Keep this Packet

BENEFIT SUMMARY

MAJOR MEDICAL

DENTAL

BASE LIFE

OPTIONAL LIFE

DISABILITY

Voluntary Accident

Voluntary Cancer/Critical Illness

401K

Effective 12/1/2022

EMPLOYEE BENEFITS

Weekly Premiums

Medical	Individual	Employee + Spouse	Employee + Children	Family
- PA Inside Advantage & Ohio PPO Option	$31.26	$78.92	$72.07	$88.25
- PA EPO Option	$43.11	$108.85	$99.40	$121.73
Dental	$1.89	$4.25	$4.54	$6.29
Accident	$4.28	$6.22	$8.65	$10.82
Cancer/ Intensive Care - Low Option	$3.61	$5.75	$4.96	$7.09
- Median Option	$5.63	$8.79	$7.87	$11.03
- High Option	$7.28	$11.46	$10.32	$14.50

Critical Illness

Low Plan - $10,000 Basic Benefit Amount

non-tobacco		
Ages	EE & EE+Child	EE+ SP & F
18-35	$0.89	$1.29
36-50	$2.18	$3.21
51-60	$4.53	$6.74
61-63	$7.47	$11.15
64+	$11.84	$17.70

tobacco		
Ages	EE & EE+Child	EE+ SP & F
18-35	$1.28	$1.87
36-50	$3.43	$5.09
51-60	$7.28	$10.87
61-63	$11.23	$16.79
64+	$17.93	$26.84

High Plan - $20,000 Basic Benefit Amount

non-tobacco		
Ages	EE & EE+Child	EE+ SP
18-35	$1.43	$2.08
36-50	$4.00	$5.94
51-60	$8.69	$12.99
61-63	$14.57	$21.81
64+	$23.32	$34.92

tobacco		
Ages	EE & EE+Child	EE+ SP
18-35	$2.20	$3.25
36-50	$6.49	$9.68
51-60	$14.21	$21.26
61-63	$22.09	$33.08
64+	$35.49	$53.18

Semi-Monthly Premiums

Medical	Individual	Employee + Spouse	Employee + Children	Family
- PA Inside Advantage & Ohio PPO Option	$62.52	$157.84	$144.14	$176.50
- PA EPO Option	$86.22	$217.70	$198.80	$243.46
Dental	$ 3.78	$8.50	$ 9.08	$12.58
Accident	$8.56	$12.44	$17.30	$21.64
Cancer/ Intensive Care				
- Low Option	$7.22	$11.50	$9.92	$14.18
- Median Option	$11.26	$17.58	$15.74	$22.06
- High Option	$14.56	$22.92	$20.64	$29.00

Critical Illness

Low Plan - $10,000 Basic Benefit Amount

non-tobacco		
Ages	EE & EE+Child	EE+ SP & F
18-35	$1.78	$2.58
36-50	$4.36	$6.42
51-60	$9.06	$13.48
61-63	$14.94	$22.30
64+	$23.68	$35.40

tobacco		
Ages	EE & EE+Child	EE+ SP & F
18-35	$2.56	$3.74
36-50	$6.86	$10.18
51-60	$14.56	$21.74
61-63	$22.46	$33.58
64+	$35.86	$53.68

High Plan - $20,000 Basic Benefit Amount

non-tobacco		
Ages	EE & EE+Child	EE+ SP & F
18-35	$2.86	$4.16
36-50	$8.00	$11.88
51-60	$17.38	$25.98
61-63	$29.14	$43.62
64+	$46.64	$69.84

tobacco		
Ages	EE & EE+Child	EE+ SP & F
18-35	$4.40	$6.50
36-50	$12.98	$19.36
51-60	$28.42	$42.52
61-63	$44.18	$66.16
64+	$70.98	$106.36

Contact Information

MAJOR MEDICAL:

UPMC
Customer Service: 1-866-884-8579
www.upmchealthplan.com.

DENTAL:

Concordia Dental
Customer Service: 1-800-332-0366
https://www.deltadentaltn.com

BASE LIFE:

Cigna
Customer Service: 1-800-977-1654
https://www.cigna.com/

OPTIONAL LIFE:

Cigna
Customer Service: 1-800-977-1654
https://www.cigna.com/

LONG TERM DISABILITY:

Cigna
Customer Service: 1-800-977-1654
https://www.cigna.com/

Base Life Insurance

Accidental Death & Dismemberment

Cigna

Your employer provides, **at no cost to you**, a Basic Life and Accidental Death & Dismemberment Insurance Plan for eligible employees.

- Life **Benefit Amount is** equal to 2 times your Base Annual Earnings. Accidental Death & Dismemberment amount the same.
- Your amount of Life and Accidental Death & Dismemberment Insurance reduces to 75% when you reach age 70 and to 50% when you reach age 75.

Optional Life

Cigna

You have the opportunity through payroll deduction, to purchase Term Life insurance that can supplement the employer paid Base Life coverage. The cost is based on your age and the amount of coverage you elect.

Coverage Details:

Benefit Amounts-Employee Only:

- Employee may elect life insurance in $5,000 increments. Coverage is subject to a minimum of $5,000 and a maximum of $1,000,000 . Guarantee issue amount is up to $400,000 at initial enrollment.

Spouse Coverage:

- You may elect Spouse Life Insurance in $5,000 increments subject to a maximum of 50% of your elected Life Insurance benefit or $100,000. Guarantee issue amount of $30,000 at initial enroll-ment.

Dependent Children:

- Minimum Benefit $10,000 to a Maximum Benefit of $10,000. Include those 14 days old, up to age 26 if a full-time student.

Short Term Disability

Cigna

Your employer provides a Short Term Disability plan. This plan will provide you with 60% of your monthly base earnings.

- Starts the 8th day of your disability
- Last for 180 days
- Cost covered 100% by Employer

Long Term Disability

Cigna

Your employer provides a Long Term Disability plan. This plan will provide you with 60% of your Total Monthly Base Earnings to a maximum benefit of $10,000.

- Benefits are payable to your Normal Retirement Age or until you are no longer disabled
- Starts on 181st day of disability
- Minimum monthly benefit is $100
- Cost covered 100% by Employer

401k

Principal

Your employer helps you save for retirement by providing a 401K plan. In addition to the plan, your employer will match 50% of the first 5% you contribute. For example, you contribute 5%, Miller puts in 2.5%. All employees are automatically enrolled at 5% if not specified otherwise.

401K plan:

- Employer match
- Pre-tax savings
- No tax on the growth
- Payroll Deduction
- Your money is always yours—company contribution vest at 100% after 5 years of service
- Eligible after 90 days of employment

Accident Plan

Allstate

Guarantee Issue: No evidence of insurance is required at initial enrollment

Accident Plan—includes Routine Physician Reimbursement of $100 routine Physician reimbursement is limited to 2 person and 4 family for any Physician.
Visit including Dental, Eye, Routine, OBGYN, and Pediatrician to name a few.

***Key Benefits Include**:*

Physician Treatment	*$150*
Emergency Room Services	*$300*
X-rays	*$300*

Plan pays per incident with no limits each year
Pays for visits to Emergency Room/Urgent Care Facilities/Physician Office

Cancer/Intensive Care

Allstate

Guarantee Issue: No Evidence of insurance is required at initial enrollment

$100 Wellness Reimbursement for annual health screenings for each family member covered.
Some of the screenings covered are; Pap Smear/Test, Mammogram, PSA Test, Colonoscopy, Blood test for triglycerides, Echocardiogram, EKG, Lipid Panel (total cholesterol count), stress test on bike or treadmill and HPV.

***Intensive Care Coverage**: For any reason admitted into ICU including; Heart Issues Strokes/Accidents*
Cancer coverage: Radiation, chemotherapy, anesthesia and medical imaging

Critical Illness

Allstate

Option to enhance Cancer/ICU

Heart Attack, Stroke, Coronary Artery Bypass Surgery, End-Stage Renal Failure & other Critical Illnesses
$25 Wellness Screening Benefit

Miller Industries PA

Health Reimbursement Arrangement (HRA)

Plan Year: December 01, 2022 thru November 30, 2023

The Health Reimbursement Arrangement (HRA) account reimburses the In-Network deductible under the Miller Industries PA health care plan according to the HRA Plan.

Any Miller Industries PA employee who participates in the company health care plan with UPMC Health Plan is eligible.

The HRA account will reimburse expenses that are applied to the $8,150.00 individual/ $16,300.00 family In-Network deductible after the employee pays the first $750.00 for an individual plan or $ 1,500.00 for a family plan. Charges that are not eligible and denied by UPMC Health Plan are not covered under this plan.

Copayments will be $30.00 for Primary Care Physicians (PCP) and $60.00 for Specialist.

There is an urgent care clinic available for minor injuries and other medical conditions that is not severe enough for the hospital emergency room but needs to be addressed right away; they are located at UPMC Urgent Care, 1075 North Hermitage Road, Hermitage PA 16148. Hours are 9am to 9pm, 7 days a week.

Copays for prescriptions will change to $15/$40/$80/$95.00. You will pay the lowest copay when your prescription is filled with a generic on the formulary list. Some prescriptions require prior authorization. A complete list is available on UPMC Health Plan website. The website address is www.upmchealthplan.com and click on Members. Prescription copay differences are NOT reimbursed under the HRA Plan.

Miller Industries PA has contracted with the UPMC Health Plan to handle all claims processing for your HRA account. If you have any questions regarding claims, please contact UPMC Health Plan or Human Resources.

Dental will renew 01/01/2021, the deductibles will reset at $25.00 for individuals and $75.00 for family. Also, the annual program maximum is $1,000.00 per person.

