NATIONAL ELEVATOR INDUSTRY HEALTH BENEFIT PLAN

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Summary of Material Modifications

November 2025

To: All Participants in the National Elevator Industry Health Benefit Plan, IUEC Local Unions, and Regional Directors

From: Robert O. Betts, Jr.
Executive Director for the Board of Trustees

IMPORTANT ANNOUNCEMENT CONCERNING YOUR DENTAL CARE BENEFIT!

The Summary of Material Modifications set forth below describes important changes to how the Plan's Dental Care Benefit program will be administered effective **January 1, 2026**.

OVERVIEW OF THE ADMINISTRATIVE CHANGES TO YOUR DENTAL CARE BENEFIT

- Currently, the Plan's Dental Care Benefit program is self-administered through the Plan's Dental Claims Department.
- Currently, the Plan's preferred dental provider network is Guardian Life Insurance Company of America's (Guardian) DentalGuard Preferred Select network.
- Effective January 1, 2026, the Plan's Dental Care Benefit program will be administered by Guardian. Guardian will adjudicate all dental claims and handle Member services related to the Plan's Dental Care Benefit program.
- Effective January 1, 2026, the Plan's preferred dental provider network will be Guardian's DentalGuard Preferred network, a preferred dental provider network that is broader than the Plan's current network. This broader network of preferred dental providers will deliver significant cost savings to members and the Plan.

The table below helps explain how this change will impact administration of the Plan's Dental Care Benefit program.

Old Dental Benefit Administration	New Dental Benefit Administration through Guardian Effective January 1, 2026
In General. The Plan's Dental Benefits program has been administered through the Plan's Benefits Office with Dental Benefit claims processed through the Plan's Dental Claims Department	**In General.** Effective **January 1, 2026**, the Plan's Dental Benefit program will be administered by **Guardian**.
Submitting Claims. A Member or Member's dental provider submitted claim forms to the Benefits Office.	**Submitting Claims**. Effective **January 1, 2026**, your dentist, whether in network or out-of-network, will submit claims directly to Guardian.
Processing Dental Claims. The Plan's Dental Claims Department processed Dental Benefit claims.	**Processing Dental Claims**. Effective **January 1, 2026**, Guardian will process all Dental Benefit claims.
Member Inquiries. ▪ To find an in-network dentist, a Member called Guardian or accessed Guardian's online **DentalGuard Preferred Select** network provider list. ▪ With respect to other Dental Benefit inquiries, a Member would contact the Benefits Office.	**Member Inquiries.** ▪ Beginning **January 1, 2026**, to find a dental provider in the **DentalGuard Preferred** network, you may: – Call Guardian at 833-634-3368, or – visit www.GuardianAnytime.com from your computer or smartphone.

