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INTRODUCTION

This benefit booklet has been written to provide a clear understanding of the benefits available under this Plan. The benefits as herein described take precedence over, and replace any previous literature furnished.

Except where otherwise indicated by the context, any masculine terminology used herein shall also include the feminine and vice versa, and the definition of any term herein in the singular shall also include the plural and vice versa.

The definition section shall prevail for all purposes within the Plan.

This benefit booklet is designed to help you understand your benefit Plan by explaining who is eligible for benefits, when you are eligible for benefits, what your benefits are, and how to file claims for your benefits.

This benefit booklet contains all the terms of the Plan and may be amended from time to time by Central Michigan University or alternatively may be terminated by Central Michigan University. Any changes so made shall be binding on each covered participant and on any other covered persons referred to in this benefit booklet. In the case of a collectively bargained plan, these terms shall be maintained pursuant to the collectively bargained agreement.
DENTAL EXPENSE BENEFITS

DEDUCTIBLE

The deductible refers to the “first-dollar” covered expenses that are not reimbursed by your Dental Plan. The family deductible amount shown in the Schedule of Benefits limits the deductible amount that members of a family have to pay during a plan year. When the maximum deductible has been paid, dental benefits become available to all family members with no further deductibles during that plan year.

DENTAL EXPENSES – PRE-TREATMENT ESTIMATE

A pre-treatment estimate allows you to know what services are covered and what payments will be made for treatment before the work is done. If you are likely to incur dental expenses over $200.00, request your dentist to file a pre-treatment estimate.

This feature of the Dental Plan assures that both you and the dentist will know in advance just what part of the dentist’s charges the Plan will pay. Here is how it works:

a. The dentist informs Meritain Health of the proposed course of treatment by itemizing the services and charges on a standard claim form.

b. Meritain Health then determines the amount the Plan will pay and informs you and the dentist of its payment decision. You and your dentist should discuss the result before the work is done.

Pre-treatment estimates will help you avoid surprises. Most dentists are familiar with the pre-treatment estimate.
DENTAL SCHEDULE OF BENEFITS

Central Michigan University is offering Dentemax, a preferred provider network of dentists who render quality care and accept lower reimbursement for services provided. Therefore, by using a Dentemax network provider, your co-payment and balances due will be lower. You will have the choice of whether or not to use a Dentemax network provider each time you seek dental treatment.

To determine if your dentist is in the network, or to locate network providers in your area, call:

Dentemax at: 1-800-752-1547 toll free

Or use the internet website address: www.dentemax.com

<table>
<thead>
<tr>
<th>BENEFIT</th>
<th>PLAN D 100/75/50/50</th>
<th>PLAN D 100/50/50</th>
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<tbody>
<tr>
<td>Plan year maximum benefit for combined Type A, B and C expenses:</td>
<td>$1,500.00 per covered person</td>
<td>$1,000.00</td>
</tr>
<tr>
<td>Lifetime maximum benefit for Type D expenses:</td>
<td>$2,000.00 per covered dependent child to age nineteen (19)</td>
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<tr>
<td>Deductibles:</td>
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<tr>
<td>Individual/Plan Year</td>
<td>-0-</td>
<td>$50.00</td>
</tr>
<tr>
<td>Family of two (2)/Plan Year</td>
<td>-0-</td>
<td>$100.00</td>
</tr>
<tr>
<td>Family of three (3) or more/Plan Year</td>
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<td>$150.00</td>
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<tr>
<td>Type A Expenses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic and Preventive Services</td>
<td>100% Reasonable and Customary (hereafter referred to as R&amp;C)</td>
<td>100% R&amp;C, deductible waived</td>
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<tr>
<td>Type B Expenses</td>
<td></td>
<td></td>
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<tr>
<td>Basic Services</td>
<td>75% R&amp;C</td>
<td>50% R&amp;C after the plan year deductible</td>
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<tr>
<td>Type C Expenses</td>
<td></td>
<td></td>
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<td>Major Services</td>
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<td>50% R&amp;C after the plan year deductible</td>
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<tr>
<td>Type D Expenses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orthodontics</td>
<td>50% R&amp;C</td>
<td>N/A</td>
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</table>
DENTAL SERVICES
TYPE A - DIAGNOSTIC AND PREVENTIVE SERVICES

PERIODIC ORAL EXAM
Office visit during regular office hours for oral exam - limit of two (2) visits in any plan year.

DENTAL X-RAYS
1. Bitewing x-rays - limit of two (2) times in any plan year
2. Complete mouth survey or panoramic x-rays - limit of one (1) time in any three (3) plan years (unless dentally necessary and requested by a physician or other licensed or certified provider)
3. Periapical x-rays or intraoral x-rays
4. Extraoral x-rays - limit of two (2) times in any plan year
5. Posteroanterior lateral facial bone film, sialography or cephalometric film series

PROPHYLAXIS OTHER THAN PERIODONTAL
Includes scaling and polishing - limit of two (2) treatments in any plan year

TOPICAL APPLICATION OF FLUORIDE

SPACE MAINTAINERS
Including all adjustments within six (6) months of insertion - limited to children under the age of nineteen (19).
1. Fixed-cast, unilateral band, stainless steel crown, lingual palatal band, or distal shoe type
2. Removable, acrylic

EMERGENCY PALLIATIVE TREATMENT
Paid as a separate benefit only if no other service (except x-rays) was rendered during the regular office hours or after hours visit.

SEALANTS
One (1) application per tooth every five (5) years - available for participants under age twenty (20)

PULP VITALITY TEST
DENTAL SERVICES
TYPE B - BASIC SERVICES

BIOPSY

Biopsy and exam of oral tissue. (If a biopsy is performed for a medical purpose, this will be paid under your Medical Plan, not under this Dental Plan.)

SEDATIVE FILLINGS

Paid as a separate benefit only if no other service (except x-rays) was rendered during the regular office hours or after hours visit.

ORAL SURGERY

1. Simple extraction
2. Surgical extraction – erupted, soft tissue impaction, partial bony impaction, or complete bony impaction
3. Root recovery - surgical removal of residual root
4. Removal of dentigerous or odontulous cyst
5. Incision and drainage of an abscess
6. General anesthesia (including nitrous oxide) - paid as a separate procedure only when required for complex oral surgical procedures for which benefits are payable under the dental coverage
7. Therapeutic antibiotic drug injection
8. Prescription drugs - limited to those prescribed for a dental condition if administered by the dentist in his/her office
9. Surgical exposure of impacted tooth to aid eruption
10. Alveoplasty - surgical preparation of ridge for dentures
11. Stomatoplasty
12. Removal of exostosis
13. Frenectomy
14. Excision of hyperplastic tissue or redundant tissue
15. Oral anterior fistula closure or anterior root resection
16. Removal of mandibular tori
17. Excision of pericoronal gingiva
18. Reimplantation of tooth
19. Suture of soft tissue injury
20. Sialolithotomy for removal of salivary calculus
21. Closure of salivary fistula
22. Dilation of salivary duct
23. Sequestrectomy for osteomyelitis or bone abscess, superficial
24. Maxillary sinusotomy for removal of tooth fragment or foreign body

PERIODONTICS
1. Initial diagnostic consultation - limit of one (1) consultation in any plan year
2. The following procedures per area of the mouth
   • gingivectomy
   • gingival curettage
   • gingival flap procedure
   • mucogingival surgery
   • osseous surgery
   • osseous grafts
3. Pedicle or free soft tissue grafts
4. Vestibuloplasty
5. Provisional splinting
6. Periodontal occlusal adjustment - if done with periodontal surgery
7. Periodontal appliance - limit of one (1) appliance in any three (3) plan years
8. Periodontal scaling and root planing
9. Periodontal prophylaxis - limit of two (2) prophylaxis treatments in any plan year
10. Periodontal pulpal procedures
11. Case pattern - includes all necessary diagnostic, surgical and adjunctive services
   • gingivitis - shallow pockets, no bone loss
   • early periodontitis - moderate pockets, minor to moderate bone loss, satisfactory topography
   • moderate periodontitis - moderate to deep pockets, moderate to severe bone loss, unsatisfactory topography, slight mobility of teeth
   • advanced periodontitis - deep pockets, severe bone loss, advanced mobility patterns
12. Occlusal guards for the treatment of bruxism
ENDODONTICS

1. Pulpotomy
2. Root canal therapy
3. Apicoectomy and retrograde filling - paid as a separate benefit only if done more than one (1) year after the root canal therapy is completed
4. Root resection
5. Hemisection
6. Apical curettage
7. Apexification
8. Therapeutic apical closure
9. Pulp capping, direct

RESTORATIVE DENTISTRY

1. Amalgam silicate, plastic or composite restoration - multiple restorations on the same surface will be considered as a single restoration; mesial-lingual, distal-lingual, mesial-buccal and distal-buccal restorations on anterior teeth will be considered a single restoration
2. Amalgam restoration, permanent or deciduous
3. Composite restorations
4. Pin retention, if done in conjunction with an amalgam or composite restoration
5. Re-cement inlays or onlays, crowns, bridges, space maintainers
6. Crown build-up if done for teeth that require crowns
7. Repair of crowns - replace broken facing with other facing
8. Repairs and adjustments to dentures, including relining - repair broken complete or partial dentures; replacing an existing prosthetic tooth; or replace broken clasp with new clasp on denture

   Limited to repairs or adjustments more than one (1) year after the initial insertion

   Limited to relining done more than one (1) year after the initial insertion and one (1) relinement in any two (2) plan years
PROSTHODONTICS

1. Precious metal and porcelain inlays and onlays if tooth cannot be restored by amalgam or composite fillings

2. Crowns if tooth cannot be restored by a filling - plastic prefabricated, porcelain, porcelain fused to metal, stainless steel, or gold thimble

3. Posts and cores

SPECIAL LIMITATION FOR TYPE B - BASIC SERVICES

If any of the above Type B procedures are covered expenses under a medical plan offered by Central Michigan University they will not simultaneously be paid under this Dental Plan.
DENTAL SERVICES
TYPE C - MAJOR SERVICES

BRIDGES AND DENTURES

1. Full dentures
2. Partial dentures, including base, all clasps and teeth
3. Fixed bridges
4. Jump case, complete
5. Abutments
6. Stress breaker

DENTAL IMPLANTS

Dental implants performed in a dental office. (Bridge procedure codes D06720 through D06792 for the same tooth as the implant are excluded.)

