Health Alliance Plan of Michigan
Health Maintenance Organization (HMO) Plan
Summary of Benefits
AA001150 / XR001153

HMO
AA001150 / XR001153

Health Care Services	In-Network	Out-of-Network	Limitations
Plan Attributes			
Benefit Period	Calendar Year		
Annual Deductible	$500 Individual; $1,000 Family	N/A	Deductible does not include copays or coinsurance. Deductible applies to the annual Out-of-Pocket Maximum.
Coinsurance	0%	N/A	
Annual Coinsurance Maximum	N/A	N/A	
Annual Out-of-Pocket Maximum	$6,600 Individual; $13,200 Family	N/A	These values do not accumulate: Premiums, balance-billed charges, and health care this plan doesn't cover. All other cost sharing accumulates unless otherwise specified.
Preventive Services			
Routine Well Visits	Covered - Deductible does not apply	N/A	
Related Laboratory and Radiology Services	Covered - Deductible does not apply	N/A	
Pap Smear, Mammogram, Tubal Ligation	Covered - Deductible does not apply	N/A	
Immunizations	Covered - Deductible does not apply	N/A	
Outpatient & Physician Services			
Primary Care Office Visit	$15 Copay - Deductible does not apply	N/A	
HAP Telehealth	$15 Copay - Deductible does not apply	N/A	Through our designated telehealth partner.
Specialist Office Visit	$15 Copay - Deductible does not apply	N/A	
Routine Audiology Exam	Covered - Deductible does not apply	N/A	One exam per benefit period. For non-routine visits see Specialist Office Visit.
Routine Eye Exam	Covered - Deductible does not apply	N/A	One exam per benefit period. For non-routine visits see Specialist Office Visit.
Chiropractic Services	$15 Copay - Deductible does not apply	N/A	Up to 35 visits per benefit period.
Allergy Treatment	Covered after Deductible	N/A	
Allergy Injections	Covered after Deductible	N/A	
Laboratory & Pathology	Covered after Deductible	N/A	Some services require preauthorization.
Imaging MRI, CT & PET Scans	Covered after Deductible	N/A	Services require preauthorization.
Radiology (X-ray)	Covered after Deductible	N/A	Some services require preauthorization.
Radiation Therapy & Chemotherapy	Covered after Deductible	N/A	
Dialysis	Covered after Deductible	N/A	
Outpatient Medical Drugs	Covered after Deductible	N/A	
Outpatient Surgical Services			
Outpatient Surgery	Covered after Deductible	N/A	
Ambulatory Surgical Center	Covered after Deductible	N/A	
Professional Surgical and Related Services	Covered after Deductible	N/A	
Emergency/Urgent Care			
Urgent Care	$35 Copay - Deductible does not apply		
Emergency Room Care	$100 Copay - Deductible does not apply		Copay will be waived if admitted
Emergency Medical Transportation	Covered after Deductible		Emergency transport only.
Inpatient Hospital Services			
Facility Fee	Covered after Deductible	N/A	
Physician Services, Surgery, Therapy, Laboratory, Radiology, Hospital Services and Supplies	Covered after Deductible	N/A	
Bariatric Surgery and Related Services	$1,000 Copay after Deductible	N/A	One procedure per lifetime
Maternity Services			
Routine Prenatal Office Visits	Covered - Deductible does not apply	N/A	Covered under Preventive Services. For non-routine visits, see Specialist Office Visit.
Routine Postnatal Office Visits	Covered - Deductible does not apply	N/A	Covered under Preventive Services. For non-routine visits, see Specialist Office Visit.
Labor Delivery and Newborn Care	See Inpatient Hospital Services	N/A	