PA Residents Only

UPMC Health Plan

Schedule of Benefits

UPMC Inside *Advantage*
EPO IA $5,000 $30/$60 - Premium Network
Deductible: ~~$5,000 / $10,000~~
Coinsurance: 0%
Total Annual Out-of-Pocket: ~~$8,150 / $16,300~~

Primary Care Provider: $30 Copayment per visit
Specialist: $60 Copayment per visit
Emergency Department: $150 Copayment per visit
Urgent Care Facility: $75 Copayment per visit
Rx: $15/$40/$80/$95

This Schedule of Benefits will be an important part of your Certificate of Coverage (COC) or your Summary Plan Description (SPD). If your plan has an SPD, it is issued by your employer or labor trust fund. It is not issued by UPMC Health Plan. It is important that you review and understand your COC and/or SPD because they describe in detail the services your plan covers. The Schedule of Benefits describes what you pay for those services.

For Covered Services to be paid at the level described in your Schedule of Benefits, they must be Medically Necessary.

They must also meet all other criteria described in your COC and/or SPD. Criteria may include Prior Authorization requirements.

Please note that your plan may not cover all of your health care expenses, such as Copayments and Coinsurance. To understand what your plan covers, review your COC and/or SPD. You may also have Riders and Amendments that expand or restrict your benefits.

If you have any questions about your benefits, or would like to find a Participating Provider near you, visit **www.upmchealthplan.com**. You can also call UPMC Health Plan Member Services at the phone number on the back of your member ID card.

For more information on your plan, please refer to the final page of this document.

Plan Information	UPMC Inside *Advantage* Network Benefit Level 1	Other Participating UPMC Facilities Level 2
Benefit Period	Plan Year	
Primary Care Provider (PCP) Required	Encouraged, but not required	
Prior Authorization Requirements	Provider Responsibility	

Member Cost Sharing	UPMC Inside *Advantage* Network Benefit Level 1	Other Participating UPMC Facilities Level 2
Level 1 means you receive the highest level of benefits and have the lowest Out-of-Pocket costs. Level 1 includes all UPMC providers and UPMC-owned facilities along with many community owned providers and facilities. At Level 2 your Out-of-Pocket costs may increase. Level 2 includes many UPMC contracted facilities and the services affiliated with the contracted facilities such as laboratory and pathology tests, x-ray, MRI therapy services, etc. If you have questions regarding your Benefit Levels, contact Member Services at the phone number on the back of your member ID card.		
Annual Deductible		
Individual	~~$5,000~~	~~$7,000~~
Family	~~$10,000~~	~~$14,000~~

Member Cost Sharing	UPMC Inside *Advantage* Network Benefit Level 1	Other Participating UPMC Facilities Level 2
Your plan has an embedded Deductible, which means the plan pays for Covered Services in these two scenarios — whichever comes first: *When an individual within a family reaches his or her individual Deductible. At this point, only that person on the plan is considered to have met the Deductible; OR *When a combination of family members' expenses reaches the family Deductible. At this point, all covered family members are considered to have met the Deductible. - If you receive services at Benefit Level 1 providers or facilities, amounts applied to the Deductible listed at Benefit Level 1 will also apply to the Deductible listed at Benefit Level 2. - If you receive services at Benefit Level 2 providers or facilities, amounts applied to the Deductible listed at Benefit Level 2 will also apply to Benefit Level 1.		
Deductible applies to all Covered Services you receive during the Benefit Period, unless the service is specifically excluded.		
Coinsurance		
	You pay $0 after Deductible.	You pay 35% after Deductible.
	Copayments may apply to certain Participating Provider services.	
Any covered services for which cost-sharing is not specified in the "Covered Services" table below will pay subject to the applicable Deductible and Coinsurance identified above.		
Total Annual Out-of-Pocket Limit		
Individual	$8,150	
Family	$16,300	
Your plan has an embedded Out-of-Pocket Limit, which means the Out-of-Pocket Limit per Benefit Level is satisfied in one of two ways — whichever comes first: *When an individual within a family reaches his or her individual Out-of-Pocket Limit for a Benefit Level. At this point, only that person will have benefits covered at 100% for the remainder of the Benefit Period for that Benefit Level; OR *When a combination of family members' expenses reaches the family Out-of-Pocket Limit for a Benefit Level. At this point, all covered family members are considered to have met the Out-of-Pocket Limit and benefits will be covered at 100% for the remainder of the Benefit Period for that Benefit Level. - If you receive services at Benefit Level 1 providers or facilities, amounts applied to the Out-of-Pocket listed at Benefit Level 1 will also apply to the Out-of-Pocket listed at Benefit Level 2. - If you receive services at Benefit Level 2 providers or facilities, amounts applied to the Out-of-Pocket listed at Benefit Level 2 will also apply to Benefit Level 1.		
Out-of-Pocket costs (Copayments, Coinsurance, and Deductibles) for Covered Services apply toward satisfaction of the Out-of-Pocket Limit specified in this Schedule of Benefits.		

Preventive Services	UPMC Inside *Advantage* Network Benefit Level 1	Other Participating UPMC Facilities Level 2
Preventive Services will be covered in compliance with requirements under the Affordable Care Act (ACA). Please refer to the Preventive Services Reference Guide for additional details.		
Pediatric preventive/health screening examination	Covered at 100%; you pay $0.	
Pediatric immunizations	Covered at 100%; you pay $0.	

Preventive Services	UPMC Inside *Advantage* Network Benefit Level 1	Other Participating UPMC Facilities Level 2
Well-baby visits	Covered at 100%; you pay $0.	
Adult preventive/health screening examination	Covered at 100%; you pay $0.	
Adult immunizations required by the ACA to be covered at no cost-sharing	Covered at 100%; you pay $0.	
Screening gynecological exam	Covered at 100%; you pay $0.	
Breast cancer and cervical cancer screening	Covered at 100%; you pay $0.	
Diagnostic services and procedures required by the ACA	Covered at 100%; you pay $0.	

Covered Services	UPMC Inside *Advantage* Network Benefit Level 1	Other Participating UPMC Facilities Level 2
Hospital Services		
Hospital inpatient	You pay $0 after Deductible.	You pay 35% after Deductible.
Outpatient/Ambulatory surgery	You pay $0 after Deductible.	You pay 35% after Deductible.
Observation stay	You pay $0 after Deductible.	
Maternity – hospital services associated with delivery	You pay $0 after Deductible.	You pay 35% after Deductible.
Emergency Services		
Emergency department	You pay $150 Copayment per visit. Copayment waived if you are admitted to hospital.	
Emergency transportation	You pay $0 after Deductible.	
Surgical Services		
Surgical services (professional provider services)	You pay $0 after Deductible.	
Provider Medical Services		
Inpatient medical care visits, intensive medical care, consultation, and newborn care	You pay $0 after Deductible.	
Adult immunizations not required to be covered by the ACA	You pay $0 after Deductible.	
Primary care provider office visit	You pay $30 Copayment per visit.	
Specialist office visit	You pay $60 Copayment per visit.	
Convenience care visit	You pay $30 Copayment per visit.	
Urgent care facility	You pay $75 Copayment per visit.	
Virtual Visits		
UPMC AnywhereCare – Virtual Urgent Care and Children's AnywhereCare	You pay $5 Copayment per visit.	
Virtual visit – Primary Care	You pay $15 Copayment per visit.	
Virtual visit – Specialist	You pay $30 Copayment per visit.	
Virtual visit – Behavioral Health	You pay $15 Copayment per visit.	

Covered Services	UPMC Inside *Advantage* Network Benefit Level 1	Other Participating UPMC Facilities Level 2
UPMC *My*Health 24/7 Nurse Line		
If you would like to speak to a registered nurse about a specific health concern or when to seek treatment, call our UPMC *My*Health 24/7 Nurse Line at 1-866-918-1591 (TTY: 711) for care 365 days/year. You may also send an email for non-urgent issues using the web nurse request system at **www.upmchealthplan.com** and a nurse will respond within 24 hours.		
Allergy Services		
Treatment, injections, and serum	You pay $0 after Deductible.	You pay 35% after Deductible.
Diagnostic Services		
Advanced imaging (e.g., PET, MRI)	You pay $0 after Deductible.	You pay 35% after Deductible.
	Non-hospital services will be covered at the Level 1 cost-share for Participating Providers.	
Other imaging (e.g., x-ray, sonogram)	You pay $0 after Deductible.	You pay 35% after Deductible.
	Non-hospital services will be covered at the Level 1 cost-share for Participating Providers.	
Laboratory services	You pay $0 after Deductible.	You pay 35% after Deductible.
	Non-hospital services will be covered at the Level 1 cost-share for Participating Providers.	
Diagnostic testing	You pay $0 after Deductible.	You pay 35% after Deductible.
	Non-hospital services will be covered at the Level 1 cost-share for Participating Providers.	
Rehabilitation Therapy Services **Note:** See the Behavioral Health Services section below for Rehabilitation Therapy services prescribed for the treatment of a Behavioral Health condition.		
Physical and occupational therapy	You pay $60 Copayment per visit.	You pay 35% after Deductible.
	Covered up to 30 visits per Benefit Period for both therapies combined.	
Speech therapy	You pay $60 Copayment per visit.	You pay 35% after Deductible.
	Covered up to 30 visits per Benefit Period.	
Cardiac rehabilitation	You pay $0 after Deductible.	You pay 35% after Deductible.
	Covered up to 36 visits per Benefit Period.	
Pulmonary rehabilitation	You pay $60 Copayment per visit.	You pay 35% after Deductible.
	Covered up to 36 visits per Benefit Period.	
Habilitation Therapy Services **Note**: See the Behavioral Health Services section below for Habilitation Therapy services prescribed for the treatment of a Behavioral Health condition.		
Physical and occupational therapy	You pay $60 Copayment per visit.	You pay 35% after Deductible.
	Covered up to 30 visits per Benefit Period for both therapies combined.	
Speech therapy	You pay $60 Copayment per visit.	You pay 35% after Deductible.
	Covered up to 30 visits per Benefit Period.	
Medical Therapy Services		
Chemotherapy, radiation therapy, dialysis therapy	You pay $0 after Deductible.	You pay 35% after Deductible.
	Non-hospital services will be covered at the Level 1 cost-share for Participating Providers.	
Injectable, infusion therapy, or other drugs administered or provided by a medical professional in an outpatient or office setting	You pay $0 after Deductible.	You pay 35% after Deductible.
	Non-hospital services will be covered at the Level 1 cost-share for Participating Providers.	
Pain Management		
Pain management program	You pay $60 Copayment per visit.	You pay 35% after Deductible.