SPECIAL LIMITATIONS FOR TYPE C - MAJOR SERVICES

1. Temporary restorations and appliances and one (1) year follow-up care for the services listed above will be considered as part of the final service rather than as a separate service.

2. A bridge or denture is considered to be installed for the first time if it does not replace any existing bridge or denture.

3. Replacement of, or addition to, fixed bridges and partial dentures will be covered only if proof is given that:
   - the work is needed due to the extraction of an injured or diseased natural tooth; or
   - the existing prosthesis cannot be made fit for use and the replacement is made five (5) years after the date the existing prosthesis was installed.

4. Replacement of full dentures will be covered only if proof is given that the existing prosthesis cannot be made fit for use and the replacement is made five (5) years after the date the existing prosthesis is installed.

5. Expenses for dentures and fixed bridgework (including pontics and abutting crowns) and restorative crowns, inlays and onlays ordered before termination of a family member’s coverage will be considered to be incurred when they were ordered if the services and supplies are finally received by the family member within thirty (30) days after termination of coverage.
Dentures are considered to be “ordered” when impressions have been taken to prepare the denture. Fixed bridgework, restorative crowns, inlays and onlays will be considered to be “ordered” when the impressions have been taken and when teeth which will serve as retainers or support or which are being restored have been fully prepared.

6. Charges for porcelain on crowns or pontics posterior to the second bicuspid will be a covered expense.
DENTAL SERVICES
TYPE D - ORTHODONTIC SERVICES

ORTHODONTICS

Appliance, surgical or functional/myofunctional treatment of dental irregularities which result from abnormal growth and development of teeth, gums or jaws or as a result of an accidental injury which requires repositioning (except for preventive treatment) of teeth to establish normal occlusion.

SPECIAL LIMITATION FOR TYPE D - ORTHODONTIC SERVICES

If orthodontic treatment is terminated for any reason before completion, only the expenses incurred for the orthodontic services rendered and supplies received before the date of termination may be included as orthodontic services.

Orthodontic services are limited to coverage for eligible dependent children only who are under age nineteen (19) when services begin.
DENTAL EXCLUSIONS AND LIMITATIONS

1. Any portion of a dental procedure performed before the effective date or after the termination date of the individual’s coverage.

2. Expenses that do not meet the standards of dental practice accepted by the American Dental Association.

3. Services or supplies not essential for the treatment of the patient’s dental condition, except as specifically listed as covered services.

4. Expenses in excess of the reasonable and customary charges.

5. Expenses incurred in excess of any plan maximums.

6. Expenses incurred for cosmetic procedures, including charges to personalize a denture.

7. Dental service to correct congenital or developmental malformation or primarily for improving appearance.

8. Appliances, restorations, or services necessary to increase dimension, restore or correct occlusion, or treat jaw-joint disorders.

9. Expenses due to a missing, lost or stolen appliance, repairs, and replacement of appliances.


11. Bridge procedure codes D06720 through D06792 for the same tooth as an implant.

12. Charges for veneers placed on crowns or pontics other than the ten (10) lower and ten (10) upper anterior teeth.

13. Adjustment to dentures within six (6) months of installation.


15. Charges for services, care, supplies or devices which are experimental or investigational in nature.

16. Charges for cleaning of teeth unless done by or under the supervision of a dentist (supervision means the dentist is available but not necessarily at chair side during the procedure).

17. Charges for treatment given by someone other than the dentist.

18. Dental appointments that are not kept, or charges for completing dental claim forms.

19. Charges for instruction in oral hygiene, diet control, or plaque control.
CLAIMS FILING AND REVIEW PROCEDURES

THE SUBMISSION OF CLAIMS:

Time Lines

New time lines are established for responding to and reviewing health care claims, based on whether the claim is determined by the health care plan as it relates to pre-service urgent care, pre-service non-urgent care, post service care, or a concurrent care decision. For applicable time lines see Examples A & B at the end of this section.

The Plan Administrator shall notify the claimant of the benefit determination within ninety (90) days after receipt of a claim by the Plan, unless the Plan Administrator determines that special circumstances require an extension of time up to an additional ninety (90) days for processing the claim.

If the claimant fails to provide the Plan Administrator with sufficient information to make a determination, the Plan Administrator shall notify the claimant of the specific information necessary to complete the claim. The claimant shall be afforded forty-five (45) days to provide the specified information.

NOTIFICATION OF THE INITIAL BENEFIT:

Urgent Care Determinations

An urgent care claim is any claim for which the application of the standard time periods for determining claims a prudent layperson would consider, or the patient’s physician determines, could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or for which delayed treatment would cause the patient severe pain.

In the case of a determination involving urgent care, the Plan Administrator shall notify the claimant of the Plan’s benefit determination within seventy-two (72) hours after receipt of the claim, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan.

If the claimant fails to provide the Plan Administrator with sufficient information to make a determination, the Plan Administrator shall notify the claimant within twenty-four (24) hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim. The claimant shall be permitted forty-eight (48) hours to provide the specified information.

NOTE: Informal DOL guidance has indicated, that urgent care claims are a sub-set of pre-service claims, such as claims that by the terms of the Plan will not be covered unless approved prior to the treatment, service or the procedure is provided.

Pre-Service Determinations

A pre-service non-urgent care claim is one where the receipt of the benefit is conditioned on approval before the service is rendered.
In the case of an initial pre-service determination, the Plan Administrator shall notify the claimant of the Plan’s benefit determination within fifteen (15) days after receipt of the claim, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. This period may be extended for fifteen (15) additional days, if the Plan Administrator determines that such an extension is necessary due to matters beyond the control of the Plan.

If the claimant fails to provide the Plan Administrator with sufficient information to make a determination, the Plan Administrator shall notify the claimant of the specific information necessary to complete the claim. The claimant shall be permitted forty-five (45) days to provide the specified information.

**Post-Service Determinations**

A post-service care claim is one that may be filed and approved after the service is rendered.

In the case of a post-service claim, the Plan Administrator shall notify the claimant of the Plan’s benefit determination within thirty (30) days after receipt of the claim, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. This period may be extended for fifteen (15) additional days, if the Plan Administrator determines that such an extension is necessary due to matters beyond the control of the Plan.

If the claimant fails to provide the Plan Administrator with sufficient information to make a determination, the Plan Administrator shall notify the claimant of the specific information necessary to complete the claim. The claimant shall be permitted forty-five (45) days to provide the specified information.

**Concurrent Care Determinations**

A concurrent care decision is one where the Plan has approved an ongoing course of treatment, and then the Plan reduces or terminates coverage for that course of treatment (other than by amendment or plan termination) before the end of the pre-approved course of treatment. This is an adverse benefit determination that can be appealed as a concurrent care claim.

In the case of a reduction or termination of an ongoing course of treatment that the Plan had previously approved, the Plan Administrator shall notify the claimant of the Plan’s benefit determination within a reasonable period of time.

In the case of a claimant’s request to extend the course of treatment previously approved by the Plan, the Plan Administrator shall notify the claimant of the Plan’s benefit determination within a reasonable period of time. In no event shall the period of time exceed twenty-four (24) hours after receipt of the claim.

**NOTIFICATION OF INITIAL ADVERSE BENEFIT DETERMINATION:**

A notice of benefit determination will be sent to the claimant in written or electronic format in a manner considered to be understood by the claimant as outlined below.
The notification to the claimant shall include:

1. The specific reason or reasons for the adverse determination;

2. Reference to the specific Plan provisions on which the determination is based; and

3. A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; and

4. A description of the Plan’s review procedures and the time limits applicable to such procedures; and

5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination; a copy of such rule, guideline, protocol, or other criterion will be provided to the claimant at no charge, upon written request; and

6. If the adverse benefit determination is based on medical necessity, experimental treatment or similar exclusion or limitation, then either an explanation of the scientific or clinical judgment relied upon for the determination, applying the terms of the Plan to the claimant’s medical circumstances, or a statement that such explanation will be provided at no charge, upon written request; and

7. If a medical or vocational expert is consulted by the Plan, the identity of that person or persons must be provided, even if their advice was not relied upon in making the decision.

NOTIFICATION APPLICABLE TO CLAIMS INVOLVING URGENT CARE:

The Plan Administrator shall be entitled to inform the claimant orally within the time frame prescribed within this Plan, provided that a written or electronic notification is furnished to the claimant within three (3) days after the oral notification.