Mental Health & Substance Use Disorder			
Inpatient Services	See Inpatient Hospital Services	N/A	
Outpatient Services	$15 Copay - Deductible does not apply	N/A	
Other Services			
Home Health Care	50% Coinsurance after Deductible	N/A	Does not include Rehabilitation Services. Up to 60 visits per benefit period.
Hospice Care	Covered after Deductible	N/A	Up to 210 days per lifetime
Skilled Nursing Care	50% Coinsurance after Deductible	N/A	Covered for authorized services. Up to 100 days per benefit period.
Durable Medical Equipment; Prosthetics & Orthotics	50% Coinsurance after Deductible	N/A	Covered for approved equipment only.
Rehabilitation Services: Physical, Occupational, and Speech Therapy	$15 Copay after Deductible	N/A	May be rendered at home. Up to 60 combined visits per benefit period.
Habilitation Services: Physical, Occupational, and Speech Therapy	$15 Copay after Deductible	N/A	Limited to services associated with the treatment of Autism Spectrum Disorders. See Rehabilitation Services for non-autism Habilitation cost sharing and limits. Covered for authorized services only.
Applied Behavioral Analysis	$15 Copay - Deductible does not apply	N/A	Limited to services associated with the treatment of Autism Spectrum Disorders. Covered for authorized services only.
Voluntary Sterilizations	See Outpatient Surgical Services	N/A	Limited to vasectomy
Infertility Services	Covered after Deductible	N/A	Services for diagnosis, counseling, and treatment of bodily disorders causing infertility. Covered for authorized services only.
Temporomandibular Joint Disorder	Covered after Deductible	N/A	Coverage for non-invasive treatments only.
Pharmacy (Affiliated pharmacy providers only)			
Tier 1	$10 Copay 30 day supply, $20 Copay 90 day supply		A 90-day supply of non-maintenance drugs must be filled at our designated mail order pharmacy. Other exclusions & limitations may apply. Certain specialty drugs may be approved for 60 or 90 days. In this case, if a copay or max is shown for specialty drugs, you will pay two times that amount for up to 60 days, three times that amount for up to 90 days.
Tier 2	$10 Copay 30 day supply, $20 Copay 90 day supply		
Tier 3	$40 Copay 30 day supply, $80 Copay 90 day supply		
Tier 4	$40 Copay 30 day supply, $80 Copay 90 day supply		
Tier 5	$40 Copay 30 day supply at specialty pharmacy only		
Tier 6	$40 Copay 30 day supply at specialty pharmacy only		

- In case of conflict between this summary and your HMO Subscriber Contract and Riders, the terms and conditions of the HMO Subscriber Contract and Riders will govern.
- Elective hospital admissions require that HAP be notified prior to the admission. HAP must be notified within 48 hours after any emergency hospital admission. Failure to notify HAP could result in a reduction or denial of benefits.
- Some services require prior authorization. Failure to obtain prior authorization before services are received could result in a reduction or denial of benefits.
- Students away at school are covered for acute illness and injury related services according to HAP criteria.
- For Outpatient Mental Health & Substance Use Disorder Services delivered via HAP Telehealth, you will pay the lower of either the Outpatient Mental Health & Substance Use Disorder Cost-Share or the HAP Telehealth Cost-Share.

Health Alliance Plan of Michigan
Health Maintenance Organization (HMO) Plan
Summary of Benefits
AA001141 / XR001234

