MEBS
Better Decisions. Better Healthcare.

Tawas Area Schools

Dental Summary Plan Description (SPD) for

Teachers, Administrators
and Non-Certified Personnel

Effective July 1, 1996

Revised April 1, 2010

Updated July 1, 2010

About Your Self-Funded Dental Plan

Your employer may offer several different Plans. Provisions specific to your Plan are detailed in the following chart.

To avoid unnecessary expenses, we recommend your dentist provide a treatment plan for any amounts over $250.

Effective Date	Effective July 1, 1996 Revised April 1, 2010 Updated July 1, 2010
Plan Name	Tawas Area Schools Dental Plan
Group Number	138
Employer	Tawas Area Schools 245 West M-55 Tawas City, MI 48763 (989) 984-2250
Employer Identification Number (EIN)	38-6018192
Eligible Employees	Teachers and Administrators Non-Certified Personnel
Service Requirement	First of the month following date of hire
Minimum Hour Requirement	20 hours per week
Employee Contributions	Teachers and Administrators : No contributions Non-Certified Personnel: No contributions for self, however, contributions are required for spouse and dependent coverage
Open Enrollment Period	The month of September, October and November
Termination of Coverage	Date of termination
Assignment of Benefits	Benefits may be assigned

Coordination of Benefits	This Plan coordinates benefits
Network	A.D.N. and Dentemax
Benefit Administrator	MEBS, Inc. 3809 Lake Eastbrook Boulevard Grand Rapids, MI 49546 (800) 968-6327 or (616) 458-6327 Customerservice@mebs.com www.mebs.com
Benefit Period	January 1 through December 31
Plan Year	The records of the Plan are kept separately for each Plan Year. The Plan Year begins on July 1st and ends on June 30th.
Agent for Service of Legal Process	Tawas Area Schools 245 West M-55 Tawas City, MI 48763 (989) 984-2250

SELF FUNDED DENTAL
SCHEDULE OF BENEFITS

Tawas Area Schools

Teachers, Administrators, Non-Certified Personnel

Type I	Preventative		
	Percentage		60%
Type II	Restorative		
	Percentage		60%
Type III	Replacement Services		
	Percentage		50%
Type IV	Orthodontia Services (Applicable only for Covered Individuals under age 19)		
	Percentage		50%

Plan Maximums

Type I, II, and III Services:

Maximum Annual Benefit Per Covered Member		$800.00

Type IV Services:

Maximum Lifetime Benefit Per Covered Member		$600.00

This Plan Utilizes the ADN/Dentemax Network

If using a ADN/Dentemax Provider, the member may have less out of pocket expenses.

Plan Modifications

The following Plan Modifications have been included:
Crowns are paid as Type I service 60%

Dear Member:

We are pleased to provide you with this updated Summary Plan Description (SPD), which also serves as the Plan Document.

The Plan offers vision benefits to eligible members. Since benefit plans can be technical and hard to understand, we have tried to describe your benefits in this booklet as completely as possible and in everyday language. This booklet includes:

- An ***About Your Plan*** section, which includes basic administrative information.
- A ***Summary of Benefits***, which summarizes the benefits available through the Plan**.**
- **Eligibility** information that tells you when you are eligible and can enroll for coverage, who in your family is eligible, what you need to do to continue eligibility, when coverage ends and what you need to do when coverage ends.
- **Detailed information** about the vision benefits provided, including what is ***not*** covered.
- **Claims and appeals** information that explains how to file a claim, how benefits are coordinated with other coverage and third parties and what to do if your claim is denied.
- **General Plan information** that provides legally required information about how the Plan operates.
- **Definitions** of key terms used throughout this booklet.

If you have any questions about your benefits, please contact the MEBS, Inc. customer service staff. To ensure efficient service and prompt payment of eligible claims:

- Be sure to keep your information on file with MEBS up to date. For example:
    - Notify MEBS (and your employer) as soon as possible if your home address changes.
    - Notify MEBS (and your employer) within 30 days of the date you gain or lose a dependent for any reason (for example, if you get married, divorced or have a child).
- When you contact MEBS, be sure to provide your name and identification number.

The Plan is here to help you meet your vision care needs. However, it is your responsibility to know what your benefits are and how to use them. Please read this booklet thoroughly and share it with your family members.

Sincerely,
MEBS, Inc.
3809 Lake Eastbrook Boulevard
Grand Rapids, MI 49546
(800) 968-6327 or (616) 458-6327
customerservice@mebs.com
www.mebs.com

Important Notice

This SPD/Plan Document is meant to help you understand Plan benefits as of the effective date listed in this booklet. This edition, which includes all changes since the last edition, replaces and supersedes any previous SPD/Plan Document.

Any reference in this booklet to a coverage not listed in this booklet does not apply. This document and supplemental documents, serve as the Plan's controlling legal documents. These documents are used to determine eligibility for benefits and to interpret the benefits described in this booklet. However, if there is any conflict or difference between this booklet and any official documents and/or policies, the official documents and policies will control.

The official documents under which this booklet is issued may be amended or discontinued at any time by the Plan Sponsor and Plan Administrator. The Plan Sponsor and Plan Administrator are authorized, at any time and on such basis as deemed appropriate, at their sole discretion, to amend, modify, add to or eliminate any provision or benefit from the Plan. Any changes may be made by formal Plan amendment, resolution and/or other methods that may be permissible. The Plan Sponsor and Plan Administrator also reserve the right to terminate the Plan, at any time and for any reason, under the conditions of the official documents and/or policies. You will be notified of any change in writing.

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Employee Eligibility

You are eligible for coverage as of the date:

- The Plan is in effect for your employer;
- You are in a class of employees eligible for Plan coverage;
- You are actively at work and meet the minimum hours per week and service requirements shown in the ***About Your Plan*** section, which are based on your collective bargaining agreement and your employer's personnel policies; **and**
- You complete an enrollment form authorizing your employer to deduct the required contribution amount, if any, from your paycheck.

When you are eligible you will be asked to complete an enrollment form and authorize payroll deductions.

When You First Become Eligible

Your eligibility is based on your eligible class and the service requirements for your class, as stated above.

You must complete an enrollment form ***within 30 days*** after the date you first become eligible for coverage. If you do not, you may not enroll for coverage until a later open enrollment period. However, you may be eligible for a special enrollment in certain situations; see the ***Changes in Status – Special Enrollment*** section for more information.

Note: The Plan will not deny, limit or cancel health care coverage for you or your dependents based on genetic information.

Effective Date of Coverage

Your effective date of coverage is the date you meet the initial eligibility requirements for coverage (as described above). The Plan will not cover any expenses you and/or your dependents incur before this date.

Please note that no benefits will be paid until you submit a completed enrollment form.

Dependent Eligibility

In general, eligible dependents include your:

- ***Spouse,*** from whom you are not divorced or legally separated (a divorced or otherwise legally separated spouse may be considered your dependent if you are required by a court order or ruling to provide health care benefits).
- ***Dependent children,*** which include your natural children, stepchildren, legally adopted children (including children placed for adoption) or legal guardianship (a copy of the court order appointing guardianship must be submitted with the enrollment form) and any other children required to be covered by a Qualified Medical Child Support Order or other court order or ruling, who are not married and who:
    - Are younger than age 19 (coverage will continue until the end of the year they turn 19
    - Are any age if they are totally and permanently disabled, either physically or mentally, as long as they became disabled before age 19 are incapable of self-sustaining employment, depend primarily on you for more than half of their support and were reported as dependents on your most recent federal income tax return. The children's disability must be certified by a physician.
    - Between the ages of 19 and a maximum age of 25, coverage ends as of the end of the year they turn the maximum age who:
        - Are members of your household (this includes children who are away at school or camp);
        - Live with you (this includes children who are temporarily away at school or summer camp); and
        - Are full-time students for at least five months of the year or have received gross income of less than four times the current personal exemption as identified by the IRS; and
        - You provide more than half of the children's support.

      Note: If your dependent child is eligible for coverage as a full-time student but is unable to maintain full-time student status due to a medically necessary leave, his or her coverage may continue for up to one year or, if earlier, to the date on which coverage would otherwise end under the Plan.
- ***Principally Supported Children,*** who includes children who are not your or your spouse's offspring, but who:
    - Are related by blood or marriage;
    - Are not married;
    - Are under age 19 as of December 31;
    - Are a member of your household;
    - Are claimed as a dependent on your most recent federal income tax return or qualify in the current tax year for dependency status; and
    - You provided support for at least nine consecutive months before requesting the addition of the child. Following this period, there is a 90-day waiting period for coverage to begin. You must complete an enrollment and change form and submit a notarized affidavit

stating the date principal support began.

- ***Sponsored Dependents,*** who are dependents who live with you or who are related to you by blood or marriage and who depend on you for more than half of their support, as defined by the U.S. Internal Revenue Code. You must submit and have an application approved by MEBS before a sponsored dependent is eligible for coverage.

Effective Date of Coverage

Your dependent's coverage will begin on the date your coverage begins, as long as you enroll your dependents at the same time you enroll. If you do not enroll your dependents when you are first eligible, you may enroll them during any later open enrollment period.

If you need to add a new dependent, you may do so. However, you must enroll your new dependent within 30 days of the date he or she first becomes eligible to have coverage. If you do not enroll your new dependent within 30 days, you must wait for an open enrollment period to enroll your new dependent.

Please note that no benefits will be paid until you submit a completed enrollment form for your dependents.

Enrollment

Open Enrollment

Each year the Plan has an open enrollment period. This is your opportunity to enroll yourself and/or your dependents for coverage. Your open enrollment period is listed in the ***About Your Plan*** section; in addition, your employer may let you know when this period is.

Identification Cards

Once enrolled, you will receive a benefit verification card from MEBS. Your card contains important information, such as the effective date of coverage, your group number and the contract number. Please show your identification card(s) at the time of service.

Only you and your dependents may use the card. Don't lend your card to anyone else; this is illegal and subject to investigation for possible fraud. If you lose your card, you can still use your coverage, but you must report the loss immediately to your employer or MEBS.