	▪ Beginning **January 1, 2026**, if you have questions or need assistance regarding the Plan's Dental Benefit program in general, or have specific questions regarding a dental claim, you may call Guardian weekdays at 833-634-3368, 8:00 AM – 8:30 PM, EST or you may chat with a Guardian virtual assistant 24/7 about your dental benefits, dental claims inquiries, or for help using Guardian Anytime.
Online Tools and Information Regarding Dental Benefits. ▪ Members could access information about the Plan's Dental Benefit Program by visiting the NEI Benefit Plans website. See Dental » NEI Benefit Plans. ▪ The Plan's Dental Benefit program is set forth in full in the National Elevator Industry Health Benefit Plan Summary Plan Description (SPD). The SPD (and subsequent Summaries of Material Modifications (SMMs) including this SMM) serves as the Plan's official, governing document. See NEI-Health-Benefit-Plan-Summary-Plan-Descripton.pdf.	**Online Tools and Information Regarding Dental Benefits.** ▪ www.GuardianAnytime.com: Members will be able to view, download, and print materials by registering in **Guardian Anytime**. Once you sign up, you will be able to: – View, download, and print materials → Member Dental ID Card → Benefit Summaries → Forms – Check claim status – Receive email alerts when claims are paid or view information – Find a dental provider in **the DentalGuard Preferred** network through your computer or smartphone. ▪ Members may continue to access information about the Plan's Dental Benefit Program by visiting the NEI Benefit Plans website. See Dental » NEI Benefit Plans. ▪ The Plan's Dental Benefit program is set forth in full in the National Elevator Industry Health Benefit Plan Summary Plan Description (SPD). The SPD (and subsequent Summaries of Material Modifications (SMMs) including this SMM) serves as the Plan's official, governing document. See NEI-Health-Benefit-Plan-Summary-Plan-Descripton.pdf.
At the Dentist Office: A Member could present their NEI Health Benefit Plan ID Card or provide their name and plan number to their provider.	**At the Dentist Office:** **Beginning January 1, 2026**, you may present your **Guardian ID Card** or provide your name and **Guardian Group Number: 083746** to your dental provider. (Your Guardian ID Card is not required to obtain coverage). You can view and print an image of your Guardian ID Card at www.GuardianAnytime.com or directly from your smartphone with the GuardianAnytime Mobile app.
Claims Denial and Appeal: ▪ Initial Denial. If a Member's dental claim was denied, all or in part (**adverse benefit determination**), the basis for that adverse benefit determination was included in the Explanation of Benefits (**EOB**) the Member received from the Plan's Dental Claims Department. That EOB also notified the Member of his or her right to appeal this adverse benefit determination to the Plan's Board of Trustees or a committee of the Trustees. ▪ Appeal to the Trustees. A Member had the right to appeal the Plan's adverse benefit determination with respect to his or her dental claim to the Board of Trustees, or a committee of Trustees, who would consider the Member's appeal in accordance with the Plan's appeals procedures.	**Claims Denial and Appeal:** **Effective for dental claims incurred on or after January 1, 2026:** ▪ Initial Denial. If your dental claim is denied, all or in part (**adverse benefit determination**), the basis for that adverse benefit determination will be included in the Explanation of Benefits (**EOB**) you receive from **Guardian**. That EOB will also notify you of your right to appeal this adverse benefit determination to the Plan's Board of Trustees or a committee of the Trustees. ▪ Appeal of Denial of Dental Claims. The Trustees have delegated to Guardian the authority to review appeals of adverse benefit determinations of dental claims. If you exhaust your appeal rights with Guardian, and if Guardian denied your appeal, you may submit a voluntary appeal to the Trustees.

IMPORTANT: Although these are significant changes to <u>how</u> the Plan's Dental Benefit program will be administered. There are no changes to the schedule of Dental Benefits the Plan will continue to provide members.

SUMMARY OF MATERIAL MODIFICATIONS TO NATIONAL ELEVATOR INDUSTRY HEALTH BENEFIT PLANS SUMMARY PLAN DESCRIPTION

Effective January 1, 2026, the Plan's Dental Benefit will be administered by Guardian. The following modifications to the Plan's Summary Plan Description (SPD) reflect how these changes will impact how the Plan's Dental Benefit program will be administered.

- ***The first table below the Section "Important Contact Information" on page 6 of the SPD is amended to reflect the Plan's Dental Benefit program will be administered by Guardian:***

FOR INFORMATION ABOUT	CONTACT	PHONE NUMBER	WEBSITE
Life Insurance/Weekly Income	Benefits Office	1-800-252-4611	www.neibenefits.org
Medical/Behavioral Health Claims	Benefits Office	1-800-252-4611	www.neibenefits.org
Dental Care Benefits	Guardian	1-833-634-3368	www.GuardianAnytime.com
Vision Member Services	Benefits Office	1-800-252-4611	www.neibenefits.org
Hearing Care Benefits	TruHearing	1-844-547-5326	www.truhearing.com/neihbp/
Medical/Behavioral Health PPO Network	Blue Cross Blue	1-800-810-BLUE	www.bcbs.com
Precertification	Kepro	1-800-634-4832	N/A
Prescriptions—Pharmacy	Express Scripts	1-866-830-3890	www.express-scripts.com
Prescriptions—Home Delivery	Express Scripts	1-866-830-3890	www.express-scripts.com
Vision Care	EyeMed	1-877-226-1115	www.eyemedvisioncare.com
Virta Health (Type 2 Diabetes, Prediabetes, and Obesity Programs)	Virta Health		www.virtahealth.com/join/neibenefits
Social Security Disability Representation	Allsup, Inc.	1-800-383-2495	www.allsupinc.com