HMO
AA001141 / XR001234

Health Care Services	In-Network	Out-of-Network	Limitations
Plan Attributes			
Benefit Period	Calendar Year		
Annual Deductible	$1,000 Individual; $2,000 Family	N/A	Deductible does not include copays or coinsurance. Deductible applies to the annual Out-of-Pocket Maximum.
Coinsurance	0%	N/A	
Annual Coinsurance Maximum	N/A	N/A	
Annual Out-of-Pocket Maximum	$6,600 Individual; $13,200 Family	N/A	These values do not accumulate: Premiums, balance-billed charges, and health care this plan doesn't cover. All other cost sharing accumulates unless otherwise specified.
Preventive Services			
Routine Well Visits	Covered - Deductible does not apply	N/A	
Related Laboratory and Radiology Services	Covered - Deductible does not apply	N/A	
Pap Smear, Mammogram, Tubal Ligation	Covered - Deductible does not apply	N/A	
Immunizations	Covered - Deductible does not apply	N/A	
Outpatient & Physician Services			
Primary Care Office Visit	$20 Copay - Deductible does not apply	N/A	
HAP Telehealth	$20 Copay - Deductible does not apply	N/A	Through our designated telehealth partner.
Specialist Office Visit	$20 Copay - Deductible does not apply	N/A	
Routine Audiology Exam	Covered - Deductible does not apply	N/A	One exam per benefit period. For non-routine visits see Specialist Office Visit.
Routine Eye Exam	Covered - Deductible does not apply	N/A	One exam per benefit period. For non-routine visits see Specialist Office Visit.
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Dialysis	Covered after Deductible	N/A	
Outpatient Medical Drugs	Covered after Deductible	N/A	
Outpatient Surgical Services			
Outpatient Surgery	Covered after Deductible	N/A	
Ambulatory Surgical Center	Covered after Deductible	N/A	
Professional Surgical and Related Services	Covered after Deductible	N/A	
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Urgent Care	$50 Copay - Deductible does not apply		
Emergency Room Care	$100 Copay - Deductible does not apply		Copay will be waived if admitted
Emergency Medical Transportation	Covered after Deductible		Emergency transport only.
Inpatient Hospital Services			
Facility Fee	Covered after Deductible	N/A	
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Labor Delivery and Newborn Care	See Inpatient Hospital Services	N/A	

Mental Health & Substance Use Disorder			
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Infertility Services	Covered after Deductible	N/A	Services for diagnosis, counseling, and treatment of bodily disorders causing infertility. Covered for authorized services only.
Temporomandibular Joint Disorder	Covered after Deductible	N/A	Coverage for non-invasive treatments only.
Pharmacy (Affiliated pharmacy providers only)			
Tier 1	$15 Copay 30 day supply, $30 Copay 90 day supply		A 90-day supply of non-maintenance drugs must be filled at our designated mail order pharmacy. Other exclusions & limitations may apply. Certain specialty drugs may be approved for 60 or 90 days. In this case, if a copay or max is shown for specialty drugs, you will pay two times that amount for up to 60 days, three times that amount for up to 90 days.
Tier 2	$15 Copay 30 day supply, $30 Copay 90 day supply		
Tier 3	$50 Copay 30 day supply, $100 Copay 90 day supply		
Tier 4	$50 Copay 30 day supply, $100 Copay 90 day supply		
Tier 5	$50 Copay 30 day supply at specialty pharmacy only		
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- Some services require prior authorization. Failure to obtain prior authorization before services are received could result in a reduction or denial of benefits.
- Students away at school are covered for acute illness and injury related services according to HAP criteria.
- For Outpatient Mental Health & Substance Use Disorder Services delivered via HAP Telehealth, you will pay the lower of either the Outpatient Mental Health & Substance Use Disorder Cost-Share or the HAP Telehealth Cost-Share.

ADN Administrators, Inc.
PO Box 610
Southfield, MI 48037
248-901-3705

UTICA COMMUNITY SCHOOLS Dental Benefits Plan — Group # 9210

Non-Affiliated & Food Service

The Plan-at-a-Glance	PPO Networks: ADN Dental Network, DenteMax
Maximum Benefits	**Plan year July 1st through June 30th**
Annual Maximum	$1000 per eligible individual for covered class I, II and III services.