Change in Status – Special Enrollment

In general, you may only enroll yourself and/or your eligible dependents when you are first eligible for coverage or during the open enrollment period. However, you may be eligible for a special enrollment due to:

- **Other Coverage Change.** If you decline enrollment for yourself and/or your dependents because you have other coverage, including Medicare, you may be eligible for a special enrollment when you and/or your dependents lose this other coverage. You must submit a written enrollment form and authorize payroll deductions, if any within 30 days after the other health coverage ends. If you do not enroll within 30 days, you will have to wait until the next open enrollment period to enroll for coverage.
- **New Dependents.** If you have a new dependent due to marriage, birth, legal guardianship, adoption or placement for adoption, you may be eligible for a special enrollment for yourself and/or your dependents. You must submit a written enrollment form and authorize payroll deductions, if any, within 30 days of the marriage, birth, adoption or placement for adoption. If you do not enroll within 30 days, you will have to wait until the next open enrollment period to enroll for coverage.
- **State Children's Health Insurance Program (SCHIP) Coverage Change:** SCHIP provides free or low-cost health care services for eligible children. If your child is covered under this Program, you may be eligible for a special enrollment for yourself and your dependents when your dependent child loses this coverage or when you become eligible for a contribution subsidy for SCHIP coverage. You must submit a written enrollment within 60 days after the SCHIP coverage ends or of becoming eligible for the contribution subsidy. If you do not enroll within 60 days, you will have to wait until the next open enrollment period to enroll for coverage.
- **Medicaid Coverage Change:** If you or your dependent is covered under Medicaid, you may be eligible for a special enrollment for yourself and your dependents when you or your dependent loses Medicaid coverage or when you become eligible for a contribution subsidy for Medicaid coverage. You must submit a written enrollment within 60 days after the Medicaid coverage ends or of becoming eligible for the contribution subsidy. If you do not enroll within 60 days, you will have to wait until the next open enrollment period to enroll for coverage.

How Your Dental Benefits Work

The Plan's dental benefits are designed to help you and your family meet certain dental expenses. Dental benefits cover a wide range of services. In general, this is how dental benefits work each benefit year:

- **Deductible.** The annual deductible is the amount of covered dental expenses that you and/or your dependents must pay before the Plan begins to pay for *certain* types of dental services. The deductible amount and when it applies is listed in the ***Summary of Benefits*** section.
- **Coinsurance – You and the Plan Share Expenses.** The Plan pays a percentage of covered expenses and you pay the rest; this is known as coinsurance. The percentage the Plan pays varies based on the type of dental services provided and whether you use an in-network or out-of-network provider (see ***Provider Network(s)***). The ***Summary of Benefits*** section lists the coinsurance percentages the Plan pays. The Plan pays benefits based on the reasonable fee for services, as defined in the ***Definitions*** section. The Plan does not pay any portion of a charge that exceeds the reasonable fee, as defined by the Plan.
- **Expenses are Limited.** Certain covered services are limited to specific benefit and/or lifetime maximums, which are the maximum the Plan will pay. All maximums are listed in the ***Summary of Benefits*** section.

Provider Network(s)

The Plan Administrator may contract with provider networks, as listed in the ***About Your Plan*** section. Dentists and other dental care professionals who participate in a network (in-network providers) have agreed to negotiated rates. The Plan bases payment on the reasonable fee (as defined in the ***Definitions*** section) for covered services. Generally, in-network providers accept scheduled amounts as full reimbursement for covered services.

You always have the final say about the providers you and your family use. While the amount you pay may vary, the same general range of services and treatments are covered.

To use an in-network provider:

- Find an in-network provider near you by contacting MEBS at www.mebs.com or the network provider(s).
- Choose an in-network provider and schedule an appointment. Since providers participating in the network sometimes change occasionally, check that the provider is in the network when you call to make your appointment.

Alternate Procedures

There is often more than one way to treat a dental condition. If this is the case for your condition, the maximum amount the Plan will reimburse will be based on the least expensive procedure that will, as determined by the Benefit Administrator, produce a professionally satisfactory result.

In addition, if a charge is for care that is not listed as covered, but one or more services related to the care is covered, then a portion of the charge may be covered. The Plan will cover the charge for the least expensive of the covered services in lieu of the actual charge incurred.

Dental Treatment Plan

To find out if a course of treatment or dental procedure is covered, your dentist should provide a dental treatment plan to the Benefits Administrator and ask for a predetermination of benefits before treatment is provided. Submitting a dental treatment plan is not required as a precondition for benefits, but will allow the Benefits Administrator to let you know of any limitations or exclusions that may apply before you incur expenses. A predetermination is good for 60 days after approval by the Benefit Administrator. The predetermination is based on the eligibility and coverage available at the time of the approval and may change based on eligibility and coverage when services are actually provided.

Extension of Benefits

In some cases the Plan may pay benefits for covered expenses you incur within 30 days after your coverage ends. Any extended benefits provided are on the same basis as if you were covered under the Plan and are subject to all Plan provisions (such as coinsurance and maximums). Benefits may only be extended for:

- An appliance or modification of an appliance for which the impression was taken while you were covered under the Plan;
- A crown, bridge or gold restoration for which a tooth was prepared while you were covered under the Plan; or
- Root canal therapy where the pulp chamber was opened while you were covered under the Plan.

Any extended benefits will only apply if you have no other coverage available.

Dental Covered Services

The following sections lists covered dental services available under the Plan. Refer to the ***Summary of Benefits*** section for information on what the Plan pays and any limits that apply. Any service that is not listed is not covered.

Type I Services: Preventive Care

Visits and Examinations

- Office visits during regular office hours for the treatment and observation of teeth and supporting structure.
- Office visits, other than for routine operative procedures, during regular office hours for treatment and observations of injuries to teeth and supporting structure.
- Professional visits after hours (payment will be made based on the services provided or as an office visit, whichever is greater).
- Specialist consultations when diagnostic procedures have been performed by a general dentist.
- Prophylaxis (cleaning), including scaling and polishing, limited to two per year.
- Difficult prophylaxis (cleaning) requiring more than one visit (excess of 45 minutes); limited to once every five years.
- Topical application of fluoride, including prophylaxis for members up to age 19; limited to one treatment per calendar year.
- Emergency palliative (treatment of oral conditions requiring immediate care) treatment.
- Sealants on permanent molars for members up to age 14.

X-Rays and Pathology

Except for films due to injuries, film fees include review and diagnosis.

- Intraoral, periapical and additional films; limited to eight each.
- Intraoral, complete series, including bite wings if necessary; limited to once every two calendar years.
- Intraoral, occlusal view (maxillary or mandibular).
- Extraoral
- Bite wing films, including examination; limited to two per calendar year.
- Panoramic survey (maxillary and mandibular) single films (considered an entire full-mouth series).
- Biopsy and examination of oral tissue.
- Microscopic examination.

Space Maintainers

For members up to age 19, covered passive appliances include:

- Fixed space maintainer, band type (unilateral or bilateral).
- Removable (unilateral or bilateral).
- Recementation of space maintainer.
- Adjustments within six months after installation.

Type II Services: Restorative Care

Oral Surgery

- Local anesthesia, suturing and routine post-operative care (certain services will be covered after the Medical Plan has determined any benefits.
- Uncomplicated (single) extractions, including root removal.
- Surgical extractions, including removal:
    - Tooth (soft tissue, partially bony and completely bony).
    - Erupted tooth.
- Alveolar or gingival reconstructions, including:
    - Alveoloplasty (edentulous and removal of teeth).
    - Vestibuloplasty (ridge extension).
    - Removal of palatal torus.
    - Removal of mandibular tori.
    - Excision of hyperplastic tissue.
    - Excision of pericoronal gingivate.
- Cysts, neoplasms and tumors, including:
    - Incision and drainage of abscess.
    - Radical resection of mandible with bone graft.
    - Removal of cyst or tumor.
- Other surgical procedures, including;
    - Biopsy of oral tissue.
    - Closure of salivary fistula.
    - Transseptal fiberotomy.
    - Transplantation of tooth or tooth bud.
    - Removal of foreign body from bone.
    - Partial ostectomy.
    - Closure of oral fistula of maxillary sinus.

- Alveolus (teeth stabilization).
- Removal of foreign body from soft tissue.
- Frenulectomy.
- Suture of soft tissue injury.
- Crown exposure for orthodontia.

Temporomandibular Joint (TMJ) Dysfunction Therapy

TMJ therapy is subject to a lifetime maximum; and includes:

- Occlusal orthotic/appliance.
- Follow up treatment to appliance therapy.

Anesthesia

- General anesthesia provided in conjunction with a surgical procedure.

Periodontics

- Emergency treatment (periodontal abscess, acute periodontitis, etc.).
- Gingival curettage (not prophylaxis).
- Provisional splinting.
- Gingivectomy gingivoplasty (including post-surgical visits), osseous of muco-gingival surgery (including post-surgical visits) and tooth treatment (fewer than six teeth).
- Root planning scaling.
- Periodontal maintenance.

Endodontics

- Pulp capping (direct and indirect); limited to once per tooth.
- Therapeutic pulpotomy (in addition to restoration); limited to once per tooth.
- Pulpal therapy (anterior and posterior); limited to once per tooth.
- Pulpal debridement (emergency endodontics); limited to once per tooth.
- Root canals (limited to once per tooth), including necessary x-rays and cultures (but excluding final restoration), including:
    - Anterior.
    - Bicuspid.
    - Molar.
    - Incomplete endodontic therapy (inoperable or fractured tooth).
    - Retreatment.
    - Apexification/recalcification.
    - Apricoectomy.

- Retrograde filling.
- Root amputation.
- Hemisection.

Restorative

Multiple restoration in one surface are considered a single restoration.

Covered expenses, not including inlays, crowns (other than stainless steel) and bridges, include:

- Amalgam restorations (primary and permanent teeth).
- Resin-based composite restorations (anterior, posterior-primary and posterior-permanent teeth).
- Pins, including pin retention when part of the restoration used instead of gold or crown restoration.
- Crowns, including:
  - Stainless steel when tooth cannot be restored with a filling material.
  - Full or partial acrylic denture and crown repairs.
  - Recement inlay or crown.
  - Sedative filling.