The notification to the claimant shall include:

1. The specific reason or reasons for the adverse determination;

2. Reference to the specific Plan provisions on which the determination is based; and

3. A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; and

4. A description of the Plan’s review procedures and the time limits applicable to such procedures, including a statement of the claimant’s right to bring a civil action following an adverse benefit determination; and

5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination; a copy of such rule, guideline, protocol, or other criterion will be provided to the claimant at no charge, upon written request; and

6. If the adverse benefit determination is based on medical necessity, experimental treatment or similar exclusion or limitation, either an explanation of the scientific or clinical judgment
relied upon for the determination, applying the terms of the Plan to the claimant’s medical circumstances, or a statement that such explanation will be provided at no charge, upon written request; and

7. A description of the review process applicable to such claims will be sent to the claimant.

TIMING TO APPEAL AN ADVERSE BENEFIT DETERMINATION:

The claimants who wish to appeal an adverse benefit determination shall:

1. Receive full and fair review of the claim and the appeal of the adverse benefit determination;

2. The request for an appeal of an adverse benefit determination must be in writing, and filed with the third party administrator who shall receive the request on behalf of the Plan Administrator who is the named fiduciary of the Plan. Address your appeal request to:

   Plan Administrator – Appeals
   c/o Meritain Health
   2370 Science Parkway
   Okemos, MI 48864

3. Claimants shall have one hundred-eighty (180) days to file an appeal following receipt of an adverse benefit determination.

4. Any and/or all additional information must be submitted to Meritain Health before the final decision has been made by the Plan Administrator. No additional information will be considered after that final decision.

PROCESS FOR APPEAL OF ADVERSE DETERMINATIONS:

An appeal of an adverse determination shall:

1. Provide for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject to the appeal, nor the subordinate of such individual;

2. Provide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

3. Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant’s adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination;

4. Provide that the health care professional engaged for purposes of a consultation shall be an individual who is neither an individual who was consulted in connection with the adverse
benefit determination that is the subject of the appeal, nor the subordinate of any such individual; and

5. Provide, in the case of a claim involving urgent care, for an expedited review process.

CLAIMANT’S RIGHT TO BRING CIVIL SUIT:

1. The claimant has the right to bring a civil action following an adverse benefit determination on review; and

2. Other voluntary alternative dispute resolutions may be available. The claimant should contact the local office of the DOL or the state insurance regulatory agency as indicated within the Plan Document. Copies of the documents, records and other information relevant to the denied claim shall be made available to the claimant at no charge, upon written request.

TIMING OF NOTIFICATION OF BENEFIT DETERMINATION OF A CLAIM REVIEW:

1. Urgent Care Determinations. The Plan Administrator shall notify the claimant of the benefit determination concerning the urgent care claim within seventy-two (72) hours after receipt of claimant’s request.

2. Pre-Service Determinations. The Plan Administrator shall notify the claimant of the benefit determination concerning a pre-service claim within thirty (30) days after receipt of claimant’s request.

3. Post-Service Determinations. The Plan Administrator shall notify the claimant of the benefit determination within sixty (60) days after receipt of claimant’s request.

4. Concurrent Care Determinations. The Plan Administrator shall notify the claimant of the Plan’s benefit determination within a reasonable period of time not to exceed seventy-two (72) hours, thirty (30) days or sixty (60) days as applicable in the case of a reduction or termination of an ongoing course of treatment that the Plan had previously approved.

NOTE: For applicable time lines see Examples A & B at the end of this section.

CONTENT OF THE NOTIFICATION OF A BENEFIT REVIEW:

A notice of benefit determination of the claim will be sent to the claimant in written or electronic format in a manner calculated to be understood by the claimant containing the information as specified below.

The notification to the claimant shall include:

1. The specific reason or reasons for the adverse determination; and

2. Reference to the specific Plan provisions on which the benefit determination is based; and

3. A statement that the claimant is entitled to receive at no charge and upon written request, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant’s claim for benefits; and
4. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination; a copy of such rule, guideline, protocol, or other criterion will be provided to the claimant at no charge and upon request; and

5. If the adverse benefit determination is based on medical necessity, experimental treatment or similar exclusion or limitation, then either an explanation of the scientific or clinical judgment relied upon for the determination, applying the terms of the Plan to the claimant’s medical circumstances, or a statement that such explanation will be provided at no charge and upon written request; and

6. You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State Insurance Regulatory Agency.
## EXAMPLE A

### TIME PERIODS FOR FILING AND REVIEWING CLAIMS FOR GROUP HEALTH PLANS*

<table>
<thead>
<tr>
<th></th>
<th>Notice of Improperly Filed Claim</th>
<th>Notice of Insufficient Information</th>
<th>Initial Determination</th>
<th>Time Allowed Claimant to Provide Additional Information</th>
<th>Extensions on Initial Determination</th>
<th>Time to Seek Review of Denied Claim</th>
<th>Time for Decision on Review</th>
<th>Extensions for Decision on Review</th>
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<tbody>
<tr>
<td><strong>Urgent Care Claims</strong></td>
<td>24 hours</td>
<td>24 hours</td>
<td>72 hours from time claim filed, or earlier of 48 hours after info provided or time to do so ends**</td>
<td>At least 48 hours</td>
<td>N/A</td>
<td>No specific time period provided, but up to 180 days allowed</td>
<td>72 hours</td>
<td>No extension allowed</td>
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<tr>
<td><strong>Pre-service Claims</strong></td>
<td>5 days</td>
<td>Within 15 days</td>
<td>15 days</td>
<td>Up to 45 days</td>
<td>One extension of 15 days, if needed</td>
<td>Up to 180 days</td>
<td>30 days</td>
<td>No extension allowed</td>
</tr>
<tr>
<td><strong>Post-service Claims</strong></td>
<td>N/A</td>
<td>Within 30 days</td>
<td>30 days</td>
<td>Up to 45 days</td>
<td>One extension of 15 days, if needed</td>
<td>Up to 180 days</td>
<td>60 days</td>
<td>No extension allowed</td>
</tr>
<tr>
<td><strong>Concurrent Care Claims</strong></td>
<td>N/A</td>
<td>N/A</td>
<td>24 hours, if urgent care; otherwise, enough time before cut-off to appeal</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>72 hours, 30 days or 60 days, as applicable</td>
<td>No extension allowed</td>
</tr>
</tbody>
</table>

*All time is measured in calendar days from date claim is received, even if incomplete. Where additional information is requested, no time is counted until information is received.

** Adverse determination may be given orally, if written or electronic notice is provided within 3 days.
## EXAMPLE B

### D.O.L. TIME PERIODS FOR FILING AND REVIEWING CLAIMS

#### Urgent Care Claims
- Notice of Improperly Filed Claim: 24 hours
- Notice of Insufficient Information: 24 hours
- Initial Determination: 72 hours from time filed, or earlier of 48 hours after info provided or time to do so ends
- Time Allowed Claimant to Provide Additional Info: At least 48 hours
- Extensions on Initial Determination: N/A

#### Time Frames

<table>
<thead>
<tr>
<th>Action</th>
<th>Time Frames</th>
</tr>
</thead>
<tbody>
<tr>
<td>Notice of Improperly Filed Claim</td>
<td>24 hours</td>
</tr>
<tr>
<td>Notice of Insufficient Information</td>
<td>24 hours</td>
</tr>
<tr>
<td>Initial Determination</td>
<td>72 hours from time filed, or earlier of 48 hours after info provided or time to do so ends</td>
</tr>
<tr>
<td>Time Allowed Claimant to Provide Additional Info</td>
<td>At least 48 hours</td>
</tr>
<tr>
<td>Extensions on Initial Determination</td>
<td>N/A</td>
</tr>
</tbody>
</table>

#### Pre-Service Claims
- Notice of Improperly Filed Claim: 5 days
- Notice of Insufficient Information: Within 15 days
- Initial Determination: 15 days
- Time Allowed Claimant to Provide Additional Info: Up to 45 days
- Extensions on Initial Determination: One extension of 15 days, if needed

#### Post-Service Claims
- Notice of Improperly Filed Claim: N/A
- Notice of Insufficient Information: N/A
- Initial Determination: 30 days
- Time Allowed Claimant to Provide Additional Info: Not less than 45 days
- Extensions on Initial Determination: One extension of 15 days, if needed

#### Concurrent Care Claims
- Notice of Improperly Filed Claim: N/A
- Notice of Insufficient Information: N/A
- Initial Determination: 24 hours if urgent care; otherwise, enough time before cut-off to appeal
- Time Allowed Claimant to Provide Additional Info: N/A
- Extensions on Initial Determination: N/A

### APPEALS

#### Urgent Care Claims
- Time to Seek Review of Denied Claim: No specific time period provided, up to 180 days allowed
- Time for Decision on Review: 72 hours
- Extensions for Decisions on Review: No extension allowed

#### Pre-Service Claims
- Time to Seek Review of Denied Claim: Up to 180 days
- Time for Decision on Review: 30 days
- Extensions for Decisions on Review: No extension allowed

#### Post Service Claims
- Time to Seek Review of Denied Claim: Up to 180 days
- Time for Decision on Review: 60 days
- Extensions for Decisions on Review: No extension allowed

#### Concurrent Care Claims
- Time to Seek Review of Denied Claim: N/A
- Time for Decision on Review: 72 hours, 30 days or 60 days as applicable
- Extensions for Decisions on Review: No extension allowed
CLAIM FILING PROCEDURE

Meritain Health of Lansing, Michigan will process your claims.

PLEASE FOLLOW THESE INSTRUCTIONS CAREFULLY. THIS WILL ASSURE PROMPT PAYMENT OF YOUR CLAIMS.