Class I Preventive Services – 75% In-Network / 75% Out-of-Network	
Oral Examinations	Twice per plan year
Bitewing X-Rays	Once per plan year
Prophylaxis/Periodontal Maintenance	Twice per plan year
Topical Application of Fluoride	Twice per plan year to age 19
Full-Mouth Series or Panoramic X-Rays	Once per 60 months
All Other X-Rays	
Space Maintainers	Under age 16, initial appliance only, one bilateral per arch or One unilateral per quadrant, per lifetime

Class II Restorative Services – 75% In-Network / 75% Out-of-Network	
Composite and Amalgam fillings	Once per tooth surface per 12 months
Root Canal Therapy / Endodontics	
Periodontal Root Planing	Once per quadrant per 24 months
Periodontal Surgery	Limitations apply based on service
Oral Surgery and Extractions	
General Anesthesia or IV Sedation	With covered oral surgery
Consultations	Once per specialty per 12 months
Inlays, Onlays, Crowns**	Once per permanent tooth in 60 months
Denture Repair or Adjustment	
Denture Reline or Rebase	Once per 24 months, per arch
Addition of Teeth to Partial Dentures	
Occlusal Guards	Once per lifetime, only within 6 months following Osseous Surgery

Class III Major Services – 50% In-Network / 50% Out-of-Network	
Complete and Partial Removable Dentures**	Once per arch per 60 months
Fixed Partial Dentures (Bridges)**	Once per arch per 60 months

Not Covered

Orthodontics Sealants Implants and Restorations over implants Cosmetic Treatments
TMJ/TMD Treatment, Therapy, Appliances

Deductible – None
Missing Tooth Clause – None
12 Month Billing Limitation
Waiting Periods – None
COB – Standard

**Porcelain and ceramic facings are not covered for posterior teeth, alternate benefit applies
**Prosthetics are considered on seat/delivery date

****Note – Quotes of benefits do not constitute a guarantee of payment. Covered benefits may have limitations or exclusions affecting plan payment. Refer to plan booklet for additional coverage details and limitation. Predetermination is strongly encouraged for all non-emergency dental treatment exceeding $300.00 in charges. The treatment plan should be submitted to ADN prior to beginning any treatment.**

National Vision Administrators, L.L.C.

Your NVA Vision Benefit Summary

Utica Community Schools (NVA2)

Effective 01/01/2026

Group Number #8169

Schedule of Vision Benefits

Benefit Frequency	Participating Provider	Non-Participating Provider
Examination Once Every Plan Year	▪ Covered 100% After $6.50 copay	Reimbursed Amount ▪ Up to $28.50 (OD) ▪ Up to $38.50 (MD)
Lenses Once Every Plan Year	Standard Glass or Plastic	
▪ Single Vision	▪ Covered 100% After $18 copay	▪ Up to $29
▪ Bifocal		▪ Up to $51
▪ Trifocal		▪ Up to $63
▪ Lenticular		▪ Up to $75
▪ Oversized	▪ Covered 100%	▪ N/A
▪ Rimless Mounting	▪ Covered 100%	▪ N/A
▪ Blended Bifocal (Segment)	▪ Covered 100%	▪ N/A
▪ Glass Photogrey	▪ Covered 100%	▪ N/A
▪ Transitions	▪ Covered 100%	▪ N/A
▪ Polarized	▪ Covered 100%	
▪ Single Vision		▪ Up to $18
▪ Bifocal		▪ Up to $30
▪ Trifocal		▪ Up to $38
▪ Lenticular		▪ Up to $44
▪ Tints	▪ Covered 100%	
▪ Single Vision		▪ Up to $4
▪ Bifocal		▪ Up to $10
▪ Trifocal		▪ Up to $12
▪ Lenticular		▪ Up to $14
Frame Once Every Plan Year	Retail Allowance ▪ Up to $65 (20% discount off balance)*	▪ Up to $44
Contact Lenses Once Every Plan Year	In lieu of Lenses & Frame	In lieu of Lenses & Frame
Elective Contact Lenses	▪ Up to $90 Retail① (15% discount (Conventional) or 10% discount (Disposable) off balance)**	▪ Up to $90
Medically Necessary***	▪ Covered 100%	▪ Up to $175

How Your Vision Care Program Works

Eligible members and dependents are entitled to receive a vision examination and one (1) pair of lenses and a frame or contact lenses once every plan year.