Type III Services: Replacement Care

Inlays and Crowns

Gold and porcelain/ceramic restoration and crowns are covered only when teeth cannot be restored with a filling material.

- Inlays/onlays.
- Crowns (not available for members under age 16), including:
  - Resin.
  - Resin with metal.
  - Porcelain/ceramic.
  - Porcelain with metal.
  - Gold (full or ¾ cast).
  - Provisional crown.
- Core buildup.
- Cast, post and core.
- Temporary crown (fractured tooth).

Prosthodontics (Replacement Care)

- Bridge abutments.
- Pontics, including:
    - Cast high noble or noble.
    - Porcelain/ceramic.
    - Resin fused to high noble or noble.
    - Porcelain fused to high noble or noble.
- Removable unilateral bridge (one piece casting, gold or chrome cobalt alloy clasp attachment, all types).
- Re-cementation and repair, including:
    - Connector bar.
    - Precision attachment.
    - Posts and cores.
- Complete and partial dentures (fee for dentures, partial dentures and relining include adjustments within six months after installation. Specialized techniques and characterizations are not eligible.), including:
    - Complete maxillary and mandibular.
    - Immediate maxillary and mandibular.
    - Partial dentures maxillary and mandibular resin base or cast metal base (including any conventional clasps, rests and teeth).
    - Precision attachment.
    - Rebase procedures.
    - Denture reline.
    - Special tissue conditioning.
    - Adjustments to denture more than six months after installation.
- Adding teeth to partial denture to replace extracted natural teeth.
- Full and partial denture repairs, including:
    - Broken dentures where no teeth are involved.
    - Replacing missing or broken teeth.
    - Repair complete denture base.

Type IV Services: Orthodontic Care

Orthodontia is only covered when provided for members to age 19 in connection with an orthodontic procedure required due to:

- Overbite or overjet of at least four millimeters;
- Maxillary (upper) and mandibular (lower) arches in either protrusive or retrusive relation of at least one cusp; or
- Cross-bite.

Benefits, which are limited to the lifetime maximum listed in the ***Summary of Benefits*** section, are paid in equal quarterly installments over a period equal to the estimated duration of the orthodontic treatment plan. The first installment is made at the end of the three-month period following initial placement of orthodontic appliances and subsequent installments are made at the end of each three-month period thereafter. However, payments may be made more often than quarterly.

Covered orthodontic care includes:

- Orthodontic services, including appliance and monthly active treatment visits, for:
    - Limited orthodontic treatment (primary, transitional or adolescent).
    - Interceptive orthodontic treatment (primary or transitional).
    - Comprehensive orthodontic treatment (transitional or adolescent).
    - Diagnostic x-rays and photos.
    - Casts
- Minor treatment to control harmful habits, including:
    - Removable or fixed appliance therapy, includes appliances for thumb sucking and tongue thrusting.
    - Fixed appliance therapy, includes appliances for thumb sucking and tongue thrusting.

General Plan Limitations and Exclusions

Only expenses listed as covered are considered covered expenses.

Limitations

The limitations or exclusions listed here may not apply to your Plan. Please refer to the ***Summary of Benefits*** to review modifications to your Plan.

- If an expense is eligible under both this Plan and another plan offered by the employer (i.e., medical), then this Plan will only pay after the other plan has paid, not to exceed the amount that would have been paid in the absence of the other coverage.
- This Plan will only cover a partial or full removable denture, fixed bridgework (or for the addition of teeth thereto), crown or onlay if no such restoration had been completed within the preceding five-year period.
- This Plan will only cover the replacement or modification to a partial or full removable denture, fixed bridgework, crown or onlay if no such restoration has been completed within the preceding five-year period.
- Any charges for an orthodontic appliance installed before the first day on which the person became a covered member. If a pre existing modification exists, (refer to ***Summary of Benefits***), then any charges incurred after the person becomes a covered member will be considered eligible charges.

Exclusions

In addition to any limitations and exclusions listed elsewhere in this booklet, no payment will be made for:

- Any service not reasonably necessary or not customarily performed for a member's dental care, which includes services for which no valid dental need can be shown or that are experimental in nature.
- Any service not provided by a dentist or a licensed dental hygienist under the supervision of a dentist or is not an x-ray ordered by a dentist.
- Any service furnished by or on behalf of the United States Government or any other government, unless payment of the charge is legally required
- Any service that is provided by any law or governmental program under which the member is or could be covered.
- Any appliance or modification of an appliance for which an impression was made before the member was covered.
- Any crown, bridge or gold restoration for which a tooth was prepared before the member was covered.
- Any expense incurred before being covered under the Plan.

- Root canal therapy for which the pulp chamber was opened before the member was covered.
- Prescription drugs for analgesia, bleaching and/or inflammation.
- Instructions for dietary, oral hygiene and plaque control
- Completion of forms.
- Charges for hospitalization, general anesthesia and/or intravenous sedation for restorative dentistry.
- Diagnostic casts made specifically to fabricate devices or restorations.
- Relines and rebases, except those performed within 24 months from the date the service was last provided.
- Gold, porcelain and/or ceramic restorations unless teeth cannot be restored with filling material.
- Gold, porcelain and/or ceramic restorations for members under age 16.
- Surgical corrections to the jaw and bone structure, including, but not limited to, surgical implants.
- Services based solely on a member's age, mental status or physical status.
- Cosmetic services unless necessitated as a result of accidental injuries. Facings on crowns or pontics posterior to the second bicuspid are considered cosmetic and are not covered.
- Dental care of a congenital or developmental malformation.
- Replacement of lost or stolen appliances or appliances or restoration necessary to increase vertical dimension, restore occlusion or for implantology techniques.
- Care for injuries or disease, arising out of or in the course of any employment for wage or profit, that is covered by any workers' compensation law, occupational disease law or similar legislation.
- A service provided by a professional who ordinarily resides in the same household with a member or who is part of the member's immediate family (i.e., children or spouse) where charges are normally not made.
- Any orthodontic charge not specifically listed as covered.
- Any portion of any charge in excess of the reasonable fee, as defined by the Plan.
- Replacement or repair of orthodontic appliances.

Claims and Appeals

Filing a Claim

Many providers will file claims for you. If your provider does not, follow the steps listed in this section. If a claim is denied, in whole or in part, there is a process you can follow to have your claim reviewed.

In-network providers and many other providers will submit claims for you. Be sure to show your Benefit Verification card to your provider so they will know where to submit the claim. If your provider does not submit your claim for you, then you must do so. When you need to submit a claim, follow the steps listed below to make sure your claim is processed as quickly as possible:

Step 1: When you receive covered services or supplies, be sure your bill or statement shows the:

- Provider's name and address;
- Full name of the patient (no nicknames);
- Date of service;
- Charges, listed separately for each service;
- Description of services;
- Diagnosis (if applicable); and
- Identification number from your Benefit Verification card.

Step 2: Complete the claim.

- Make sure to provide all requested information.
- Use a separate claim form for each member.
- Review the form to insure accuracy; incomplete forms will be returned to you, which will cause a delay in payment.
- Make a copy of the claim for your records; originals cannot be returned to you.
- Be sure to sign and date the form.

Step 3: Submit the form to the address listed on your Benefit Verification card.

- Be sure to enclose the original bill or statement with the form; cash register receipts, cancelled checks and money order stubs are not acceptable.
- If you or your dependent has coverage under any other plan, be sure to include information on the other coverage, including any Explanation of Benefits (EOB) if the other plan paid first.

Claim Filing Deadlines

Claims can be filed by you, your dependent, your beneficiary or someone authorized to act on your or their behalf. However, claims should be submitted as soon as possible, but no later than 15 months after the expense was incurred. If a claim is not submitted within this 15 month period, it will be denied.

Assignment of Benefits

Benefits are assignable unless otherwise indicated in this document. The Plan is not responsible for the validity or sufficiency of any assignment. The Plan will direct benefits to the provider or member based on the assignment.

Explanation of Benefit (EOB)

Whenever a claim is processed, you will receive a printed summary, called an Explanation of Benefits (EOB). An EOB is an itemized statement that shows what action has been taken on a claim; it is not a bill. It is provided to help you understand how expenses were paid and that the information received by the Plan was correct. An EOB is for your information and files. When you receive an EOB, you should review it to verify that it is accurate; be sure to contact MEBS to report any inaccuracies.

If you receive an EOB from other coverage, contact MEBS and be sure to provide it along with your related claim.

Claim Decisions

Once your claim is submitted, it will be reviewed to determine if you are eligible for benefits and the amount of benefits payable, if any, will be calculated. All claims are processed promptly, when complete claim information is received. Determinations will be made as soon as administratively possible as follows:

- **Urgent Care Claims.** A determination will be made within 72 hours from receipt of the claim. Notice of a decision on an urgent care claims may be provided verbally within 72 hours and then confirmed in writing within three days after the oral notice. If more information is needed to process the claim, you will be notified within 24 hours of receipt of the claim. You will then have up to 48 hours to respond. You will be notified of a determination within 48 hours of the later of receipt of the additional information or the end of the 48-hour period for you to provide the additional information.
- **All Other Claims.** An initial determination will be made within 30 days of receipt of the claim.
    - If more time is needed due to matters beyond the Plan's control, you will be informed, within this 30-day deadline, that an extension of up to 30 additional days is needed.
    - If more information is needed to process your claim, you will be notified within 30 days of receipt of your claim and you then have up to 45 days to provide the requested information. After 45 days or, if sooner, after the information is received, you will be notified of a determination within 15 days.

If an extension is needed, the extension notice will include the reasons for the extension and the date a decision is expected.