- ***Delete the second table ("ADDRESSES") on page 6 of the SPD in its entirety.***
- ***In the SPD's "Schedule of Health Benefits" section, amend the schedule of Dental Benefits (page 9) as follows:***

DENTAL BENEFITS

The Plan's Dental Benefits program is administered by **Guardian**, and Guardian's **DentalGuard Preferred** network is the Plan's preferred dental provider network.

You and your eligible dependents are eligible for Dental Benefits. The chart below shows the Plan's annual dental benefit deductible, the Plan's dental benefit Annual Maximum and Lifetime Maximum (orthodontia), and the amount of your coinsurance after you've met the annual dental benefit deductible. If you visit an in-network (Guardian DentalGuard Preferred PPO) provider, you are only responsible for amounts applied to your deductible and coinsurance. You cannot be balance billed for amounts above the contracted rate. If you visit an out-of-network provider for dental care, benefits are paid at the UCR Rate. You must pay any amount your out-of-network provider charges that exceeds the UCR Rate, in addition to any annual deductible and your coinsurance.

*For convenient access to important information about the Plan's Dental Benefits program, forms, your dental claims, dental providers in your area, and more, you're encouraged to register with **Guardian Anytime**. To register, go to signin.guardianlife.com/signin/.*

Visit www.GuardianAnytime.com to access information regarding the Plan's Dental Benefits program.

DENTAL BENEFITS		
Annual Deductible (Does not apply to preventive and diagnostic services	$50 per person or $100 per family	
Annual Maximum Amounts the Plan Will Pay	$2,000 per Covered Individual for Type II and Type III services	
	$2,000 per Covered Individual for dental implant procedures	
	No Annual Maximum for Covered Individuals ages 18 and under	
Lifetime Maximum Amount the Plan Will Pay for Orthodontia	Up to $2,500 per Covered Individual. Lifetime Maximum does not apply to pediatric Medically Necessary Orthodontia.	
Lifetime Temporomandibular Joint Dysfunction Benefit	$1,500 per Covered Individual	
	You Pay In-Network	**You Pay Out-Of-Network**
Exams *	$0	100% of amount over UCR Rate
Cleanings *	$0	100% of amount over UCR Rate
X-Rays *	$0	100% of amount over UCR Rate
Fluoride *	$0	100% of amount over UCR Rate
Sealants *	$0	100% of amount over UCR Rate
Fillings	20% of PPO contracted rate	20% of the UCR Rate plus amount over UCR Rate
Oral Surgery	20% of PPO contracted rate	20% of the UCR Rate plus amount over UCR Rate
Periodontics	20% of PPO contracted rate	20% of the UCR Rate plus amount over UCR Rate
Denture Repairs	20% of PPO contracted rate	20% of the UCR Rate plus amount over UCR Rate

Crowns & Inlays	30% of PPO contracted rate	30% of the UCR Rate plus amount over UCR Rate
Full or Partial Dentures or Bridges	30% of PPO contracted rate	30% of the UCR Rate plus amount over UCR Rate
Implants	30% of PPO contracted rate	30% of the UCR Rate plus amount over UCR Rate
Braces (Orthodontics)	Up to $2,500 paid in installment payments every 90 days for up to two years while receiving active treatment ($2,500 Lifetime Maximum does not apply to pediatric Medically Necessary Orthodontia)	

**** Services do not apply to Annual Dental Maximum***

➢ ***Replace in its entirety, the SPD's section currently titled "Dental Care" (pages 51 - 56) as follows:***

Dental Benefits

Healthy teeth and gums are an important party of your overall health. That's why the Health Benefit Plan provides a comprehensive dental benefit program administered by Guardian Life Insurance Company of America (Guardian). To maximize cost savings for you and your Health Benefit Plan, you should choose to visit a Dentist in Guardian's nationwide DentalGuard Preferred PPO network; however, the Health Benefit Plan also offers you the flexibility to choose a Dentist outside of the DentalGuard Preferred PPO network.