Covered Services	UPMC Inside *Advantage* Network Benefit Level 1	Other Participating UPMC Facilities Level 2
	Non-hospital services will be covered at the Level 1 cost-share for Participating Providers.	
Behavioral Health (Mental Health and Substance Use Disorder) Services Contact UPMC Health Plan Behavioral Health Services at 1-888-251-0083.		
Inpatient services (including inpatient hospital services, inpatient rehabilitation, detoxification, non-hospital residential treatment)	You pay $0 after Deductible.	
Office visits, including psychotherapy and counseling	You pay $30 Copayment per visit.	
Outpatient services (includes intensive outpatient and partial hospitalization programs)	You pay $0 after Deductible.	
Laboratory services related to a Behavioral Health condition	You pay $0 after Deductible.	
Physical, occupational, or speech therapy related to a Behavioral Health condition	You pay $30 Copayment per visit. Visit limits do not apply.	
Other Medical Services Refer to the Certificate of Coverage (COC) for specific Benefit Limitations that may apply to the services listed below.		
Acupuncture	You pay $60 Copayment per visit. Covered up to 12 visits per Benefit Period.	
Applied behavior analysis for the treatment of Autism Spectrum Disorder	You pay $0 after Deductible.	
Corrective appliances	You pay $0 after Deductible. Physician Services will be covered at the Level 1 cost-share for Participating Providers.	You pay 35% after Deductible.
Dental services related to accidental injury	You pay $0 after Deductible. Non-hospital services will be covered at the Level 1 cost-share for Participating Providers.	You pay 35% after Deductible.
Durable medical equipment	You pay $0 after Deductible. Physician Services will be covered at the Level 1 cost-share for Participating Providers.	You pay 35% after Deductible.
Fertility testing	You pay $0 after Deductible.	You pay 35% after Deductible.
Home health care	You pay $0 after Deductible. Covered up to 60 days per Benefit Period.	You pay 35% after Deductible.
Hospice care	You pay $0 after Deductible.	You pay 35% after Deductible.
Medical nutrition therapy	You pay $0 after Deductible.	You pay 35% after Deductible.
Nutritional counseling	You pay $0 after Deductible. Covered up to six visits per Benefit Period.	You pay 35% after Deductible.
Nutritional products	Covered at 100%; you pay $0. Nutritional products for the treatment of PKU and related disorders are not subject to Deductible.	You pay 35%. Deductible does not apply.

Covered Services	UPMC Inside *Advantage* Network Benefit Level 1	Other Participating UPMC Facilities Level 2
Oral surgical services	You pay $0 after Deductible.	You pay 35% after Deductible.
	Non-hospital services will be covered at the Level 1 cost-share for Participating Providers.	
Podiatry care	You pay $60 Copayment per visit.	
Private duty nursing	You pay $0 after Deductible.	
Skilled nursing facility	You pay $0 after Deductible.	You pay 35% after Deductible.
	Covered up to 120 days per Benefit Period.	
	Non-hospital services will be covered at the Level 1 cost-share for Participating Providers.	
Therapeutic manipulation	You pay $60 Copayment per visit.	
	Covered up to 20 visits per Benefit Period.	
Diabetic Equipment, Supplies, and Education		
Diabetic equipment and supplies (NOTE: If you have prescription drug coverage through a program other than Express Scripts, Inc., that plan will pay for diabetic supplies and equipment first.)		
Glucometer, test strips, and lancets, insulin and syringes	Must be obtained at a Participating Pharmacy. See applicable pharmacy rider for coverage information.	
Diabetic education	Covered at 100%; you pay $0.	You pay 35% after Deductible.

Prescription Medication Coverage **For additional information on your pharmacy benefits, refer to your Prescription Medication Rider.** **Tier names describe the most common type(s) of medication (such as brands and generics) within that tier.** **The Your Choice pharmacy program will apply (mandatory generic).** **Not subject to Plan Deductible** **UPMC Health Plan has determined that your prescription medication benefit plan constitutes Creditable coverage**	
Retail prescription medication • Prescriptions must be dispensed by a participating pharmacy. • 30-day supply.	Tier 1: You pay $15 Copayment for preferred generic medications. Tier 2: You pay $40 Copayment for preferred brand medications. Tier 3: You pay $80 Copayment for nonpreferred medications (brand and generic). Tier 5: You pay $0 Copayment for preventive medications. 90-day maximum retail supply available for three copayments
Specialty prescription medication • Specialty medications are limited to a 30-day supply. See Prescription Medication Rider for additional information. • Most specialty medications must be filled at our contracted specialty pharmacy provider (list available upon request).	Tier 4: You pay $95 Copayment for specialty medications (brand and generic). You pay $0 Copayment for oral chemotherapy medications. 30-day maximum supply
Mail-order prescription medication • A three-month supply (up to 90 days) of medication may be dispensed through the contracted mail-service pharmacy.	Tier 1: You pay $30 Copayment for preferred generic medications. Tier 2: You pay $80 Copayment for preferred brand medications. Tier 3: You pay $160 Copayment for nonpreferred medications (brand and generic). Tier 5: You pay $0 Copayment for preventive medications. 90-day maximum mail-order supply
If the brand-name medication is dispensed instead of the generic equivalent, you must pay the Copayment associated with the brand-name medication as well as the price difference between the brand-name medication and the generic medication.	

The capitalized words and phrases in this Schedule of Benefits mean the same as they do in your Certificate of Coverage (COC). Also, the headings under the Covered Services section are the same as those in your COC.

At all times, UPMC Health Plan administers the coverage described in this document in full compliance with applicable laws and regulations. If any part of this Schedule of Benefits conflicts with any applicable law, regulation, or other controlling authority, the requirements of that authority will prevail.

Your plan documents will always include the Schedule of Benefits, the COC, and the Summary of Benefits and Coverage. You can log into *My*Health OnLine to view these documents. If you have questions, call Member Services.

UPMC Health Plan is the marketing name used to refer to the following companies, which are licensed to issue individual and group health insurance products or which provide third party administration services for group health plans: UPMC Health Network Inc., UPMC Health Options Inc., UPMC Health Coverage Inc., UPMC Health Plan Inc., UPMC Health Benefits Inc., UPMC *for You* Inc., Community Care Behavioral Health Organization, and/or UPMC Benefit Management Services Inc.

UPMC Health Plan
U.S. Steel Tower
600 Grant Street
Pittsburgh, PA 15219

www.upmchealthplan.com

Ohio Residents Only

UPMC Health Plan

Schedule of Benefits

UPMC Consumer *Advantage*
HRA PPO – Premium Network
Deductible: ~~$6,350 / $12,700~~
Coinsurance: 0%
Total Annual Out-of-Pocket: ~~$8,150 / $16,300~~

Primary Care Provider: $30 Copayment per visit
Specialist: $60 Copayment per visit
Emergency Department: $250 Copayment per visit
Urgent Care Facility: $75 Copayment per visit
Rx: $15/$40/$80/$95

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For more information on your plan, please refer to the final page of this document.

Plan Information	Participating Provider	Non-Participating Provider
Benefit Period	Plan Year	
Primary Care Provider (PCP) Required	Encouraged, but not required	
Prior Authorization Requirements	Provider Responsibility	Member Responsibility
		If you fail to obtain Prior Authorization for certain services, you may not be eligible for reimbursement under your plan. Please see additional information below.

Member Cost Sharing	Participating Provider	Non-Participating Provider
HRA: Health reimbursement arrangement (HRA) annual allocation		
Ask your employer for details.		
Employer funds are allocated into the HRA.		
Annual Deductible		
Individual	~~$6,350~~	~~$10,000~~
Family	~~$12,700~~	~~$10,000~~

Member Cost Sharing	Participating Provider	Non-Participating Provider
Your plan has an embedded Deductible, which means the plan pays for Covered Services in these two scenarios — whichever comes first: *When an individual family member reaches his or her individual Deductible. At this point, only that person is considered to have met the Deductible; OR *When a combination of family members' expenses reaches the family Deductible. At this point, all covered family members are considered to have met the Deductible.		
Deductible applies to all Covered Services you receive during the Benefit Period, unless the service is specifically excluded.		
Coinsurance		
	You pay $0 after Deductible.	You pay 20% after Deductible.
	Copayments may apply to certain Participating Provider services.	
Any covered services for which cost-sharing is not specified in the "Covered Services" table below will pay subject to the applicable Deductible and Coinsurance identified above.		
Total Annual Out-of-Pocket Limit		
Individual	$8,150	$10,000
Family	$16,300	$10,000
Your plan has an embedded Out-of-Pocket Limit, which means the Out-of-Pocket Limit is satisfied in one of two ways — whichever comes first: *****When an individual within a family reaches his or her individual Out-of-Pocket Limit. At this point, only that person will have Covered Services paid at 100% for the remainder of the Benefit Period; OR *****When a combination of family members' expenses reaches the family Out-of-Pocket Limit. At this point, all covered family members are considered to have met the Out-of-Pocket Limit and Covered Services will be paid at 100% for the remainder of the Benefit Period.		
Out-of-Pocket costs (Copayments, Coinsurance, and Deductibles) for Covered Services apply toward satisfaction of the Out-of-Pocket Limit specified in this Schedule of Benefits.		

