as a Retiree, early Retiree or Disabled Participant; and (b) such incapacity began before the date the Child's coverage would otherwise terminate under the Plan (for example, the disability began before the Child was age twenty-six (26). Proof of the Child's incapacity must be submitted to the Benefits Office within thirty-one (31) days of the date such Dependent's coverage would have otherwise terminated;

- An individual through a valid order of a court, by the Board of Trustees to be a QMCSO under applicable federal law, which creates or recognizes the right of an alternate recipient to benefits as your eligible Dependent under the Plan; or

- Any person for whom a court has appointed you as his/her legal guardian and who is under the age of twenty-six (26).

→ **Disabled:** As a result of a physical or mental condition, that the Board of Trustees finds, on the basis of medical evidence, to permanently and totally prevent the Participant from engaging in any work within the jurisdiction claimed by the Union for remuneration or profit. The disability must be, on the basis of medical evidence, expected to continue during the remainder of his/her life or will be expected to continue for at least one (1) year. To be Disabled, such disability cannot have been caused by: (a) the use of illegal narcotics; (b) the performance of or engagement in illegal activity; or (c) the result of a self-inflicted injury that is not the result of a medical condition.

→ **Effective Date:** The effective date of this SPD, the effective date of a specific benefit, or the date an Employee or Dependent becomes eligible for benefits. The Effective Date of this Plan will be January 1, 2024.

→ **Employee:** Any person who is or has been employed by an Employer in Covered Employment, or such other employment for which the Employer is obligated by a Collective Bargaining Agreement, or any other written agreement, to contribute to the Plan.

→ **Employer:** Any of the following:

- Any member of an Employer Association and any other individual, partnership, corporation or business entity that is employing the services of individuals performing work that is within the trade jurisdiction of the Union and which has a Collective Bargaining Agreement or any other written agreement in effect, requiring contributions to the Plan;

- Any other Employer engaged in work coming within the trade, craft, and geographical jurisdiction of the Union, who is obligated by a Collective Bargaining Agreement, or such other written agreement, to make contributions to this Plan on behalf of its Employees;

- The Union, and its related international bodies, solely to the extent that it acts in the capacity of an Employer of its business representative or its Employees, provided it agrees to make contributions to the Plan on behalf of such Employees;

- Any training or other similar program operated in whole or in part by the Union, or with its approval, or in which the Union participates;

- Any board of trustees, committee or other agency established to administer or be responsible for fringe benefit plans, educational or other programs established through collective bargaining by the Union, the members of which maintain a collective bargaining relationship with the Union or one of its constituent Locals;

- Any council, committee, or other body composed of representatives of one or more labor organizations of which the Union or one of its constituent Locals is a member and agrees in writing to participate herein; or

- Any sponsoring Employer Association, whose members maintain a collective bargaining relationship with the Union, solely in its capacity as an Employer of Employees, on whose behalf it has agreed in writing to make contributions to this Plan.

→ **Employer Contributions:** The fringe benefit contributions received by the Fund for each hour worked in Covered Employment. Generally, only contributions received by the Fund will be deemed Employer Contributions for eligibility purposes, except as otherwise provided in this SPD.

→ **Experimental or Investigational:** Means any drug, service, supply, care, or treatment that, at the time provided or sought to be provided, is not recognized as conforming to accepted medical practice or to be a safe, effective standard of medical practice for a particular condition. This includes, but is not limited to:

- Items within the research, investigational, or experimental stage of development or performed within or restricted to use in Phase I, II, or III clinical trials (unless identified as a covered service elsewhere);

- Items that do not have strong, research-based evidence to permit conclusions and/or clearly define long-term effects and impact on health outcomes (i.e., that have not yet been shown to be consistently effective for the diagnosis or treatment of the specific condition for which it is sought). Strong, research-based evidence is identified as peer-reviewed published data derived from multiple, large, human, randomized, controlled clinical trials or at least one or more large, controlled, national, multi-center, population-based studies;

- Items based on anecdotal and unproven evidence (literature consisting only of case studies or uncontrolled trials), i.e., items that lack scientific validity, but may be common practice within select practitioner groups even though safety and efficacy is not clearly established;

- Items that have been identified through research-based evidence to not be effective for a medical condition and/or do not have a beneficial effect on health outcomes;

- FDA and/or Medicare approval does not guarantee that a drug, supply, care, or treatment is accepted medical practice; however, lack of such approval will be a consideration in determining whether a drug, service, supply, care, or treatment is considered Experimental Investigational, or Unproven. In assessing cancer care claims, sources such as the National Comprehensive Cancer Network (NCCN) Compendium, Clinical Practice Guidelines in Oncology, TM or National Cancer Institute (NCI) standard of care compendium guidelines, or similar material from other or successor organizations will be considered along with benefits provided under the Plan and any benefits required by law. Furthermore, off-label drug or device use (sought for outside FDA-approved indications) is subject to medical review for appropriateness based on prevailing peer-reviewed medical literature, published opinions and evaluations by national medical associations, consensus panels, technology evaluation bodies, and/or independent review organizations to evaluate the scientific quality of supporting evidence;

- The foregoing definition shall not apply to any clinical trials or other experimental services required to be covered under the Patient Protection and Affordable Care Act (PPACA).

→ **Final Adverse Benefit Determination:** An Adverse Benefit Determination that has been upheld by the Board of Trustees at the completion of the internal Appeals process.

→ **Initial Eligibility:** The requirements that a covered individual and his/her Dependents must meet to become initially eligible for coverage under the Plan.

→ **Medical Provider or Physician:** Any of the following:

- A doctor of medicine, osteopathy, chiropractor, podiatry or optometry, legally qualified and licensed to practice medicine, perform surgery, or provide services at the time and place services are performed;

- A person who is licensed or certified as a psychologist (but not including a person acting within the scope of a partial or limited license or certification);

- A person who is a member or Fellow of the American Psychological Association if there is no licensure or certification in the jurisdiction where such person renders service; and

- A Physician's Assistant, nurse, or person of a similar position working under the direction of the treating Physician. The Plan will provide coverage for services administered by a Physician's Assistant or an otherwise qualified person working under a Physician, however, the Plan or its network provider may seek Physician verification prior to approving payment for any claims or benefits or audit claims.

→ **Medically Necessary:** Means any health care services provided for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, mental illness, substance use disorder, condition, or disease or its symptoms, that generally meet the following criteria as determined by the Trustees or their designee, within their sole discretion:

- In accordance with Generally Accepted Standards of Medical Practice; and

- Clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for the Participant's illness, injury, mental illness, substance use disorder, or disease or its symptoms; and

- Not mainly for the person's convenience or that of the person's doctor or other health care provider; and

- Is the most appropriate, most cost-efficient level of service(s), supply, or drug that can be safely provided to the person and that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the person's illness, injury, disease, or symptoms.

The fact that a Medical Provider has performed, prescribed, recommended, ordered, or approved a service, treatment plan, supply, medicine, equipment, or facility, or that it is the only available procedure or treatment for a condition, does not, in itself, make the utilization of the service, treatment plan, supply, medicine, equipment, or facility Medically Necessary.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician Specialty Society recommendations or professional standards of care may be considered. The Trustees reserve the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Medical Provider specialty society recommendations, the choice of expert, and the determination of when to use any such expert opinion will be within the Trustees' sole discretion.

→ **Plan Year or Fiscal Year:** The time period of June 1 through May 31.

→ **Post-Service Claims:** Any Claim that is not a Pre-service, Urgent Care, or Concurrent Care Claim.

→ **Pre-Service Claim:** Any Claim that, under the terms of the Plan, conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

→ **Qualified Medical Child Support Order:** A medical support order:

- Which creates or recognizes the existence of an alternate recipient's right to receive benefits as a Dependent under this Plan, and

- Includes:

  - The name and the last known mailing address (if any) of the Participant and the name and mailing address of each alternate recipient covered by the order;

- A reasonable description of the type of coverage to be provided by the Plan to each such alternate recipient, or the manner in which such type of coverage is to be determined (not to exceed the level of coverage offered by the Plan);

- The period to which such order applies; and

- The legal name of this Plan.

→ **Reasonable and Customary Charge:** Charges that do not exceed charges normally made by other hospitals, physicians, or service providers in this geographic area. For purposes of foregoing, covered charges will mean the actual cost or charge to an eligible Participant or Dependent, but only to the extent they will be deemed Reasonable and Customary Charges for Medically Necessary care and services that are ordered by a legally qualified Physician, but not to exceed the maximums provided in the Schedule of Benefits.

→ **Rescission:** A cancellation of coverage that has a retroactive effect and that is not the result of fraud or an intentional misrepresentation of a material fact. Cancellation of coverage due to non-payment of premiums or contributions toward the cost of coverage, including self-payments or COBRA premiums, is not a Rescission. Prospective cancellations of coverage will not be based upon any health factor, as defined in 26 CFR 54.9802-1.

→ **Residential Treatment Center:** A licensed facility setting offering a defined course of therapeutic intervention and special programming in a controlled environment which also offers a degree of security, supervision, structure and is licensed by the appropriate state and local authority to provide such service. Patients with such facilities are medically monitored with twenty-four (24) hour medical availability and twenty-four (24)-hour onsite nursing services for patients with Mental Illness and/or Substance Abuse disorders. It does not include halfway houses, supervised living, group homes, wilderness, equine or similar programs, boarding houses or other facilities that provide primarily a supportive environment and address long-term social needs, even if counseling is provided in such facilities; any services, irrespective of whether they are based on Medically Necessity, at the specified and/or related facilities will not be covered under the Plan.

→ **Retiree (Early and Medicare):** An individual who has met the initial eligibility requirements for coverage as a Retiree under the Plan and who has established and continuously maintained eligibility for benefits under this Plan. Residential Employees and their Dependents are not eligible for coverage under the Plan.

→ **Sickness:** Disease, mental, emotional, or nervous disorders, and covered pregnancy. A recurrent Sickness will be considered as one (1) Sickness. All related Sicknesses will be considered as one (1) Sickness. Concurrent Sicknesses will be deemed to be one (1) Sickness unless such Sicknesses are totally unrelated.

→ **Spouse:** The individual to whom a Participant is legally married (a marriage certificate will be required as proof of spousal relationship).

→ **Union:** The International Association of Heat and Frost Insulators and Allied Workers Regional Local Union No. 207, its affiliate Local Unions, or any successor thereto.

→ **Urgent Care Claims:** Any Claim for medical care or treatment that cannot be decided under normal time frames because (a) it can seriously jeopardize the life or health of the claimant or the ability of the Claimant to regain maximum function, or (b) in the opinion of a Medical Provider with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Claim. Any Claim that a Medical Provider with knowledge of the Claimant's medical condition determines is an Urgent Care Claim will be treated as an Urgent Care Claim by the Plan. Otherwise, the determination regarding whether a Claim involves Urgent Care will be made by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

APPENDIX B:
HAP SCHEDULE OF BENEFITS, EXCLUSIONS AND CLAIMS PROCEDURE

Schedule of Benefits

ALLIANCE HEALTH AND LIFE INSURANCE COMPANY
Preferred Provider Organization (PPO) plan

GROUP NUMBER:	**10006038**	**GROUP NAME:**	**ABATEMENT WORKERS NATIONAL HEALTH AND WELFARE AHL**
PRODUCT ID:	**PPS01973 / XRS02857**	**PRODUCT TYPE:**	**PPO**
COVERAGE DATES:	**11/01/2024 - 10/31/2025**	**BENEFIT PERIOD:**	**Calendar Year**
PLAN NAME:	**HAP PPO Custom 4209 / Rx PPO Custom 4209**		

This Schedule of Benefits provides you with information regarding the Cost-Sharing and any Maximum Benefits related to the Covered Services provided under the Policy. Please read the entire Policy and the Schedule of Benefits carefully.

In-Network Benefits:

Covered Services provided by Affiliated Providers and Covered Services that are paid at the In-Network Level of Benefits are subject to the Deductibles, Copays, Coinsurance and Out-of-Pocket Limits shown in the Schedule of Benefits under the In-Network Benefits column, unless otherwise indicated below.

Covered Services provided by Non-Affiliated Providers or paid at the Out-of-Network Level of Benefits do not count toward the Deductibles, Coinsurance Maximum or Out-of-Pocket Limits for In-Network Services.

Out-of-Network Benefits:

Covered Services provided by Non-Affiliated Providers and Covered Services that are paid at the Out-of- Network Level of Benefits are subject to the Deductibles, Coinsurance and Out-of-Pocket Limits shown in the Schedule of Benefits under the Out-of-Network Benefits column, unless otherwise indicated below.

Covered Services provided by Affiliated Providers or paid at the In-Network Level of Benefits do not count toward the Deductible, Coinsurance Maximum or Out-of-Pocket Limits for Out-of-Network Services.

Covered Services may be subject to a Copayment, the Deductible and/or the Coinsurance as shown in this Schedule of Benefits below.