If a Claim Is Denied

If a claim is denied (in whole or in part), you (or your beneficiary) will receive a written notice, within the timeframes described above, that includes:

- The specific reason(s) for the decision;
- Reference to the Plan provision(s) on which the decision was based;
- A description of any additional information or material needed to properly process the claim and an explanation of why it is needed;
- A copy of the Plan's review procedures and periods to request a appeal the decision, including a:
    - Description of the expedited review process of urgent care claims, if applicable; and
    - Statement that you may bring a lawsuit under ERISA after appealing the denial; and
- If applicable, a statement that a copy of any:
    - Rule, guideline, protocol or similar criteria on which the claim is denied is available at no cost upon request, if applicable; or
    - Scientific or clinical judgment relating to medical necessity, experimental treatment or similar exclusion or limit on which the claim is denied is available at no cost upon request.

In most cases, disagreements about benefit eligibility or amounts can be handled informally by calling MEBS. However, if a disagreement is not resolved, there is a formal procedure you can follow to have your claim reconsidered.

Appealing a Denied Claim

If a claim is denied (including if the claim is denied based on eligibility) or you disagree with the amount of the benefit, you may have the initial decision reviewed. You must follow and exhaust the Plan's appeals procedure before you file a lawsuit under ERISA (the federal law governing employee benefits) or initiate proceedings before any administrative agency.

Written requests for an appeal should be sent as soon as possible to MEBS at:

MEBS, Inc.
3809 Lake Eastbrook Boulevard
Grand Rapids, Michigan 49546
(800) 968-6327 or (616) 458-6327
www.mebs.com
customerservice@mebs.com

Requests for an urgent care claim appeal may be made verbally or sent by fax.

If the claim is denied or you are otherwise dissatisfied with a Plan determination, a written appeal must be filed within 180 days (10 days for expedited appeal) from the date of decision.

Your written appeal should explain the reasons you disagree with the decision and any other information requested in the denial notice. When filing an appeal you may:

- Submit additional materials, including comments, statements or documents;
- Request to review all relevant information (free of charge);
- Request a copy of any internal rule, guideline, protocol or other similar criteria on which the denial was based; and
- Request a copy of any explanation of the scientific or clinical judgment on which the denial was based if the denial was based on medical necessity, experimental treatment or similar exclusion or limitation.

Appeal Decisions

If an appeal is filed on time, following the required procedures, a new, full and independent review of the claim will be made. The new decision will not consider the initial decision. An appropriate Plan fiduciary will conduct the review and the decision will be based on all information used in the initial determination as well as any additional information provided. If the request for review involves a claim for benefits that are provided by an insurance company, that company will make the review and final decision. A determination will be made within 60 days.

Written notification of the decision will be provided within five days after a determination is made. However, oral notice of a determination on an urgent care claim may be provided sooner. The written notice will include all required information, including a statement that you may bring a lawsuit under ERISA after the denial of an appealed claim. However, no legal action may begin until 60 days after notice has been provided that the appeal is denied. In addition, any legal action must begin within two years the claim originated.

Expedited Appeal for Urgent Care Claims

There is an expedited appeal process for appeals relating to a claim where the normal time frame for reaching a determination would seriously jeopardize your life and/or health or would jeopardize your ability to regain maximum function. In these cases, the Plan will make a determination within 72 hours after receipt a written appeal. However, the request for an expedited appeal must be provided in writing within 10 after receipt of the determination (in accordance with Public Act 251 of 2000). The initial determination may be provided verbally, with written confirmation provided within two days after the oral notice.

Authorized Representatives

When appealing a claim, you may authorize a representative to act on your behalf. However, you must provide written notification authorizing this representative and comply with the Plan's procedures. Written notification must be received before a determination is made. The Plan will not address any representative unless it is absolutely sure that he or she is your representative. You or your representative may review the pertinent records and documents.

You may have, at your own expense, legal representation at any stage of the review process. If any Plan provision is determined to be unlawful or illegal, the illegality will apply only to the provision in question and will not apply to any other Plan provisions.

Medical Judgments

If a claim or appeal is denied based on a medical judgment, the Plan will consult with a health care professional who:

- Has appropriate training and experience in the field of medicine involved in the judgment; and
- Was not consulted (or does not report to the person who was consulted) in connection with the original denial of the claim.

You may request the identity of any medical experts consulted in making a determination of your claim.

Incompetence

If the Plan determines that a person entitled to benefits is unable to care for his or her affairs because of illness, accident or incapacity (either physical or mental), payment that would otherwise be made to that person will be made to that person's appointed legal representative. If no legal representative has been appointed, payment will, at the discretion of the Plan, be made to that person's spouse, child or such person who has care and custody of that person.

Release of Information

As a member, you authorize providers to provide the Plan, upon request, with information relating to services that you are or may be entitled to under the Plan. This authorization allows the Plan to examine records with respect to the services and to provide information requested. All information related to treatment remains confidential except for the purpose of determining rights and liabilities arising under the Plan.

Right of Recovery

The Plan has the right to reimbursement for benefits provided or paid for which you were not eligible under Plan terms. Reimbursement is due and payable immediately upon Plan request. In addition, the Plan has the right to reduce or refuse payment of future benefits to recover any reimbursement. The acceptance of premiums or other fees or the providing or paying of benefits by the Plan does not constitute a waiver of the Plan's rights to enforce this provision in the future. This provision is in addition to, and not instead of, any other remedy available to the Plan at law or in equity.

Subrogation

If you incur expenses due to a bodily injury or illness caused by negligence or wrong of a third party and benefits are payable under this Plan, you will receive benefits. However, the Plan has the right to recover any payment it made on behalf of any eligible member from a liable party. You must execute the necessary documents or perform any other act required to secure this Plan right.

If any amounts are recovered from the third party, whether by judgment, settlement or otherwise, you, your dependents or your personal representative must reimburse the Plan for the total amount of benefits paid. The amount to be reimbursed will not exceed the proceeds of any recovery after the deduction of reasonable and necessary expenditures, including attorney's fees, incurred in effecting such recovery.

Coordination of Benefits

When "you" is used in this section it refers to each member covered under this Plan and any other plan.

This Plan is designed to help you meet certain health care costs. However, this Plan coordinates its coverage with any coverage you may have under any other plan, as defined in the ***Definitions*** section. Specifically, that means that this Plan will either pay:

- Regular benefits in full if this Plan is determined to pay first; or
- If this Plan is not required to pay first, a reduced amount that, when added to benefits paid by any other plan, equals 100% of allowable expenses under this Plan.

If you are subject to any cost containment provisions under any other plan that is primary, any cost containment sanction imposed by that plan will not be payable as a benefit or a secondary balance by any of the other secondary plan(s).

Order of Payment

If you are covered under any other plan, Plan reimbursements are coordinated with your other coverage, with one plan paying first. The plan that pays benefits first (the primary plan) determines benefits first, regardless of payment from any other plan. Other plans then pay secondary, in accordance with this Plan's guidelines.

If this Plan is the primary plan, it will pay its benefits as if there were no other plan. If this Plan is secondary, it will pay its benefits in accordance with Plan guidelines, except that this Plan will pay no more of a covered expense than, when added to the part(s) payable by the other plan(s), equals 100% of the allowable expense under this Plan.

Which plan pays first is based on the following rules:

- Any other plan that does not have a coordination of benefits provision determines benefits first, before this Plan.
- The plan covering a member as an employee pays first before a plan covering the member as a dependent. If a member is covered as an employee under this Plan and any other plan, then:
    - Benefits of the plan that covers the member as an employee who is neither laid off nor retired (or as that member's dependent) are determined before those of a plan that covers the member as a laid off or retired employee (or as that member's dependent). If the other plan does not have this rule, and as a result the plans do not agree on the order of payment, this rule does not apply.
    - The plan that has covered the member for the longest continuous time pays first.
- *If a dependent child is covered by more than one plan and the parents are **not** divorced or legally separated,* the plan that covers the child of the parent whose date of birth, excluding year of birth, occurs earlier in a calendar year pays first. If the other plan does not have this birthday rule and as a result the plans do not agree on the order of payment, coordination will be determined under the rules of the other plan.

- *If a dependent child is covered by more than one plan and the parents **are** divorced or legally separate and there is:*
    - A court decree that specifically states which parent is responsible for the child's health care expenses, the plan of that parent will pay first; this supersedes any other order below; or
    - No court decree, then:
        - The plan of the parent with custody pays first;
        - If the parent with custody is married, the plan of the stepparent with custody pays next; and
        - The plan of the parent without custody pays next.

If a dependent spouse or child is also covered as an employee member, the Plan's coordination of benefits provisions may also apply.

When Eligibility Ends

Your eligibility for coverage will end on the first of the following dates:

- On the first day of the month for which employer contributions on your behalf are no longer current; however, your coverage may be reinstated as of the first day of the month for which contributions resume, as long as you are otherwise eligible;
- On the first day of the month for which your contribution is not current (i.e., it is over 30 days past due); however, your coverage may be reinstated as of the next open enrollment period if required contributions are made at least 30 days in advance, as long as you are otherwise eligible (if you are on an approved FMLA leave, your coverage will continue for 90 days; if your leave extends beyond 90 days, coverage may be reinstated when you return to work);
- On the day you are no longer a member of a class of eligible employees, due to termination of employment or for any other reason;
- On the day that the class of employees to which you belong is no longer eligible for coverage; or
- The date the Plan ends.

Your dependent's eligibility ends when your eligibility ends or sooner if your dependent no longer meets the Plan's definition of a dependent.

See the ***About Your Plan*** section for more information on when your coverage ends. In addition, you may end your coverage at any time, either due to a status change or during any open enrollment period. You must provide written notice indicating why you are ending coverage.

When Coverage Ends

If your or your dependent's coverage ends, you and/or your dependent may be eligible to continue coverage by applying and paying for COBRA continuation coverage. See the ***COBRA Continuation Coverage*** section for more information.

When coverage, including COBRA coverage, ends, you and/or your dependent will be provided with a certificate of creditable coverage, free of charge, within 14 days after coverage ends. The certificate will include the:

- Date the certificate was issued;
- Name, address and identification number of the member(s);
- Plan name providing the certificate;
- Name of any dependents to whom the certificate applies;
- Plan waiting/affiliation period;
- Date that creditable coverage began and ended or will end; and
- Name, address and telephone number of the Plan Administrator.