FAST FACTS:

WHAT ARE TYPE I, TYPE II AND TYPE III SERVICES?

Type I services are preventive and diagnostic, such as cleaning and x-rays. Type II services include fillings and root canal work. Type III services include tooth repair, crowns and dentures. For a more complete listing, see below.

- **Your dental benefits program provides coverage for the care and treatment of the teeth and gums, including:**
  - **Preventive and diagnostic services such as cleaning, fluoride treatment, oral exams, sealants, and x-rays;**
  - **Restorative services, extractions, oral surgery, bridgework and dentures; and**
  - **Orthodontia services and supplies.**
- **The Plan's Dental Benefit program is administered by Guardian.**
- **The Plan's Preferred Dental Provider Network is Guardian's DentalGuard Preferred PPO Network.**
- **Your Dentist, whether in network or out-of-network, submits claims directly to Guardian.**
- **"Guardian Anytime" makes it easy and convenient for you to access your dental benefits online, anytime anywhere. To register with Guardian Anytime:**
  - **Go to www.guardianlife.com/signin/**
  - **Choose "Register" and select "Guardian Anytime"**
  - **Select "member" for yourself or "child or spouse" for your dependents**
  - **Complete the self-registration process, click "Submit" and you're done.**

YOUR DENTAL BENEFITS AT-A-GLANCE

Annual Deductible	Per person—$50; Per family—$100
Annual Maximums (excluding orthodontia)	$2,000 per Covered Individual for Type II and Type III services
	$2,000 per Covered Individual for dental implant procedures
	No Annual Maximum for Covered Individuals ages 18 and under
Lifetime Maximum Orthodontia Benefit	$2,500
Preventive and Diagnostic Services	No deductible applies
Lifetime Temporomandibular Joint Dysfunction (TMJ) Benefit	$1,500

	THE PLAN PAYS (PPO DENTIST)	YOU PAY (PPO DENTIST)	THE PLAN PAYS (OUT-OF-NETWORK PROVIDER)	YOU PAY (OUT-OF NETWORK PROVIDER)
Type I Services (diagnostic and preventive)	100% of contracted rate	$0	100% of the UCR Rate	The difference between the UCR Rate and the amount your provider charges
Type II Services (minor restorative)	80% of contracted rate	20% of the contracted rate; deductible applies	80% of the UCR Rate	20% after deductible, plus the difference between the UCR Rate and the amount your provider charges
Type III Services (major restorative)	70% of contracted rate	30% of the contracted rate; deductible applies	70% of the UCR Rate	30% after deductible, plus the difference between the UCR Rate and the amount your provider charge
Dental Implant Procedures	70% of contracted rate	30% of the contracted rate; deductible applies	70% of the UCR Rate	30% after deductible, plus the difference between the UCR Rate and the amount your provider charges
Orthodontia	Benefits are paid, up to the $2,500 Lifetime Maximum benefit, in equal installments while in active treatment every 90 days for up to two years. Medically Necessary services for Covered Individuals age 18 and under are not subject to the Lifetime Maximum.			

GUARDIAN DENTALGUARD PREFERRED PPO NETWORK

Providers in the Guardian DentalGuard Preferred PPO Network have agreed to accept the Guardian's contracted rate for covered services as payment in full—you're not responsible for paying the difference between what the provider charges and what the Plan pays, except for your applicable coinsurance based on that rate.

Finding a Guardian DentalGuard Preferred PPO Network Provider

To find a dental provider in the DentalGuard Preferred Network, you may:

- Call Guardian at 833-634-3368 or
- visit www.GuardianAnytime.com from your computer or smartphone.

OUT-OF-NETWORK CARE

If you visit a provider that does not participate in the Guardian DentalGuard Preferred PPO Network, the Plan will pay for your covered dental expenses based on the UCR Rate. If your provider charges more than the UCR Rate, you will be responsible for paying the difference, as well as any coinsurance.