PLAN ATTRIBUTES	IN-NETWORK BENEFITS	OUT-OF-NETWORK BENEFITS
Annual Deductible		
• **Individual**	$500	$1,000
• **Family**	$1,000	$2,000
Coinsurance	20%	40%
Annual Coinsurance Maximum		
• **Individual**	None	None
• **Family**	None	None
Annual Out-of-Pocket Limit		
• **Individual**	$6,800	$13,600
• **Family**	$13,600	$27,200

Schedule of Benefits

ALLIANCE HEALTH AND LIFE INSURANCE COMPANY
Preferred Provider Organization (PPO) plan

HEALTH CARE SERVICE	IN-NETWORK BENEFITS	OUT-OF-NETWORK BENEFITS
Preventive Services		
Office Visit / Physical Exam / Well Baby Exam	Covered; Deductible does not apply	Not Covered
Related Laboratory and Radiology Services	Covered; Deductible does not apply	Not Covered
Pap smear, mammogram, tubal ligation	Covered; Deductible does not apply	Not Covered
Immunizations	Covered; Deductible does not apply	Not Covered
Outpatient & Physician Services		
Primary Care Physician Office Visits to treat Illness or Injury • Family Practice • General Practice • Internal Medicine • Pediatrician Includes Physician home visits	$20 Copay per visit; Deductible does not apply	40% Coinsurance after Deductible
Telehealth Visits Through Our Contracted Telehealth Services Provider Only	$20 Copay per visit; Deductible does not apply	Not Covered
Specialist Office Visit Includes Physician home visits	$20 Copay per visit; Deductible does not apply	40% Coinsurance after Deductible
Routine Audiology Exam One exam per benefit period. For non-routine visits see Specialist Office Visit.	Covered; Deductible does not apply	Not Covered
Routine Eye Exam One exam per benefit period. For non-routine visits see Specialist Office Visit.	Covered; Deductible does not apply	Not Covered
Chiropractic Services Manipulation of spine for subluxation only.Up to 20 visits per benefit period. (Combined In-Network and Out-of-Network)	$20 Copay per visit; Deductible does not apply	40% Coinsurance after Deductible
Allergy Treatment	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Allergy Injections	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Diagnostic Laboratory & Pathology	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Imaging Services • MRI's • CT Scans • PET Scans • Other imaging services	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Radiology (X-ray)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Radiation Therapy & Chemotherapy	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Dialysis Out-of-Network benefits are not covered unless Prior Authorized.	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Outpatient Medical Drugs Drugs that are injected or infused by a healthcare professional	20% Coinsurance after Deductible	40% Coinsurance after Deductible

Schedule of Benefits

ALLIANCE HEALTH AND LIFE INSURANCE COMPANY
Preferred Provider Organization (PPO) plan

HEALTH CARE SERVICE	IN-NETWORK BENEFITS	OUT-OF-NETWORK BENEFITS
Outpatient Hospital and Ambulatory Surgical Center Services		
Physician & Other Professional Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Diagnostic Laboratory & Pathology	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Imaging Services • MRI's • CT Scans • PET Scans • Other imaging services	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Radiology (X-ray)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Outpatient Hospital Surgical Facility (OP Hosp)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Ambulatory Surgical Center (ASC)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Radiation Therapy & Chemotherapy	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Dialysis Out-of-Network benefits are not covered unless Prior Authorized.	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Emergency / Urgent Care		
Urgent Care	$30 Copay per visit; Deductible does not apply	
Emergency Room Services Copay will be waived if admitted	$150 Copay per visit; Deductible does not apply	
Emergency Medical Transportation Emergency Transport Only	20% Coinsurance after In-Network Deductible	
Inpatient Hospital Services		
Facility Fee	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Physician Services, Surgery, Therapy & Other Hospital Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Diagnostic & Laboratory Services • X-rays • Lab Tests • MRI's • CT Scans • PET Scans • Other imaging services	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Bariatric Surgery & Related Services One procedure per lifetime	20% Coinsurance after Deductible	Not Covered
Maternity Services		
Routine Prenatal Office Visits Covered under Preventive Services. For non-routine visits, see Specialist Office Visit.	Covered; Deductible does not apply	Not Covered
Routine Postnatal Office Visits Covered under Preventive Services. For non-routine visits, see Specialist Office Visit.	Covered; Deductible does not apply	Not Covered
Inpatient Hospital, Labor, Delivery & Newborn Care	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Transplant Services		
Organ Transplant Surgery & Related Services	20% Coinsurance after Deductible	Not Covered

Schedule of Benefits

ALLIANCE HEALTH AND LIFE INSURANCE COMPANY
Preferred Provider Organization (PPO) plan

HEALTH CARE SERVICE	IN-NETWORK BENEFITS	OUT-OF-NETWORK BENEFITS
Mental Health & Substance Use Disorder		
Inpatient Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Outpatient Services	$20 Copay per visit; Deductible does not apply	40% Coinsurance after Deductible
Habilitation Services / Autism Spectrum Disorder Services - Coverage is limited to Subscribers & Dependents who are under age 19 only		
Physical, Occupational and Speech Therapy.	$20 Copay per visit; Deductible does not apply	Not Covered
Applied Behavioral Analysis (ABA)	$20 Copay per visit; Deductible does not apply	Not Covered
Other Services		
Home Health Care Does not include Rehabilitation Services.Up to 100 visits per benefit period. (Combined In-Network and Out-of-Network)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Hospice Care Unlimited.	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Skilled Nursing Facility Up to 100 days per benefit period. (Combined In-Network and Out-of-Network)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Durable Medical Equipment (DME); Prosthetics & Orthotics Covered for approved equipment only.	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Physical, Occupational & Speech Therapy May be rendered at home.Up to 60 combined visits per benefit period (Combined In-Network and Out-of-Network).	$20 Copay per visit; Deductible does not apply	40% Coinsurance after Deductible
Temporomandibular Joint Disorder Coverage for non-invasive treatments only.	20% Coinsurance after Deductible	40% Coinsurance after Deductible

Schedule of Benefits

ALLIANCE HEALTH AND LIFE INSURANCE COMPANY
Preferred Provider Organization (PPO) plan

HEALTH CARE SERVICE	IN-NETWORK BENEFITS	OUT-OF-NETWORK BENEFITS
Additional Health Care Services		
Voluntary Sterilizations Limited to vasectomy	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Infertility Services Services for diagnosis, counseling & treatment of bodily disorders causing infertility.	20% Coinsurance after Deductible	40% Coinsurance after Deductible

Schedule of Benefits

ALLIANCE HEALTH AND LIFE INSURANCE COMPANY
Preferred Provider Organization (PPO) plan

Drug Type	Retail Pharmacy	Mail Order & 90-Day Retail Pharmacy*
Tier 1 – Preferred Generic Drugs	$15 Copay ;Deductible does not apply	$30 Copay ;Deductible does not apply
Tier 1A – Non-Preferred Generic Drugs	$15 Copay ;Deductible does not apply	$30 Copay ;Deductible does not apply
Tier 2 – Preferred Brand Drugs	$40 Copay ;Deductible does not apply	$80 Copay ;Deductible does not apply
Tier 3 – Non-Preferred Brand Drugs	$80 Copay ;Deductible does not apply	$160 Copay ;Deductible does not apply
Tier 4 – Preferred Specialty Drugs	20% Coinsurance($200 Maximum) ;Deductible does not apply	Not Applicable**
Tier 4A – Non-Preferred Specialty Drugs	20% Coinsurance($300 Maximum) ;Deductible does not apply	Not Applicable**
Maximum Supply per prescription or refill	Up to a 30-day supply and/or restricted quantity limit.	Up to a 90-day supply and/or restricted quantity limit.

*** A 90-day supply of non-Maintenance Drugs must be filled at the designated mail order pharmacy.**
** Tier 4 & Tier 4A (specialty drugs) are limited to a 30-day supply per fill. In certain situations, greater than a 30-day supply may be approved. If a Copay or Maximum is shown above, You will pay two times that amount for a supply of up to 60 days, and three times that amount for a supply of up to 90 days.

****For Outpatient Mental Health & Substance Use Disorder Services delivered via Telehealth, you will pay the lower of either the Outpatient Mental Health & Substance Use Disorder Cost-Share or the Telehealth Cost-Share.

Schedule of Benefits

ALLIANCE HEALTH AND LIFE INSURANCE COMPANY
Preferred Provider Organization (PPO) plan

Schedule of Benefits Definitions

Coinsurance means the percentage of the Allowable Amount for certain Covered Services paid by You after the Deductible has been met. Coinsurance may vary depending upon the Covered Services received. The Coinsurance percentages are for In-Network Services is shown in this Schedule of Benefits under the In-Network Benefits column. The Coinsurance percentage for Out-of-Network Services is shown in this Schedule of Benefits under the Out-of-Network Benefits column.

Coinsurance Maximum means the maximum Coinsurance dollar amount paid by You for Covered Services during a Benefit Period. The Coinsurance Maximum does not include Copayments or the Deductible. If applicable, the Coinsurance Maximum is shown in this Schedule of Benefits.

Copayment or Copay means the set dollar amount You must pay for certain Covered Services each time You obtain the Covered Service. Applicable Copayment amounts are shown in this Schedule of Benefits. Not all Covered Services have a Copayment. Copayments do not count toward the Deductible, Coinsurance or Coinsurance Maximum. Copayments do count toward the Out-of-Pocket Limits.

Deductible means the set dollar amount You must pay for certain Covered Services before payment of benefits under this Policy begins. There are separate Deductibles for In-Network Services and Out-of-Network Services. The Deductible applies to each Subscriber and Dependent and must be met each Benefit Period. Copayments are not applied towards the Deductible. The Deductibles are shown in this Schedule of Benefits.

a. **In-Network Individual Deductible**
This is the Deductible amount that You pay each Benefit Period for certain Covered Services obtained from Affiliated Providers and/or covered at the In-Network Level of Benefits. The Allowable Amounts for these Covered Services are applied toward the In-Network Individual Deductible for the Subscriber and each Dependent individually. Once Your In-Network Individual Deductible is met, In-Network benefits are payable for You only during that same Benefit Period.

b. **In-Network Family Deductible**
This is the Deductible amount that the Subscriber and all Dependents must collectively pay each Benefit Period for certain Covered Services obtained from Affiliated Providers and/or covered at the In-Network Level of Benefits. The Allowable Amounts for Covered Services that are applied toward each In-Network Individual Deductible are also applied toward the In-Network Family Deductible until the In-Network Family Deductible is met. Once the In-Network Family Deductible is met, In-Network benefits are payable for the Subscriber and all Dependents during that same Benefit Period.

c. **Out-of-Network Individual Deductible**
This is the Deductible amount that You pay each Benefit Period for Covered Services obtained from Non-Affiliated Providers that are covered at the Out-of-Network Level of Benefits. The Allowable Amounts for these Covered Services are applied toward the Out-of-Network Individual Deductible for the Subscriber and each Dependent individually. Once Your Out-of-Network Individual Deductible is met, Out-of-Network benefits are payable for You only during that same Benefit Period.

d. **Out-of-Network Family Deductible**
This is the Deductible amount that the Subscriber and all Dependents must collectively pay each Benefit Period for Covered Services obtained from Non-Affiliated Providers that are covered at the Out-of- Network Level of Benefits. The Allowable Amounts for Covered Services that are applied toward each Out-of-Network Individual Deductible are also applied toward the Out-of-Network Family Deductible until the Out-of-Network Family Deductible is met. Once the Out-of-Network Family Deductible is met, Out-of-Network benefits are payable for the Subscriber and all Dependents during that same Benefit Period.

Schedule of Benefits

ALLIANCE HEALTH AND LIFE INSURANCE COMPANY
Preferred Provider Organization (PPO) plan

Out-of-Pocket Limit is the most You will pay for the combined total of all Copays, Coinsurance and deductibles for Covered Services in a Benefit Period. There are separate Out-of-Pocket Limits for In-Network Services and Out-of-Network Services. The Out-of-Pocket Limits are shown in this Schedule of Benefits.

a. In-Network Individual Out-of-Pocket Limit
This is the most You will pay each Benefit Period for Covered Services obtained from Affiliated Providers and/or covered at the In-Network Level of Benefits. The In-Network Cost-Sharing amounts paid are applied toward the In-Network Out-of-Pocket Limit for the Subscriber and each Dependent individually. Once Your In-Network Individual Out-of-Pocket Limit is met, In-Network benefits are payable for You only at 100% of the Allowable Amount for the rest of the Benefit Period.

b. In-Network Family Out-of-Pocket Limit
This is the most the Subscriber and all Dependents will collectively pay each Benefit Period for Covered Services obtained from Affiliated Providers and/or covered at the In-Network Level of Benefits. The In- Network Cost-Sharing amounts that are applied toward each In-Network Individual Out-of-Pocket Limit are also applied to the In-Network Family Out-of-Pocket Limit until the In-Network Family Out-of-Pocket Limit is met. Once the In-Network Family Out-of-Pocket Limit is met, In-Network benefits are payable for the Subscriber and all Dependents at 100% of the Allowable Amount for the rest of the Benefit Period.

c. Out-of-Network Individual Out-of-Pocket Limit
This is the most You will pay each Benefit Period for Covered Services obtained from Non-Affiliated Providers that are covered at the Out-of-Network Level of Benefits. The Out-of-Network Cost-Sharing amounts paid are applied toward the Out-of-Network Out-of-Pocket Limit for the Subscriber and each Dependent individually. Once Your Out-of-Network Individual Out-of-Pocket Limit is met, Out-of- Network benefits are payable for You only at 100% of the Allowable Amount for the rest of the Benefit Period.