Preventive Services	Participating Provider	Non-Participating Provider
Preventive Services will be covered in compliance with requirements under the Affordable Care Act (ACA). Please refer to the Preventive Services Reference Guide for additional details.		
Pediatric preventive/health screening examination	Covered at 100%; you pay $0.	You pay 20% after Deductible.
Pediatric immunizations	Covered at 100%; you pay $0.	You pay 20%. Deductible does not apply.
Well-baby visits	Covered at 100%; you pay $0.	You pay 20% after Deductible.
Adult preventive/health screening examination	Covered at 100%; you pay $0.	You pay 20% after Deductible.
Adult immunizations required by the ACA to be covered at no cost-sharing	Covered at 100%; you pay $0.	You pay 20% after Deductible.
Screening gynecological exam	Covered at 100%; you pay $0.	You pay 20% after Deductible.
Breast cancer and cervical cancer screening	Covered at 100%; you pay $0.	You pay 20% after Deductible.
Diagnostic services and procedures required by the ACA	Covered at 100%; you pay $0.	You pay 20% after Deductible.

Covered Services	Participating Provider	Non-Participating Provider
Hospital Services		
Hospital inpatient	You pay $0 after Deductible.	You pay 20% after Deductible.
Outpatient/Ambulatory surgery	You pay $0 after Deductible.	You pay 20% after Deductible.
Observation stay	You pay $0 after Deductible.	You pay 20% after Deductible.
Maternity – hospital services associated with delivery	You pay $0 after Deductible.	You pay 20% after Deductible.
Emergency Services		
Emergency department	You pay $250 Copayment per visit. Copayment waived if you are admitted to hospital.	
Emergency transportation	You pay $0 after Deductible.	
Surgical Services		
Surgical services (professional provider services)	You pay $0 after Deductible.	You pay 20% after Deductible.
Provider Medical Services		
Inpatient medical care visits, intensive medical care, consultation, and newborn care	You pay $0 after Deductible.	You pay 20% after Deductible.
Adult immunizations not required to be covered by the ACA	You pay $0 after Deductible.	You pay 20% after Deductible.
Primary care provider office visit	You pay $30 Copayment per visit.	You pay 20% after Deductible.
Specialist office visit	You pay $60 Copayment per visit.	You pay 20% after Deductible.
Convenience care visit	You pay $25 Copayment per visit.	You pay 20% after Deductible.
Urgent care facility	You pay $75 Copayment per visit.	You pay 20% after Deductible.
Virtual Visits		
UPMC AnywhereCare – Virtual Urgent Care and Children's AnywhereCare	You pay $5 Copayment per visit.	You pay 20% after Deductible.
Virtual visit – Primary Care	You pay $15 Copayment per visit.	You pay 20% after Deductible.
Virtual visit – Specialist	You pay $30 Copayment per visit.	You pay 20% after Deductible.
Virtual visit – Behavioral Health	You pay $15 Copayment per visit.	You pay 20% after Deductible.
UPMC *My*Health 24/7 Nurse Line		
If you would like to speak to a registered nurse about a specific health concern or when to seek treatment, call our UPMC *My*Health 24/7 Nurse Line at 1-866-918-1591 (TTY: 711) for care 365 days/year. You may also send an email for non-urgent issues using the web nurse request system at **www.upmchealthplan.com** and a nurse will respond within 24 hours.		
Allergy Services		
Treatment, injections, and serum	You pay $0 after Deductible.	You pay 20% after Deductible.
Diagnostic Services		
Advanced imaging (e.g., PET, MRI)	You pay $0 after Deductible.	You pay 20% after Deductible.
Other imaging (e.g., x-ray, sonogram)	You pay $0 after Deductible.	You pay 20% after Deductible.
Laboratory services	You pay $0 after Deductible.	You pay 20% after Deductible.
Diagnostic testing	You pay $0 after Deductible.	You pay 20% after Deductible.
Rehabilitation Therapy Services **Note:** See the Behavioral Health Services section below for Rehabilitation Therapy services prescribed for the treatment of a Behavioral Health condition.		
	You pay $0 after Deductible.	You pay 20% after Deductible.

Covered Services	Participating Provider	Non-Participating Provider
Physical, speech, and occupational therapy	Covered up to 45 inpatient days or 30 outpatient visits per Benefit Period for all three therapies combined.	
Cardiac rehabilitation	You pay $0 after Deductible.	You pay 20% after Deductible.
	Covered up to 36 visits per Benefit Period.	
Pulmonary rehabilitation	You pay $0 after Deductible.	You pay 20% after Deductible.
	Covered up to 36 visits per Benefit Period.	
Habilitation Therapy Services Note: See the Behavioral Health Services section below for Habilitation Therapy services prescribed for the treatment of a Behavioral Health condition.		
Physical, speech, and occupational therapy	You pay $0 after Deductible.	You pay 20% after Deductible.
	Covered up to 45 inpatient days or 30 outpatient visits per Benefit Period for all three therapies combined.	
Medical Therapy Services		
Chemotherapy, radiation therapy, dialysis therapy	You pay $0 after Deductible.	You pay 20% after Deductible.
Injectable, infusion therapy, or other drugs administered or provided by a medical professional in an outpatient or office setting	You pay $0 after Deductible.	You pay 20% after Deductible.
Pain Management		
Pain management program	You pay $60 Copayment per visit.	You pay 20% after Deductible.
Behavioral Health (Mental Health and Substance Use Disorder) Services Contact UPMC Health Plan Behavioral Health Services at 1-888-251-0083.		
Inpatient services (including inpatient hospital services, inpatient rehabilitation, detoxification, non-hospital residential treatment)	You pay $0 after Deductible.	You pay 20% after Deductible.
Office visits, including psychotherapy and counseling	You pay $30 Copayment per visit.	You pay 20% after Deductible.
Outpatient services (includes intensive outpatient and partial hospitalization programs)	You pay $0 after Deductible.	You pay 20% after Deductible.
Laboratory services related to a Behavioral Health condition	You pay $0 after Deductible.	You pay 20% after Deductible.
Physical, occupational, or speech therapy related to a Behavioral Health condition	Covered at 100%; you pay $0.	You pay 20% after Deductible.
	Visit limits do not apply.	
Other Medical Services Refer to the Certificate of Coverage (COC) for specific Benefit Limitations that may apply to the services listed below.		
Acupuncture	You pay $0 after Deductible.	You pay 20% after Deductible.
	Covered up to 12 visits per Benefit Period.	
Applied behavior analysis for the treatment of Autism Spectrum Disorder	You pay $0 after Deductible.	You pay 20% after Deductible.
Corrective appliances	You pay $0 after Deductible.	You pay 20% after Deductible.
Dental services related to accidental injury	You pay $0 after Deductible.	You pay 20% after Deductible.

Covered Services	Participating Provider	Non-Participating Provider
Durable medical equipment	You pay $0 after Deductible.	You pay 20% after Deductible.
Fertility testing	You pay $0 after Deductible.	You pay 20% after Deductible.
Home health care	You pay $0 after Deductible.	You pay 20% after Deductible.
	Covered up to 120 days per Benefit Period for Participating Provider, 60 days per Benefit Period for Non-Participating Provider, 120 days per Benefit Period combined.	
Hospice care	You pay $0 after Deductible.	You pay 20% after Deductible.
Medical nutrition therapy	You pay $0 after Deductible.	You pay 20% after Deductible.
Nutritional counseling	You pay $0 after Deductible.	You pay 20% after Deductible.
	Covered up to six visits per Benefit Period.	
Nutritional products	Covered at 100%; you pay $0.	You pay 20%. Deductible does not apply.
	Nutritional products for the treatment of PKU and related disorders are not subject to Deductible.	
Oral surgical services	You pay $0 after Deductible.	You pay 20% after Deductible.
Podiatry care	You pay $60 Copayment per visit.	You pay 20% after Deductible.
Private duty nursing	You pay $0 after Deductible.	You pay 20% after Deductible.
Skilled nursing facility	You pay $0 after Deductible.	You pay 20% after Deductible.
	Covered up to 100 days per Benefit Period for Participating Provider, 50 days per Benefit Period for Non-Participating Provider, 100 days per Benefit Period combined.	
Therapeutic manipulation	You pay $50 Copayment per visit.	You pay 20% after Deductible.
	Covered up to 20 visits per Benefit Period.	
Tubal ligation	You pay $300 Copayment per visit (when billed with a non-preventative diagnosis).	You pay 20% after Deductible.
Vasectomy	You pay $300 Copayment per visit.	You pay 20% after Deductible.
Diabetic Equipment, Supplies, and Education		
Diabetic equipment and supplies (NOTE: If you have prescription drug coverage through a program other than Express Scripts, Inc., that plan will pay for diabetic supplies and equipment first.)		
Glucometer, test strips, and lancets, insulin and syringes	Must be obtained at Participating Pharmacy. See applicable pharmacy rider for coverage information.	
Diabetic education	Covered at 100%; you pay $0.	You pay 20% after Deductible.