A. DENTAL EXPENSES

Each time you go to the dentist, present your dental identification card. All itemized dental claims must be submitted directly to Meritain Health:

Meritain Health
P.O. Box 30132
Lansing, Michigan 48909-7632

B. ORIGINAL BILLS

Submit only the original bills. Keep copies for your records, your spouse’s or Other Eligible Individual’s insurance. Copies will be accepted only if the CMU Dental Benefit Booklet is secondary in coordination.

C. ITEMIZED BILLS

Your Plan requires that all bills be itemized. Meritain Health will process only itemized bills.

The bill must include:

1. Patient’s name
2. Date of service
3. Services rendered
4. Amount charged for each service performed
5. Provider’s name, address and federal tax identification number

D. ACCIDENT EXPENSES

Accident-related bills must have the following information: WHEN, WHERE AND HOW THE ACCIDENT HAPPENED.

THE BILL(S) WILL NOT BE PROCESSED WITHOUT THIS INFORMATION.
E. AUTOMATIC ASSIGNMENT OF BENEFITS

1. Unpaid bills - Payment of all unpaid bills will be made payable to the provider of service and mailed to the provider.

2. Paid bills - Payment of all paid bills will be made payable to the employee and mailed to the employee. If you have paid the bill, be sure “paid” is indicated on the bill.

F. EXPLANATION OF BENEFITS

Each time Meritain Health processes a claim for you or a member of your family, they will respond with an Explanation of Benefits informing the patient what the charges were, how the charges were paid, and to whom the payments were made.

G. DEADLINE FOR FILING CLAIMS

You and your covered dependents must file any dental claim in accordance with the above procedure within twelve (12) months of the date of service in order for such claim to be considered an allowable expense under this Plan.

H. COORDINATION OF BENEFITS

If you are covered by two (2) plans (this Plan and your spouse’s or Other Eligible Individual’s plan), both plans may pay. However, the combination of payment from both plans cannot exceed 100%.

File your claims in the following manner:

1. Employees of Central Michigan University

   Submit your original bills to Meritain Health. Keep copies of the bills. When you receive the explanation of benefits, send a copy of the bill(s) and a copy of the explanation of benefits to your spouse’s or Other Eligible Individual’s insurance company.

2. Your spouse or Other Eligible Individual if covered by another employer’s plan

   Your spouse or Other Eligible Individual should send his/her bills to his/her insurance company first and Meritain Health second. Send Meritain Health a copy of the explanation of benefits from his/her insurance company and a copy of the bill(s).

3. Children

   If children are covered by both parents’ plans, the plan of the parent with the birth date earliest in the calendar year will pay first. The plan of the parent with the later birth date will pay second.
4. Divorce

The plan of the parent with custody of the children will pay first and the plan without custody will pay second unless the divorce decree mandates otherwise.

5. Motor Vehicle Accidents

This Plan will coordinate covered expenses with an individual automobile insurance policy based upon the principles of “No-Fault” coverage. The Plan Administrator reserves the right to obtain in writing a statement of primary or secondary responsibility from any automobile insurance company with which it must coordinate coverage.

6. COBRA

A plan that covers the individual as an active employee or dependent of an active employee will be considered to pay its benefits before a plan that covers the individual as a COBRA participant.
GENERAL PLAN INFORMATION

PLAN NAME
CMU Dental Benefit Booklet

TYPE OF PLAN
Welfare Plan providing dental benefits.

PLAN BENEFITS PROVIDED BY
Central Michigan University

PLAN ADMINISTRATOR AND SPONSOR
Central Michigan University
108 Rowe Hall
Mt. Pleasant, Michigan 48859
989-774-3661

BENEFIT ADMINISTRATOR – DENTAL
Meritain Health
2370 Science Parkway
Okemos, Michigan 48864

AGENT FOR SERVICE OF LEGAL PROCESS
Central Michigan University
108 Rowe Hall
Mt. Pleasant, Michigan 48859

PLAN NUMBER
Meritain Health: 140922
IRS: 503

EMPLOYER IDENTIFICATION NUMBER
38-6004447

PLAN YEAR ENDS
June 30

INSTITUTION HOLDING PLAN FUNDS
National City Bank of the Midwest
PLAN COSTS
The cost to participate in this Plan is shared by the employer and the employees.

FUNDING AND PAYMENT OF CLAIMS
The benefits described herein are self-funded by the employer and are not insured by an insurance company. Meritain Health is a Benefit Administrator who processes claims and does not insure benefits described in this Plan. If for any reason the Plan Administrator does not ultimately pay expenses under this Plan, the individuals covered by the Plan will be liable for those expenses.

PLAN ASSET DISTRIBUTION AFTER TERMINATION OF THE PLAN
Information concerning asset distribution after termination of the Plan shall be made available by the Plan Administrator at no cost upon written request.

GOVERNING LAW
This Agreement shall be governed by and construed under the laws of the State of Michigan to the extent not preempted by Federal law.

RIGHTS RESERVED
The right is reserved in the Plan for the Plan Sponsor to terminate, suspend, withdraw, amend or modify the Plan and any or all benefits provided under the Plan, covering any active employee or current or future retiree or dependent in whole or in part at any time. Any such change or termination in benefits will be based solely on the decision of the Plan Sponsor and may apply to all eligible active and nonactive employees and dependents as either separate groups or as one group, regardless of status. For the Union employees, this Plan is maintained pursuant to a collective bargaining agreement.

When changes are made to Central Michigan University benefit plan(s), they are made in the form of amendments and/or summaries of material modification. The procedure for amending a plan is as follows:

a. The proposed amendment request by the Plan Sponsor is sent to the Benefit Administrator of the plan.

b. The Benefit Administrator develops an amendment and/or summary of material modification in accordance with the amendment request from the Plan Sponsor. The Associate Vice President, Human Resources of Central Michigan University will then approve and sign the amendment and/or summary of material modification.
c. The approved amendment and/or summary of material modification becomes part of the plan document and summary plan description and is available to the Department of Labor upon request. Adoption of an amendment and/or summary of material modification shall be effective immediately upon approval by the Plan Sponsor. Alternatively, the amendment and/or summary of material modification shall be retroactively effective (to the extent permitted by law) if the amendment and/or summary of material modification so states. The Plan Sponsor will notify plan participants of the amendment and/or summary of material modification, in writing.

NAMED FIDUCIARY

Central Michigan University
108 Rowe Hall
Mt. Pleasant, Michigan 48859
989-774-3661

The Plan has granted the Plan Fiduciary final discretionary authority in determining eligibility for benefits or to interpret the terms of the Plan for claims purposes.
COORDINATION OF BENEFITS

NOTE: This Plan is intended to comply with the National Association of Insurance Commissioners (NAIC) Model Coordination of Benefits Rules.

The Coordination of Benefits provision applies when the employee or any person in his/her family is covered by this Plan and is covered by any other group plan(s). This Plan will always pay either its benefits in full or a reduced amount which, when added to the benefits payable by the other plan or plans, will not exceed 100% of allowable expenses.

Coordination of Benefits involves coordinating payments between two (2) plans. If two (2) employees are married and both are covered under this Plan, this Plan will not coordinate benefit payments within this contract. If two employees are parents of the same eligible dependent child(ren), whether or not the parents are, or have ever been, married, this Plan will not coordinate benefit payments within this contract.

In no event will this Plan coordinate benefits for expenses that are not considered “allowable expenses” under the terms and conditions of this Plan. “Allowable expense” shall be deemed to mean any necessary, reasonable and customary item of expense for services, supplies, or treatment which is covered under this Plan. “Plan” shall be deemed to mean any plan providing benefits or services by group insurance coverage or any other arrangement of coverage for individuals in a group, whether on an insured or an uninsured basis, including any governmental program (except Medicaid) or coverage required or provided by statute.

ORDER OF PAYMENT

According to the following section outlining the order of payment, one (1) plan will be designated as the “primary plan” and succeeding plans will be designated as “secondary plans.”

The “primary plan” will pay expenses based on the payment obligations it has established under its Schedule of Benefits, and all “secondary plans” will then adjust their expense payments so that the total benefits available to the covered person will not exceed the benefit allowable under the Coordination of Benefits Provisions of the Plan. This Plan will never pay more than it would without this coordination provision.

When a person is covered under two (2) or more plans, the rules below will apply to decide which plan’s benefits are payable first:

1. A plan with no provision for coordination of benefits will be considered to pay its benefits before a plan that contains such a provision.

2. A plan that covers an individual as other than a dependent (e.g., as an employee, member, subscriber, retiree) is primary and the plan that covers the person as a dependent is secondary.

3. The Plan that covers a person as an employee who is neither laid off or retired (or as that employee’s dependent) is primary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. Coverage provided to an individual as a retired worker, and as a dependent of an actively at work spouse will be determined under Rule #2.
4. If two (2) plans cover a dependent child, the Plan of the person whose birthday anniversary occurs earlier in the calendar year shall be primary if:
   a. The parents are married; or
   b. The parents are not separated (whether or not they have ever been married); or
   c. A court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage.

   If both parents have the same birthday, the Plan that has covered either of the parents longer is primary.

5. If the specific terms of a court decree state that one of the parents is responsible for the child’s health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary.

   If the parent with financial responsibility has no coverage for the child’s health care services or expenses, but that parent’s spouse does, the spouse’s plan is primary. This subparagraph shall not apply with respect to any claim determination period or plan year during which the benefits are paid or provided before the entity has actual knowledge. (If it is determined that another plan is primary due to the terms of the divorce decree after the secondary plan has paid as primary, the secondary plan will not retroactively seek refunds of the overpayments it previously issued as the primary plan.)