If the Out-of-Network Individual Out-of-Pocket Limit is NONE on this Schedule of Benefits, once You meet the Out-Of-Network Individual Deductible, You will continue to pay applicable Copayments and Coinsurance for all Out-of-Network Services for the rest of the Benefit Period.

d. Out-of-Network Family Out-of-Pocket Limit
This is the most the Subscriber and all Dependents will collectively pay each benefit Period for Covered Services obtained from Non-Affiliated Providers that are covered at the Out-of-Network Level of Benefits. The Out-of-Network Cost-Sharing amounts that are applied toward each Out-of-Network Individual Out-of-Pocket Limit are also applied to the Out-of-Network Family Out-of-Pocket Limit until the Out-of-Network Family Out-of-Pocket Limit is met. Once the Out-of-Network Family Out-of-Pocket Limit is met, Out-of-Network benefits are payable for the Subscriber and all Dependents at 100% of the Allowable Amount for the rest of the Benefit Period.

Except as otherwise specified in this Schedule of Benefits, the following amounts paid by You do not count toward the Out-of-Pocket Limit:

a. Charges that exceed the Allowable Amounts for Covered Services;
b. Charges that exceed any Maximum Benefits described in the Policy, any attached Rider or on the Schedule;
c. Charges for services that are not Covered Services in the Policy or any attached Rider;
d. Charges for services that are not Prior Authorized, if Prior Authorization is required, as described in the Policy; and
e. Premiums.

If the Out-of-Network Family Out-of-Pocket Limit is NONE on this Schedule of Benefits, once the Out-of-Network Family Deductible is met, the Subscriber and all Dependents will continue to pay applicable Copayments and Coinsurance for all Out-of-Network Services for the rest of the Benefit Period.

APPENDIX C:
HUMANA SCHEDULE OF BENEFITS, EXCLUSIONS AND MEDICARE RX

2025

Summary of Benefits

Humana Group Medicare Advantage PPO Plan
PPO 079/064

Humana.

Our service area includes specific counties within the United States, Puerto Rico and all other major US Territories.

Let's talk about the **Humana Group Medicare Advantage PPO** Plan.

Find out more about the Humana Group Medicare Advantage PPO plan – including the services it covers – in this easy-to-use guide.

The benefit information provided is a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. For a complete list of services we cover, refer to the "Evidence of Coverage".

To be eligible

To join the Humana Group Medicare Advantage PPO plan, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

Plan name:

Humana Group Medicare Advantage PPO plan

How to reach us:

Members should call toll-free **1-866-396-8810** for questions **(TTY/TDD 711)**

Call Monday – Friday, 8 a.m. - 9 p.m. Eastern Time.

Or visit our website: **Humana.com**

Humana Group Medicare Advantage PPO plan has a network of doctors, hospitals, and other providers. For more information, please call Humana Group Medicare Customer Care.

A healthy partnership

Get more from this plan — with extra services and resources provided by Humana!

Monthly Premium, Deductible and Limits

	IN-NETWORK	OUT-OF-NETWORK
PLAN COSTS		
Monthly premium You must keep paying your Medicare Part B premium.	For information concerning the actual premiums you will pay, please contact Humana, your employer/union group, or your employer group benefits plan administrator.	
Medical deductible	This plan does not have a deductible.	
Maximum out-of-pocket responsibility The most you pay for copays, coinsurance and other costs for medical services for the year.	**In-Network Maximum Out-of-Pocket** **$0** out-of-pocket limit for Medicare-covered services. The following services do not apply to the maximum out-of-pocket: Part D Pharmacy; Fitness Program; Health Education Services; Meal Benefit; Post-Discharge Personal Home Care; Post-Discharge Transportation Services; Smoking Cessation (Additional) and the Plan Premium do not apply to the in-network maximum out-of-pocket. If you reach the limit on out-of-pocket costs, we will pay the full cost for the rest of the year on covered hospital and medical services.	**Combined In and Out-of-Network Maximum Out-of-Pocket** **$0** out-of-pocket limit for Medicare-covered services. In-Network Exclusions: Part D Pharmacy; Fitness Program; Health Education Services; Meal Benefit; Post-Discharge Personal Home Care; Post-Discharge Transportation Services; Smoking Cessation (Additional) and the Plan Premium do not apply to the combined maximum out-of-pocket. Out-of-Network Exclusions: Part D Pharmacy; Worldwide Coverage and the Plan Premium do not apply to the combined maximum out-of-pocket. Your limit for services received from in-network providers will count toward this limit. If you reach the limit on out-of-pocket costs, we will pay the full cost for the rest of the year on covered hospital and medical services.

Note: *A cost share range may display, depending on the service and where the service is provided. Some services require prior authorization.*

Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
ACUTE INPATIENT HOSPITAL CARE		
This plan covers an unlimited number of days for an inpatient hospital stay. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.	**$0** per admit	**$0** per admit
OUTPATIENT HOSPITAL COVERAGE		
Outpatient hospital visits	**$0** copay	**$0** copay
Observation services	**$0** copay	**$0** copay
Ambulatory surgical center	**$0** copay	**$0** copay
DOCTOR OFFICE VISITS		
Primary care provider (PCP)	**$0** copay	**$0** copay
Specialists	**$0** copay	**$0** copay
PREVENTIVE CARE		
Including: Annual Wellness Visit, flu vaccine, colorectal cancer and breast cancer screenings. Any additional preventive services approved by Medicare during the contract year will be covered.	**Covered at no cost**	**Covered at no cost**
EMERGENCY CARE		
Emergency room	**$0** copay for Medicare-covered emergency room visit(s)	**$0** copay for Medicare-covered emergency room visit(s)
Urgently needed services Urgently needed services are care provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention.	**$0** copay	**$0** copay
DIAGNOSTIC SERVICES, LABS AND IMAGING		
Diagnostic radiology	**$0** copay	**$0** copay
Lab services	**$0** copay	**$0** copay
Diagnostic tests and procedures	**$0** copay	**$0** copay
Outpatient x-rays	**$0** copay	**$0** copay
Radiation therapy	**$0** copay	**$0** copay

Note: *A cost share range may display, depending on the service and where the service is provided. Some services require prior authorization.*

Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
HEARING SERVICES		
Medicare-covered hearing: diagnostic hearing and balance exams	**$0** copay	**$0** copay
DENTAL SERVICES		
Medicare-covered dental	**$0** copay (services include surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments or neoplastic disease)	**$0** copay (services include surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments or neoplastic disease)
VISION SERVICES		
Medicare-covered vision services	**$0** copay (services include diagnosis and treatment of diseases and injuries of the eye)	**$0** copay (services include diagnosis and treatment of diseases and injuries of the eye)
Medicare-covered diabetic eye exam (1 per year)	**$0** copay	**$0** copay
Medicare-covered glaucoma screening (1 per year)	**$0** copay	**$0** copay
Medicare-covered eyewear (post-cataract)	**$0** copay	**$0** copay
MENTAL HEALTH SERVICES		
Inpatient The inpatient hospital care limit applies to inpatient mental services provided in a general hospital or a psychiatric facility. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. 190 day lifetime limit in a psychiatric facility.	**$0** per admit	**$0** per admit
Outpatient group and individual therapy visits	**Outpatient therapy visit:** **$0** copay **Partial Hospitalization:** **$0** copay	**Outpatient therapy visit:** **$0** copay **Partial Hospitalization:** **$0** copay

Note: *A cost share range may display, depending on the service and where the service is provided. Some services require prior authorization.*

Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
SKILLED NURSING FACILITY		
This plan covers up to 100 days in a SNF. No 3-day hospital stay is required. Plan pays $0 after 100 days.	**$0** copay per day for days 1-100	**$0** copay per day for days 1-100
PHYSICAL THERAPY		
	$0 copay	**$0** copay
AMBULANCE		
Per date of service regardless of the number of trips. Limited to Medicare-covered transportation.	**$0** copay	**$0** copay
PART B PRESCRIPTION DRUGS		
Medicare Part B covered drugs	**$0** copay or **0%** of the cost	**$0** copay or **0%** of the cost
Medicare Part B insulin drugs	**$0** copay or **0%** of the cost	**$0** copay or **0%** of the cost
ACUPUNCTURE SERVICES		
Medicare-covered acupuncture visit(s) for chronic low back pain This plan allows services to be received by a provider licensed to perform acupuncture or by providers meeting the Original Medicare provider requirements.	**$0** copay for acupuncture for chronic low back pain visits up to 20 combined in and out of network visit(s) per year.	**$0** copay for acupuncture for chronic low back pain visits up to 20 combined in and out of network visit(s) per year. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
ALLERGY		
Allergy shots & serum	**$0** copay	**$0** copay
CHIROPRACTIC SERVICES		
Medicare-covered chiropractic visit(s)	**$0** copay	**$0** copay
DIABETES MANAGEMENT TRAINING		
	$0 copay	**$0** copay
FOOT CARE (PODIATRY)		
Medicare-covered foot care	**$0** copay	**$0** copay
HOME HEALTH CARE		
	$0 copay	**$0** copay

Note: *A cost share range may display, depending on the service and where the service is provided. Some services require prior authorization.*

Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
MEDICAL EQUIPMENT/SUPPLIES		
Durable medical equipment (like wheelchairs or oxygen)	**0%** of the cost	**0%** of the cost
Medical supplies (includes but not limited to: catheters, IV set-up and supplies)	**0%** of the cost	**0%** of the cost
Prosthetics (artificial limbs or braces)	**0%** of the cost	**0%** of the cost
Diabetes monitoring supplies	**$0** copay	**$0** copay
Continuous glucose monitors	**0%** of the cost	**0%** of the cost
OUTPATIENT SUBSTANCE ABUSE		
Outpatient group and individual substance abuse treatment visits	**Outpatient therapy visit:** **$0** copay **Partial Hospitalization:** **$0** copay	**Outpatient therapy visit**: **$0** copay **Partial Hospitalization:** **$0** copay
REHABILITATION SERVICES		
Occupational and speech therapy	**$0** copay	**$0** copay
Cardiac rehabilitation	**$0** copay	**$0** copay
Pulmonary rehabilitation	**$0** copay	**$0** copay
RENAL DIALYSIS		
Renal dialysis	**$0** copay	**$0** copay
Kidney disease education services	**$0** copay	**$0** copay
HUMANA IN-NETWORK TELEHEALTH VENDORS, i.e. MDLive (in addition to Original Medicare)		
Primary care provider (PCP)	**$0** copay	Not Covered
Specialist	**$0** copay	Not Covered
Urgent care services	**$0** copay	Not Covered
Substance abuse or behavioral health services	**$0** copay	Not Covered

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Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
FITNESS AND WELLNESS		
	Live a healthier, more active life through fitness and social connection at participating SilverSneakers ® locations and online.	
HEALTH EDUCATION SERVICES		
	Personal Health Coaching is an interactive inbound and outreach on-line and telephonic wellness coaching for Medicare participants who elect to participate, for wellness improvement, including weight management, nutrition, exercise, back care, blood pressure management, and blood sugar management.	
MEAL BENEFIT		
	After a member's overnight inpatient stay in a hospital or skilled nursing facility, members are eligible for nutritious meals delivered to their door at no cost.	
POST-DISCHARGE PERSONAL HOME CARE		
	After a member's overnight inpatient stay in a hospital or skilled nursing facility, members may receive assistance performing activities of daily living within the home. Types of assistance include bathing, dressing, toileting, walking, eating and preparing meals.	
POST-DISCHARGE TRANSPORTATION SERVICES		
	After a member’s overnight inpatient stay in a hospital or skilled nursing facility, members are provided transportation to plan approved locations by rideshare services, car, van or wheelchair accessible vehicle at no cost.	
SMOKING CESSATION (ADDITIONAL)		
	A comprehensive smoking cessation program available online, email and phone. Personal coaches assist via establishing goals and providing articles and resources to aid in the effort to quit smoking.	
HOSPICE You must get care from a Medicare-certified hospice. You must consult with this plan before you select hospice.		

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GHHNDN2025HUM

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Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-877-320-1235 (听障专线 : 711)。我们的中文工作人员很乐意帮助您。这是一项免费服务。

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Find out **more**

You can see this plan's provider directory at **Humana.com** or call us at the number listed at the beginning of this booklet and we will send you one.

Humana is a Medicare Advantage PPO plan with a Medicare contract. Enrollment in this Humana plan depends on contract renewal.

If you want to compare this plan with other Medicare health plans, you can call your employer or union sponsoring this plan to find out if you have other options through them.

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at http://www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Humana®

Humana.com

SB079064EN25

2025

Prescription Drug Summary of Benefits

Humana Group Medicare Advantage Plan
Rx 5

Humana®

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Let's talk about the **Humana Group Medicare Advantage Rx** Plan.

Find out more about the Humana Group Medicare Advantage Rx plan – including the services it covers – in this easy-to-use guide.

The benefit information provided is a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. For a complete list of services we cover, refer to the "Evidence of Coverage".

Deductible

Pharmacy (Part D) deductible This plan does not have a deductible.

Prescription Drug Benefits

Initial coverage (after you pay your deductible, if applicable)
You pay the following until your total out-of-pocket drug costs reach **$2,000**. Once you reach this amount, you will enter the Catastrophic Stage.