This certificate may help reduce or eliminate any pre-existing condition limitation under a new group health care plan. You or your dependent may ask for a certificate at anytime while covered under the Plan or within 24 months of the date your coverage ends.

COBRA Continuation Coverage

When "you" is used in this section it refers to each person covered under the Plan who is or may become a qualified beneficiary, which is someone eligible for COBRA. The Plan's COBRA continuation coverage notice, available from MEBS, provides a more complete description of your COBRA rights.

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended, you and your dependents may be eligible to temporarily extend your coverage under the Plan when it would otherwise end. To continue coverage, you and/or your dependents must pay the full cost of that coverage (your share plus the employer's share, if any) plus a 2% administrative fee. **You and your dependents should take the time to read this section carefully. Your rights and responsibilities under the law are summarized below; a more complete description is provided in the Plan's COBRA notice.**

American Recovery and Reinvestment Act (ARRA): Under the ARRA, if your qualifying event is an involuntary termination of employment, you will only be responsible for paying 35% of the cost mentioned above for up to fifteen months or until COBRA coverage ends, which ever occurs first. This temporary subsidy, which is subject to change, is available to participants who become ARRA-eligible between September 1, 2008, and upon repeal. However, the subsidy will not be paid for any period before March 1, 2009. This temporary provision is not reflected in this booklet but is included in the Plan's COBRA continuation coverage notice, which you will receive after the Plan Administrator is notified of a qualifying event.

Who Is Eligible to Elect COBRA

In general, to elect COBRA coverage, you and your dependents must have been covered under the Plan on the day before the event that caused coverage to end. Each qualified beneficiary who elects COBRA will have the same Plan rights as other Plan members or beneficiaries, including open enrollment and special enrollment rights.

You and/or your dependents may be eligible to elect COBRA coverage if your coverage ends due to a qualifying event. Qualifying events include:

If you are an employee member:	*If you are a covered spouse:*	*If you are a dependent child:*
• Your hours of employment are reduced. • Your employment ends for any reason other than your gross misconduct.	• Your spouse dies. • Your spouse's hours of employment are reduced. • Your spouse's employment ends for any reason other than his or her gross misconduct. • You become divorced or legally separated from your spouse. Also, if your spouse reduces or eliminates your coverage in anticipation of a divorce or legal separation, and the divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce or legal separation.	• Your parent-employee dies. • Your parent-employee's hours of employment are reduced. • Your parent-employee's employment ends for any reason other than his or her gross misconduct. • You stop being eligible for coverage under the Plan as a "dependent child."

More Information About Who May Be a Qualified Beneficiary

- **Children.** A child born to, adopted by or placed for adoption with a member employee during a COBRA coverage period is considered a qualified beneficiary and will automatically be covered if the member employee is a qualified beneficiary who has elected COBRA coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the employee member. To be enrolled in the Plan, the child must satisfy Plan eligibility requirements (for example, regarding age). COBRA coverage provides the Plan coverage provided to similarly situated members.
- **Alternate Recipients under QMCSOs.** A child of an employee member who is receiving benefits under the Plan pursuant to a QMCSO received by the employer during the member employee's employment is entitled to the same rights to elect COBRA as a dependent child of the employee member.

Notification of Qualifying Events

MEBS must be notified of any qualifying event for you to be eligible for COBRA coverage. Your employer will notify MEBS if the qualifying event is the:

- End of employment;
- Reduction in hours of employment; or
- Death of the employee.

For all other qualifying events, **you** must notify your employer, in writing, within 60 days after the later of the date:

- Of the qualifying event; or
- On which the qualified beneficiary loses or would lose Plan due to a qualifying event.

Electing COBRA Continuation Coverage

- **How to Elect COBRA.** To elect COBRA, you must mail or hand-deliver written notice of your election to your employer. Oral communications regarding COBRA coverage (including in-person or telephone statements) and electronic communications (including e-mail and faxed communications) are not acceptable COBRA elections and will not preserve your COBRA rights.
- **Deadline for COBRA Elections.** Your election must be provided to your employer no later than 60 days after the date of your COBRA election notice. If mailed, your election must be postmarked by this date or if hand-delivered, your election must be received by your employer by this date. If written notice is not provided by this due date, you will lose your right to elect COBRA.
- **If You Reject COBRA.** If you reject COBRA before the due date, you may change your mind as long as your provide the election notice before the deadline for COBRA elections.
- **Premium Payments.** You do not have to send any payment with your election notice (additional payment information is included later in this section).
- **Independent Election Rights.** Each qualified beneficiary has an independent right to elect COBRA. For example, your spouse may elect COBRA even if you do not. COBRA may be elected for only one, several or for all dependent children who are qualified beneficiaries. You or your spouse (if eligible) may elect COBRA on behalf of all of qualified beneficiaries, and parents may elect COBRA on behalf of their children. Any qualified beneficiary for whom COBRA is not elected within then 60-day election period specified in the Plan's COBRA election notice will lose his or her right to elect COBRA coverage.
- **Coverage.** Qualified beneficiaries may be enrolled in one or more Plans (for example, medical, dental or vision) at the time of a qualifying event. If you are entitled to a COBRA election due to a qualifying event, you may elect COBRA under any or all health care Plans that you were covered under on the day before the qualifying event. For example, if you were covered under medical, dental and vision on the day before a qualifying event, you may elect medical only, dental only, vision only or any combination of these benefits.

- **Entitlement to Medicare.** When you complete the election form, you must notify your employer if any qualified beneficiary is entitled to Medicare (Part A, Part B or both) and, if so, the date of Medicare entitlement. If you become entitled to Medicare (or first learn that you are entitled to Medicare) after submitting your election form, you must immediately notify your employer of the date of Medicare entitlement.
- **If You Have Other Coverage or Medicare.** You may elect COBRA even if you have other group health plan coverage or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, as discussed in more detail later in this section, your COBRA coverage will end automatically if, after electing COBRA, you become entitled to Medicare benefits or become covered under other coverage (but only after any applicable pre-existing condition exclusions of that other plan have been exhausted or satisfied).

Considerations in Deciding Whether to Elect COBRA

When deciding whether to elect COBRA, consider:

- Election of COBRA may help you avoid having pre-existing condition exclusions of other plans if you have more than a 63-day gap in health coverage.
- You will lose the guaranteed right to purchase individual health insurance policies that do not impose a pre-existing condition provision if you do not get COBRA coverage for the maximum period available to you.
- You have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage under the Plan ends because of a qualifying event. You will also have the same special enrollment right at the end of COBRA coverage if you get COBRA coverage for the maximum period available to you.

Length of COBRA Continuation Coverage

COBRA coverage is a temporary continuation of coverage. The COBRA coverage periods described below are maximum coverage periods. COBRA coverage can end before the maximum coverage period for several reasons, which are described in the ***Termination of COBRA Continuation Coverage Before the Maximum Coverage Period*** section.

- **18 Month Maximum Coverage Period.** Coverage can generally continue for up to 18 months if Plan coverage is lost due to the end of employment or reduction in the hours of employment.
- **36 Month Maximum Coverage Period.** Coverage can generally continue for up to 36 months if Plan coverage is lost due to:
    - The death of the employee member;
    - The employee member's divorce or legal separation;
    - A dependent child's losing eligibility as a dependent child; or

- The end of employment or reduction in hours of employment and the employee member becomes entitled to Medicare less than 18 months before the qualifying event. In this instance, only coverage for qualified beneficiaries other than the employee who lose coverage as a result of the qualifying event can continue for up to 36 months. For example, if an employee member becomes entitled to Medicare eight months before the date on which employment ends, COBRA coverage for the spouse and children can last up to 36 months after the date of Medicare entitlement (this is equal to 28 months after the date of the qualifying event, which is 36 months minus 8 months). This COBRA coverage period is available only if the employee member becomes entitled to Medicare within 18 months **before** the termination or reduction in hours.

Extension of Maximum Coverage Period

If the qualifying event was an employee member's termination of employment or reduction in hours, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify your employer of a disability or second qualifying event to extend the COBRA coverage period. **If you do not provide notice of a disability or second qualifying event, you will lose your right to extend the COBRA coverage period**, as described below:

- **Disability Extension.** If a qualified beneficiary is determined by the Social Security Administration to be disabled and the employer is notified in a timely fashion, you and all other qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA coverage, for a maximum of 29 months. This extension is available only for qualified beneficiaries who are receiving COBRA coverage due to an employee member's termination of employment or reduction in hours. The disability must begin some time before the 60th day of COBRA coverage and must last at least until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months, as described above). Each qualified beneficiary will be entitled to the disability extension if one of them qualifies.

  To be eligible for this extension, you must notify your employer, in writing, of the Social Security Administration's determination of the qualified beneficiary's disability within 60 days after the latest of the date:

  - Of the Social Security Administration's disability determination;
  - Of the employee member's termination of employment or reduction in hours; or
  - On which the qualified beneficiary loses or would lose Plan coverage due to the employee member's termination of employment or reduction in hours.

  You must also provide this notice within 18 months after the member employee's termination of employment or reduction in hours to be entitled to a disability extension.

  To provide notice, you must use the Plan's ***Notice of Disability*** form and follow all required procedures. If the required procedures are not followed or if the notice is not provided as required, no disability extension of COBRA coverage will be available. A copy of this notice and the required procedures is available from your employer or MEBS.

- **Second Qualifying Event Extension.** An extension of coverage is available to spouses and dependent children receiving COBRA coverage if a second qualifying event occurs during the 18 months (or, in the case of a disability extension, the 29 months) following an employee member's termination of employment or reduction in hours. The maximum COBRA coverage period, including any extension for a second qualifying event, is 36 months. Theses qualifying events may include the death of employee member, divorce or legal separation from the employee member or a dependent child's ceasing to be eligible for coverage as a dependent. These events are a second qualifying only if they would have caused the qualified beneficiary to lose Plan coverage if the first qualifying event had not occurred. This extension is not available when an employee member becomes entitled to Medicare.

  To be eligible for this extension, you must notify your employer in writing of the second qualifying event within 60 days of the later of the date:

  - Of the second qualifying event; or
  - On which the qualified beneficiary would lose Plan coverage due to the second qualifying event if it had occurred while the qualified beneficiary was covered under the Plan.