6. If the parents are not married or are separated (whether or not they were ever married) or are divorced, and there is no court decree allocating responsibility for the child’s health care services or expenses, the order of benefit determination among the plans of the parents and the parent’s spouse (if any) is:
   a. The plan of the custodial parent
   b. The plan of the spouse of the custodial parent
   c. The plan of the non-custodial parent
   d. The plan of the spouse of the non-custodial parent

7. If a person whose coverage is provided under a right of continuation pursuant to state or federal law (e.g., COBRA) is also covered under another plan, the plan covering the person as an employee, member, subscriber, or retiree (or as that person’s dependent) is primary and the continuation coverage is secondary. If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

8. If the preceding rules do not determine the order of benefits, the plan that covered the person for the longer period of time is primary.
   a. To determine the length of time a person has been covered under a plan, two plans shall be treated as one if the covered person was eligible under the second within twenty-four (24) hours after the first ended.
b. The start of a new plan does not include:

- A change in the amount of scope of a plan’s benefits; or
- A change in the entity that pays, provides, or administers the plan’s benefits; or
- A change from one type of plan to another (such as from a single employer plan to that of a multiple employer plan).

c. A person’s length of time covered under a plan is measured from the person’s first date of coverage under that plan. If that date is not readily available for a group plan, the date the person first became a member of the group shall be used as the date from which to determine the length of time the person’s coverage under the present plan has been in force.

9. If another plan contains a provision whereby such plan considers their plan to be excess of other available benefits or considers their plan to be secondary only in normal coordination of benefits situations, this plan will coordinate to consider benefits payable on a 50%/50% basis, between this plan and the other plan.

10. If none of these preceding rules determines the primary plan, the allowable expenses shall be determined equally between the plans.

The total maximum benefit limits under this Plan will only be reduced by the charges actually paid by this Plan. Any benefits coordinated and paid by other coverage providers will not be charged against the benefit limits of this Plan.

**AUTOMOBILE INSURANCE, INCLUDING NO-FAULT INSURANCE**

This Plan will coordinate covered expenses with an individual automobile insurance policy based upon the principles of “No-Fault” coverage. The Plan Administrator reserves the right to obtain in writing a statement of primary or secondary responsibility from any automobile insurance company with which it must coordinate coverage.

**COORDINATION WITH MEDICAID**

Notwithstanding any other provisions of this Plan to the contrary, this Plan shall not take into account that a covered person or covered person’s beneficiary qualifies for medical assistance under a State Medicaid plan when determining eligibility for Plan enrollment or the payment of Plan benefits.
GENERAL PROVISIONS

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

For purposes of determining the applicability of and implementing the terms of this provision or any similar provision of any other Plan, the Benefit Administrator may, without the consent of or notice to any person, release to or obtain from any other insurance company or other organization or person, any information with respect to any person whom the Plan Administrator deems to be necessary for such purposes. Any person claiming benefits under this Plan must furnish the Benefit Administrator such information as may be necessary to implement this provision.

FACILITY OF PAYMENT

Whenever payments that should have been made under this Plan in accordance with its provisions have been made under any other plans, the employer shall have the right, exercisable alone and in its full discretion, to pay over to any organizations making such other payments any amounts it shall deem to be warranted in order to satisfy the intent of this provision, and any amount so paid shall be deemed to be benefits paid under this Plan and to the extent of such payments, the employer shall be fully discharged from liability under this Plan.

RIGHT OF RECOVERY

Whenever payments have been made by the Benefit Administrator with respect to allowable expenses in an amount that is, at any time, in excess of the maximum amount of payment necessary to satisfy the intent of this provision, the Benefit Administrator will have the right to recover such payments, to the extent of such excess, from among one or more of the following: any persons to or for or with respect to whom such payments were made, any other insurance companies, including but not limited to Worker’s Compensation carriers, and any other organizations.

If an overpayment is made in the opinion of the Plan Administrator, this Plan has the right to recover the overpayment. If a covered person is paid more than allowed by this Plan, the covered person must refund that overpayment. A request for refund will be made in writing by this Plan. If an overpayment is made by the Plan on behalf of the covered person to a hospital, physician, or other covered provider, this Plan may request a refund of the overpayment from either the covered person or the covered provider. If the refund is not received from either the covered person or the covered provider, the overpayment will be deducted from any future Plan benefits available to the covered person or collected through legal process.

STATE RECOVERY OF MEDICAID PAYMENTS

Notwithstanding any other provisions of the Plan to the contrary, if this Plan provides benefit payments on behalf of a covered person who is also covered by a State’s Medicaid program, the Plan shall be subject to the State’s right to reimbursement for benefits the State has paid on behalf of the covered person, provided that the State has an assignment of rights made by or on behalf of the covered person, or the covered person’s beneficiary, as may be required by the State Medical Assistance Plan.
SUBROGATION, REIMBURSEMENT AND THIRD PARTY RECOVERY PROVISION

If you, your spouse, one of your dependents, or anyone who receives benefits under this Plan becomes ill or is injured and entitled to receive money from any source, including but not limited to any party’s liability insurance or uninsured/underinsured motorist proceeds, then the benefits provided or to be provided by the Plan are secondary, not primary, and will be paid only if you fully cooperate with the terms and conditions of the Plan.

As a condition of receiving benefits under this Plan, the employee or covered person agrees that acceptance of benefits is constructive notice of this provision in its entirety and agrees to reimburse the Plan 100% of benefits provided without reduction for attorney’s fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise. The person receiving benefits further agrees that any funds received by said person and/or their attorney, if any, from any source for any purpose shall be held in trust until such time as the obligation under this provision is fully satisfied. If the employee or covered person retains an attorney, then the employee or covered person agrees to only retain one who will not assert the Common Fund or Made-Whole Doctrines. Reimbursement shall be made immediately upon collection of any sum(s) recovered regardless of its legal, financial or other sufficiency. If the injured person is a minor, any amount recovered by the minor, the minor’s trustee, guardian, parent, or other representative, shall be subject to this provision regardless of State law and/or whether the minor’s representative has access or control of any recovery funds.

The employee or covered person agrees to sign any documents requested by the Plan including but not limited to reimbursement and/or subrogation agreements as the Plan or its agent(s) may request. Also, the employee or covered person agrees to furnish any other information as may be requested by the Plan or its agent(s). Failure or refusal to execute such agreements or furnish information does not preclude the Plan from exercising its right to subrogation or obtaining full reimbursement. Any settlement or recovery received shall first be deemed for reimbursement of medical expenses paid by the Plan. Any excess after 100% reimbursement of the Plan may be divided up between the employee or covered person and their attorney if applicable. If any provision is made for future medical expenses in the settlement or recovery, accident related claims made after satisfaction of this obligation shall be paid by the employee or covered person and not the plan.

The employee or covered person agrees to take no action that in any way prejudices the rights of the Plan. If it becomes necessary for the Plan to enforce this provision by initiating any action against the employee or covered person, then the employee or covered person agrees to pay the Plan’s attorney’s fees and costs associated with the action regardless of the action’s outcome.

The Plan Administrator has sole discretion to interpret the terms of this provision in its entirety and reserves the right to make changes as it deems necessary.

If the employee or covered person takes no action to recover money from any source, then the employee or covered person agrees to allow the Plan to initiate its own direct action for reimbursement.

HONOR OF STATE SUBROGATION RIGHTS

Notwithstanding any other provision of this Plan to the contrary, the Plan will honor any subrogation rights that a State may have gained from a Medicare eligible beneficiary covered by the
Plan by virtue of the State’s having paid Medicare benefits, provided that the Plan has a legal liability for coverage.

PRIVACY

In administering your Plan benefits, the Benefit Administrator will comply with all applicable privacy and access statutes, rules and regulations.
DEFINITIONS FOR THE PURPOSE OF THIS PLAN

ACCIDENT: Sudden and unexpected injury to the body caused by an external force. Lifting, bending, stooping, simple exertion, etc., are not, in themselves, accidental events.

ADVERSE BENEFIT DETERMINATION: The appeals procedures are triggered by an adverse benefit determination. According to the new regulations the term “adverse benefit determination” means a denial, reduction or termination of, or a failure to provide, or make payment (in whole or in part) for a benefit. Requests for determinations of eligibility under the Plan are not required to be treated as claims for benefits for purposes of the claims procedure. However, where a claim for benefits is made and the claim is denied because the claimant is not eligible for benefits under the terms of the Plan, the claimant shall be afforded the right to appeal that determination in accordance with the claims procedures outlined in the Plan.

AGENT FOR SERVICE OF LEGAL PROCESS: Legal process may be served on the Plan Administrator at the address indicated on the General Plan Information page.

AMENDMENT: A formal document that changes the provision of this Plan that is adopted through a formal resolution by the employer through its governing body or authorized executive.

The employer may amend this Plan at any time and will provide written notice to participants. Summary of Material Modifications (SMM) must be distributed within sixty (60) days after a material reduction in benefits has been adopted. Plan Amendments can be made retroactive to the extent permitted by law.

ASSIGNMENT OF BENEFITS: Assignment of Benefits occurs when you file a claim and authorize the Plan to pay your doctor or hospital directly.