Prescription Medication Coverage **For additional information on your pharmacy benefits, refer to your Prescription Medication Rider.** **Tier names describe the most common type(s) of medication (such as brands and generics) within that tier.** **The Your Choice pharmacy program will apply (mandatory generic).** **Not subject to Plan Deductible**	
Retail prescription medication • Prescriptions must be dispensed by a participating pharmacy. • 30-day supply.	Tier 1: You pay $15 Copayment for preferred generic medications. Tier 2: You pay $40 Copayment for preferred brand medications. Tier 3: You pay $80 Copayment for nonpreferred medications (brand and generic). Tier 5: You pay $0 Copayment for preventive medications. 90-day maximum retail supply available for three copayments
Specialty prescription medication • Specialty medications are limited to a 30-day supply. See Prescription Medication Rider for additional information. • Most specialty medications must be filled at our contracted specialty pharmacy provider (list available upon request).	Tier 4: You pay $95 Copayment for specialty medications (brand and generic). You pay $0 Copayment for oral chemotherapy medications. 30-day maximum supply
Mail-order prescription medication • A three-month supply (up to 90 days) of medication may be dispensed through the contracted mail-service pharmacy.	Tier 1: You pay $30 Copayment for preferred generic medications. Tier 2: You pay $80 Copayment for preferred brand medications. Tier 3: You pay $160 Copayment for nonpreferred medications (brand and generic). Tier 5: You pay $0 Copayment for preventive medications. 90-day maximum mail-order supply
If the brand-name medication is dispensed instead of the generic equivalent, you must pay the Copayment associated with the brand-name medication as well as the price difference between the brand-name medication and the generic medication.	

Prior Authorization for out-of-network services

Certain out-of-network non-emergent care must be Prior Authorized in order to be eligible for reimbursement under your plan. This means you must contact UPMC Health Plan and obtain Prior Authorization before receiving services. A list of services that must be Prior Authorized is available 24/7 on our website at www.upmchealthplan.com. You can also contact Member Services by calling the phone number on the back of your member ID card. Your out-of-network provider may also access this list at www.upmchealthplan.com or your provider may call Provider Services at 1-866-918-1595 to initiate the Prior Authorization process on your behalf. Regardless, you must confirm that Prior Authorization has been given in advance of your receiving services in order for those services to be eligible for reimbursement in accordance with your plan. Please note, the list of services that require Prior Authorization is subject to change throughout the year. You are responsible for verifying you have the most current information as of your date of service.

The capitalized words and phrases in this Schedule of Benefits mean the same as they do in your Certificate of

Coverage (COC). Also, the headings under the Covered Services section are the same as those in your COC.

At all times, UPMC Health Plan administers the coverage described in this document in full compliance with applicable laws and regulations. If any part of this Schedule of Benefits conflicts with any applicable law, regulation, or other controlling authority, the requirements of that authority will prevail.

Your plan documents will always include the Schedule of Benefits, the COC, and the Summary of Benefits and Coverage. You can log into *My*Health OnLine to view these documents. If you have questions, call Member Services.

UPMC Health Plan is the marketing name used to refer to the following companies, which are licensed to issue individual and group health insurance products or which provide third party administration services for group health plans: UPMC Health Network Inc., UPMC Health Options Inc., UPMC Health Coverage Inc., UPMC Health Plan Inc., UPMC Health Benefits Inc., UPMC *for You* Inc., Community Care Behavioral Health Organization, and/or UPMC Benefit Management Services Inc.

UPMC Health Plan
U.S. Steel Tower
600 Grant Street
Pittsburgh, PA 15219

www.upmchealthplan.com

PA Residents Only

UPMC Health Plan

Schedule of Benefits

UPMC Consumer *Advantage*
HRA EPO – Premium Network
Deductible: ~~$6,350 / $12,700~~
Coinsurance: 0%
Total Annual Out-of-Pocket: ~~$8,150 / $16,300~~

Primary Care Provider: $30 Copayment per visit
Specialist: $60 Copayment per visit
Emergency Department: $250 Copayment per visit
Urgent Care Facility: $75 Copayment per visit
Rx: $15/$40/$80/$95

This Schedule of Benefits will be an important part of your Certificate of Coverage (COC) or your Summary Plan Description (SPD). If your plan has an SPD, it is issued by your employer or labor trust fund. It is not issued by UPMC Health Plan. It is important that you review and understand your COC and/or SPD because they describe in detail the services your plan covers. The Schedule of Benefits describes what you pay for those services.

For Covered Services to be paid at the level described in your Schedule of Benefits, they must be Medically Necessary.

They must also meet all other criteria described in your COC and/or SPD. Criteria may include Prior Authorization requirements.

Please note that your plan may not cover all of your health care expenses, such as Copayments and Coinsurance. To understand what your plan covers, review your COC and/or SPD. You may also have Riders and Amendments that expand or restrict your benefits.

If you have any questions about your benefits, or would like to find a Participating Provider near you, visit **www.upmchealthplan.com**. You can also call UPMC Health Plan Member Services at the phone number on the back of your member ID card.

For more information on your plan, please refer to the final page of this document.

Plan Information	Participating Provider
Benefit Period	Plan Year
Primary Care Provider (PCP) Required	Encouraged, but not required
Prior Authorization Requirements	Provider Responsibility

Member Cost Sharing	Participating Provider
HRA: Health reimbursement arrangement (HRA) annual allocation	
Ask your employer for details.	
Employer funds are allocated into the HRA.	
Annual Deductible	
Individual	~~$6,350~~
Family	~~$12,700~~
Your plan has an embedded Deductible, which means the plan pays for Covered Services in these two scenarios — whichever comes first: *When an individual family member reaches his or her individual Deductible. At this point, only that person is considered to have met the Deductible; OR *When a combination of family members' expenses reaches the family Deductible. At this point, all covered family members are considered to have met the Deductible.	

Member Cost Sharing	Participating Provider
Deductible applies to all Covered Services you receive during the Benefit Period, unless the service is specifically excluded.	
Coinsurance	
	You pay $0 after Deductible.
	Copayments may apply to certain Participating Provider services.
Any covered services for which cost-sharing is not specified in the "Covered Services" table below will pay subject to the applicable Deductible and Coinsurance identified above.	
Total Annual Out-of-Pocket Limit	
Individual	$8,150
Family	$16,300
Your plan has an embedded Out-of-Pocket Limit, which means the Out-of-Pocket Limit is satisfied in one of two ways — whichever comes first: *When an individual within a family reaches his or her individual Out-of-Pocket Limit. At this point, only that person will have Covered Services paid at 100% for the remainder of the Benefit Period; OR *When a combination of family members' expenses reaches the family Out-of-Pocket Limit. At this point, all covered family members are considered to have met the Out-of-Pocket Limit and Covered Services will be paid at 100% for the remainder of the Benefit Period.	
Out-of-Pocket costs (Copayments, Coinsurance, and Deductibles) for Covered Services apply toward satisfaction of the Out-of-Pocket Limit specified in this Schedule of Benefits.	

Preventive Services	Participating Provider
Preventive Services will be covered in compliance with requirements under the Affordable Care Act (ACA). Please refer to the Preventive Services Reference Guide for additional details.	
Pediatric preventive/health screening examination	Covered at 100%; you pay $0.
Pediatric immunizations	Covered at 100%; you pay $0.
Well-baby visits	Covered at 100%; you pay $0.
Adult preventive/health screening examination	Covered at 100%; you pay $0.
Adult immunizations required by the ACA to be covered at no cost-sharing	Covered at 100%; you pay $0.
Screening gynecological exam	Covered at 100%; you pay $0.
Breast cancer and cervical cancer screening	Covered at 100%; you pay $0.
Diagnostic services and procedures required by the ACA	Covered at 100%; you pay $0.

Covered Services	Participating Provider
Hospital Services	
Hospital inpatient	You pay $0 after Deductible.
Outpatient/Ambulatory surgery	You pay $0 after Deductible.
Observation stay	You pay $0 after Deductible.
Maternity – hospital services associated with delivery	You pay $0 after Deductible.
Emergency Services	
Emergency department	You pay $250 Copayment per visit.

Covered Services	Participating Provider
	Copayment waived if you are admitted to hospital.
Emergency transportation	You pay $0 after Deductible.
Surgical Services	
Surgical services (professional provider services)	You pay $0 after Deductible.
Provider Medical Services	
Inpatient medical care visits, intensive medical care, consultation, and newborn care	You pay $0 after Deductible.
Adult immunizations not required to be covered by the ACA	You pay $0 after Deductible.
Primary care provider office visit	You pay $30 Copayment per visit.
Specialist office visit	You pay $60 Copayment per visit.
Convenience care visit	You pay $30 Copayment per visit.
Urgent care facility	You pay $75 Copayment per visit.
Virtual Visits	
UPMC AnywhereCare – Virtual Urgent Care and Children's AnywhereCare	You pay $5 Copayment per visit.
Virtual visit – Primary Care	You pay $15 Copayment per visit.
Virtual visit – Specialist	You pay $30 Copayment per visit.
Virtual visit – Behavioral Health	You pay $15 Copayment per visit.
UPMC *My*Health 24/7 Nurse Line	
If you would like to speak to a registered nurse about a specific health concern or when to seek treatment, call our UPMC *My*Health 24/7 Nurse Line at 1-866-918-1591 (TTY: 711) for care 365 days/year. You may also send an email for non-urgent issues using the web nurse request system at www.upmchealthplan.com and a nurse will respond within 24 hours.	
Allergy Services	
Treatment, injections, and serum	You pay $0 after Deductible.
Diagnostic Services	
Advanced imaging (e.g., PET, MRI)	You pay $0 after Deductible.
Other imaging (e.g., x-ray, sonogram)	You pay $0 after Deductible.
Laboratory services	You pay $0 after Deductible.
Diagnostic testing	You pay $0 after Deductible.
Rehabilitation Therapy Services Note: See the Behavioral Health Services section below for Rehabilitation Therapy services prescribed for the treatment of a Behavioral Health condition.	
Physical and occupational therapy	You pay $0 after Deductible.
	Covered up to 30 visits per Benefit Period for both therapies combined.
Speech therapy	You pay $0 after Deductible.
	Covered up to 30 visits per Benefit Period.
Cardiac rehabilitation	You pay $0 after Deductible.
	Covered up to 36 visits per Benefit Period.
Pulmonary rehabilitation	You pay $0 after Deductible.
	Covered up to 36 visits per Benefit Period.