  To provide this notice, you must use the Plan's ***Notice of Second Qualifying Event*** form and follow all required procedures. If the required procedures are not followed or if the notice is not provided as required, no extension of COBRA coverage will be available. A copy of this notice and the required procedures is available from your employer or MEBS.

Cost of COBRA Continuation Coverage

Each qualified beneficiary is required to pay the entire cost of COBRA coverage. The required amount will not exceed 102% (or, in the case of an extension of COBRA coverage due to a disability, 150%) of the cost to the Plan (including both employer and employee contributions) for coverage of a similarly situated Plan member or beneficiary who is not receiving COBRA coverage. Your COBRA premium amount may change from time to time during your COBRA coverage period and will most likely increase over time. You will be notified of any COBRA premium change.

Claims for reimbursement will not be processed or paid until you have elected COBRA and made the first payment. If you do not make your first payment for COBRA coverage in full within 45 days after the date of your election, you will lose all COBRA rights under the Plan.

Payment for COBRA Continuation Coverage

- **How Premium Payments Must Be Made.** All COBRA premiums must be mailed or hand-delivered to the address shown on your election notice.
- **When Premium Payments Are Considered to Be Made.** If mailed, your payment is considered to be made on the date that it is postmarked. If hand-delivered, your payment is considered to be made when it is received at the address shown on your election notice. You are not considered to have made any payment if your check is returned due to insufficient funds or otherwise.

- **First Payment for COBRA coverage.** If you elect COBRA, you do not have to send any payment with your election. However, you must make your first payment no later than 45 days after the date of your election. The date of your election is the date your election form is postmarked if mailed or received at the address shown on the election notice if hand-delivered.

  Your first payment must cover the cost of COBRA coverage from the time your coverage under the Plan would have otherwise ended through the end of the current month. Also, as discussed below, you will have to pay your premium before the next due date to continue uninterrupted coverage. You are responsible for making sure that the amount of your first payment is correct. You may contact your employer to confirm the correct amount.

- **Monthly Payments for COBRA Coverage.** After you make your first payment for COBRA coverage, you are required to make monthly payments for each subsequent month of COBRA coverage. The amount due for each month for each qualified beneficiary will be included in the election notice provided to you at the time of your qualifying event. Each monthly payment is due on the first day of the month for that month's COBRA coverage. If you make a monthly payment on or before the first day of the month to which it applies, your COBRA coverage will continue for that month without any break. **You will not receive periodic notices of payments due; it is your responsibility to pay COBRA premiums on time.**

- **Grace Periods for Monthly COBRA Premium Payments.** Although monthly payments are due on the first day of each month, you are given a grace period of 30 days after the first day of the month to make each monthly payment. Your COBRA coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that payment. However, if you pay a monthly payment later than the first day for the month to which it applies, but before the end of the grace period for the month, your coverage under the Plan will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the month) when the monthly payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and you may have to resubmit it once your coverage is reinstated. **If you do not make a monthly payment before the end of the grace period for that month, you will lose all rights to COBRA coverage under the Plan.**

Termination of COBRA Continuation Coverage Before the Maximum Coverage Period

COBRA coverage will automatically end before the end of the maximum period if:

- Any required premium is not paid in full on time;
- A qualified beneficiary becomes covered, after electing COBRA, under another group health plan (but only after any pre-existing condition exclusions of the other plan for a pre-existing condition of the qualified beneficiary have been exhausted or satisfied);
- A qualified beneficiary becomes entitled to Medicare (Part A, Part B or both) after electing COBRA;
- The employer ceases to provide any group health plan for its employees; or
- During a disability extension period, the disabled qualified beneficiary is determined by the Social Security Administration to no longer be disabled.

COBRA coverage may also end for any reason the Plan would terminate coverage of a member or beneficiary not receiving COBRA coverage (such as fraud).

If You Become Entitled to Medicare or Obtain Other Coverage

After electing COBRA, you must notify your employer in writing within 30 days if a qualified beneficiary becomes entitled to Medicare (Part A, Part B or both) or becomes covered under other coverage (after any pre-existing condition exclusions of that other plan have been exhausted or satisfied). You must use the Plan's ***Notice of Other Coverage, Medicare Entitlement or Cessation of Disability*** form and follow the required procedures. A copy of this notice and the required procedures is available from your employer or MEBS.

COBRA coverage will end (retroactively, if applicable) as of the date of Medicare entitlement or as of the date other coverage begins (after exhaustion or satisfaction of any pre-existing condition exclusions). You are required to repay the Plan for any benefits paid after the termination date, regardless of whether or when you provide notice of Medicare entitlement or other coverage. However, any premium you paid for COBRA coverage after the termination date will be refunded to you, net of any repayments you may owe.

If a Qualified Beneficiary Is No Longer Disabled

If a disabled beneficiary is determined by the Social Security Administration to no longer be disabled, you must notify your employer in writing within 30 days after the Social Security Administration's determination. To provide notice, you must use the Plan's ***Notice of Other Coverage, Medicare Entitlement or Cessation of Disability*** form and follow the required procedures. A copy of this notice and the required procedures is available from your employer or MEBS.

If the Social Security Administration's determination that a qualified beneficiary is no longer disabled occurs during a disability extension period, COBRA coverage for all qualified beneficiaries will end (retroactively if applicable) as of the first day of the month that is more than 30 days after the Social Security Administration's determination. You are required to repay the Plan for any benefits paid after the termination date, regardless of whether or when you provide notice that the disabled qualified beneficiary is no longer disabled. Any premium you paid for COBRA coverage after the termination date will be refunded to you, net of any repayments you may owe.

Important

- **If You Have Questions.** Questions concerning the Plan or your COBRA rights should be directed to your employer or MEBS.
- **Keep the Plan Informed of Address Changes.** To protect your family's rights, you should keep your employer and MEBS informed of any changes in your address or the address of family members. You should also keep a copy, for your records, of any notices you send to your employer.
- **Plan Contact Information.** For information about the Plan and COBRA coverage, contact your employer or MEBS, as listed in the ***About Your Plan*** section. The contact information for the Plan may change from time to time.

Trade Adjustment Assistance (TAA)

Note: Only you can know if you are eligible for the TAA program; this information is being provided for informational purposes only.

The Trade Act of 1974 established the TAA program to assist workers employed by a firm who lose their jobs or whose hours of work and wages are reduced as a result of increased imports or shifts in production to foreign countries.

The TAA program provides an array of reemployment and retraining services. Workers who believe they have been adversely affected by foreign trade, or others acting for those workers, may petition the U.S. Department of Labor (DOL) for a determination of eligibility. Workers certified as eligible to apply for TAA may receive reemployment services, training in new occupational skills, a job search allowance when suitable employment is not available in the workers' normal commuting area, a relocation allowance when the worker obtains permanent employment outside the commuting area and Trade Readjustment Allowances (TRA) while the worker is in training.

Health Coverage Tax Credit (HCTC)

If you are certified by the U.S. Department of Labor (DOL) as eligible for benefits under the TAA program, you may be eligible for both a new opportunity to elect COBRA coverage and a HCTC.

If you and/or your dependents did not elect COBRA coverage during your election period, but are later certified by the DOL for the TAA program, you may be entitled to an additional 60-day COBRA coverage election period beginning on the first day of the month in which you were certified. However, in no event would this benefit allow you to elect COBRA coverage later than six months after your Plan coverage ended.

Eligible TAA program individuals can either take a tax credit or get advance payment of a percentage (currently 80%) of premiums paid for qualified health insurance, including COBRA coverage. More information about the Trade Act is also available at www.doleta.gov/tradeact.

Family and Medical Leave

The Family and Medical Leave Act (FMLA) allows you to take up to 12 weeks of unpaid leave during any 12-month period due to:

- The birth, adoption or placement with you for adoption of a child;
- The care of a seriously ill spouse, parent or child;
- Your serious illness; or
- A qualifying urgent need for leave because your spouse, son, daughter or parent is on active duty in the armed services in support of a military operation.

In addition, you may be able to take up to 26 weeks of unpaid leave during any 12-month period to care for a service member. The service member must be:

- Your spouse, son, daughter, parent or next of kin;
- Undergoing medical treatment, recuperation or therapy for a serious illness or injury incurred in the line of duty while in military service; and
- An outpatient or on the temporary disability retired list of the armed services.

Your eligibility for FMLA leave and benefits are determined by your employer. Generally, you are eligible for a leave under FMLA if you:

- Have worked for a covered employer for at least 12 months;
- Have worked at least 1,250 hours over the previous 12 months; and
- Work at a location where at least 50 employees are employed by the employer within a 75-mile radius.

Contact your employer to determine if you are eligible for FMLA leave. During your leave, you will maintain your Plan coverage on the same basis as other similarly situated members. Your eligibility will be maintained until the end of the leave, as long as your employer properly grants the leave under the federal law and your employer makes the required notification and payments are made on your behalf. If you and your employer have a disagreement over your eligibility and coverage under FMLA, the Plan will have no direct role in resolving the dispute.

If you take FMLA leave and do not return to work at the end of the leave, you (and you spouse and dependent children) may be eligible for COBRA coverage. See the ***COBRA Continuation Coverage*** section for more information.

Military Service

If you lose coverage because you enter into active military duty covered under the Uniformed Services Employment and Reemployment Rights Act (USERRA) of 1994, you and your dependents are eligible to continue your coverage as long as you pay the cost to continue that coverage.

Your rights under COBRA and USERRA are similar but not identical. Any COBRA election you make will also be an election under USERRA, and COBRA and USERRA will both apply with respect to the coverage elected. If COBRA and USERRA give you (or your covered spouse or dependent children) different rights or protections, the law that provides the greater benefit will apply. The administrative policies and procedures described in the ***COBRA Election Notice*** also apply to USERRA coverage, unless compliance with the procedures is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances.