AUTHORIZED REPRESENTATIVE: A claimant may act through an authorized representative. The Department of Labor (DOL) has clarified, that it is reasonable to require written authorization signed by the Plan participant or beneficiary, on a form specified by the Plan for an authorized representative to act on behalf of the Plan participant or beneficiary in connection with non-urgent and post-service claims. However, if an urgent care claim is involved, a health care professional evidencing knowledge of a claimant’s medical condition will have to be accepted as sufficient to establish authorized representative status. According to the DOL, a medical service provider does not become an authorized representative within the meaning of the regulations as a result of an assignment of benefits by a plan participant or beneficiary.

The claimant has the right to revoke the assignment of an authorized representative at any time.

BENEFIT ADMINISTRATOR: The firm providing administrative services to the employer in connection with the operation of the Plan and performing certain functions, including underwriting, enrollment applications, maintaining current Plan data, billing, processing and payment of claims and providing the employer with any other information deemed necessary by the Third Party Administrator.

CLAIM: A claim is any request for a plan benefit or benefits, made by a claimant or by a representative of a claimant that complies with a Plan’s reasonable procedure for making benefit
claims. A request for benefits includes a request for coverage determination, for pre-authorization or approval of a plan benefit, or for a utilization review determination in accordance with the terms of the Plan.

Requests for determinations of eligibility under the Plan are not required to be treated as claims for benefits for purposes of the claims procedure. However, where a claim for benefits is made and the claim is denied because the claimant is not eligible for benefits under the terms of the Plan, the claimant shall be afforded the right to appeal that determination in accordance with the claims procedures outlined in the Plan.

Under the terms of this Plan, a claim is not deemed to be a claim when there is a casual inquiry about benefits. For this Plan to consider a request for benefits as a claim, it is required that a claim for pre-service care, post-service care and concurrent care benefits must be filed in writing or submitted electronically and must include applicable codes. Less stringent guidelines may apply in the case of an urgent care claim.

CONCURRENT CARE CLAIM: A concurrent care decision is one where the Plan has approved an ongoing course of treatment, and then the Plan reduces or terminates coverage for that course of treatment (other than by amendment or plan termination) before the end of the pre-approved course of treatment. This is an adverse benefit determination that can be appealed as a concurrent care claim.

Reduction or termination of benefits: In the case of a reduction or termination of an ongoing course of treatment which the Plan had previously approved, the Plan Administrator shall notify the claimant of the Plan’s benefit determination within a reasonable period of time.

Request to extend benefits: In the case of a request of a claimant to extend the course of treatment which the Plan had previously approved, the Plan Administrator shall notify the claimant of the Plan’s benefit determination within a reasonable period of time but in no event greater than twenty-four (24) hours after receipt of the claim by the Plan.

CONSENT: Permitted disclosures allow a covered entity to disclose Protected Health Information (PHI) to the individual whose PHI is being disclosed and with consent of the individual for the purposes of treatment, payment or health care operations. Covered entities may use or disclose PHI with written authorization from plan participants. The claimant has the authority to revoke an authorized consent at any time.

COORDINATION OF BENEFITS: If an individual is covered by another benefit plan, this Plan will coordinate its payment of benefits with the other plan to allow as complete claim reimbursement as possible, within the coverage limits, without providing duplicate payments.

DATE OF INCURRAL: A charge is incurred on the date: (1) the final impression is taken in the case of dentures or partial dentures; (2) the preparation of the tooth is begun in the case of fixed bridges, inlays, onlays or crown work; (3) the pulp chamber is opened and explored to the apex in the case of root canal therapy; (4) the surgery is performed in the case of periodontal surgery; (5) the work is performed in the case of any other work. (In the case of dental implants, if the work is performed in more than one session, each session will be considered separately.)
DAY: The term used in the regulations means calendar days, not business days. 65 Fed. Reg. 70248,n.9 (Nov. 21, 2000).

DEDUCTIBLE: The amount of covered expenses that an individual must pay before being eligible for the benefit payment.

DENTALLY NECESSARY: Treatment that is generally accepted by dental professionals in the United States as proven, effective and appropriate for the condition based on recognized standards of the health care specialty involved.

“Proven” means the care is not considered Experimental/Investigational, meets a particular standard of care accepted by the medical community and is approved by the Food and Drug Administration (FDA), for treatment.

“Effective” means the treatments beneficial effects can be expected to outweigh any harmful effects. Effective care is treatment proven to have a positive effect on your health, while addressing particular problems caused by disease, injury, illness or a clinical condition.

“Appropriate” means the treatment’s timing and setting are proper and cost effective

DENTAL HYGIENIST: A person who is licensed to practice dental hygiene and is acting under the supervision and direction of a dentist.

DENTIST: A person duly licensed to practice dentistry by the governmental authority having jurisdiction over the licensing and practice of dentistry in the locality where the service is rendered.

DENTURIST: A person who is licensed to make dentures.

DISCLOSURE, ACCOUNTING OF: Under HIPAA this is a list of any entities that have received personally identifiable health care information for uses unrelated to treatment and payment.

DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) (to include minimum necessary scope): Release or divulgence of information by an entity to persons or organizations outside of that entity.

ELECTRONIC DATA INTERCHANGE (EDI): This usually means X12 and similar variable-length formats for the electronic exchange of structured data. It is sometimes used more broadly to mean any electronic exchange of formatted data.

EXPERIMENTAL OR INVESTIGATIONAL SERVICES:

1. Care, procedure, treatment or technology which: (a) is not widely accepted as safe, effective and appropriate for the injury or illness throughout the recognized medical profession or established medical societies in the United States; (b) is experimental, in the research or investigational stage, or conducted for research or similar purposes.

2. Drugs and tests which: (a) the Federal Food and Drug Administration has not approved for general use; (b) are considered experimental; or (c) are for investigational use. Drugs and tests approved for a specific medical condition but which are used for another condition will be considered experimental.
In determining any of the above, reliance will be placed on recognized medical sources such as, but not limited to, the American Medical Association, the National Institutes of Health, the U.S. Food and Drug Administration and other broadly accepted medical authorities and sources.

FULL AND FAIR REVIEW: A full and fair review of the appeal of an adverse benefit determination must be made by the fiduciary of the Plan, the Plan Administrator, who is neither the party who made the initial adverse determination, nor the subordinate of such person. The review may not defer to the initial adverse benefit determination. The review must take into account all comments, documents, records and other information submitted by the claimant without regard to whether such information was previously submitted or relied upon in the initial determination.

FUNDING: Funds for payment of claims are paid into an Employee Benefit Account or Trust from which claims are paid. All funds received by the account or trust shall be applied toward payment of claims and reasonable expenses of administration of the Plan.

HEALTH AND HUMAN SERVICES (HHS): The federal government department that has primary responsibility for implementing HIPAA.

HEALTH CARE CLEARINGHOUSE: Under HIPAA, this is an entity that processes or facilitates the processing of information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction, or that receives a standard transaction from another entity and processes or facilitates the processing of that information into nonstandard format or nonstandard data content for a receiving entity.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA): A federal law that allows persons to qualify immediately for comparable health insurance coverage when they change their employment relationships. Title II, Subtitle F, of HIPAA gives HHS the authority to mandate the use of standards for the electronic exchange of health care data; to specify what medical and administrative code sets should be used within those standards; to require the use of national identification systems for health care patients, providers, payers (or plans), and employers (or sponsors); and to specify the types of measures required to protect the security and privacy of personally identifiable health care information. Also known as the Kennedy-Kassebaum Bill, the Kassebaum-Kennedy Bill, K2, or Public Law 104-191.

INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI): Is information that is a subset of health information, including demographic information collected from an individual, and:

1. Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and

2. Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and

   a. That identifies the individual; or

   b. With respect to which there is a reasonable basis to believe the information can be used to identify the individual.
**MINIMUM NECESSARY REQUIREMENT:** Whenever using or disclosing PHI reasonable efforts to limit the PHI used or disclosed to the minimum necessary to accomplish the intended purpose of the use or disclosure must be maintained.

**MOTOR VEHICLE:** A vehicle, including a trailer, operated or designed for operation upon a public highway by power other than muscular which has more than two (2) wheels. Motor vehicle does not include a motorcycle or a moped, as defined by the State of Michigan. Motor vehicle does not include a farm tractor or other implement of husbandry that is not subject to the registration requirements of the Michigan Vehicle Code.

**NAMED FIDUCIARY:** The employer is the named fiduciary of the Plan. The employer shall exercise all discretionary authority and control with respect to management of the Plan that is not specifically granted to the Benefit Administrator or any fiduciary.

The employer may delegate certain of its fiduciary responsibilities under the Plan to persons who are not named fiduciaries of the Plan. If the employer delegates its fiduciary responsibilities to another person, the delegation shall be made in writing by the employer, and a copy of the delegation will be kept with the records of the Plan.

Each fiduciary is solely responsible for its own acts or omissions. No fiduciary has the duty to question whether any other fiduciary is fulfilling all of the responsibilities imposed upon the other fiduciary by law. No fiduciary shall have any liability for a breach of fiduciary responsibility by another fiduciary with respect to the Plan unless it participates knowingly in such breach, knowingly undertakes to conceal such breach, has actual knowledge of such breach, fails to take responsible remedial action to remedy such breach or, through its negligence in performing its own specific fiduciary responsibilities which give rise to its status as a fiduciary, it enables such other fiduciary to commit a breach of the latter’s fiduciary responsibility.

No fiduciary is liable for a breach of fiduciary duty committed before it became a fiduciary and nothing in the Plan shall relieve any person from liability for his or her own misconduct or fraud.