Tier	Standard Retail Pharmacy	Standard Mail Order
30-day supply		
1 (Generic or Preferred Generic)	**$4** copay	**$4** copay
2 (Preferred Brand)	**$25** copay	**$25** copay
3 (Non-Preferred Drug)	**$40** copay	**$40** copay
4 (Specialty Tier)	**33%** of the cost	**33%** of the cost
90-day supply		
1 (Generic or Preferred Generic)	**$12** copay	**$0** copay
2 (Preferred Brand)	**$75** copay	**$50** copay
3 (Non-Preferred Drug)	**$120** copay	**$80** copay
4 (Specialty Tier)	N/A	N/A

There may be generic and brand-name drugs, as well as Medicare-covered drugs, in each of the tiers. To identify commonly prescribed drugs in each tier, see the Prescription Drug Guide/Formulary. To view the most complete and current Drug Guide information online, visit **www.humana.com/SearchResources**, locate Prescription Drug section, select **www.humana.com/MedicareDrugList** link; under Printable drug lists, click Printable Drug lists, select future plan year, select Group Medicare under Plan Type and search for GRP**2**.

Important Message About What You Pay for Vaccines – This plan covers most Part D vaccines at no cost to you (even if you haven't paid your deductible, if applicable). Call Humana Group Medicare Customer Care for more information.

Important Message About What You Pay for Insulin – You won't pay more than **$35** for a one-month supply of each insulin product covered by this plan, no matter what cost-sharing tier it's on.

Catastrophic Coverage

After your total out-of-pocket costs reach **$2,000**, you pay **$0** for plan-covered Part D drugs.

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APPENDIX D:
DENTAL SCHEDULE OF BENEFITS

DELTA DENTAL®

Delta Dental PPO™ (Point-of-Service)
Summary of Dental Plan Benefits
For Group# 0207-0001, 0002, 0003, 0004
Abatement Worker's National Health and Welfare Fund

This Summary of Dental Plan Benefits should be read along with your Certificate. Your Certificate provides additional information about your Delta Dental plan, including information about plan exclusions and limitations. If a statement in this Summary conflicts with a statement in the Certificate, the statement in this Summary applies to you and you should ignore the conflicting statement in the Certificate. The percentages below are applied to Delta Dental's allowance for each service and it may vary due to the Dentist's network participation.*

Control Plan – Delta Dental of Michigan

Benefit Year – January 1 through December 31

Covered Services –	**Delta Dental PPO™ Dentist**	**Delta Dental Premier® Dentist**	**Nonparticipating Dentist**
	Plan Pays	**Plan Pays**	**Plan Pays***
Diagnostic & Preventive			
Diagnostic and Preventive Services – exams, cleanings, fluoride, and space maintainers	100%	100%	80%
Palliative Treatment – to temporarily relieve pain	100%	100%	80%
Sealants – to prevent decay of permanent teeth	100%	100%	80%
Brush Biopsy – to detect oral cancer	100%	100%	80%
Radiographs – X-rays	100%	100%	80%
Basic Services			
Minor Restorative Services – fillings and crown repair	100%	100%	80%
Endodontic Services – root canals	100%	100%	80%
Periodontic Services – to treat gum disease	100%	100%	80%
Oral Surgery Services – extractions and dental surgery	100%	100%	80%
Major Restorative Services – crowns	100%	100%	80%
Other Basic Services – misc. services	100%	100%	80%
Relines and Repairs – to prosthetic appliances	100%	100%	80%
Major Services			
Prosthodontic Services – bridges, implants, dentures, and crowns over implants	100%	100%	80%
Orthodontic Services			
Orthodontic Services – braces	100%	100%	80%
Orthodontic Age Limit –	through age 18 and under	through age 18 and under	through age 18 and under

* When you receive services from a Nonparticipating Dentist, the percentages in this column indicate the portion of Delta Dental's Nonparticipating Dentist Fee that will be paid for those services. This amount may be less than what the Dentist charges and you are responsible for that difference.

- Oral exams (including evaluations by a specialist) are payable twice per calendar year.
- Prophylaxes (cleanings) are payable twice per calendar year. Two additional periodontal maintenance procedures are payable per calendar year for individuals with a documented history of periodontal disease.
- People with specific at-risk health conditions may be eligible for additional prophylaxes (cleanings) or fluoride treatment. The patient should talk with his or her Dentist about treatment.
- Fluoride treatments are payable twice per calendar year for people age 18 and under.
- Space maintainers are Covered Services without limitations.
- Bitewing X-rays are payable twice per calendar year and full-mouth X-rays (which include bitewing X-rays) or a panorex are payable once in any five-year period.
- ViziLite is a Covered Service.
- Sealants are payable for permanent bicuspids and molars. The surface must be free from decay and restorations.
- Composite resin (white) restorations are payable on posterior teeth.
- Inlays (any material) are Covered Services.
- Porcelain and resin facings on crowns are payable on posterior teeth.

- Overdentures and precision attachments on dentures (and their replacement) are Covered Services.
- Implants are payable once per tooth in any five-year period. Implant related services are Covered Services.
- Crowns over implants are payable once per tooth in any five-year period. Services related to crowns over implants are Covered Services.
- Antibiotic drug injections are Covered Services. Occlusal guards are payable with no time limitations.
- People with special health care needs may be eligible for additional services including exams, hygiene visits, dental case management, and sedation/anesthesia. Special health care needs include any physical, developmental, mental, sensory, behavioral, cognitive, or emotional impairment or limiting condition that requires medical management, healthcare intervention, and/or use of specialized services or programs. The condition may be congenital, developmental, or acquired through disease, trauma, or environmental cause and may impose limitations in performing daily self-maintenance activities or substantial limitations in a major life activity.

Having Delta Dental coverage makes it easy for you to get dental care almost everywhere in the world! You can now receive expert dental care when you are outside of the United States through our Passport Dental program. This program gives you access to a worldwide network of Dentists and dental clinics. English-speaking operators are available around the clock to answer questions and help you schedule care. For more information, check our website or contact your benefits representative to get a copy of our Passport Dental information sheet.

Maximum Payment – There is no maximum payment for diagnostic and preventive, basic or major services up to age 19. $2,300 per person over age 19 total per calendar year on all services except orthodontics. $2,400 per person total per lifetime on orthodontic services.

Payment for Orthodontic Service – When orthodontic treatment begins, your Dentist will submit a payment plan to Delta Dental based upon your projected course of treatment. In accordance with the agreed upon payment plan, Delta Dental will make an initial payment to you or your Participating Dentist equal to Delta Dental's stated Copayment on 30% of the Maximum Payment for Orthodontic Services as set forth in this Summary of Dental Plan Benefits. Delta Dental will make additional payments as follows: Delta Dental PPO™ Dentist - Delta Dental will pay 100% of the per month fee charged by your Dentist based upon the agreed upon payment plan provided by Delta Dental to your Dentist. Delta Dental Premier® Dentist - Delta Dental will pay 100% of the per month fee charged by your Dentist based upon the agreed upon payment plan provided by Delta Dental to your Dentist. Nonparticipating Dentist - Delta Dental will pay 80% of the per month fee charged by your Dentist based upon the agreed upon payment plan provided by Delta Dental to your Dentist.

Deductible – None.

Waiting Period – Enrollees who are eligible for Benefits are covered as defined by your Fund office.

Eligible People – As defined by your Fund office: Active (0001), Office Employees (0002), Early Retirees (0003) and COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) enrollees (0004).

Also eligible are your Spouse and your Children to the end of the month in which they turn 26, including your Children who are married, who no longer live with you, who are not your dependents for Federal income tax purposes, and/or who are not permanently disabled.

Coordination of Benefits – If you and your Spouse are both eligible to enroll in This Plan as Enrollees, you may be enrolled as both an Enrollee on your own application and as a Dependent on your Spouse's application. Your Dependent Children may be enrolled on both your and your Spouse's applications as well. Delta Dental will coordinate benefits between your coverage and your Spouse's coverage.

Benefits will cease on the last day of the month in which your employment is terminated.

Delta Dental PPO™

Our national PPO program

Welcome!

Your dental program is administered by Delta Dental Plan of Michigan, Inc., a nonprofit dental care corporation doing business as Delta Dental of Michigan. Delta Dental of Michigan is the state's dental benefits specialist. Good oral health is a vital part of good general health, and your Delta Dental program is designed to promote regular dental visits. We encourage you to take advantage of this program by calling your Dentist today for an appointment.

This Certificate, along with your Summary of Dental Plan Benefits, describes the specific benefits of your Delta Dental program and how to use them. If you have any questions about this program, please call our Customer Service department at 800-524-0149 or access our website at www.DeltaDentalMI.com.

You can easily verify your own Benefit, Claims and eligibility information online 24 hours a day, seven days a week by visiting www.DeltaDentalMI.com and selecting the link for our Member Portal. The Member Portal will also allow you to print claim forms and ID cards, select paperless Explanation of Benefits statements (EOBs), search our Dentist directories, and read oral health tips.

We look forward to serving you!

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Please read this Certificate together with the Summary of Dental Plan Benefits. The Summary of Dental Plan Benefits lists the specific provisions of your group dental plan. If a statement in the Summary conflicts with a statement in this Certificate, the statement in the Summary applies to This Plan and you should ignore the conflicting statement in this Certificate.

I. Delta Dental PPO Certificate

Delta Dental Plan of Michigan, Inc., referred to herein as Delta Dental, issues this Certificate to you, the Enrollee. The Certificate is a summary of your dental benefits coverage. It reflects and is subject to a contract between Delta Dental and the Contractor.

The Benefits provided under This Plan may change if any state or federal laws change.

Delta Dental agrees to provide Benefits as described in this Certificate and the Summary of Dental Plan Benefits.

All the provisions in the following pages form a part of this document as fully as if they were stated over the signature below.

IN WITNESS WHEREOF, this Certificate is executed at Delta Dental's home office by an authorized officer.

Goran M. Jurkovic, CPA, CGMA
President and CEO
Delta Dental Plan of Michigan, Inc.

II. Definitions

Adverse Benefit Determination

Any denial, reduction or termination of the benefits for which you filed a Claim. Or a failure to provide or to make payment (in whole or in part) of the benefits you sought, including any such determination based on eligibility, application of any utilization review criteria, or a determination that the item or service for which benefits are otherwise provided was experimental or investigational, or was not medically necessary or appropriate.

Allowed Amount

The amount permitted under the applicable fee schedule for This Plan, which was selected by your Contractor, and upon which Delta Dental will base its payment for a Covered Service.

Benefit Year

The period during which any benefit frequency limitation and/or annual maximum payment will apply. This will be the calendar year unless your Contractor elects a different period to serve as the Benefit Year. (See the Summary of Dental Plan Benefits for your Benefit Year.) If the Benefit Year is based upon a calendar year, the terms Benefit Year and Calendar Year may be used interchangeably.

Benefits

Payment for the Covered Services that have been selected under This Plan.

Certificate

This document. Delta Dental will provide Benefits as described in this Certificate. Any changes in this Certificate will be based on changes to the contract between Delta Dental and the Contractor.

Child(ren)

Your natural child(ren), stepchild(ren), adopted child(ren), child(ren) by virtue of legal guardianship, or child(ren) who is/are residing with you during the waiting period for adoption or legal guardianship.

Claim

A request for payment for a Covered Service. Claims are not conditioned upon your seeking advance approval, certification, or authorization to receive payment for any Covered Service.

Completion Date

The date that treatment is complete. Some procedures may require more than one appointment before they can be completed. Treatment is complete:

- For dentures and partial dentures, on the delivery dates;
- For crowns and bridgework, on the permanent cementation date;
- For root canals and periodontal treatment, on the date of the final procedure that completes treatment.

Copayment

The percentage of the charge, if any, that you must pay for Covered Services.

Contractor

The employer, organization, group, or association sponsoring This Plan.

Covered Services

The unique dental services selected for coverage as described in the Summary of Dental Plan Benefits and subject to the terms of this Certificate.

Deductible

The amount a person and/or a family must pay toward Covered Services before Delta Dental begins paying for those services under this Certificate. The Summary of Dental Plan Benefits lists the Deductible that applies to you, if any.

Delta Dental

Delta Dental Plan of Michigan, Inc., a nonprofit dental care corporation providing dental benefits. Delta Dental is not an insurance company.

Delta Dental Member Plan

An individual dental benefit plan that is a member of the Delta Dental Plans Association, the nation's largest, most experienced system of dental health plans.

Delta Dental Premier® Dentist Schedule

The maximum fee allowed per procedure for services rendered by a Premier Dentist as determined by that Dentist's local Delta Dental Member Plan.

Dentist

A person licensed to practice dentistry in the state or jurisdiction in which dental services are performed.

- **Delta Dental PPO Dentist ("PPO Dentist")** – a Dentist who has signed an agreement with the Delta Dental Member Plan in his or her state to participate in Delta Dental PPO.
- **Delta Dental Premier® Dentist ("Premier Dentist")** – a Dentist who has signed an agreement with the Delta Dental Member Plan in his or her state to participate in Delta Dental Premier.
- **Non-Participating Dentist** – a Dentist who has not signed an agreement with any Delta Dental Member Plan to participate in Delta Dental PPO or Delta Dental Premier.
- **Out-of-Country Dentist** – A Dentist whose office is located outside the United States and its territories. Out-of-Country Dentists are not eligible to sign participating agreements with Delta Dental.