How Long USERRA Coverage May Last

When you take military leave, USERRA coverage for you (and covered dependents for whom you elect coverage) begins the day after you (and covered dependents) lose coverage under the Plan, and it can continue for up to 24 months. However, USERRA coverage will end earlier if:

- A premium payment is not made within the required time;
- You do not return to work within the period required under USERRA (see below) following the completion of your service in the uniformed services; or
- You lose your rights under USERRA due to a dishonorable discharge or other conduct specified in USERRA.

Your right to continue coverage under USERRA will end if you do not notify your employer of your intent to return to work within the period required under USERRA following the completion of your military service by either reporting to work (if your military service was less than 31 days) or applying for reemployment (if your military service was for more than 30 days). The deadline for returning to work, depending on the period of military service, is as follows:

Period of Service	Return-to-Work Requirement
Less than 31 days	The beginning of the first regularly scheduled work period on the day following the completion of your service, after allowing for safe travel home and an eight hour rest period or, if that is unreasonable or impossible through no fault of your own, as soon as is possible.
More than 30 days but less than 181 days	Within 14 days after completion of your service or, if that is unreasonable or impossible through no fault of your own, the first day on which it is possible to do so.
More than 180 days	Within 90 days after completion of your service.
Any period if for purposes of an examination for fitness to perform uniformed service	The beginning of the first regularly scheduled work period on the day following the completion of your service, after allowing for safe travel home and an eight hour rest period or, if that is unreasonable or impossible through no fault of your own, as soon as possible.
Any period if you were hospitalized for or are convalescing from an injury or illness incurred or aggravated as a result of your service	Same as above depending on length of service period, except that that period begins when you have recovered from your injury or illness rather than on completion of your service. The maximum period for recovering is limited to two years, but the two-year period may be extended if circumstances beyond your control make it impossible or unreasonable for you to report to work within the above periods.

COBRA and USERRA coverage are concurrent. This means that COBRA coverage and USERRA coverage begin at the same time. However, COBRA coverage can continue for up to 18 months (it may continue for a longer period and is subject to early termination, as described in the ***COBRA Continuation Coverage*** section.) In contrast, USERRA coverage can continue for up to 24 months, as described above.

Premium Payments for USERRA Continuation Coverage

If you elect to continue your coverage (or spouse or dependent children's coverage) under USERRA, you pay the same rate as COBRA. However, if your uniformed service period is less than 31 days, you are not required to pay more than the amount you would pay as an active employee for that coverage.

General Plan Information

The following information, along with the information included in the ***About Your Plan*** section, applies to the benefits described in this Summary Plan Description (SPD)/Plan Document.

Benefit Administrator

While the Plan is established, funded, maintained and sponsored by the Plan Sponsor and Plan Administrator, MEBS, Incorporated has been contracted to provide administration services.

Only employees of MEBS are qualified to answer questions about eligibility, benefits and certain other Plan provisions. However, any insurance companies providing coverage are qualified to answer questions about benefits as well. If you have a question, contact:

MEBS, Inc.
3809 Lake Eastbrook Boulevard
Grand Rapids, MI 49546
(800) 968-6327 or (616) 458-6327
customerservice@mebs.com
www.mebs.com

If you would like to see or receive copies of additional documents relating to the Plan, contact MEBS. You may be charged a reasonable fee to cover the cost of reproducing any materials you request.

The Benefit Administrator:

- Does not guarantee or warrant that this is an insured plan. The Plan Sponsor and Plan Administrator assume all responsibilities for insuring or providing benefits on behalf of members.
- Does not insure, reinsure or fund the Plan. If the Plan Sponsor or Plan Administrator elects not to reinsure the Plan, and ultimately not fund expenses that are eligible for payment for any reason, you may be liable for those expenses.
- Merely processes claims and does not insure eligible Plan expenses nor guarantee that eligible expenses will be paid.
- Will promptly process complete claim submissions. If there are delays in processing claims, you have no rights to interest or other remedies against the Benefit Administrator, except as otherwise provided by law.

Plan Year

The Plan's fiscal records are maintained on a plan year basis. The plan year is listed in the ***About Your Plan*** section.

Plan Funding

Benefits may be provided on a self-funded and/or an insured basis by contributions from employers and, in some cases, by employees. Contributions are used to pay any insurance premiums and finance any self-funded benefits. Assets are held in trust by the Plan Sponsor for members. The Plan Sponsor is responsible for the management of assets; but may, from time to time, use the service of an investment manager to invest assets.

Any self-funded benefits are provided through the Plan Sponsor. If, for any reason, the Plan does not pay eligible expenses under any self-funded portion of the Plan, you may be liable for these expenses.

Employer agreements determine the amount of contributions and employees on whose behalf an employer contributes. You may request, in writing, from MEBS, the name and address of a particular employer and whether an employer is participating.

Legal Action

You must wait 60 days after getting written proof of a loss from a claim before initiating legal action against the Plan. In addition, no legal action may be brought more than two years after the earlier of the:

- Expiration of the time within which proof of loss is required; or
- Two years after the filing of a claim.

Michigan Public Act 350

As a Plan member, you may be entitled to legal rights under the Michigan Public Act 350 of 1980, which is a state law governing insurers in Michigan. If you would like more information please contact MEBS.

Agent for Service of Legal Process

If legal disputes involving the Plan arise, any legal documents should be served on the agent for service of legal process. The agent is listed in the ***About Your Plan*** section.

Eligibility

Eligibility requirements are described in this SPD/Plan Document. Circumstances that may cause you to lose eligibility are also explained. Note that your coverage does not constitute a guarantee of employment and you are not vested in any benefits described in this booklet. In addition, no benefits are assignable or transferable, other than assigning benefits to a health care provider.

This Plan does not take the place of or affect any requirement for coverage by workers' compensation insurance.

Plan Interpretation and Determination

The Plan Administrator, Plan Sponsor and, in some cases, the individuals or organizations that have been designated by the Plan Administrator and Plan Sponsor have sole responsibility and authority to interpret and apply Plan provisions and to determine eligibility for coverage and benefits. To carry out this responsibility, the Plan Sponsor and Plan Administrator have exclusive authority and discretion to:

- Determine whether an individual is eligible for any Plan benefit;
- Determine the amount of Plan benefits, if any, a member is entitled to;
- Determine or find facts that are relevant to any claim for Plan benefits;
- Interpret all Plan provisions;
- Interpret all provisions of this Summary Plan Description/Plan Document;
- Interpret the provision of any collective bargaining agreement or written participation agreement involving or impacting the Plan;
- Interpret the provisions of any trust agreement governing Plan operation;
- Interpret all provisions of any other document or instrument involving or impacting the Plan;
- Interpret all of the terms used in this Plan and any other previously mentioned agreement, document and instrument; and
- Amend, modify or discontinue all or part of the Plan whenever, in their sole and absolute discretion, conditions so warrant.

Any Plan Sponsor/Plan Administrator determination and/or interpretation will:

- Be final and binding on any member claiming Plan benefits and on all employees, employers, unions and parties who have executed any agreement with the Plan Sponsor, Plan Administrator or the union;
- Be given deference in all courts of law to the greatest extent allowed by applicable law; and
- Not be overturned or set aside by any court of law unless the court finds that the Plan Sponsor, Plan Administrator or their designee, acted in an arbitrary and/or capricious manner.

Plan Amendment or Termination

The Plan Sponsor and Plan Administrator have the right to change, modify or terminate all or any part of a Plan at any time, in accordance with all official documents, the Employee Retirement Income Security Act and subject to any applicable labor agreements. If any changes are made to the Plan benefits, you will be notified, in writing.

Although it is intended that the Plan remain in effect, the Plan Sponsor and Plan Administrator reserve the right to terminate this Plan at any time. Any funds remaining in the Plan at termination will be distributed for members' benefit in a manner determined by the Plan Sponsor and Plan Administrator. You will be notified, in writing, if the Plan or any part of the Plan ends.

Your ERISA Rights

As a Plan member, you are entitled to certain rights and protections under the Employee Retirement Income Security Act (ERISA) of 1974, as amended. ERISA provides that you are entitled to the rights described in this section.

Receive Information about Plan and Benefits

You have the right to:

- Examine, without charge, at the MEBS office, your employer or other specified locations (as applicable), such as worksites and union halls, all documents governing the Plan. These include any insurance contracts, collective bargaining agreements and copies of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).
- Obtain, upon written request, copies of documents governing the operation of the Plan. These include any insurance contracts, collective bargaining agreements and copies of the latest annual report (Form 5500 series) and current Summary Plan Description/Plan Document. A reasonable charge may be required for the copies.

Continue Group Health Plan Coverage

You also have the right to:

- Continue health care coverage for yourself and your eligible spouse and/or dependents if there is a loss of coverage as a result of a qualifying event. You or your dependents may have to pay for this coverage. You will be provided with more information regarding your COBRA coverage rights.
- Reduce or eliminate exclusionary periods of coverage for pre-existing conditions under a group health plan if you have creditable coverage from another plan. You should be provided with a certificate of creditable coverage, free of charge, from the Plan when:
    - You lose Plan coverage, including the loss of coverage due to reaching an overall Plan lifetime maximum;
    - You become entitled to elect COBRA coverage; or
    - Your COBRA coverage ends.

    You may request the certificate of creditable coverage before losing coverage or within 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan members, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called Plan fiduciaries, have a duty to do so prudently and in the interest of you and other Plan members 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 welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, 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, all within certain time schedules. However, you may not begin any legal action, including proceedings before administrative agencies, until you have followed and exhausted the Plan's claim and appeal procedures.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of a Plan document or the latest annual report and do not receive it within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the Plan Administrator's control.

If you have a claim 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 medical child support order, you may file suit in federal court. If you believe that Plan fiduciaries have misused the Plan's money or if you believe that you have been 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, for example, if it finds your claim is frivolous.

Assistance with Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA or if you need assistance in getting documents from the Plan Administrator, you should contact the nearest office of the EBSA or the national office at:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue NW
Washington, DC 20210
(866) 444-3272

For more information about your rights and responsibilities under ERISA or for a list of EBSA offices, contact the EBSA by visiting their web site at www.dol.gov/ebsa

Disclosures to Authorized Persons

Effective Februaruy 19, 2010 the following provisions also apply.