Covered Services	Participating Provider
Habilitation Therapy Services Note: See the Behavioral Health Services section below for Habilitation Therapy services prescribed for the treatment of a Behavioral Health condition.	
Physical and occupational therapy	You pay $0 after Deductible. Covered up to 30 visits per Benefit Period for both therapies combined.
Speech therapy	You pay $0 after Deductible. Covered up to 30 visits per Benefit Period.
Medical Therapy Services	
Chemotherapy, radiation therapy, dialysis therapy	You pay $0 after Deductible.
Injectable, infusion therapy, or other drugs administered or provided by a medical professional in an outpatient or office setting	You pay $0 after Deductible.
Pain Management	
Pain management program	You pay $60 Copayment per visit.
Behavioral Health (Mental Health and Substance Use Disorder) Services Contact UPMC Health Plan Behavioral Health Services at 1-888-251-0083.	
Inpatient services (including inpatient hospital services, inpatient rehabilitation, detoxification, non-hospital residential treatment)	You pay $0 after Deductible.
Office visits, including psychotherapy and counseling	You pay $30 Copayment per visit.
Outpatient services (includes intensive outpatient and partial hospitalization programs)	You pay $0 after Deductible.
Laboratory services related to a Behavioral Health condition	You pay $0 after Deductible.
Physical, occupational, or speech therapy related to a Behavioral Health condition	Covered at 100%; you pay $0. Visit limits do not apply.
Other Medical Services Refer to the Certificate of Coverage (COC) for specific Benefit Limitations that may apply to the services listed below.	
Acupuncture	You pay $0 after Deductible. Covered up to 12 visits per Benefit Period.
Applied behavior analysis for the treatment of Autism Spectrum Disorder	You pay $0 after Deductible.
Corrective appliances	You pay $0 after Deductible.
Dental services related to accidental injury	You pay $0 after Deductible.
Durable medical equipment	You pay $0 after Deductible.
Fertility testing	You pay $0 after Deductible.
Home health care	You pay $0 after Deductible. Covered up to 60 days per Benefit Period.

Covered Services	Participating Provider
Hospice care	You pay $0 after Deductible.
Medical nutrition therapy	You pay $0 after Deductible.
Nutritional counseling	You pay $0 after Deductible.
	Covered up to six visits per Benefit Period.
Nutritional products	Covered at 100%; you pay $0.
	Nutritional products for the treatment of PKU and related disorders are not subject to Deductible.
Oral surgical services	You pay $0 after Deductible.
Podiatry care	You pay $60 Copayment per visit.
Private duty nursing	You pay $0 after Deductible.
Skilled nursing facility	You pay $0 after Deductible.
	Covered up to 120 days per Benefit Period.
Therapeutic manipulation	You pay $60 Copayment per visit.
	Covered up to 20 visits per Benefit Period.
Diabetic Equipment, Supplies, and Education	
Diabetic equipment and supplies (NOTE: If you have prescription drug coverage through a program other than Express Scripts, Inc., that plan will pay for diabetic supplies and equipment first.)	
Glucometer, test strips, and lancets, insulin and syringes	Must be obtained at Participating Pharmacy. See applicable pharmacy rider for coverage information.
Diabetic education	Covered at 100%; you pay $0.

Prescription Medication Coverage **For additional information on your pharmacy benefits, refer to your Prescription Medication Rider.** **Tier names describe the most common type(s) of medication (such as brands and generics) within that tier.** **The Your Choice pharmacy program will apply (mandatory generic).** **Not subject to Plan Deductible**	
Retail prescription medication • Prescriptions must be dispensed by a participating pharmacy. • 30-day supply.	Tier 1: You pay $15 Copayment for preferred generic medications. Tier 2: You pay $40 Copayment for preferred brand medications. Tier 3: You pay $80 Copayment for nonpreferred medications (brand and generic). Tier 5: You pay $0 Copayment for preventive medications. 90-day maximum retail supply available for three copayments
Specialty prescription medication • Specialty medications are limited to a 30-day supply. See Prescription Medication Rider for additional information. • Most specialty medications must be filled at our contracted specialty pharmacy provider (list available upon request).	Tier 4: You pay $95 Copayment for specialty medications (brand and generic). You pay $0 Copayment for oral chemotherapy medications. 30-day maximum supply
Mail-order prescription medication • A three-month supply (up to 90 days) of medication may be dispensed through the contracted mail-service pharmacy.	Tier 1: You pay $30 Copayment for preferred generic medications. Tier 2: You pay $80 Copayment for preferred brand medications. Tier 3: You pay $160 Copayment for nonpreferred medications (brand and generic). Tier 5: You pay $0 Copayment for preventive medications. 90-day maximum mail-order supply
If the brand-name medication is dispensed instead of the generic equivalent, you must pay the Copayment associated with the brand-name medication as well as the price difference between the brand-name medication and the generic medication.	

The capitalized words and phrases in this Schedule of Benefits mean the same as they do in your Certificate of Coverage (COC). Also, the headings under the Covered Services section are the same as those in your COC.

At all times, UPMC Health Plan administers the coverage described in this document in full compliance with applicable laws and regulations. If any part of this Schedule of Benefits conflicts with any applicable law, regulation, or other controlling authority, the requirements of that authority will prevail.

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UPMC Health Benefits Inc., UPMC *for You* Inc., Community Care Behavioral Health Organization, and/or UPMC Benefit Management Services Inc.

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www.upmchealthplan.com

UNITED CONCORDIA® DENTAL
Protecting More Than Just Your Smile®

Dental Benefits Summary for Miller Industries

Effective Date: January 1, 2023 **Network: Advantage *Plus***

Benefit Category	CONCORDIA FLEX PLAN	
	In-Network[1]	Non-Network[1]
Class I – Diagnostic/Preventive Services		
Exams	100%	100%
All X-rays		
Cleanings (1 additional cleaning during pregnancy)		
Fluoride Treatments		
Sealants		
Palliative Treatment (Emergency)		
Class II – Basic Services		
Space Maintainers	80%	80%
Basic Restorative (Fillings, etc.)		
Endodontics		
Nonsurgical Periodontics		
Surgical Periodontics		
Repairs of Crowns, Inlays, Onlays, Bridges & Dentures		
Simple Extractions		
Complex Oral Surgery		
General Anesthesia		
Class III – Major Services		
Inlays, Onlays, Crowns	50%	50%
Prosthetics (Bridges, Dentures)		
Orthodontics for dependent children to age 19		
Diagnostic, Active, Retention Treatment	50%	50%
Included Plan Features		
Smile for Health®--Wellness[2] *Provides periodontal care for people with certain chronic medical conditions. Eligible conditions: diabetes, heart disease, lupus, organ transplant, rheumatoid arthritis, stroke and head & neck radiation.*	• Covers 1 additional periodontal maintenance per year and all are covered at 100% • Scaling and root planing are covered at 100% • 4 periodontal surgery procedures are covered at 100%	
Annual Maximum Rollover[3]	Members can roll over $300 of unused benefit dollars to the following plan year	
Maximums & Deductibles (applies to the combination of services received from network and non-network dentists)		
Calendar Year Program Deductible (per person/per family)	$25/$75 Excludes Class I & Orthodontics	
Calendar Year Program Maximum (per person)	$1,000 Excludes Orthodontics	
Lifetime Orthodontic Maximum (per person)	$1,000	
Reimbursement	**Advantage *Plus***	**Advantage MAC**

Representative listing of covered services – certificate of coverage provides a detailed description of benefits.

1. Reimbursement is based on our schedule of maximum allowable charges (MACs). Network dentists agree to accept our allowances as payment in full for covered services. Non-network dentists may bill the member for any difference between our allowance and their fee (also known as balance billing). United Concordia Dental's standard exclusions and limitations apply.
2. Members (subscribers or covered dependents) with certain medical conditions must sign up for this program through **My Dental Benefits** on **UnitedConcordia.com**.
3. A member is eligible to roll over $300 of unused benefit dollars to the next plan year if he/she received an exam, used less than 50% of annual program maximum during plan year, and was enrolled in the dental plan a minimum of 100 days prior to end of plan year. Each covered member can roll over $300 per year, up to $1,200 per person.

Program Availability

- Products are not available in any state where prohibited by law or where United Concordia does not have regulatory approval.
- Domestic partner coverage is not permitted in Idaho.

State Mandated Provisions

CA: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

FL: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

AZ, GA, KY, NE & NH: All statements made by a Policyholder or by any Insured Member shall be deemed representations and not warranties, and no statements made for the purpose of effecting coverage shall void such coverage or reduce benefits unless contained in writing and signed by the Policyholder.