**NO-FAULT MOTOR VEHICLE PLAN:** A compulsory motor vehicle plan that may provide payments for medical, dental care, or wage loss which are payable, in whole or in part, without regard to fault.

**ORTHODONTIC TREATMENT:** The corrective movement of teeth through bone by means of an active appliance to correct a malocclusion of the mouth.

**PHYSICIAN OR OTHER LICENSED OR CERTIFIED PROVIDERS:** Means a duly licensed doctor of medicine (M.D.), osteopath (D.O.), podiatrist (D.P.M.), chiropractor (D.C.), fully licensed psychologist (Ph.D.) or psychiatrist, or any other provider rendering a covered service, acting within the scope of his license who is required to be recognized as such by an applicable State code.
PLAN ADMINISTRATOR, AND PLAN ADMINISTRATION: The employer is the Plan Administrator of the Plan. As Plan Administrator, the company must supply you with this document and other information and file various reports and documents with government agencies. In its role of administering the Plan, the Plan Administrator also may make rulings, interpret the Plan, prescribe procedures, gather needed information, receive and review financial information regarding the Plan, employ or appoint individuals to assist in any administrative function, and generally do all other things needed to administer the Plan.

The Plan Administrator has all powers and authority needed to enable it to carry out its duties under the Plan, including by way of illustration and not limitation, the power and authority to make regulations with respect to the Plan not inconsistent with the terms of the Plan and to determine, consistent with those regulations all the status and rights of participants, beneficiaries and other persons.

Failure by the Plan or Plan Administrator to insist upon compliance with any provisions of the plan at any time or under any set of circumstances shall not operate to waive or modify the provision or in any manner render it unenforceable as to any other time or as to any other occurrence, whether the circumstances are or are not the same. No waiver of any term or condition of the Plan shall be valid unless contained in a written memorandum expressing the waiver and signed by a person authorized by the Plan Administrator to sign the waiver.

The Plan Administrator shall interpret the Plan under Federal law.

PLAN MODIFICATION: The Plan may be modified or amended by the employer from time to time. Modifications that affect covered participants will be communicated to the Plan participants.

PLAN SPONSOR: Defined as (i) the employer in the case of an employee benefit plan established or maintained by a single employer, (ii) the employee organization in the case of a plan established or maintained by an employee organization, or (iii) in the case of a plan established or maintained by two (2) or more employers or jointly by one (1) or more employers and one (1) or more employee organizations, the association, committee, joint board of trustee, or other similar group of representatives of the parties who establish or maintain the plan. The right is reserved in the Plan for the Plan Sponsor to terminate, suspend, withdraw, amend or modify the Plan and any or all benefits provided under the Plan, covering any active employee or current or future retiree or dependent in whole or in part at any time. Any such change or termination in benefits will be based solely on the decision of the Plan Sponsor and may apply to all eligible active and nonactive employees and dependents as either separate groups or as one group, regardless of status.

PLAN YEAR: A period commencing with the effective date of this Plan or a Plan anniversary and terminating the day before the next succeeding Plan anniversary date.

POST-SERVICE CLAIM: A post-service care claim is one that may be filed and approved after the service is rendered.

In the case of post-service claims, the Plan Administrator shall notify the claimant of the Plan’s benefit determination within thirty (30) days after receipt of the claim by the Plan, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. This period may be extended for fifteen (15) additional days, if
the Plan administrator determines that such an extension is necessary due to matters beyond the control of the Plan.

If the claimant fails to provide the Plan Administrator with sufficient information to make a determination, the Plan Administrator shall notify the claimant of the specific information necessary to complete the claim. The claimant shall be afforded forty-five (45) days to provide the specified information.

**PRECIOUS METAL**: Material that contains, in any combination, more than 50% of gold, platinum or palladium.

**PRESCRIPTION DRUG**: This term means: (a) Federal Legend Drugs - a drug or medicine whose label must bear the legend: “CAUTION: Federal Law prohibits dispensing without a prescription,” (b) State Restricted Drugs - a drug or medicine which can be dispensed in a State or jurisdiction by prescription only; (c) Compounded Medications - a drug or medicine mixture which has in it at least one Federal Legend Drug or State Restricted Drug; (d) Injectable insulin; (e) insulin needles and syringes.

**PRESCRIPTION ORDER**: This term means: (a) An order issued by a doctor for prescription drugs. This order must be written in the name of the person for whom it is prescribed; (b) An authorized refill of that order.

**PRE-SERVICE NON-URGENT CARE CLAIM**: A pre-service non-urgent care claim is one where the receipt of the benefit is conditioned on approval before the service is rendered.

In the case of pre-service determinations, the Plan Administrator shall notify the claimant of the Plan’s benefit determination within fifteen (15) days after receipt of the claim by the Plan, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. This period may be extended for fifteen (15) additional days, if the Plan Administrator determines that such an extension is necessary due to matters beyond the control of the Plan.

If the claimant fails to provide the Plan Administrator with sufficient information to make a determination, the Plan Administrator shall notify the claimant of the specific information necessary to complete the claim. The claimant shall be afforded forty-five (45) days to provide the specified information.

**PROTECTED HEALTH INFORMATION (PHI)**: Individually Identifiable Health Information

1. Except as provided in paragraph (2) of this definition, that is:
   a. Transmitted by electronic media;
   b. Maintained in any medium described in the definition of electronic media; or
   c. Transmitted or maintained in an other form or medium.

2. Protected Health Information excludes Individually Identifiable Health Information in:
a. Education records covered by the Family Educational Right and Privacy Act, as amended, 20 U.S.C. 1232g; and


**REASONABLE AND CUSTOMARY CHARGE:** A reasonable and customary (“R&C”) charge shall be the usual charge made by a supplier of services, medicines, or supplies and shall not exceed the general level of charges made by others rendering or furnishing such services, medicines, or supplies within the area in which the charge is incurred for the treatment. The term “area” as it would apply to any particular service, medicine, or supply means a county or such greater areas as is necessary to obtain a representative cross section of the level of charges.

**SOUND, NATURAL TOOTH:** A tooth that is whole or properly restored and is without impairment, periodontal or other conditions and which is not in need of treatment for any reason other than an accidental injury.

**SUMMARY HEALTH INFORMATION:** Information, that may be Individually Identifiable Health Information, and:

1. That summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan; and

2. From which the information described at §164.514(b)(2)(i) has been deleted except that the geographic information described in §164.514(b)(2)(i)(B) need only be aggregated to the level of a five digit zip code.

**TEMPOROMANDIBULAR JOINT DYSFUNCTION:** A malfunction of the joint formed by the lower jawbone and the temporal bone.

**TPO (TREATMENT – PAYMENT – HEALTH CARE OPERATIONS):**

**TREATMENT** - Means the provision, coordination or management of health care and related services by one or more health care providers, including the coordination and management of health care by a provider and a third party, consultation between health care providers relating to a patient or the referral of a patient for health care from one provider to another.

**PAYMENT** - Means activities undertaken by a health plan to obtain premiums or to determine or fulfill its responsibility for coverage and provisions of benefits including but not limited to: determination of eligibility or coverage; adjudication or subrogation of health benefit claims; billing; claims management; collection activities; related health care data processing; review of health care services with respect to medical necessity, coverage under the Plan, appropriateness of care, justification of charges; utilization review activities, including pre-certification, pre-authorization, concurrent and retrospective review.

Health Care **OPERATIONS** cover a wide range of activities including:

1. Quality assessments and improvement activities, case management, protocol development, and contacting providers about alternative treatments and related functions that do not include treatment.
2. Reviewing competence or qualification of health care professionals, evaluating provider or health plans performance, certification, licensing, or credentialing activities.

3. Underwriting, premium rating and other activities relating to the creation, renewal or placement of health insurance or health benefits – ceding, securing or placing a contract of reinsurance or stop-loss insurance; providing that if a health plan receives PHI for such purposes and the insurance is not placed, the health plan may not use or disclose the PHI received for any other purpose, except as may be required by law.

4. Conducting or arranging for medical review, legal services or auditing function including fraud and abuse.

5. Business planning or development such as cost management, development or improvement in payment methods or policy coverages.

6. Business management and general administrative activities of the covered entity including customer service, resolution of internal grievances, due diligence in connection with a business transaction if the potential successor is or will become a covered entity.

**URGENT CARE CLAIM:** An urgent care claim is any claim for which the application of the standard time periods for determining claims a prudent layperson would consider, or the patient’s physician determines, could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or for which delayed treatment would cause the patient severe pain.

In the case of a determination involving urgent care, the Plan Administrator shall notify the claimant of the Plan’s benefit determination within seventy-two (72) hours after receipt of the claim by the Plan, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan.

If the claimant fails to provide the Plan Administrator with sufficient information to make a determination, the Plan Administrator shall notify the claimant within twenty-four (24) hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim. The claimant shall be afforded forty-eight (48) hours to provide the specified information.
SUMMARY OF MATERIAL MODIFICATION
AND
AMENDMENT #1
TO THE
CMU DENTAL BENEFIT BOOKLET
GROUP NO. 15357

This Summary of Material Modification and Amendment describes changes to the CMU Dental Benefit Booklet effective January 1, 2009. These changes are effective as of July 1, 2018 and will remain in effect until amended in writing by the Plan Administrator.