For your convenience, at the start of the program, you will receive two identification cards with participating providers in your zip code area listed on the back. At the time of your appointment, simply present your NVA identification card to the provider or indicate that your benefit is administered by NVA. The provider will contact NVA to verify eligibility. A vision claim form is not required at an NVA participating provider.

Be sure to inform the provider of your medical history and any prescription or over-the-counter (OTC) medications you may be taking.

To verify your benefit eligibility prior to calling or visiting your eye care professional, please visit our website at www.e-nva.com or download our mobile app by searching NVA Vision, or contact NVA's Customer Service Department toll-free at 1.800.672.7723, TTY: 711 or NVA's Interactive Voice Response (IVR). Customer Service is available 24 hours a day, 7 days a week, 365 days a year. Any question any time.

If you are not a registered subscriber, you can still search our providers online by selecting the "Find a Provider" link on our home page. Be sure to choose the NVA Network 2 vision plan from the drop down box and enter group number 8169000101 or the group number on the identification card and enter in your search parameters. It's that easy!

*Does not apply to Wal-Mart / Sam's Club locations or for certain proprietary brands. **Does not apply to Wal-Mart/Sam's Club, Contact Fill (NVA Mail Order) or certain locations at: Target, Sears, Pearle, & K-Mart and may be prohibited by some manufacturers. ***Pre-approval from NVA required.

①Additional professional services related to contact lenses (also known as fitting fees) would be included in the contact lens allowance shown above.

D Fixed prices/courtesy discount do not apply at Walmart/Sam's Club locations.

Lens options purchased from a participating NVA provider will be provided to the member at the amounts listed in the fixed option pricing list below:

- $50 Progressive Lenses Standard
- $100 Progressive Lenses Premium
- $10 Standard Scratch-Resistant Coating
- $12 Ultraviolet Coating
- $40 Standard Anti-Reflective
- $25 Polycarbonate (Single Vision)
- $55 High Index
- $30 Polycarbonate (Multi-Focal)

For lens options & services purchased from a participating NVA provider, NVA members will only pay the fixed maximum amount or the provider's Usual and Customary (U&C) charge less 20%, whichever is less. Options not listed will be priced by NVA providers at 20% off the Provider's Retail (U&C) price. Fixed prices are available in-network only. Discounts are not insured benefits. In certain states, members may be required to pay the full retail amount and not the negotiated discount amount at certain participating providers. Some optometrist affiliated with Optical Retail locations (i.e., Walmart, Visionworks, etc.) are independent providers and may not participate in the NVA program.

Get a Better View

Participating providers are not contractually obligated to offer sale prices in addition to outlined coverage. Regardless of medical or optical necessity, vision benefits are not available more frequently than specified in your policy.

Plan Specific Details Online: The NVA website is easy to use and provides the most up to date information for program participants:
-Locate a nearby participating provider by name, zip code, or City/State, Verify eligibility for you or a dependent
-View benefit program and specific detail, Review claims, Print ID cards (when applicable), Nominate a non-participating provider to join the NVA network

Examinations*:* The comprehensive exam includes case history, examination for pathology or anomalies, visual acuity (clearness of vision), refraction, tonometry (glaucoma test) and dilation (if professionally indicated).

Lenses: NVA provides coverage in full for standard glass or plastic eyeglass lenses.

Frames: Select any frame from the participating provider's inventory. Any amount in excess of your plan allowance is the member's responsibility. Frame choices vary from office to office. (Visit NVA's website to view the Benefit maximizer Program)

Contact Lenses: The contact lens benefit includes all types of contact lenses such as hard, soft, gas permeable and disposable lenses. Medically necessary contact lenses includes fitting and follow up and may be covered with prior authorization when prescribed for: post cataract surgery, correction of extreme visual acuity problems that cannot be corrected to 20/70 with spectacle lenses, Anisometropia or Keratoconus.

Non-Participating Providers: You will be responsible for one hundred percent (100%) of the cost at the time of service at a non-participating provider. You can request a claim form from NVA via the website www.e-nva.com or you may submit receipts along with a letter containing the member's full name, patient's full name, address, ID# and sponsoring organization to NVA, P.O. Box 2187, Clifton, NJ 07015.