In-Network vs. Out-of-Network

The chart below shows the differences between using an in-network and an out-of-network provider for dental care:

	GUARDIAN DENTALGUARD PREFERRED PPO NETWORK	OUT-OF-NETWORK
Dentist's charge for a root canal (minor restorative)	**$510***	**$1,050***
Plan-negotiated amount for service	**$450***	**$1,000 is the UCR Rate***
Plan pays 80% after deductible	**$360**	**$800**

Amount applied toward your Annual Dental Maximum	**$360**	**$800**
Amount you pay	**20% of the PPO contracted rate: $90**	**20% of the UCR Rate: $200, *plus* $50 (the difference between the actual charges and the UCR Rate), for a total of $250**
***** *Amounts shown in example is for illustrative purposes only. Actual amounts will vary according to your dental care provider and location.*		

COVERED DENTAL EXPENSES

Covered dental expenses are the services or supplies listed on the following pages that are covered by the Plan. The service or supply must be necessary and given by a Dentist or Physician for the treatment of a Covered Expense. When options are available for a particular dental procedure, the Plan will cover the expense of the least costly professionally adequate procedure even if a more costly one is used.

Expenses (excluding Orthodontia) are considered incurred as of the date the service is rendered or the supply is furnished, except:

- With respect to fixed bridgework, crowns, inlays, onlays or gold restorations, the service is considered incurred on the first date of preparation of the tooth or teeth involved;
- With respect to full or partial dentures, the service is considered incurred on the date the impression was taken; and
- With respect to endodontics, the service is considered incurred on the date the tooth was opened for root canal.

Dental Annual Maximum

- The maximum amount payable by the Plan for Covered Expenses for Type II and Type III services (see below) is $2,000 per Covered Individual per calendar year.
- The Plan applies a separate annual maximum of $2,000 per Covered Individual per calendar year for Dental Implant Procedures.
- *These annual maximums do not apply to Covered Individuals ages 18 and under.*

Lifetime Maximum for Orthodontia

The Plan also applies a separate Lifetime Maximum of $2,500 per Covered Individual for Orthodontia. The Orthodontia Lifetime Maximum does not apply to Medically Necessary Orthodontia for Covered Individuals who are age 18 and under. Precertification is required for Medically Necessary Orthodontia.

Preventive and Diagnostic Services (Type I)

- Cleaning and scaling of teeth (prophylaxis) twice a calendar year.
- Periodontal cleaning of teeth twice a calendar year.
- Emergency treatment (palliative) for dental pain when no other treatment except x-rays is provided.
- Fluoride treatment or application to a dependent Child's teeth once in a calendar year.
- Oral exams twice a calendar year.
- Space maintainers and their fittings.
- X-rays needed to diagnose a dental problem or to check the progress of treatment. Examples of Type I x-rays are:
  - Bitewing x-rays twice a calendar year.
  - Full-Mouth x-rays and panoramic x-rays once every three years to the day.
  - Single tooth (periapical) x-rays.
- Dental sealants are covered once every five years for permanent molars only.

Restorative Services (Type II)

- Cutting procedures in the mouth.
- Extractions or oral surgery.
- Fillings consisting of composite, plastic, porcelain, silicate, or silver (amalgam).
- General anesthesia for oral surgery or treatment of fractures and dislocations.
- Relining or rebasing dentures that are performed at least six months after the denture was originally installed. (Charges for relining or rebasing performed less than six months after the denture was originally installed are usually covered in the cost of the denture.)
- Repairs to bridges, crowns, dentures and inlays that are performed at least six months after the item was originally installed. (Charges for repairs less than six months after the item was originally installed are usually covered in the cost of the item.)
- Root canal work (endodontia).

- Treatment of the gums (periodontia).