PPO Dentists and Delta Dental Premier Dentists are sometimes collectively referred to herein as **"Participating Dentists."** Wherever a definition or provision of this Certificate differs from another state's Delta Dental Member Plan and its agreement with Participating Dentists, the agreement in that state with that Dentist will be controlling.

Delta Dental Premier Dentists, Non-Participating Dentists, and Out-of-Country Dentists are sometimes collectively referred to herein as **"Non-PPO Dentists."**

Deny/Denied/Denial

When a Claim for a particular service is denied for payment due to certain contractual limitations/exclusions. You will be responsible for paying your Dentist the applicable amount for such service regardless of the Dentist's participating status.

Dependent(s)

Your dependents are as defined by the rules of eligibility as stated in your Summary of Dental Plan Benefits

Enrollee

You, when the Contractor notifies Delta Dental that you are eligible to receive Benefits under This Plan. An Enrollee may sometimes be referred to as a "subscriber."

Maximum Approved Fee

The Maximum Approved Fee is the lowest of:

- The Submitted Amount
- The lowest fee regularly charged, offered, or received by an individual Dentist for a dental service or supply, irrespective of the Dentist's contractual agreement with another dental benefits organization.
- The maximum fee that the local Delta Dental Member Plan approves for a given procedure in a given region and/or specialty based upon applicable Participating Dentist schedules and internal procedures.

Participating Dentists agree not to charge Delta Dental patients more than the Maximum Approved Fee for a Covered Service. In all cases, Delta Dental will make the final determination regarding the Maximum Approved Fee for a Covered Service.

Maximum Payment

The maximum dollar amount Delta Dental will pay in any Benefit Year or lifetime for Covered Services. See the Summary of Dental Plan Benefits for the maximum payments applicable to This Plan.

Member(s)

Any Enrollee or Dependent with coverage under This Plan.

Non-Participating Dentist Fee

The maximum fee allowed per procedure for services rendered by a Non-Participating Dentist as determined by Delta Dental.

Open Enrollment Period

The period of time, as determined by the Contractor, during which a Member may enroll or be enrolled for Benefits.

Out-of-Country Dentist Fee

The maximum fee allowed per procedure for services rendered by an Out-of-Country Dentist as determined by Delta Dental.

PPO Dentist Schedule

The maximum fee allowed per procedure for services rendered by a PPO Dentist as determined by that Dentist's local Delta Dental Member Plan.

Pre-Treatment Estimate

A voluntary and optional process where Delta Dental issues a written estimate of dental benefits that may be available under your coverage for your proposed dental treatment. Your Dentist submits the proposed dental treatment to Delta Dental in advance of providing the treatment.

A Pre-Treatment Estimate is for informational purposes only and is not required before you receive any dental care. It is not a prerequisite or condition for approval of future dental benefits payment. You will receive the same Benefits under This Plan whether or not a Pre-Treatment Estimate is requested. The benefits estimate provided on a Pre-Treatment Estimate notice is based on benefits available on the date the notice is issued. It is not a guarantee of future dental benefits or payment.

Availability of dental benefits at the time your treatment is completed depends on several factors. These factors include, but are not limited to, your continued eligibility for benefits, your available annual or lifetime Maximum Payments, any

coordination of benefits, the status of your Dentist, This Plan's limitations and any other provisions, together with any additional information or changes to your dental treatment. A request for a Pre-Treatment Estimate is not a Claim or a preauthorization, precertification or other reservation of future Benefits.

Processing Policies

Delta Dental's policies and guidelines used for Pre-Treatment Estimate and payment of Claims. The Processing Policies may be amended from time to time.

Special Enrollment Period

A period outside of the Open Enrollment Period in which you or your Dependent can obtain coverage under This Plan due to a qualifying life event.

Spouse

Your legal spouse.

Submitted Amount

The amount a Dentist bills to Delta Dental for a specific treatment or service. A Participating Dentist cannot charge you or your Dependents for the difference between this amount and the Maximum Approved Fee.

Summary of Dental Plan Benefits

A description of the specific provisions of your group dental coverage. The Summary of Dental Plan Benefits is and should be read as a part of this Certificate and supersedes any contrary provision of this Certificate.

This Plan

The dental coverage established for Members pursuant to this Certificate and your Summary of Dental Plan Benefits.

III. Enrolling in This Plan

The Open Enrollment Period, if applicable, will be established by the Contractor and will occur on an annual basis. During the Open Enrollment Period, all eligible persons as defined in your Summary of Dental Plan Benefits may enroll in This Plan. You and/or your Dependents may not enroll in This Plan at any other time during the applicable Benefit Year except in the following instances:

1. Newly hired or rehired employees (if applicable): You will be eligible to enroll on the date for which employment compensation begins or, if applicable, that date plus the number of days specified as a waiting period in the Summary of Dental Plan Benefits.
2. New Spouse: Your new Spouse will be eligible to enroll on the date of marriage.
3. Newborn: Your newborn will be eligible to enroll on the date of birth.
4. Legal adoptions or guardianships: Your newly adopted Child(ren) and/or the minor Child(ren) that you and/or your Spouse have guardianship over will be eligible to enroll on the earlier of (a) the date that the legal petition for adoption or guardianship becomes legally final, or (b) the date on which the Child(ren) begins residing with the Enrollee and the Enrollee assumes responsibility for the Child(ren) while waiting for adoption or guardianship to become final.
5. New Stepchild: Your new stepchild will be eligible to enroll on the date that the Child's natural parent becomes a Dependent.
6. To the extent Contractor permits Dependents other than those defined in this Certificate to enroll in This Plan, such Dependents will be eligible to enroll on the date that they become an eligible Dependent. Any such additional Dependents permitted by Contractor shall be set forth in your Summary of Dental Plan Benefits.
7. All others will be permitted on the date that Delta Dental approves in writing the enrollment or listing of those people, unless compelled by a court or administrative order to otherwise provide Benefits for a Dependent.

IV. Selecting a Dentist

You may choose any Dentist. Your out-of-pocket costs are likely to be less if you go to a Delta Dental Participating Dentist.

To verify that a Dentist is a Participating Dentist, you can use Delta Dental's online Dentist Directory at www.DeltaDentalMI.com or call 800-524-0149.

V. Accessing Your Benefits

To utilize your dental benefits, follow these steps:

1. Please read this Certificate and the Summary of Dental Plan Benefits carefully so you are familiar with your benefits, payment methods, and terms of This Plan.
2. Make an appointment with your Dentist and tell him or her that you have dental benefits with Delta Dental. If your Dentist is not familiar with This Plan or has any questions, have him or her contact Delta Dental by writing to Delta Dental, Attention: Customer Service, P.O. Box 9089, Farmington Hills, Michigan 48333-9089, or calling the toll-free number at 800-524-0149.
3. After you receive your dental treatment, you or the dental office staff will file a Claim form, completing the information portion with:
    a. The Enrollee's full name and address
    b. The Enrollee's Member ID number
    c. The name and date of birth of the person receiving dental care
    d. The Contractor's name and number

Notice of Claim Forms

Delta Dental does not require special Claim forms. However, most dental offices have Claim forms available. Participating Dentists will fill out and submit your dental Claims for you.

Mail Claims and completed information requests to:

Delta Dental
P.O. Box 9085
Farmington Hills, Michigan 48333-9085

Pre-Treatment Estimate

A Pre-Treatment Estimate is not required to receive payment, but it allows Claims to be processed more efficiently and allows you to know what services may be covered before your Dentist provides them. You and your Dentist should review your Pre-Treatment Estimate Notice before treatment. Once treatment is complete, the dental office will submit a Claim to Delta Dental for payment.

Written Notice of Claim and Time of Payment

Because the amount of your Benefits is not conditioned on a Pre-Treatment Estimate decision by Delta Dental, all Claims under This Plan are post-service Claims. All Claims for Benefits must be filed with Delta Dental within one year of the date the services were completed. Once a Claim is filed, Delta Dental will adjudicate it within 30 days of receiving it. If there is not enough information to adjudicate your Claim, Delta Dental will notify you or your Dentist within 30 days. The notice will (a) describe the information needed, (b) explain why it is needed, (c) request an extension of time in which to decide the Claim, and (d) inform you or your Dentist that the information must be received within 45 days or your Claim will be Denied if the services were performed by a Non-Participating Dentist, or not chargeable to the Member if the services were performed by a Participating Dentist. You will receive a copy of any notice sent to your Dentist. Once Delta Dental receives the requested information, it has 15 days to adjudicate your Claim. If you or your Dentist does not supply the requested information, Delta Dental will deny your Claim. In such case, you will be responsible for all charges if the services were performed by a Non-Participating Dentist. If the services were performed by a Participating Dentist, the services will not be chargeable to the Member. Once Delta Dental adjudicates your Claim, it will notify you within five days.

Authorized Representative

You may also appoint an authorized representative to deal with Delta Dental on your behalf with respect to any Claim you file or any review of a Denied Claim you wish to pursue (see the Claims Appeal Procedure section). You should contact your Contractor, call Delta Dental's Customer Service department, toll-free, at 800-524-0149, or write them at P.O. Box 9089, Farmington Hills, Michigan, 48333-9089, to request a form to designate the person you wish to appoint as your representative. Delta Dental will only recognize the person whom you have authorized on the last dated form filed with Delta Dental. Once you have appointed an authorized representative, Delta Dental will communicate directly with your representative and will not inform you of the status of your Claim. You will have to get that information from your representative. If you have not designated a representative, Delta Dental will communicate directly with you.

Questions and Assistance

Questions regarding your coverage should be directed to your Contractor or call Delta Dental's Customer Service department, toll-free, at 800-524-0149. You may also write to Delta Dental's Customer Service department at P.O. Box 9089, Farmington Hills, Michigan, 48333-9089. When writing to Delta Dental, please include your name, the Contractor's name and number, the Enrollee's Member ID number, and your daytime telephone number.

VI. How Payment is Made

Delta Dental shall make payments for Covered Services in accordance with the type of plan selected by the Contractor. The type of plan selected will be identified on your Summary of Dental Plan Benefits.

Delta Dental PPO (Point-of-Service)

If your Dentist is a Participating Dentist, Delta Dental will base payment on the Maximum Approved Fee for Covered Services.

Delta Dental will send payment directly to Participating Dentists and you will be responsible for any applicable Copayments and/or Deductibles. Unless prohibited by state law, you will be responsible for the Maximum Approved Fee for most commonly performed non-covered services. For other non-covered services, you will be responsible for the Dentist's Submitted Amount.

If your Dentist is a Non-Participating Dentist, Delta Dental will base payment on the Non-Participating Dentist Fee for Covered Services.

If your Dentist is an Out-of-Country Dentist, Delta Dental will base payment on the Out-of-Country Dentist Fee for Covered Services.

For Covered Services rendered by a Non-Participating Dentist or Out-of-Country Dentist, Delta Dental will send payment to you unless otherwise required by law or contract, and you will be responsible for making full payment to the Dentist. You will be responsible for any difference between Delta Dental's payment and the Dentist's Submitted Amount.

Delta Dental PPO (Standard)

Regardless of your Dentist's participating status, Delta Dental will base its payment on the lesser of the Submitted Amount or the PPO Dentist Schedule.

Delta Dental will send payment directly to Participating Dentists and you will be responsible for any applicable Copayments and/or Deductibles. If your Dentist is not a PPO Dentist, but is a Premier Dentist, you will also be responsible for any difference between the PPO Dentist Schedule and the Premier Dentist Schedule for Covered Services, in addition to Copayments and/or Deductibles. Unless prohibited by state law, you will be responsible for the Maximum Approved Fee for most commonly performed non-covered services. For other non-covered services, you will be responsible for the Dentist's Submitted Amount.

For Covered Services rendered by a Non-Participating Dentist or Out-of-Country Dentist, Delta Dental will send payment to you unless otherwise required by law or contract, and you will be responsible for making full payment to the Dentist. You will be responsible for any difference between Delta Dental's payment and the Dentist's Submitted Amount.

Orthodontics

If This Plan includes orthodontics, it will be identified on and paid as reflected in your Summary of Dental Plan Benefits.

Covered Services Requiring Multiple Visits

In the event a Covered Service requires more than one visit with your Dentist, payment for the Covered Service will be rendered upon Completion Date.

VII. Benefit Categories

The Benefits covered by This Plan are set forth in your Summary of Dental Plan Benefits.