Laser Eye Surgery: NVA has chosen **The National LASIK Network** to serve their members. This network was developed by **LCA Vision** in 1999 and is one of the largest panels of LASIK surgeons in the U.S. Members are entitled to significant discounts and a free initial consultation with all in-network providers.

Hearing Discount: You will receive up to 60% savings at participating provider locations through NationsHearing®.

Discounts: In addition to your funded benefit you are eligible to access the **EyeEssential® Plan discount** (in Network Only) on additional purchases during the plan period. Please see table for more detail regarding NVA's discount plan:

*Discount is not applicable to mail order; however, you may get even better pricing on contact lenses through Contact Fill.

Your NVA EyeEssential® Plan Discount – In Network Only

Service	Participating Provider	Lens Options
	Member Cost:	
Eye Examination:	Retail Less $10	$12 Solid Tint/ Gradient Tint
		$50 Standard Progressive Lenses
Contact Lens Fitting:	Retail Less 10%	$75 Polarized Lenses
		$65 Transitions Single Vision Standard
		$70 Transitions Multi-Focal Standard
Lenses:	Glass or Plastic	$15 Standard Scratch Coating
Single Vision	$35.00	$12 UV Coating
Bifocal	$55.00	$35 Polycarbonate
Trifocal or Lenticular	$70.00	$45 Standard Anti-Reflective
Frame:	Retail Less 35%	
Contact Lenses*:	**Member Cost:**	
Conventional	Retail Less 15%	
Disposable	Retail Less 10%	

Lens options purchased from a participating NVA provider will be provided to the member at the amounts listed in the fixed option price list above.

Options not listed will be priced by NVA providers at 20% off the Provider's Retail (U&C) price.

Wal-Mart / Sam's Club stores do not provide additional discounts.

Some optometrists affiliated with Optical Retail locations (i.e., Walmart, Visionworks, etc.) are independent providers and may not participate in the NVA program.

At NVA, We Work Only for Our Clients.

Insurance coverage provided by National Guardian Life Insurance Company (NGLIC), 2E Gilman, Madison, WI 53703. Policy NVIGRP 5/07. NGLIC is not affiliated with the Guardian Life Insurance Company of America, a/k/a The Guardian or Guardian Life. A full description of your coverage, its limitations, exclusions and conditions is contained in the Insurance Policy issued to your Plan Sponsor at its place of business. That full description in the form of a Certificate of Coverage can be made available to you by requesting it from your Plan Sponsor.

Exclusions / Limitations*:* No payment is made for medical or surgical treatments / Rx drugs or OTC medications / non-prescription lenses / two pair of glasses in lieu of bifocals / subnormal visual aids / vision examination or materials required for employment / replacement of lost, stolen, broken or damaged lenses/ contact lenses or frames except at normal intervals when service would otherwise be available / services or materials provided by federal, state, local government or Worker's Compensation / examination, procedures training or materials not listed as a covered service / industrial safety lenses and safety frames with or without side shields / parts or repair of frame / sunglasses.

National Vision Administrators, L.L.C. ▫ PO Box 2187 ▫ Clifton, NJ 07015
Web: www.e-nva.com ▫ Toll-Free: 1.800.672.7723
NVA® and EyeEssential® are registered marks of National Vision Administrators, L.L.C.

This document is intended as a program overview only and is not a certified document of the individual plan parameters.

COUNCIL 13 AFSCME UNION LABEL

GROUP LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE PROGRAM



GROUP LIFE INSURANCE

SCHEDULE OF BENEFITS

EFFECTIVE DATE: May 1, 2011, as amended in the Policy through July 1, 2015

ELIGIBLE CLASSES: Each active, Food Service Employee regularly working 2 to 3.5 hours per day, except any person employed on a temporary or seasonal basis.

WAITING PERIOD: 60 days of continuous employment.

INDIVIDUAL EFFECTIVE DATE: The first of the month following completion of the Waiting Period.