Members of the Plan Sponsor's workforce have access to the individually identifiable health information of Plan participants for administrative functions of the Plan. When this health information is provided from the Plan to the Plan Sponsor, it is Protected Health Information (PHI).

HIPAA implemented regulations to restrict the Plan Sponsor's ability to use and disclose PHI. The Plan Sponsor has access to PHI from the Plan only as permitted as described here or as otherwise required or permitted by HIPAA.

- **Use and Disclosure of PHI to Plan Sponsor.** Plan may disclose PHI to the Plan Sponsor only to the extent necessary for Plan Sponsor to perform the following Plan Administrative functions:
    - Reconciling billing statements.
    - Enrollment/disenrollment.
    - Plan administrative purposes, such as quality assurance, claims processing, auditing and monitoring.
    - Summary Health Information may be requested for the purpose of:
        - Obtaining premium bids from health plans for providing health insurance coverage under the Plan; or
        - Modifying, amending or terminating the Plan.
- **Plan Sponsor Certification.** The Plan agrees that it will only disclose PHI to the Plan Sponsor upon receipt of a certification that this addendum has been adopted and the Plan Sponsor agrees to abide by such conditions. Plan Sponsor is subject to the following:
    - ***Prohibition on Unauthorized Use or Disclosure of PHI.*** The Plan Sponsor will not use or disclose any PHI received from the Plan, except as permitted in the Plan's privacy rules or as required by law.
    - ***Subcontractors and Agents.*** The Plan Sponsor will require each of its subcontractors or agents to whom the Plan Sponsor may provide PHI to agree to written contractual provisions that impose at least the same obligations to protect PHI as are imposed on the Plan Sponsor.
    - ***Permitted Purposes.*** The Plan Sponsor will not use or disclose PHI for employment-related actions and decisions or in connection with any other of Plan Sponsor's benefits or employee benefit plans.
    - ***Reporting.*** The Plan Sponsor will report to the Plan any impermissible or improper use or disclosure of PHI not authorized by the Plan documents of which it becomes aware.
    - ***Access to PHI by Participants.*** The Plan Sponsor will make PHI available to the Plan to permit participants to inspect and copy their PHI contained in the designated record set.

- ***Correction of PHI.*** The Plan Sponsor will make a participant's PHI available to the Plan to permit participants to amend or correct PHI contained in the designated record set that is inaccurate or incomplete and Plan Sponsor will incorporate amendments provided by the Plan.
- ***Accounting of PHI.*** The Plan Sponsor will make a participant's PHI available to permit the Plan to provide an accounting of disclosures.
- ***Disclosure to Government Agencies.*** The Plan Sponsor will make its internal practices, books and records related to the use and disclosure of PHI available to the Plan and to the Department of Health and Human Services (DHHS) or its designee for the purpose of determining the Plan's compliance with HIPAA.
- ***Return or Destruction of Health Information.*** When the PHI is no longer needed for the purpose for which disclosure was made, the Plan Sponsor must, if feasible, return to the Plan or destroy all PHI that the Plan Sponsor received from or on behalf of the Plan. This includes all copies in any form, including any compilations derived from the PHI. If return or destruction is not feasible, the Plan Sponsor agrees to restrict and limit further uses and disclosures to the purposes that make the return or destruction infeasible.
- ***Minimum Necessary Requests.*** The Plan Sponsor will use best efforts to request only the minimum necessary type and amount of PHI to carry out the functions for which the information is requested.

Plan Sponsor further agrees that if it creates, receives, maintains or transmits any electronic PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) on behalf of the covered entity, it will implement administrative, physical and technical safeguards that reasonable and appropriately protect the confidentiality, integrity and availability of the electronic protected health information, and it will ensure than any agents (including subcontractors) to whom it provides such electronic PHI agrees to implement reasonable and appropriate security measures to protect the information. Plan Sponsor will report to the Plan any security incident of which it becomes aware.

- **Adequate Separation.** The Plan Sponsor represents that adequate separation exists between the Plan and Plan Sponsor so that PHI will be used only for Plan administration. The following employees or persons under the control of the Plan Sponsor have access to participants' PHI for the purposes set forth above:

  Superintendent, Payroll and Benefits, Administrative Assistant

- **Adequate Separation Certification.** The Plan requires the Plan Sponsor to certify that the employees identified above are the only employees that will access and use participants' PHI. The Plan Sponsor must further certify that such employees will only access and use PHI for the purposes set forth above. In the event that any of the above specified employees do not comply with the provisions of this section, that employee will be subject to disciplinary action by the Plan Sponsor for non-compliance pursuant to the Plan Sponsor's employee discipline and termination procedures. In addition, the Plan Sponsor will ensure that the provisions of this Section are supported by reasonable and appropriate security measure to the extent that the designees have access to electronic PHI.
- **Reports of Non-Compliance.** Anyone who suspects an improper use or disclosure of PHI may report the occurrence to the MEBS Privacy Officer at (800) 968-9682.

Definitions

Terms defined in this section are used throughout this booklet.

Actively at Work or Minimum Hour Requirement

When a member employee is on the job (other than absences due to a medical condition or medical treatment) and physically able to perform his or her regular full time duties for a regularly scheduled work day. The number of hours that must be worked each week to meet the minimum hour requirement, if any, is listed in the ***About Your Plan*** section.

Benefit Administrator

MEBS, Inc.
3809 Lake Eastbrook Boulevard
Grand Rapids, MI 49546
(800) 968-6327 or (616) 458-6327
www.mebs.com

Benefit Period/Benefit Year

A 12-month period during which any, and all, eligible expenses incurred by a member are subject to the Plan provisions, such as deductibles and benefit maximums.

Coinsurance

The percentage of a provider's and/or facility's approved amount that a member is required to pay for covered services.

Covered Service

A service, treatment or supply identified as payable by the Plan. Covered services must be medically necessary, unless stated otherwise.

Deductible

The amount of out-of-pocket expenses for covered services you pay before the Plan begins to pay benefits for certain covered services. Only amounts covered under the Plan may be applied toward the deductible.

Dental Treatment Plan

A dentist's report, on a form satisfactory to the Benefit Administrator, that:

- Itemizes the dental services recommended for necessary dental care;
- Shows the charge for each dental service; and
- Is accompanied by supporting pre-operative x-rays.

Treatment plans that exceed the pre-determination of benefits amount listed in the ***Summary of Benefits*** section must be submitted by the dentist to the Benefit Administrator for approval before benefits are payable.

Dentist

A licensed dentist practicing within the scope of his or her profession or any other physician providing any dental services that he or she is licensed to perform.

Dependent

See the ***Dependent Eligibility*** section.

Eligible Charge

The charge actually made to a member for services that are:

- Listed as covered by this Plan; and
- Part of an approved treatment plan.

Employee

An individual employed by an employer. Independent contractors and individuals working on behalf of an employer through another employer are not considered employees.

Employee Member Effective Date

The date this Plan's benefits become effective for an employee member.

Employer

The employer is listed in the ***About Your Plan*** section.

Experimental and/or Investigative

A service, procedure, treatment, device or supply that has not been:

- Scientifically demonstrated to be safe and effective for treatment of a condition; or
- Approved by the applicable governing entities.

Member

An employee member and an employee member's dependents who meet the Plan's definition of a dependent and are enrolled in the Plan.

Orthodontic Procedure

Movement of teeth by means of active appliances to correct the position of mal-occluded or mal-positioned teeth.

Orthodontic Treatment Plan

A Dentist's report, on a form satisfactory to the Benefit Administrator, that:

- Provides a classification of the mal-occlusion or mal-position;
- Recommends and describes necessary treatment by orthodontic procedures;
- Estimates the duration over which treatment will be completed;
- Estimates the total charges for treatment; and
- Is accompanied by cephalometric x-rays, study models and any supporting evidence the Benefit Administrator may reasonably require.

Other Plan

For coordination of benefits provisions, any plan provided by any employer or any other plan required by law that provides benefits.

Plan

This dental benefits plan.

Plan Administrator

The Employer when the plan is funded by the employer listed in the Plan Name in the ***About Your Plan*** section. When this does not apply the Plan Administrator will be the Public Employee Trust.

Plan Effective Date

The date this Plan became effective.

Plan Sponsor

The Employer that sponsors the Group Health Plan, and certifies the health information will be protected as outlined in HIPAA.

Plan Year

The 12-month period over which billing and claims records are maintained, which is used for filing government forms.

Provider Network

A network of providers who have agreed to accept a scheduled fee. The provider network is listed in the ***Summary of Benefits*** section.

- **In-Network Provider.** A dentist or other dental care professional who has contracted with the provider network to provide services to members and accepts the provider network's payment as full reimbursement for covered services.
- **Out-of-Network Provider.** A dentist or other dental care professional who has not signed an agreement with the provider network.

Qualified Medical Child Support Order or QMCSO

A court order that recognizes the right of an alternate recipient (child) to receive Plan benefits. A QMCSO is usually issued in a divorce where an employee member or the former spouse is ordered by the court to continue to provide medical support for their child(ren). A QMCSO may not require the Plan to provide a type or form of benefit not otherwise provided to eligible dependent children.

As required by with federal law, the Plan will recognize a QMCSO mandating health care coverage for certain dependent children. When the Plan Administrator receives an order that may be a QMCSO, it will review the order and make a determination as to the order's qualified status. The member and possible alternate recipient will then be notified by the Plan Administrator of the determination.

Reasonable Fee or Usual, Reasonable and Customary (UCR) Fee

The usual charge made by a provider for a like service in the absence of coverage. This fee will not be more than the prevailing charge, as determined by the Plan Administrator, for dental care of a comparable nature made by providers of similar training and experience, within the area in which the service is actually provided.

"Area" means the municipality (or in the case of a large city, the subdivision) in which the service is actually provided or a greater area as is necessary to obtain a representative cross section of charges for a like service.

Service Requirement

The amount of continuous time an employee member must be actively employed in a covered class with the employer before he or she is eligible for Plan coverage. The service requirement is listed in the ***About Your Plan*** section.