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

Central Michigan University (the “Plan Sponsor”) is amending the CMU Dental Benefit Booklet (the “Plan”) as follows:

1. The Benefit Administrator - Dental section under General Plan Information is hereby deleted and replaced with the following:

   GENERAL PLAN INFORMATION

   BENEFIT ADMINISTRATOR – DENTAL

   Meritain Health
   P.O. Box 853921
   Richardson, TX 75085-3921
   (800) 925-2272

2. The General Provisions section of the Plan is hereby deleted and replaced as shown in Exhibit A.

3. The definition of Reasonable and Customary Charge under the Definitions for the Purpose of this Plan section is hereby deleted and replaced with the following:

   DEFINITIONS FOR THE PURPOSE OF THIS PLAN

   Reasonable and Customary Charge (R&C) means charges made for medical or dental services or supplies essential to the care of the individual that will be subject to a Reasonable and Customary determination. Subject to the rest of this definition, the Reasonable and Customary Charge means the lesser of the charge by other providers in the same geographic area or billed charges for the same or comparable service or supply. From time to time, the Plan may enter into an agreement with a provider (directly or indirectly through a third party) which sets the rate the Plan will pay for a service or supply. In these cases the Reasonable and Customary Charge will be the rate established in such agreement with the provider.
The Plan may reduce the Reasonable and Customary Charge by applying reimbursement policies administered by the Plan’s Third Party Administrator. These reimbursement policies address the appropriate billing of services, taking into account factors that are relevant to the cost of the service such as:

1. The duration and complexity of a service;
2. Whether multiple procedures are billed at the same time but no additional overhead is required;
3. Whether an Assistant Surgeon is involved and necessary for the service;
4. If follow up care is included;
5. Whether there are any other characteristics that may modify or make a particular service unique; and
6. When a charge includes more than one claim line, whether any services described by a claim line are part of or incidental to the primary service provided.

The reimbursement policies utilized are based on review of the policies developed for Medicare; the generally accepted standards of medical and dental practice, which are based on credible scientific evidence published in peer-reviewed literature generally recognized by the relevant medical or dental community or which are otherwise consistent with Physician or dental specialty society recommendations; and the views of Physicians and Dentists practicing in the relevant clinical areas.

All other provisions of this Plan shall remain unchanged.

In Witness Whereof, Central Michigan University has caused this Amendment to take effect, be attached to, and form a part of their Benefit Booklet.

Authorized Signature  
Date  
Title

Witness  
Date  
Title

15357-01  
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EXHIBIT A

GENERAL PROVISIONS

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

For purposes of determining the applicability of and implementing the terms of this provision or any similar provision of any other Plan, the Benefit Administrator may, without the consent of or notice to any person, release to or obtain from any other insurance company or other organization or person, any information with respect to any person whom the Plan Administrator deems to be necessary for such purposes. Any person claiming benefits under this Plan must furnish the Benefit Administrator such information as may be necessary to implement this provision.

FACILITY OF PAYMENT

Whenever payments that should have been made under this Plan in accordance with its provisions have been made under any other plans, the employer shall have the right, exercisable alone and in its full discretion, to pay over to any organizations making such other payments any amounts it shall deem to be warranted in order to satisfy the intent of this provision, and any amount so paid shall be deemed to be benefits paid under this Plan and to the extent of such payments, the employer shall be fully discharged from liability under this Plan.

STATE RECOVERY OF MEDICAID PAYMENTS

Notwithstanding any other provisions of the Plan to the contrary, if this Plan provides benefit payments on behalf of a covered person who is also covered by a State’s Medicaid program, the Plan shall be subject to the State’s right to reimbursement for benefits the State has paid on behalf of the covered person, provided that the State has an assignment of rights made by or on behalf of the covered person, or the covered person’s beneficiary, as may be required by the State Medical Assistance Plan.

PRIVACY

In administering your Plan benefits, the Benefit Administrator will comply with all applicable privacy and access statutes, rules and regulations.

SUBROGATION, THIRD-PARTY RECOVERY AND REIMBURSEMENT

Payment Condition

1. The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, Illness, disease or disability is caused in whole or in part by, or results from the acts or omissions of you and/or your Dependents, plan beneficiaries and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as “Covered Person”) or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other insurance or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party (collectively “Coverage”).
2. The Covered Person, his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan’s conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan’s conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan’s assignee. By accepting benefits the Covered Person agrees the Plan shall have an equitable lien on any funds received by the Covered Person and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Covered Person agrees to include the Plan’s name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Covered Person understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Covered Person shall be a trustee over those Plan assets.

3. In the event a Covered Person settles, recovers or is reimbursed by any Coverage, the Covered Person agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Covered Person. If the Covered Person fails to reimburse the Plan out of any judgment or settlement received, the Covered Person will be responsible for any and all expenses (fees and costs) associated with the Plan’s attempt to recover such money.

4. If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Covered Person is/are only one or a few, that unallocated settlement fund is considered designated as an “identifiable” fund from which the Plan may seek reimbursement.

Subrogation

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

2. If a Covered Person receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Covered Person may have against any Coverage and/or party causing the Illness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Covered Person is obligated to notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Covered Person is also obligated to hold any and all funds so received in trust on the Plan’s behalf and function as a trustee as it applies to those funds until the Plan’s rights described herein are honored and the Plan is reimbursed.

3. The Plan may, at its discretion, in its own name or in the name of the Covered Person, commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

4. The Covered Person authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Covered Persons and/or the Plan’s name and agrees to fully cooperate with the Plan in the prosecution of any such claims if the Covered Person fails to file a claim or pursue damages against:

   a. The responsible party, its insurer or any other source on behalf of that party;

   b. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
c. Any policy of insurance from any insurance company or guarantor of a third party;

d. Workers’ Compensation or other liability insurance company; or

e. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments and school insurance coverage.

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

Right of Reimbursement

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

2. No court costs, experts’ fees, attorneys’ fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan’s recovery without the prior, express written consent of the Plan.

3. The Plan’s right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Covered Person, whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan’s recovery will not be applicable to the Plan and will not reduce the Plan’s reimbursement rights.

4. These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Covered Person.

5. This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Illness, Injury, disease or disability.

Covered Person is a Trustee Over Plan Assets

1. Any Covered Person who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any Injury or Accident. By virtue of this status, the Covered Person understands that he/she is required to:

   a. Notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds;

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b. Instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts;

c. In circumstances where the Covered Person is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Person obtains a settlement, judgment or other source of Coverage to include the Plan or its authorized representative as a payee on the settlement draft; and,

d. Hold any and all funds so received in trust, on the Plan’s behalf, and function as a trustee as it applies to those funds, until the Plan’s rights described herein are honored and the Plan is reimbursed.

2. To the extent the Covered Person disputes this obligation to the Plan under this section, the Covered Person or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan’s interests, and without reduction in consideration of attorneys’ fees, for which he/she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

3. No Covered Person, beneficiary, or the agents or representatives thereof, exercising control over plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan’s interest on the Plan’s behalf.

Excess Insurance
If at the time of Injury, Illness, disease or disability, there is available or potentially available any coverage (including but not limited to coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of coverage, except as otherwise provided for under the Plan’s “Coordination of Benefits” section.

The Plan’s benefits shall be excess to any of the following:

1. The responsible party, its insurer or any other source on behalf of that party;

2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;

3. Any policy of insurance from any insurance company or guarantor of a third party;

4. Workers’ Compensation or other liability insurance company; or

5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments and school insurance coverage.

Separation of Funds
Benefits paid by the Plan, funds recovered by the Covered Person and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Covered Person, such that the death of the Covered Person or filing of bankruptcy by the Covered Person, will not affect the Plan’s equitable lien, the funds over which the Plan has a lien or the Plan’s right to subrogation and reimbursement.

Wrongful Death
In the event that the Covered Person dies as a result of his or her Injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan’s subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Covered Person(s) and all others that benefit from such payment.
Obligations
1. It is the Covered Person’s obligation at all times, both prior to and after payment of medical benefits by the Plan:
   a. To cooperate with the Plan or any representatives of the Plan, in protecting its rights, including discovery, attending depositions and cooperating in trial to preserve the Plan’s rights;
   b. To provide the Plan with pertinent information regarding the Illness, disease, disability or Injury, including Accident reports, settlement information and any other requested additional information;
   c. To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
   d. To do nothing to prejudice the Plan's rights of subrogation and reimbursement;
   e. To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received;
   f. To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement;
   g. To not settle or release, without the prior consent of the Plan, any claim to the extent that the Covered Person may have against any responsible party or coverage;
   h. To instruct his/her attorney to ensure that the Plan or its authorized representative is included as a payee on any settlement draft;
   i. In circumstances where the Covered Person is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Person obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft; and
   j. To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Covered Person over settlement funds is resolved.

2. If the Covered Person and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the Covered Person will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Covered Person.

3. The Plan’s rights to reimbursement and/or subrogation are in no way dependent upon the Covered Persons’ cooperation or adherence to these terms.

Offset
If timely repayment is not made, or the Covered Person and/or his or her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Covered Person’s amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Covered Person in an amount equivalent to any outstanding amounts owed by the Covered Person to the Plan. This provision applies even if the Covered Person has disbursed settlement funds.
Minor Status
1. In the event the Covered Person is a minor as that term is defined by applicable law, the minor’s parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

2. If the minor’s parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor’s parents or court-appointed guardian.

Language Interpretation
The Plan Sponsor retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision and to administer the Plan’s subrogation and reimbursement rights.

Severability
In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

Notwithstanding anything contained herein to the contrary, to the extent this Plan is not governed by ERISA, the Plan’s right to subrogation and reimbursement may be subject to applicable state subrogation laws.