VIII. Exclusions and Limitations

Exclusions

Delta Dental will make no payment for the following services or supplies, unless otherwise specified in the Summary of Dental Plan Benefits. All charges for these services will be your responsibility:

1. Services for injuries or conditions payable under Workers' Compensation or Employer's Liability laws. Services received from any government agency, political subdivision, community agency, foundation, or similar entity. NOTE: This provision does not apply to any programs provided under Medicaid or Medicare.
2. Services or supplies, as determined by Delta Dental, for correction of congenital or developmental malformations, with the exception of congenitally missing teeth.
3. Cosmetic surgery or dentistry for aesthetic reasons, as determined by Delta Dental.
4. Services completed or appliances completed before a person became eligible under This Plan. This exclusion does not apply to orthodontic treatment in progress (if a Covered Service).
5. Prescription drugs (except intramuscular injectable antibiotics), premedication, medicaments/ solutions, and relative analgesia.
6. General anesthesia and intravenous sedation for (a) surgical procedures, unless medically necessary, or (b) restorative dentistry.
7. Charges for hospitalization, laboratory tests, histopathological examinations and miscellaneous tests.
8. Charges for failure to keep a scheduled visit with the Dentist.
9. Services or supplies, as determined by Delta Dental, for which no valid dental need can be demonstrated.
10. Services or supplies, as determined by Delta Dental that are investigational in nature, including services or supplies required to treat complications from investigational procedures.
11. Services or supplies, as determined by Delta Dental, which are specialized procedures or techniques.
12. Treatment by other than a Dentist, except for services performed by a licensed dental hygienist under the supervision of a licensed Dentist. Treatment rendered by any other licensed dental professional may be covered only as solely determined by the Contractor and/or Delta Dental.
13. Services or supplies for which the patient is not legally obligated to pay, or for which no charge would be made in the absence of Delta Dental coverage.
14. Services or supplies received due to an act of war, declared or undeclared, or terrorism.
15. Services or supplies covered under a hospital, surgical/medical, or prescription drug program.
16. Services or supplies that are not within the categories of Benefits selected by the Contractor and that are not covered under the terms of this Certificate.
17. Fluoride rinses, self-applied fluorides, or desensitizing medicaments.
18. Caries preventive medicament.
19. Preventive control programs (including oral hygiene instruction, caries susceptibility tests, dietary control, tobacco counseling, immunization counseling, home care medicaments, etc.).
20. Space maintainers for maintaining space due to premature loss of anterior primary teeth.
21. Lost, missing, or stolen appliances of any type, or replacement or repair of orthodontic appliances or space maintainers.
22. Cosmetic dentistry, including repairs to facings posterior to the second bicuspid position.
23. Veneers.
24. Prefabricated crowns used as final restorations on permanent teeth.
25. Appliances, surgical procedures, and restorations for increasing vertical dimension; for altering, restoring, or maintaining occlusion; for replacing tooth structure loss resulting from attrition, abrasion, abfraction, or erosion; or for periodontal splinting. If Orthodontic Services are Covered Services, this exclusion will not apply to Orthodontic Services as limited by the terms and conditions of the Contract between Delta Dental and the Contractor.
26. Implant/abutment supported interim fixed denture for edentulous arch.
27. Soft occlusal guard appliances.

28. Paste-type root canal fillings on permanent teeth.
29. Replacement, repair, relines, or adjustments of occlusal guards.
30. Chemical curettage.
31. Services associated with overdentures.
32. Metal bases on removable prostheses.
33. The replacement of teeth beyond the normal complement of teeth.
34. Personalization or characterization of any service or appliance.
35. Temporary crowns used for temporization during crown or bridge fabrication.
36. Posterior bridges in conjunction with partial dentures in the same arch, sharing at least one posterior edentulous space in common.
37. Precision abutments, attachments and stress breakers.
38. Biologic materials to aid in soft and osseous tissue regeneration when submitted on the same day as tooth extraction, periradicular surgery, soft tissue grafting, guided tissue regeneration, implants, ridge augmentation, ridge preservation/extraction sites, apicoectomy sites, hemisections, and periodontal or implant bone grafting.
39. Bone replacement grafts and specialized implant surgical techniques, including radiographic/surgical implant index.
40. Indexing for osteotomy using dynamic robotic assisted or dynamic navigation.
41. Appliances, restorations, or services for the diagnosis or treatment of disturbances of the temporomandibular joint.
42. Diagnostic photographs and cephalometric films, unless done for orthodontics and orthodontics are a Covered Service.
43. 3-D scans and images, and printings of such scans and images.
44. Myofunctional therapy.
45. Mounted case analyses.
46. Molecular, antigen or antibody testing for a public health related pathogen.
47. Vaccinations.
48. Bone replacement grafts when performed in conjunction with a hemisection.
49. Fabrication, adjustment, reline, or repair of sleep apnea appliances.
50. The administration of a home sleep apnea test, or screening for sleep apnea related breathing disorders.
51. Fabrication, delivery, or titration of oral appliance therapy (OAT) morning repositioning device.
52. Fabrication and placement of a custom removable clear plastic temporary aesthetic appliance.
53. Removal of non-resorbable barrier.
54. Intraoral tomosynthesis images.
55. Direct to consumer orthodontic services and/or supplies, unless Delta Dental has received a Delta Dental-approved and signed treating dentist attestation form from a Dentist licensed in the state where the Member resides.
56. Any and all taxes applicable to the services.
57. Processing policies may otherwise exclude payment by Delta Dental for services or supplies.

Delta Dental will make no payment for the following services or supplies. Participating Dentists may not charge Members for these services or supplies. All charges from Non-Participating Dentists for the following services or supplies are your responsibility:

1. Services or supplies, as determined by Delta Dental, which are not provided in accordance with generally accepted standards of dental practice.
2. The completion of forms or submission of Claims.
3. Consultations, patient screening, or patient assessment when performed in conjunction with examinations or evaluations.
4. Caries risk assessment performed on a Member age two or under.
5. Local anesthesia.
6. Acid etching, cement bases, cavity liners, and bases or temporary fillings.
7. Infection control.
8. Temporary, interim, or provisional crowns.
9. Gingivectomy as an aid to the placement of a restoration.
10. The correction of occlusion, when performed with prosthetics and restorations involving occlusal surfaces.
11. Diagnostic casts, when performed in conjunction with restorative or prosthodontic procedures.
12. Palliative treatment, when any other service is provided on the same date except X-rays and tests necessary to diagnose the condition.
13. Post-operative X-rays, when done following any completed service or procedure.
14. Periodontal charting.
15. Pins and preformed posts, when done with core buildups.
16. Any substructure when done for inlays, onlays, and veneers.
17. Excavation of a tooth resulting in the determination of non-restorability.
18. A pulp cap, when done with a sedative filling or any other restoration. A sedative or temporary filling, when done

with pulpal debridement for the relief of acute pain prior to conventional root canal therapy or another endodontic procedure. The opening and drainage of a tooth or palliative treatment, when done by the same Dentist or dental office on the same day as completed root canal treatment.

19. A pulpotomy on a permanent tooth, except on a tooth with an open apex.
20. A therapeutic apical closure on a permanent tooth, except on a tooth where the root is not fully formed.
21. Retreatment of a root canal by the same Dentist or dental office within two years of the original root canal treatment.
22. A prophylaxis or full mouth debridement, when done on the same day as periodontal maintenance or scaling in the presence of gingival inflammation.
23. Scaling in the presence of gingival inflammation when done on the same day as periodontal maintenance.
24. Prophylaxis, scaling in the presence of gingival inflammation, or periodontal maintenance when done within 30 days of three or four quadrants of scaling and root planing or other periodontal treatment.
25. Full mouth debridement when done within 30 days of scaling and root planing.
26. Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces without flap entry and closure, when performed within 12 months of implant restorations, provisional implant crowns and implant or abutment supported interim dentures.
27. Scaling and debridement in the presence of inflammation or mucositis of a single implant, when done on the same day as a prophylaxis, scaling in the presence of gingival inflammation, periodontal maintenance, full mouth debridement, periodontal scaling and root planing, periodontal surgery or debridement of a peri-implant defect.
28. Full mouth debridement, when done on the same day as comprehensive periodontal evaluation.
29. A sealant, sealant repair, preventive resin restoration or interim caries arresting medicament is not payable when done on the same day as a sealant, sealant repair, preventive resin restoration or interim caries arresting medicament performed on the same tooth.
30. Interim caries arresting medicament is not payable when done on the same day as the application of hydroxyapatite regeneration medicament when performed on the same tooth.
31. Application of hydroxyapatite regeneration medicament is not payable on the same day as a restoration or a fixed partial denture retainer when performed by the same dentist or dental office.
32. An occlusal adjustment, when performed on the same day as the delivery of an occlusal guard.
33. Reline, rebase, or any adjustment or repair within six months of the delivery of a denture.
34. Reline or any adjustment or repair to a sleep apnea appliance within six months of the delivery.
35. Adjustments, temporary relines, or tissue conditioning within three months of delivery of an immediate denture.
36. Tissue conditioning, when performed on the same day as the delivery of a denture or the reline or rebase of a denture.
37. Periapical and/or bitewing X-rays, when done within a clinically unreasonable period of time of performing full mouth X-rays, as determined solely by Delta Dental.
38. Charges or fees for overhead, internet/video connections, software, hardware or other equipment necessary to deliver services, including but not limited to teledentistry services.
39. Capture only images which are not associated with any interpretation or reporting.
40. Frenulectomy when performed on the same day as any other surgical procedure(s) in the same surgical area by the same dentist or dental office.
41. Surgical removal of implant body when performed within three months of an implant/mini-implant on the same tooth by the same dentist or dental office.
42. Non-surgical implant removal when performed within six months of an implant/mini-implant on the same tooth by the same dentist or dental office.
43. Accessing and retorquing loose implant screw is not payable when performed on the same day as implant maintenance and repair procedures on an implant supported prosthesis by the same dentist or dental office.
44. Scaling and root planing when performed on the same day as surgical root repair or exposures.
45. Surgical repair or exposure of root when performed on the same day as endodontic or periodontal surgical procedures.
46. Intraorifice barriers.
47. Removal of non-resorbable barrier when performed by the same dentist who placed the barrier.
48. Excision of benign or malignant lesions or salivary glands when performed in the same area and on the same day as another surgical procedure by the same dentist or dental office.
49. Processing policies may otherwise exclude payment by Delta Dental for services or supplies.

Limitations

The Benefits for the following services or supplies are limited as follows, unless otherwise specified in the Summary of

Dental Plan Benefits. All charges for services or supplies that exceed these limitations will be your responsibility. All time limitations are measured from the actual date (i.e., to the day) of the applicable prior dates of services in our records with any Delta Dental Member Plan or, at the request of your Contractor**, any dental plan:**

1. Bitewing X-rays are payable once per calendar year, unless a full mouth X-ray which include bitewings has been paid in that same year.
2. Panoramic or full mouth X-rays (which may include bitewing X-rays) are payable once in any five-year period.
3. Any combination of teeth cleanings (prophylaxes (general or periodontal cleanings), full mouth debridement, scaling in the presence of inflammation, and periodontal maintenance procedures) are payable twice per calendar year. Full mouth debridement is payable once in a lifetime.
4. Oral examinations and evaluations (not including limited problem focused evaluations or patient screenings) are only payable twice per calendar year, regardless of the Dentist's specialty.
5. Patient screening is payable once per calendar year.
6. Preventive fluoride treatments are payable twice per calendar year for people age 18 and under.
7. Bilateral space maintainers are payable once per arch in a lifetime for people age 13 and under.
8. Unilateral space maintainers are payable once per quadrant in a lifetime for people age 13 and under.
9. A distal shoe space maintainer is payable for first permanent molars once per quadrant for people age eight and under.
10. Cast restorations (including jackets, crowns and onlays) and associated procedures (such as core buildups and post substructures) are payable once in any five-year period per tooth. Subsequent minor restorations on the same tooth are also subject to this five-year limitation.
11. Crowns or onlays are payable only for extensive loss of tooth structure due to caries (decay) or fracture (lost or mobile tooth structure).
12. Individual crowns over implants are payable at the prosthodontic benefit level once in a five-year period.
13. Substructures, porcelain, porcelain substrate, and cast restorations are not payable for people age 11 and under.
14. Band stabilization is payable once per lifetime only on posterior permanent teeth.
15. Hard full or partial arch occlusal guards are payable once in any five-year period.
16. An interim partial denture is payable only for the replacement of permanent anterior teeth for people age 16 and under or during the healing period for people age 17 and over. Absent a showing of medical necessity, the healing period shall not exceed 30 days from the date of the extraction.
17. Biologic materials to aid in soft and osseous tissue regeneration are payable once per natural tooth in a 36-month period.
18. Prosthodontic Services limitations:
    a. One complete upper and one complete lower denture, and any implant used to support a denture, are payable once in any five-year period.
    b. A removable partial denture, endosteal implant (other than to support a denture), or fixed bridge is payable once in any five-year period unless the loss of additional teeth requires the construction of a new appliance.
    c. A removable unilateral partial denture is payable once per quadrant in any five-year period unless the loss of additional teeth requires the construction of a new appliance.
    d. Fixed bridges and removable partial dentures are not payable for people age 15 and under.
    e. Rebase hybrid prostheses are payable once in any five-year period per appliance.
    f. A reline or the complete replacement of denture base material is payable once in any three-year period per appliance.
    g. Implant removal is payable once per tooth or area in a five-year period.
    h. Implant maintenance is payable once per any 12-month period.
    i. Removal of a broken implant retaining screw is payable once in a five-year period.
    j. Accessing and retorquing loose implant screw is payable once every 24 months per implant.
19. Orthodontic Services limitations, if covered under your Plan pursuant to your Summary of Dental Plan Benefits:
    a. Orthodontic Services are payable for Members pursuant to the age limits specified in your Summary of Dental Plan Benefits.
    b. If the treatment plan terminates before completion for any reason, Delta Dental's obligation for payment ends on the last day of the month in which the patient was last treated.
    c. Upon written notification to Delta Dental and to the patient, a Dentist may terminate treatment for lack of patient interest and cooperation. In those cases, Delta Dental's obligation for payment ends on the last day of the month in which the patient was last treated.
20. Delta Dental's obligation for payment of Benefits ends on the last day of coverage. However, Delta Dental will make

payment for Covered Services provided on or before the last day of coverage, as long as Delta Dental receives a Claim for those services within one year of the date of service.