Major Services (Type III)

- Adding teeth to fixed bridgework or partial dentures to replace missing natural teeth.
- Crowns to repair a tooth that is damaged by decay, injury, or to replace a crown that was installed at least five years before and cannot be repaired.
- Full or partial dentures to replace missing or natural teeth, or when the prior denture was installed at least five years before and cannot be repaired. The maximum covered expense for a permanent denture when replacing a temporary denture is limited to the charge for the permanent denture.
- Inlays to repair a tooth that is damaged by decay, injury, or when the prior inlay was installed at least five years before and cannot be repaired.

Dental Implant Procedures

- Dental implants, when necessary, but not more often than once every five (5) years.

Predetermination

To assist you in managing your total costs, the Plan, through Guardian, offers a predetermination of benefits. Dentists may submit their treatment plan to Guardian for review and an estimate of coverage before procedures are started. Guardian will advise your Dentist regarding the services that will be covered and your potential out-of-pocket costs. The actual payment for these predetermined services depends on eligibility, any Plan limitations, coordination of benefits and the remaining maximum at the time services are performed. A predetermination plan is subject to change based on the Dentist's network participation status at the time of treatment. Once issued, a predetermination plan is valid for 180 days. You are not required to obtain a predetermination of benefits, but it is strongly recommended for dental services expected to exceed $500.

For information regarding Guardian's predetermination services, your Dentist may call Guardian's Provider Services at (800) 541-7846 or visit www.GuardianAnytime.com.

Temporomandibular Joint Dysfunction (TMJ)

Benefits are payable for covered Temporomandibular Joint Dysfunction (TMJ) treatment or services. Covered Expenses are those charges made by a Dentist for services or supplies in connection with surgical or non-surgical treatment of TMJ. Surgical treatment of TMJ may also be covered as a medical expense after the TMJ Lifetime Maximum of $1,500 is met. Charges for non-surgical services or supplies in excess of the TMJ Lifetime Maximum of $1,500 are not covered.

Orthodontia

Benefits are payable for Orthodontia treatment or services up to an Orthodontia Lifetime Maximum of $2,500 per Covered Individual. Medically Necessary Orthodontia services for Covered Individuals age 18 and under are not subject to the Orthodontia Lifetime Maximum. Precertification is required in order for Orthodontia services to be considered Medically Necessary.

For information regarding precertification of Orthodontia treatment and services, your provider should call Guardian's Provider Services at (800) 541-7846..

How Orthodontia Benefits are Paid

Benefits for an entire course of treatment will be paid in equal installments every 90 days. These installments will be made during the course of active treatment or over a two-year period, whichever is less. Benefits are calculated by dividing the Covered Expenses by the number of 90-day treatments. You must be covered on the first day of the 90-day period to receive benefits for that period. The first 90-day period starts on the date an appliance is installed. Your Orthodontist should send written verification of treatment to Guardian every 90 days for the benefit to be paid. Orthodontia benefit claims will not be paid without written verification of active Orthodontia treatment from the Orthodontist.

FILING DENTAL CLAIMS

To submit claims to Guardian, your dental care provider may submit claims to Guardian by electronic claims submission: Payor ID: 64246, or by mail:

Guardian Dental Claims
P.O. Box 981572
El Paso, TX 79998-1572

WHAT'S NOT COVERED

The following dental services are not covered by the Health Benefit Plan:

Additional charges for adjustment within six months from installation of a denture or bridge.

- Any service or treatment performed by someone other than a Dentist, Orthodontist, Physician or dental technician under the direct supervision of a Dentist or Physician.
- Any service performed or supply provided to increase the distance between the nose and chin (vertical dimension) or restore occlusion, except for appliances to correct TMJ, other than in connection with the moving of teeth.
- Any service, unless otherwise indicated, not performed to enhance the performance of a natural tooth or covered prosthetic.
- Facings or veneers on molar crowns or molar false teeth.
- Fluoride treatment or application for anyone who is not a dependent Child.
- Mandibular repositioning appliances (orthotics).
- Precision attachments.
- Special techniques that are not considered standard dental treatment.
- Special or non-standard work on a bridge, crown, denture, or inlay.
- Study models for other than Orthodontia service, TMJ services, bridgework and full or partial dentures.
- Tooth bleaching.
- Topical analgesic, as a separate charge when restorative procedures are performed.
- Training or supplies used for dietary counseling, oral hygiene or plaque control.