KS: Any person who knowingly and with intent to defraud, as stated on this Application, may be committing a fraudulent insurance act which may be a crime.

LA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NJ: All statements made by applicant are true and complete to the best of the applicant's knowledge and belief. Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NY: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

OR: Any person who knowingly and with intent to defraud, as stated on this Application, may be committing a fraudulent insurance act which may be a crime.

OR: Contestability is limited to two years as stated in the Group Policy.

TN: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

UT: Any matter in dispute between you and the company may be subject to arbitration as an alternative to court action pursuant to the Rules of (the American Arbitration Association or other recognized arbitrator), a copy of which is available on request from the company. Any decision reached by arbitration shall be binding upon both you and the company. The arbitration award may include attorney's fees if allowed by state law and may be entered as a judgement in any court of proper jurisdiction.

VA: Any person who within the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

United Concordia operates as a wholly owned subsidiary under the name listed below in the following states:

- United Concordia Dental Corporation of Alabama—AL
- United Concordia Dental Plans, Inc.—DC, MD, NJ
- United Concordia Dental Plans of California, Inc.—CA
- United Concordia Dental Plans of Florida, Inc.—FL
- United Concordia Dental Plans of Kentucky, Inc.—KY
- United Concordia Dental Plans of the Midwest, Inc.—MI, MO, OH
- United Concordia Dental Plans of Pennsylvania, Inc.—PA
- United Concordia Dental Plans of Texas, Inc.—TX
- United Concordia Insurance Company—AK, AR, AZ, CA, CO, CT, FL, GA, HI, IA, ID, IN, KS, LA, MA, MD, ME, MI, MN, MS, MT, NE, NH, NV, NM, ND, OH, OK, OR, RI, SC, SD, TN, TX, UT, VT, VA, WA, WV, WY
- United Concordia Life and Health Insurance Company—DE, DC, IL, KY, MD, MO, NC, NJ, PA
- United Concordia Insurance Company of New York—NY

Discrimination is Against the Law
The Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex assigned at birth, gender identity or recorded gender. Furthermore, the Plan will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. The Plan will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual.

The Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmark.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

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

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

AMERICAN HERITAGE LIFE INSURANCE COMPANY
HOME OFFICE:
1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FLORIDA 32224-6688
(904) 992-1776

A Stock Company

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- Hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- Outpatient prescription drugs if you are enrolled in Medicare Part D
- Other approved items and services

Before You Buy This Insurance

✓ Check the coverage in **all** health insurance policies you already have.
✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
✓ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIIP).

Offered by Life Insurance Company of North America, a Cigna company

Employer-Paid
TERM LIFE INSURANCE

SUMMARY OF BENEFITS

Prepared for: Miller Industries, Inc.
Hourly

Term Life insurance can help protect your loved ones' financial health if you are no longer there to support them.

Who Is Eligible For Coverage?:

You: All active, Full-Time Hourly Employees of the Employer paid weekly regularly working a minimum of 24 hours per week in the United States, who are citizens or permanent resident aliens of the United States.
You will be eligible for coverage after 90 days of active service.

Available Coverage:

	Benefit Amount	Maximum	Guaranteed Issue Amount
Employee	2.0 Times Salary	Lesser of 2.0 Times Salary or $150,000	Lesser of 2.0 Times Salary or $150,000

Guaranteed Issue means that you may be able to purchase coverage without medical exams or health questions. See "Guaranteed Issue" below for more information.

Additional Features:

Waiver of Premium – If you become Disabled prior to age 60, and you remain Disabled continuously for a 6 month period and thereafter, you won't need to pay premiums for your life insurance coverage, provided we/the Insurance Company determine(s) you are Disabled. "Disabled" for this coverage means, because of injury or sickness, you are unable to perform the material duties of your regular occupation, or are receiving disability benefits under a program sponsored by your employer, for the first 12 months after your Disability began. Thereafter, you must be unable to perform the material duties of any occupation that you are or may reasonably become qualified based on your education, training or experience. If you qualify for this coverage and have insured your spouse or children, the insurance company will also waive their premium if applicable.

Conversion – To convert, you must apply for the conversion policy and pay the first premium payment within 31 days after your group coverage ends.

Important Definitions and Policy Provisions:

When Your Coverage Begins and Ends – Coverage becomes effective on the later of the program's effective date, the date you become eligible, the date your enrollment elections are received if applicable, or the date you authorize any necessary payroll deductions if applicable. Your coverage will not begin unless you are actively at work on the effective date. Dependent coverage, if applicable, will not begin for any spouse or child who on the effective date is an inpatient in a facility or is home confined and under the care of a physician. Coverage will end on the earliest of the date you are eligible for coverage under a plan intended to replace this coverage, you or your dependents if applicable, are no longer eligible, the group policy is no longer in force, or required premiums are not paid.

Benefit Reductions, Exclusions and Limitations:

Benefit Reduction Schedule - If you are still employed, your benefits will reduce to 75% at age 70, 50% at age 75, 50% at age 80, 50% at age 85, 50% at age 90 and 50% at age 95.

Waiver of Premium – After premiums have been waived for 12 months, they will be waived for future periods of 12 months if you remain Disabled. This benefit will remain active until age 70 subject to proof of continuing disability each year.

Guaranteed Issue:

If you are a new hire and you apply within 31 days after you are eligible to elect coverage for yourself, you are entitled to choose any coverage offered up to the Guaranteed Issue Amount, without providing proof of good health. If you apply for an amount of coverage greater than the Guaranteed Issue Amount, coverage in excess of the Guaranteed Issue Amount will not be issued until the insurance company approves acceptable proof of good health. If you apply for coverage for yourself more than 31 days from the date you become eligible to elect coverage under this plan, the Guaranteed Issue Amount will not apply, unless Guaranteed Issue has been approved by your employer for a specific period of time. Coverage will not be issued until the insurance company approves acceptable proof of good health.

These are summarized definitions only. To be eligible for coverage, the covered illness or event must meet the definitions and other terms and conditions set forth in the group policy.

THIS POLICY PROVIDES LIMITED COVERAGE. IT PAYS A FIXED BENEFIT AND DOES NOT COVER MEDICAL EXPENSES AS INCURRED. THIS IS NOT A SUBSTITUTE FOR COMPREHENSIVE OR MAJOR MEDICAL HEALTH INSURANCE. THIS COVERAGE DOES NOT SATISFY THE INDIVIDUAL MANDATE OF THE AFFORDABLE CARE ACT BECAUSE THE COVERAGE DOES NOT MEET THE REQUIREMENTS OF MINIMUM ESSENTIAL COVERAGE.

Terms and conditions of coverage for Term Life insurance are set forth in Group Policy No. FLX 969760. This is not intended as a complete description of the insurance coverage offered. This is not a contract. Complete coverage details, including premiums, eligible conditions, their respective payments and policy exclusions and limitations are contained in the Policy. Please see your Plan Sponsor to obtain a copy of the Policy. If there are any differences between this summary and the group policy, the information in the group policy takes precedence. Product availability, costs, benefits, riders, covered conditions and/or features may vary by state. Please keep this material as a reference. Insurance coverage is issued on group policy form number: Policy Form TL-004700. Coverage is underwritten by Life Insurance Company of North America, 1601 Chestnut St. Philadelphia, PA 19192.

Offered by Life Insurance Company of North America, a Cigna company

Employee-Paid
TERM LIFE INSURANCE

SUMMARY OF BENEFITS

Prepared for: Miller Industries, Inc.

Term Life insurance can help protect your loved ones' financial health if you are no longer there to support them.

Who Is Eligible For Coverage?:

You: All active, Full-Time Hourly Employees of the Employer paid weekly regularly working a minimum of 24 hours per week in the United States, who are citizens or permanent resident aliens of the United States.
You will be eligible for coverage after 90 days of active service.
Your Spouse: Up to age 85, as long as you apply for and are approved for coverage yourself.
Your Child(ren): Is eligible as long as you apply for and are approved for coverage yourself.

Available Coverage:

	Benefit Amount	Maximum	Guaranteed Issue Amount
Employee	Units of $5,000	$1,000,000	$400,000
Spouse	Units of $5,000	$100,000	$30,000
Children	$10,000	$10,000; under 14 Days old $500; under 6 months old $500	All amounts

Guaranteed Issue means that you may be able to purchase coverage without medical exams or health questions. See "Guaranteed Issue" below for more information.

Additional Features:

Waiver of Premium – If you become Disabled prior to age 60, and you remain Disabled continuously for a 6 month period and thereafter, you won't need to pay premiums for your life insurance coverage, provided we/the Insurance Company determine(s) you are Disabled. "Disabled" for this coverage means, because of injury or sickness, you are unable to perform the material duties of your regular occupation, or are receiving disability benefits under a program sponsored by your employer, for the first 12 months after your Disability began. Thereafter, you must be unable to perform the material duties of any occupation that you are or may reasonably become qualified based on your education, training or experience. If you qualify for this coverage and have insured your spouse or children, the insurance company will also waive their premium if applicable.

Portability – If your employment is terminated, you can continue your life insurance on a direct-bill basis. Coverage may also be continued for your spouse/children. Premiums will increase at this time. Coverage can be continued to age 70, unless the insurance company terminates portability for all insured persons. Refer to your certificate for details.
Conversion – To convert, you must apply for the conversion policy and pay the first premium payment within 31 days after your group coverage ends.