21. When services in progress are interrupted, Delta Dental will not issue payment for any incomplete services; however, Delta Dental will calculate the Maximum Approved Fee that the dentist may charge you for such incomplete services, and those charges will be your responsibility. In the event the interrupted services are completed later by a Dentist, Delta Dental will review the Claim to determine the amount of payment, if any, to the Dentist in accordance with Delta Dental's policies at the time services are completed.
22. Care terminated due to the death of a Member will be paid to the limit of Delta Dental's liability for the services completed or in progress.
23. Optional treatment: If you select a more expensive service than is customarily provided, Delta Dental may make an allowance for certain services based on the fee for the customarily provided service. You are responsible for the difference in cost. In all cases, Delta Dental will make the final determination regarding optional treatment and any available allowance.

    Listed below are services for which Delta Dental will provide an allowance for optional treatment. Remember, you are responsible for the difference in cost for any optional treatment.

    a. Overdentures – Delta Dental will pay only the amount that it would pay for a conventional denture.
    b. Inlays, regardless of the material used – Delta Dental will pay only the amount that it would pay for an amalgam or composite resin restoration.
    c. Implant/abutment supported complete or partial dentures – Delta Dental will pay only the amount that it would pay for a conventional denture.
    d. Gold foil restorations – Delta Dental will pay only the amount that it would pay for an amalgam or composite restoration.
    e. Posterior stainless steel crowns with esthetic facings, veneers or coatings – Delta Dental will pay only the amount that it would pay for a conventional stainless steel crown.
24. Maximum Payment: All Benefits available under This Plan are subject to the Maximum Payment limitations set forth in your Summary of Dental Plan Benefits.
25. If a Deductible amount is stated in the Summary of Dental Plan Benefits, Delta Dental will not pay for any services or supplies, in whole or in part, to which the Deductible applies until the Deductible amount is met.
26. Caries risk assessments are payable once in any 12-month period for Members age 3-18.
27. Application of hydroxyapatite regeneration medicament is payable twice per tooth per Benefit Year.
28. Assessments of salivary flow by measurement are payable once in any 36-month period.
29. Scaling and debridement in the presence of inflammation or mucositis of a single implant is payable once per tooth in any 24-month period.
30. A sealant, sealant repair, preventive resin restoration or interim caries arresting medicament is not payable when done on the same day as restorations involving the occlusal surface.
31. Interim caries arresting medicament is payable twice per tooth per Benefit Year and is limited to five applications per day.
32. Sealants are covered once per tooth per lifetime on first permanent molars for Members age nine and under.
33. Sealants are covered once per tooth per lifetime on second permanent molars for Members age 14 and under.
34. One cone beam CT is allowed within a 12-month period except when performed for TMD treatment.
35. Restorations performed within two months of caries arresting medicament.
36. Excisional biopsy of minor salivary glands is payable twice per lifetime, absent showing of medical necessity.
37. Processing policies may otherwise limit payment by Delta Dental for services or supplies.

Delta Dental will make no payment for services or supplies that exceed the following limitations. All charges are your responsibility. However, Participating Dentists may not charge Members for these services or supplies when performed by the same Dentist or dental office. All time limitations are measured from the actual date (i.e., to the day) of the applicable prior dates of services in our records with any Delta Dental Member Plan or, at the request of your Contractor, any dental plan:

1. Amalgam and composite resin restorations are payable once in any two-year period, regardless of the number or combination of restorations placed on a surface.
2. Core buildups and other substructures are payable only when needed to retain a crown on a tooth with excessive breakdown due to caries (decay) and/or fractures.
3. Recementation of a crown, onlay, inlay, veneer, space maintainer, or bridge within six months of the seating date.
4. Retention pins are payable once in any two-year period. Only one substructure per tooth is a Covered Service.
5. Root planing is payable once in any two-year period.
6. Periodontal surgery is payable once in any three-year period.
7. A complete occlusal adjustment is payable once in any five-year period. The fee for a complete occlusal adjustment includes all adjustments that are necessary for a five-year

period. A limited occlusal adjustment is not payable more than three times in any five-year period. The fee for a limited occlusal adjustment includes all adjustments that are necessary for a six-month period.

8. Tissue conditioning is payable twice per arch in any three-year period.
9. The allowance for a denture repair (including reline or rebase) will not exceed half the fee for a new denture.
10. Services or supplies, as determined by Delta Dental, which are not provided in accordance with generally accepted standards of dental practice.
11. Scaling and debridement in the presence of inflammation or mucositis of a single implant is payable once per tooth in any 24-month period when performed by the same office.
12. A sealant, sealant repair, preventive resin restoration or interim caries arresting medicament is not payable when done on the same day as restorations involving the occlusal surface when performed by the same office.
13. A sealant, sealant repair or preventive resin restoration is not payable when performed within 24 months of a sealant, sealant repair or preventive resin restoration performed on the same tooth.
14. One caries risk assessment is allowed on the same date of service.
15. One caries risk assessment is allowed within a 12-month period when done by the same dentist/dental office.
16. Restorations placed within six months of the application of hydroxyapatite regeneration medicament are not payable when performed by the same dentist or dental office.
17. One assessment of salivary flow by measurement is allowed within a 12-month period when done by the same dentist/dental office.
18. Processing policies may otherwise limit payment by Delta Dental for services or supplies.

IX. Coordination of Benefits

Coordination of Benefits ("COB") applies to This Plan when a Member has dental benefits under more than one plan. The objective of COB is to make sure the combined payments of the plans are no more than your actual dental bills. COB rules establish whether This Plan's Benefits are determined before or after another plan's benefits.

You must submit your bills to the primary plan first. The primary plan must pay its full benefits as if you had no other coverage. If the primary plan denies your Claim or does not pay the full bill, you may then submit the remainder of the bill to the secondary plan.

Which Plan is Primary?

To decide which plan is primary, Delta Dental will consider both the COB provisions of the other plan and the relationship of the Member to This Plan's Enrollee, as well as other factors. The primary plan is determined by the first of the following rules that applies:

1. Non-coordinating Plan

If you have another plan that does not coordinate benefits, it will always be primary.

2. Enrollee v. Dependent Coverage

The plan that covers the Member as an Enrollee will be primary over a plan that covers the Member as a dependent. However, please note that if the Member is a Medicare beneficiary, federal law may reverse this order.

3. Children (Parents Divorced or Separated)

If a court decree makes one parent responsible for health care expenses, that parent's plan is primary.

If a court decree states that the parents have joint custody without stating that one of the parents is responsible for the Child's health care expenses, Delta Dental follows the birthday rule (see rule 4 below).

If neither of these rules applies, the order will be determined as follows:

a. First, the plan of the parent with custody of the Child will be primary;

b. Then, the plan of the spouse of the parent with custody of the Child will be primary;

c. Next, the plan of the parent without custody of the Child will be primary; and

d. Last, the plan of the spouse of the parent without custody of the Child will be primary.

4. Children and the Birthday Rule

The plan of the parent whose birthday is earliest in the calendar year is always primary for Children. For example, if your birthday is in January and your spouse's birthday is in March, your plan will be primary for all of your Children. If both parents have the same birthday, the plan that has covered the parent for the longer period will be primary.

5. Laid Off or Retired Employees

The plan that covers the Member as a laid off or retired employee or as a dependent of a laid off or retired employee will be primary.

6. COBRA Coverage

The plan that is provided under a right of continuation pursuant to federal law or a similar state law (that is, COBRA) will be primary.

7. Other Plans

If none of the rules above determines the order of benefits, the plan that has covered the Member for the longer period will be primary.

If the other plan does not have rule 5 and/or rule 6 (above) and decides the order of benefits differently from This Plan, This Plan may ignore either of those rules.

In the event that these rules do not determine how Delta Dental should coordinate benefits with another plan, Delta Dental will follow its internal policies and procedures for determining which plan is primary, unless prohibited by applicable law.

How Delta Dental Pays as Primary Plan

When Delta Dental is the primary plan, it will pay for Covered Services as if you had no other coverage.

How Delta Dental Pays as Secondary Plan

When Delta Dental is the secondary plan, it will pay for Covered Services based on the amount left after the primary plan has paid. It will not pay more than that amount, and it will not pay more than it would have paid as the primary plan.

When Benefits are reduced as described above, each Benefit is reduced in proportion. Benefits are then charged against any applicable benefit limit of This Plan.

Right to Receive and Release Needed Information

Delta Dental needs certain facts to apply these COB rules, and it has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person regarding the Claim being coordinated. Delta Dental need not tell or get the consent of any person to do this. Each person claiming Benefits under This Plan must give Delta Dental any facts it needs to pay the Claim.

Facility of Payment

A payment made under another plan may include an amount that should have been paid under This Plan. If it does, Delta Dental may pay that amount to the organization that made the payment.

That amount will then be treated as though it were a Benefit paid under This Plan, and Delta Dental will not have to pay that amount again. The term “payment made” includes providing benefits in the form of services, in which case “payment made” means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by Delta Dental is more than it should have paid under this COB provision, Delta Dental may recover the excess from one or more of the persons it has paid or for whom it has paid, or any other person or organization that may be responsible for the benefits or services provided for the Member.

Payment includes the reasonable cash value of any benefits provided in the form of services.

X. Reconsideration and Claims Appeal Procedure

Reconsideration

If you receive notice of an Adverse Benefit Determination and you think that Delta Dental incorrectly denied all or part of your Claim, you or your Dentist may contact Delta Dental’s Customer Service department and ask them to reconsider the Claim to make sure it was processed correctly. You may do this by calling the toll-free number, 800-524-0149, and speaking to a telephone advisor. You may also mail your inquiry to the Customer Service Department at P.O. Box 9089, Farmington Hills, Michigan, 48333-9089.

When writing, please enclose a copy of your explanation of benefits and describe the problem. Be sure to include your name, telephone number, the date, and any information you would like considered about your Claim.

A request for reconsideration is not required and should not be considered a formal request for review of a denied Claim. Delta Dental provides this opportunity for you to describe problems or submit an explanation or additional information that might indicate your Claim was improperly denied, and allow Delta Dental to correct any errors quickly and immediately.

Whether or not you have asked Delta Dental informally to reconsider its initial determination, you can request a formal review using the Formal Claims Appeal Procedure described below.

Formal Claims Appeal Procedure

If you receive notice of an Adverse Benefit Determination, you, or your Authorized Representative, should seek a review as soon as possible, but you must file your request for review within 180 days of the date that you received that Adverse Benefit Determination.

To request a formal review of your Claim, send your request in writing to:

Dental Director
Delta Dental
P.O. Box 30416
Lansing, Michigan 48909-7916

Please include your name and address, the Enrollee’s Member ID, the reason why you believe your Claim was wrongly denied, and any other information you believe supports your Claim. You also have the right to review the contract between Delta Dental and the Contractor and any documents related to it. If you would like a record of your request and proof that Delta Dental received it, mail your request certified mail, return receipt requested.

The Dental Director or any person reviewing your Claim will not be the same as, nor subordinate to, the person(s) who initially decided your Claim. The reviewer will grant no deference to the prior decision about your Claim. The reviewer will assess the information, including any additional information that you have provided, as if he or she were deciding the Claim for the first time. The reviewer's decision will take into account all

comments, documents, records and other information relating to your Claim even if the information was not available when your Claim was initially decided.

If the decision is based, in whole or in part, on a dental or medical judgment (including determinations with respect to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate), the reviewer will consult a dental health care professional with appropriate training and experience, if necessary. The dental health care professional will not be the same individual or that person's subordinate consulted during the initial determination.

The reviewer will make a determination within 60 days of receipt of your request. If your Claim is denied on review (in whole or in part), you will be notified in writing. The notice of an Adverse Benefit Determination during the Formal Claims Appeal Procedure will meet the requirements described below.

Manner and Content of Notice

Your notice of an Adverse Benefit Determination will inform you of the specific reasons(s) for the denial, the pertinent plan provisions(s) on which the denial is based, the applicable review procedures for dental Claims, including time limits and that, upon request, you are entitled to access all documents, records and other information relevant to your Claim free of charge. This notice will also contain a description of any additional materials necessary to complete your Claim, an explanation of why such materials are necessary, and a statement that you have a right to bring a civil action in court if you receive an Adverse Benefit Determination after your Claim has been completely reviewed according to this Formal Claims Appeal Procedure. The notice will also reference any internal rule, guideline, protocol, or similar document or criteria relied on in making the Adverse Benefit Determination, and will include a statement that a copy of such rule, guideline or protocol may be obtained upon request at no charge. If the Adverse Benefit Determination is based on a matter of medical judgment or medical necessity, the notice will also contain an explanation of the scientific or clinical judgment on which the determination was based, or a statement that a copy of the basis for the scientific or clinical judgment can be obtained upon request at no charge.