Other exclusions that may apply to these benefits are listed under the section entitled "What's Not Covered" on page 70.

➢ ***The table below "Filing Your Claims" on page 75 of the SPD is amended to indicate Guardian will be processing Dental Claims:***

In-Network and Out-of-Network Medical, Mental Health, and Substance Use Disorder Claims (Except Medicare Primary Claims)	Your Local BCBS Plan
Medicare Secondary Claims	National Elevator Industry Health Benefit Plan P.O. Box 910 Newtown Square, PA 19073-0901
Non-BCBS Medical Claims	National Elevator Industry Health Benefit Plan P.O. Box 477 Newtown Square, PA 19073-0477
In-Network and Out-of-Network Dental Claims	Dental Provider submits claims: ▪ Mailing Address: Guardian Dental Claims P.O. Box 981572 El Paso, TX 79998-1572 ▪ Electronic Claim Submission: Payor ID: 64246
Weekly Income Benefit and Non-EyeMed Vision Claims	National Elevator Industry Health Benefit Plan P.O. Box 476 Newtown Square, PA 19073-0476
Life Insurance and Accidental Death and Dismemberment Claims	National Elevator Industry Health Benefit Plan 19 Campus Blvd., Suite 200 Newtown Square, PA 19073 Attn: Eligibility Unit
Prescription Drug Claims	Express Scripts Attn: Benefit Coverage Review Department, PO Box 66587 St Louis, MO 63166-6587

- ***The Section "Claims and Appeals Procedures for Most Health Benefit Claims" is amended by deleting "dental" in the first bullet point under the heading "Overview."***
- ***Immediately preceding the Section "Claims and Appeals Procedures for Prescription Drug Claims" add a new Section—"Claims Procedures for Dental Benefit Claims"***

CLAIMS PROCEDURES FOR DENTAL BENEFIT CLAIMS

Overview

As the Plan's Dental Benefit program administrator, Guardian has agreed to be responsible for reviewing initial Dental Benefit claims submitted by dental providers of Covered Individuals. In addition, the Trustees have delegated to Guardian the authority to review appeals of Adverse Benefit Determinations of Dental Benefit claims. Guardian has agreed that it will process all initial Dental Benefit claims and appeals in accordance with the Department of Labor's Claims Procedure Regulations and will be the appropriate named fiduciary of the Plan in accordance with the provisions of the Claims Procedure Regulations that govern appeals of Adverse Benefit Determinations.

As noted above, the initial determination of any claim, *including a Dental Benefit claim*, that involves a determination of whether an individual is a Covered Individual eligible for benefits under the Plan shall be determined by the Benefits Office in accordance with the procedures described above, and the appeal of any adverse determination of any such claim shall be reviewed by the Trustees, or designated committee of the Trustees.

If Guardian Denies Your Claim for Dental Benefits

If Guardian denies your dental benefit claim, in whole or in part, Guardian will provide you with a written or electronic Explanation of Benefits notice (EOB) that states the reasons for the denial, refers to any pertinent Plan provisions, rules, guidelines, protocols or other similar criteria used as a basis for the denial, describes any additional material or information that might help your claim, and describes Guardian's appeals procedures.

Upon receiving an EOB from Guardian that is an Adverse Benefit Determination as defined above, you are entitled to receive from Guardian, upon request and free of charge, copies of documentation and other relevant information related to your dental claim. You have the right to appeal the Adverse Benefit Determination by writing Guardian within 180 days of receipt of the EOB. Your written appeal should be filed at the following address:

Guardian Dental Claims Appeals
Attention: Appeals Department
P.O. Box 981572
El Paso, TX 79998-1572

Guardian will review and notify you of its decision on appeal within 60 (Disability appeals within 45) days after receipt of your request. You have the right to bring a civil action under ERISA Section 502(a) following Guardian's adverse determination on appeal.