INDIVIDUAL REINSTATEMENT: Not Applicable

AMOUNT OF INSURANCE:

Basic Life: $8,000.

The Life amount will be reduced by any benefit paid under the Living Benefit Rider.

CHANGES IN AMOUNT OF INSURANCE: Increases and decreases in the Amount of Insurance because of changes in age, class or earnings (if applicable) are effective on the first of the Policy month coinciding with or next following the date of the change.

With respect to increases in the Amount of Insurance, you must be Actively At Work on the date of the change. If you are not Actively At Work when the change should take effect, the change will take effect on the day after you have been Actively At Work for one full day.

CONTRIBUTIONS: You are not required to contribute toward the cost of the Basic Insurance.

SCHEDULE OF BENEFITS

EFFECTIVE DATE: May 1, 2011, as amended in the Policy through July 1, 2015

ELIGIBLE CLASSES: Each active, Full-time Food Service Employee regularly working a minimum of 4 hours per day, except any person employed on a temporary or seasonal basis.

WAITING PERIOD: 60 days of continuous employment.

INDIVIDUAL EFFECTIVE DATE: The first of the month following completion of the Waiting Period.

INDIVIDUAL REINSTATEMENT: Not Applicable

AMOUNT OF INSURANCE:

Basic Life: $12,000.

The Life amount will be reduced by any benefit paid under the Living Benefit Rider.

CHANGES IN AMOUNT OF INSURANCE: Increases and decreases in the Amount of Insurance because of changes in age, class or earnings (if applicable) are effective on the first of the Policy month coinciding with or next following the date of the change.

With respect to increases in the Amount of Insurance, you must be Actively At Work on the date of the change. If you are not Actively At Work when the change should take effect, the change will take effect on the day after you have been Actively At Work for one full day.

CONTRIBUTIONS: You are not required to contribute toward the cost of the Basic Insurance.

GROUP ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

SCHEDULE OF BENEFITS

ELIGIBILITY: Each active, Food Service Employee regularly working 2 to 3.5 hours per day, except any person employed on a temporary or seasonal basis.

WAITING PERIOD: 60 days of continuous employment.

INDIVIDUAL EFFECTIVE DATE: The first of the month following completion of the Waiting Period.

INDIVIDUAL REINSTATEMENT: Not Applicable

AMOUNT OF INSURANCE: **PRINCIPAL SUM:**

INSURED PERSONS:

$8,000

CHANGES IN AMOUNT OF INSURANCE: Increases and decreases in the Amount of Insurance because of changes in age, class or Earnings (if applicable) are effective on the first of the Policy month coinciding with or next following the date of the change.

With respect to increases in the Amount of Insurance, you must be Actively at Work on the date of the change. If you are not Actively at Work when the change should take effect, the change will take effect on the day after you have been Actively at Work for one full day.

CONTRIBUTIONS: You are not required to contribute toward the cost of your insurance coverage.

SCHEDULE OF BENEFITS

ELIGIBILITY: Each active, Full-time Food Service Employee regularly working a minimum of 4 hours per day, except any person employed on a temporary or seasonal basis.

WAITING PERIOD: 60 days of continuous employment.

INDIVIDUAL EFFECTIVE DATE: The first of the month following completion of the Waiting Period.

INDIVIDUAL REINSTATEMENT: Not Applicable

AMOUNT OF INSURANCE: **PRINCIPAL SUM:**

INSURED PERSONS:

$12,000

CHANGES IN AMOUNT OF INSURANCE: Increases and decreases in the Amount of Insurance because of changes in age, class or Earnings (if applicable) are effective on the first of the Policy month coinciding with or next following the date of the change.

With respect to increases in the Amount of Insurance, you must be Actively at Work on the date of the change. If you are not Actively at Work when the change should take effect, the change will take effect on the day after you have been Actively at Work for one full day.

CONTRIBUTIONS: You are not required to contribute toward the cost of your insurance coverage.