The Adverse Benefit Determination notice will inform you of your right to a managerial-level conference to complete the formal grievance procedure. This notice will also advise you of your right to an external review with the Department of Insurance and Financial Services ("DIFS") under the Patient's Right to Independent Review Act ("PRIRA").

Pursuant to PRIRA, you or your authorized representative have the right to request an external review of an Adverse Benefit Determination. You are only eligible for the external review process if you have completed the internal formal claims appeal procedure, or if Delta Dental fails to complete the internal process within the allowable timeframe. The request for external review under PRIRA must be submitted within 127 days of your receipt of the final Adverse Benefit Determination.

To request external review of an Adverse Benefit Determination pursuant to your rights under PRIRA, the Health Care Request For External Review Form must be completed and filed with the Department of Insurance and Financial Services, 530 W. Allegan St., 7th Floor, Lansing, MI 48933-1521. The Health Care Request For External Review Form is available on the DIFS website: http://www.michigan.gov/documents/cis_ofis_fis_0018_250787.pdf. The request should include a copy of the final Adverse Benefit Determination, along with information and documentation to support your position. You may also file the Health Care Request For External Review Form online at https://difs.state.mi.us/Complaints/ExternalReview.aspx.

XI. Termination of Coverage

Your Delta Dental coverage may automatically terminate:

- When the Contractor advises Delta Dental to terminate your coverage.
- On the first day of the month for which the Contractor has failed to pay Delta Dental.
- For fraud or misrepresentation in the submission of any Claim.
- For your Dependent, when they no longer qualify as a Dependent.
- For any other reason stated in the Contract between Delta Dental and the Contractor.

Delta Dental will not continue eligibility for any person covered under This Plan beyond the termination date requested by the Contractor. A person whose eligibility is terminated may not continue group coverage under this Certificate, except as required by the continuation coverage provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 or comparable, non-preempted state law ("COBRA").

XII. Continuation of Coverage

If the Contractor is required to comply with COBRA and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and your dental coverage would otherwise end, you and your Dependents may have the right to continue that coverage at your expense.

When is Plan Continuation Coverage Available?

Continuation coverage is available if your coverage or a covered Dependent's coverage would end because:

1. Your employment, if applicable, ends for any reason other than your gross misconduct.
2. You do not qualify as an Enrollee as set forth in your Summary of Dental Plan Benefits.
3. You are divorced or legally separated.
4. You die.
5. Your Dependent is no longer a Dependent.

6. You become enrolled in Medicare (if applicable).
7. You are called to active duty in the armed forces of the United States.

If you believe you are entitled to continuation coverage, you should contact the Contractor to receive the appropriate documentation required under the Employee Retirement Income Security Act of 1974 ("ERISA").

XIII. General Conditions

Assignment

Services and Benefits are for the personal benefit of Members and cannot be transferred or assigned, other than to pay Participating Dentists directly.

Subrogation and Right of Reimbursement

To the extent that This Plan provides or pays Benefits for Covered Services, Delta Dental is subrogated to any right you and/or your Dependent has to recover from another party or entity, including but not limited to, that party's insurer, or any other insurer that you or your Dependent may have, which would have been the primary payer if not for the payments made by Delta Dental. This includes but is not limited to, automobile, home, and other liability insurers, as well as any other group health plans.

To the extent that Delta Dental has a subrogation right, you and/or your Dependent must:

1. Provide Delta Dental with any information necessary to identify any other person, entity or plan that may be obligated to provide payments or benefits for the Covered Services that were paid for by Delta Dental,
2. Cooperate fully in Delta Dental's exercise of its right to subrogation and reimbursement,
3. Not do anything to prejudice those rights (such as settling a claim against another party without notifying Delta Dental, or not including Delta Dental as a co-payee of any settlement amount),
4. Sign any document that Delta Dental determines is relevant to protect Delta Dental's subrogation and reimbursement rights, and
5. Provide relevant information when requested.

The term "information" includes any documents, insurance policies, and police or other investigative reports, as well as any other facts that may reasonably be requested to help Delta Dental enforce its rights. Failure by you or your Dependent to cooperate with Delta Dental may result, at the discretion of Delta Dental, in a reduction of future benefit payments available to you or your Dependent under This Plan of an amount up to the aggregate amount paid by Delta Dental that was subject to Delta Dental's equitable lien, but for which Delta Dental was not reimbursed.

Obtaining and Releasing Information

While you and/or your Dependent(s) are enrolled in This Plan, you and/or your Dependent(s) agree to provide Delta Dental with any information it needs to process Claims and administer Benefits for you and/or your Dependent(s). This includes allowing Delta Dental access to your dental records.

Dentist-Patient Relationship

Members are free to choose any Dentist. Each Dentist is solely responsible for the treatment and/or dental advice provided to the Member, and Delta Dental does not have any liability resulting therefrom.

Loss of Eligibility During Treatment

If a Member loses eligibility while receiving dental treatment, only Covered Services received while that person was covered under This Plan will be payable.

Certain services begun before the loss of eligibility may be covered if they are completed within 60 days from the date of termination. In those cases, Delta Dental evaluates those services in progress to determine what portion may be paid by Delta Dental. The difference between Delta Dental's payment and the total fee for those services is your responsibility. This provision does not apply to orthodontics if covered under This Plan.

Late Claims Submission

Delta Dental will make no payment for services or supplies if a Claim for such has not been received by Delta Dental within one year following the date the services or supplies were completed. In the event that a Participating Provider submits a Claim more than one year from the date of service, Delta Dental will deny that portion of the Claim that Delta Dental would have paid if the Claim had been timely submitted, and such denied portion of the Claim will not be chargeable to the Member. However, you will remain responsible for any applicable Deductible and/or Copayments. In the event that a Non-Participating Provider submits a Claim more than one year from the date of service, Delta Dental will Deny the Claim and you may be responsible for the full amount.

Change of Certificate or Contract

No changes to this Certificate, your Summary of Dental Plan Benefits, or the underlying contract are valid unless Delta Dental approves them in writing.

Actions

You cannot bring an action on a legal claim arising out of or related to this Certificate unless you have provided at least 60 days' written notice to Delta Dental, unless prohibited by applicable state law. In addition, you cannot bring an action more than three years after the legal claim first arose or after expiration of the applicable statute of limitations, whichever is shorter. Any person seeking to do so will be deemed to have waived his or her right to bring suit on such legal claim. Except as set forth above, this provision does not preclude you from seeking a judicial decision or pursuing other available legal remedies.

Change of Status

You must notify Delta Dental, through the Contractor, of any event that changes the status of a Dependent. Events that can affect the status of a Dependent include, but are not limited to, marriage, birth, death, divorce, and entrance into military service.

Governing Law

This Certificate and the underlying group Contract will be governed by and interpreted under the laws of the state of Michigan.

Right of Recovery Due to Fraud

If Delta Dental pays for services that were sought or received under fraudulent, false, or misleading pretenses or circumstances, pays a Claim that contains false or misrepresented information, or pays a Claim that is determined to be fraudulent due to your acts or acts of your Dependents, it may recover that payment from you or your Dependents. Delta Dental may recover any payment determined to be based on false, fraudulent, misleading, or misrepresented information by deducting that amount from any payments properly due to you or your Dependents. Delta Dental will provide an explanation of the payment recovery at the time the deduction is made.

Legally Mandated Benefits

If any applicable law requires broader coverage or more favorable treatment for you or your Dependents than is provided by this Certificate, that law shall control over the language of this Certificate.

Any person intending to deceive an insurer, who knowingly submits an application or files a Claim containing a false or misleading statement, is guilty of insurance fraud.

Insurance fraud significantly increases the cost of health care. If you are aware of any false information submitted to Delta Dental, please call our toll-free hotline. We only accept anti-fraud calls at this number.

ANTI-FRAUD TOLL-FREE HOTLINE:

800-524-0147

APPENDIX E:
VISION SCHEDULE OF BENEFITS – ACTIVE

Make Eye Health a Priority with VSP! Your health comes first with VSP ACTIVE and CLASS O coverage. Take a look at your VSP vision care coverage.

Routine eye exams have saved lives.

Did you know an eye exam is the only non-invasive way to view blood vessels in your body? Your VSP® network eye doctor can detect signs of over 270 health conditions during and eye exam.*

Savings you'll love.

See and look your best without breaking the bank. VSP members get exclusive savings on popular frame brands and contact lenses, and they get additional discounts on things like LASIK, and more.

The choice is yours!

With thousands of choices, getting the most out of your benefits is easy at a VSP Premier Edge™ location.

Shop online and connect your benefits.

Save up to $250 on Featured Frame Brands when you shop on Eyeconic®, the VSP online eyewear store.

Provider Network: VSP Choice

Create an account today.
Questions?
http://www.vsp.com or **800.877.7195**

Scan QR code or visit **vsp.com** to learn more.

vsp vision care

BENEFIT	DESCRIPTION	COPAY
YOUR COVERAGE WITH A VSP DOCTOR		
WELLVISION EXAM	• Focuses on your eyes and overall wellness • Routine retinal screening • Every 12 months	$0 Up to $39
ESSENTIAL MEDICAL EYE CARE	• Retinal imaging for members with diabetes covered-in-full • Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more. • Coordination with your medical coverage may apply. Ask your VSP network doctor for details. • Available as needed	$20 per exam
PRESCRIPTION GLASSES		
FRAME+	• $150 Frame allowance • $170 Enhanced Featured Frame Brands allowance • 20% savings on the amount over your allowance • $150 Walmart/Sam's Club/Costco frame allowance • Every 24 months	$0
LENSES	• Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children • Every 12 months	$0
LENS ENHANCEMENTS	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 30% on other lens enhancements • Every 12 months	$0 $95 - $105 $150 - $175
CONTACTS (INSTEAD OF GLASSES)	• $150 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation) • Every 12 months	Up to $60
ADDITIONAL PAIRS OF EYEWEAR		
FRAME+	• $150 frame allowance • 20% savings on the amount over your allowance • $150 Walmart/Sam's Club/Costco frame allowance • Every 24 months	$0
LENSES	• Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children • Every 12 months	$0
CONTACTS (INSTEAD OF GLASSES)	• $150 allowance for additional contacts • Contact lens exam (fitting and evaluation) • Every 12 months	Up to $60
PROTEC SAFETY® (EMPLOYEE-ONLY COVERAGE)		
FRAME+	• Fully covered when you choose a safety frame from your VSP doctor's ProTec Eyewear® collection or Visionworks' safety frame selection • $65 frame allowance for any other safety frame outside of the ProTec Eyewear collection only available from a VSP provider, 20% savings on the amount over your allowance • Certified according to the American National Standards Institute (ANSI) guidelines for impact protection	$0
LENSES	• Prescription single vision, lined bifocal, and lined trifocal • Certified according to the American National Standards Institute (ANSI) guidelines for impact protection	$0

*Full Picture of Eye Health, American Optometric Association, 2020.

+Coverage with a retail chain may be different or not apply.

VSP guarantees member satisfaction from VSP providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business. TruHearing is not available directly from VSP in the states of California and Washington. VSP Premier Edge™ is not available for some members in the state of Texas.

To learn about your privacy rights and how your protected health information may be used, see the VSP Notice of Privacy Practices on **vsp.com**. Eyeconic is a VSP-affiliated company.

APPENDIX E: (Continued)
VISION SCHEDULE OF BENEFITS – RETIREE

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vsp PREMIER edge

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eyeconic a vsp vision company

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PRESCRIPTION GLASSES		
FRAME+	• $150 Frame allowance • $170 Enhanced Featured Frame Brands allowance • 20% savings on the amount over your allowance • $150 Walmart/Sam's Club/Costco frame allowance • Every 24 months	$0
LENSES	• Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children • Every 12 months	$0
LENS ENHANCEMENTS	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 30% on other lens enhancements • Every 12 months	$0 $95 - $105 $150 - $175
CONTACTS (INSTEAD OF GLASSES)	• $150 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation) • Every 12 months	Up to $60
ADDITIONAL PAIRS OF EYEWEAR		
FRAME+	• $150 frame allowance • 20% savings on the amount over your allowance • $150 Walmart/Sam's Club/Costco frame allowance • Every 24 months	$0
LENSES	• Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children • Every 12 months	$0
CONTACTS (INSTEAD OF GLASSES)	• $150 allowance for additional contacts • Contact lens exam (fitting and evaluation) • Every 12 months	Up to $60
ADDITIONAL SAVINGS	**Glasses and Sunglasses** • Discover all current eyewear offers and savings at **vsp.com/offers**. • 20% savings on unlimited additional pairs of prescription or non-prescription glasses/sunglasses, including lens enhancements, from a VSP provider within 12 months of your last WellVision Exam.	
	Laser Vision Correction • Average of 15% off the regular price; discounts available at contracted facilities.	
	Exclusive Member Extras for VSP Members • Contact lens rebates, lens satisfaction guarantees, and more offers at **vsp.com/offers**. • Save up to 60% on digital hearing aids with TruHearing®. Visit **vsp.com/offers**/special-offers/hearing-aids for details. • Enjoy everyday savings on health, wellness, and more with VSP Simple Values.	

*Full Picture of Eye Health, American Optometric Association, 2020.

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