Your written appeal should state your name and address, the date of Guardian's denial, the fact that you are appealing the denial and the reasons for your appeal. You should also submit any documents that support your claim. The review of your dental claim will take into account all comments and documents that support your position, even if Guardian did not have this information in making its initial determination. This does not mean that you are required to cite all of the Plan provisions that apply or to make "legal" arguments; however, you should state clearly why you believe you are entitled to the benefit you claim. Guardian can best consider your position if they clearly understand your claims, reasons and/or objections.

Content of Notifications of Decisions on Appeal

If Guardian denies your appeal, in whole or in part, you will be provided with a written notice of denial. Guardian's notice will state:

- Sufficient information to identify the claim involved, including where applicable, the date of service of the benefits denied, the health care provider, the claim amount, and the right to receive upon request the diagnosis code, treatment code, and the meanings of these codes;
- The reason(s) for the denial of the claim (including the denial code and its corresponding meaning) and a discussion of the decision or Rescission;
- A description of any standard used to deny your claim;
- References to the specific Plan provisions on which the benefit determination or Rescission was based;

- If an internal rule or guideline was relied upon in denying your claim or rescinding your coverage, either a copy of the rule or guideline or a statement that you have the right to receive a free copy of the internal rule or guideline upon request;
- If the denial is based on Medical Necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the decision, applying the terms of the Plan to your medical circumstances, or a statement that this will be provided free of charge upon request;
- The identification of any medical or vocational experts whose advice was obtained in connection with the benefit determination, regardless of whether the advice was relied upon in making the benefit determination;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits;
- A description of the external review process, including information on how to initiate an external review and applicable time limits;
- A statement of the right to bring a civil action under Section 502(a) of ERISA;
- If applicable, disclosure of the availability of, and the contact information for, any applicable office of health insurance consumer or ombudsman established under the Public Health Service Act Section 2793.

TRUSTEE REVIEW OF DENTAL BENEFIT CLAIMS (VOLUNTARY APPEALS)

If you exhaust your appeal rights with Guardian, and if Guardian denied your Dental Benefit appeal, you may submit a voluntary appeal to the Board of Trustees. Your appeal will be considered by the Trustees or a designated committee of Trustees during the Board of Trustees' next regularly scheduled meeting, except in the case of an expedited appeal, which will be considered by the Trustees as soon as possible. The Board of Trustees encourages all participants to take advantage of this voluntary level of review to ensure that all issues relating to your Dental Benefit claim are resolved appropriately.

Your written voluntary appeal should state your name and address, the date of the denial by Guardian, the fact that your are appealing the denial, and the reasons for your appeal. You should also submit any documents that support your claim. The review of your claim will take into account all comments and documents that support your position. This does not mean that you are required to cite all of the Plan provisions that apply or to make "legal" arguments; however, you should state clearly why you believe you are entitled to the dental benefit you claim. The Trustees can best consider your position if they clearly understand your claims, reasons and/or objections.

As required by regulation, the Plan:

- Waives any right to assert that you have failed to exhaust administrative remedies because you did not elect to submit your claim to the Board of Trustees after you exhausted your appeal rights with Guardian;
- Agrees that any statute of limitations or other defense based on timeliness is tolled during the time that such voluntary appeal is pending; and
- Will not require you to pay any fees or costs associated with the voluntary review.

You may submit your dental claim for voluntary review only after exhausting all prior available levels of review, and the decision of whether to submit your claim for a voluntary review will have no effect on your rights to any other benefits under the Plan.

The Plan will provide you, upon request, sufficient information regarding the voluntary appeals process to enable you to make an informed judgment about whether to submit a voluntary appeal.

The decision of the Trustees on voluntary review is final and finding upon all parties including any person claiming a benefit on your behalf. The Board of Trustees has full discretion and authority to determine all matters relating to the benefits provided under the Plan, including, but not limited to all questions of coverage, eligibility, and methods of proving or arranging benefits. If the Trustees deny your appeal of a dental claim, and you decide to seek judicial review, the Trustees' decision shall be subject to limited judicial review to determine only whether the decision was arbitrary and capricious.