Employee's Weekly Cost of Coverage:

Age	Employee Cost Per $1,000	Spouse Cost Per $1,000	Age	Employee Cost Per $1,000	Spouse Cost Per $1,000
0-19	$0.014	$0.014	60-64	$0.258	$0.258
20-24	$0.014	$0.014	65-69	$0.415	$0.415
25-29	$0.014	$0.014	70-74	$0.704	$0.704
30-34	$0.016	$0.016	75-79	$1.212	$1.212
35-39	$0.023	$0.023	80-84	$1.212	$1.212
40-44	$0.039	$0.039	85-89	$1.212	$1.212
45-49	$0.065	$0.065	90-94	$1.212	$1.212
50-54	$0.111	$0.111	95-99	$1.212	$1.212
55-59	$0.189	$0.189			

Child Cost Per $1,000 = $0.046
Actual per pay period premiums may differ slightly due to rounding. The rates above reflect the total cost. Rates vary by age and may be subject to change in the future. Benefits will reduce based on age (see Benefits Reduction Schedule for details).

How to Calculate Your Weekly Cost:

Step 1: Use the chart above to find your **Weekly** rate based on your age as of your effective date.
Step 2: Multiply this rate by your desired coverage amount, in units. Reference the table above to find the appropriate unit amounts for employee and/or dependents.
Step 3: The result is the **Weekly** cost.

Important Definitions and Policy Provisions:

When Your Coverage Begins and Ends – Coverage becomes effective on the later of the program's effective date, the date you become eligible, the date your enrollment elections are received if applicable, or the date you authorize any necessary payroll deductions if applicable. Your coverage will not begin unless you are actively at work on the effective date. Dependent coverage, if applicable, will not begin for any spouse or child who on the effective date is an inpatient in a facility or is home confined and under the care of a physician. Coverage will end on the earliest of the date you are eligible for coverage under a plan intended to replace this coverage, you or your dependents if applicable, are no longer eligible, the group policy is no longer in force, or required premiums are not paid.

Benefit Reductions, Exclusions and Limitations:

Benefit Reduction Schedule - If you are still employed, your benefits and your spouse's benefits will reduce to 75% at age 70, 50% at age 75, 50% at age 80, 50% at age 85, 50% at age 90 and 50% at age 95.

Exclusions - Voluntary life insurance will not be paid if you commit suicide, while sane or insane, within the first two years of coverage.

Waiver of Premium – After premiums have been waived for 12 months, they will be waived for future periods of 12 months if you remain Disabled. This benefit will remain active until age 70 subject to proof of continuing disability each year.

Guaranteed Issue:

If you are a new hire and you apply within 31 days after you are eligible to elect coverage for yourself, you are entitled to choose any coverage offered up to the Guaranteed Issue Amount, without providing proof of good health. If you apply for an amount of coverage greater than the Guaranteed Issue Amount, coverage in excess of the Guaranteed Issue Amount will not be issued until the insurance company approves acceptable proof of good health. If you apply for coverage for yourself more than 31 days from the date you become eligible to elect coverage under this plan, the Guaranteed Issue Amount will not apply, unless Guaranteed Issue has been approved by your employer for a specific period of time. Coverage will not be issued until the insurance company approves acceptable proof of good health.

These are summarized definitions only. To be eligible for coverage, the covered illness or event must meet the definitions and other terms and conditions set forth in the group policy.

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Terms and conditions of coverage for Term Life insurance are set forth in Group Policy No. FLX 969760. This is not intended as a complete description of the insurance coverage offered. This is not a contract. Complete coverage details, including premiums, eligible conditions, their respective payments and policy exclusions and limitations are contained in the Policy. Please see your Plan Sponsor to obtain a copy of the Policy. If there are any differences between this summary and the group policy, the information in the group policy takes precedence. Product availability, costs, benefits, riders, covered conditions and/or features may vary by state. Please keep this material as a reference. Insurance coverage is issued on group policy form number: Policy Form TL-004700. Coverage is underwritten by Life Insurance Company of North America, 1601 Chestnut St. Philadelphia, PA 19192.

Offered by Life Insurance Company of North America, a Cigna company

Employer-Paid
TERM LIFE INSURANCE

SUMMARY OF BENEFITS

Prepared for: Miller Industries, Inc.
Semi Monthly

Term Life insurance can help protect your loved ones' financial health if you are no longer there to support them.

Who Is Eligible For Coverage?:

You: All active, Full-Time Salaried Employees of the Employer paid semi-monthly regularly working a minimum of 24 hours per week in the United States, who are citizens or permanent resident aliens of the United States.
You will be eligible for coverage immediately.

Available Coverage:

	Benefit Amount	Maximum	Guaranteed Issue Amount
Employee	2.0 Times Salary	Lesser of 2.0 Times Salary or $500,000	Lesser of 2.0 Times Salary or $500,000

Guaranteed Issue means that you may be able to purchase coverage without medical exams or health questions. See "Guaranteed Issue" below for more information.

Additional Features:

Waiver of Premium – If you become Disabled prior to age 60, and you remain Disabled continuously for a 6 month period and thereafter, you won't need to pay premiums for your life insurance coverage, provided we/the Insurance Company determine(s) you are Disabled. "Disabled" for this coverage means, because of injury or sickness, you are unable to perform the material duties of your regular occupation, or are receiving disability benefits under a program sponsored by your employer, for the first 12 months after your Disability began. Thereafter, you must be unable to perform the material duties of any occupation that you are or may reasonably become qualified based on your education, training or experience. If you qualify for this coverage and have insured your spouse or children, the insurance company will also waive their premium if applicable.

Conversion – To convert, you must apply for the conversion policy and pay the first premium payment within 31 days after your group coverage ends.

Important Definitions and Policy Provisions:

When Your Coverage Begins and Ends – Coverage becomes effective on the later of the program's effective date, the date you become eligible, the date your enrollment elections are received if applicable, or the date you authorize any necessary payroll deductions if applicable. Your coverage will not begin unless you are actively at work on the effective date. Dependent coverage, if applicable, will not begin for any spouse or child who on the effective date is an inpatient in a facility or is home confined and under the care of a physician. Coverage will end on the earliest of the date you are eligible for coverage under a plan intended to replace this coverage, you or your dependents if applicable, are no longer eligible, the group policy is no longer in force, or required premiums are not paid.

Waiver of Premium – After premiums have been waived for 12 months, they will be waived for future periods of 12 months if you remain Disabled. This benefit will remain active until age 70 subject to proof of continuing disability each year.

Guaranteed Issue:

If you are a new hire and you apply within 31 days after you are eligible to elect coverage for yourself, you are entitled to choose any coverage offered up to the Guaranteed Issue Amount, without providing proof of good health. If you apply for an amount of coverage greater than the Guaranteed Issue Amount, coverage in excess of the Guaranteed Issue Amount will not be issued until the insurance company approves acceptable proof of good health. If you apply for coverage for yourself more than 31 days from the date you become eligible to elect coverage under this plan, the Guaranteed Issue Amount will not apply, unless Guaranteed Issue has been approved by your employer for a specific period of time. Coverage will not be issued until the insurance company approves acceptable proof of good health.

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Offered by Life Insurance Company of North America, a Cigna company

Employee-Paid
TERM LIFE INSURANCE

SUMMARY OF BENEFITS

Prepared for: Miller Industries, Inc.

Term Life insurance can help protect your loved ones' financial health if you are no longer there to support them.

Who Is Eligible For Coverage?:

You: All active, Full-Time Salaried Employees of the Employer paid semi-monthly regularly working a minimum of 24 hours per week in the United States, who are citizens or permanent resident aliens of the United States.
You will be eligible for coverage immediately.
Your Spouse: Up to age 85, as long as you apply for and are approved for coverage yourself.
Your Child(ren): Is eligible as long as you apply for and are approved for coverage yourself.

Available Coverage:

	Benefit Amount	Maximum	Guaranteed Issue Amount
Employee	Units of $5,000	$1,000,000	$400,000
Spouse	Units of $5,000	$100,000	$30,000
Children	$10,000	$10,000; under 14 Days old $500; under 6 months old $500	All amounts

Guaranteed Issue means that you may be able to purchase coverage without medical exams or health questions. See "Guaranteed Issue" below for more information.

Additional Features:

Waiver of Premium – If you become Disabled prior to age 60, and you remain Disabled continuously for a 6 month period and thereafter, you won't need to pay premiums for your life insurance coverage, provided we/the Insurance Company determine(s) you are Disabled. "Disabled" for this coverage means, because of injury or sickness, you are unable to perform the material duties of your regular occupation, or are receiving disability benefits under a program sponsored by your employer, for the first 12 months after your Disability began. Thereafter, you must be unable to perform the material duties of any occupation that you are or may reasonably become qualified based on your education, training or experience. If you qualify for this coverage and have insured your spouse or children, the insurance company will also waive their premium if applicable.

Conversion – To convert, you must apply for the conversion policy and pay the first premium payment within 31 days after your group coverage ends.

Employee's Semi-Monthly Cost of Coverage:

Age	Employee Cost Per $5,000 Unit	Spouse Cost Per $5,000 Unit	Age	Employee Cost Per $5,000 Unit	Spouse Cost Per $5,000 Unit
0-19	$0.150	$0.150	60-64	$2.800	$2.800
20-24	$0.150	$0.150	65-69	$4.500	$4.500
25-29	$0.150	$0.150	70-74	$7.625	$7.625
30-34	$0.175	$0.175	75-79	$13.125	$13.125
35-39	$0.250	$0.250	80-84	$13.125	$13.125
40-44	$0.425	$0.425	85-89	$13.125	$13.125
45-49	$0.700	$0.700	90-94	$13.125	$13.125
50-54	$1.200	$1.200	95-99	$13.125	$13.125
55-59	$2.050	$2.050			

Child Cost Per $1,000 = $0.100

Actual per pay period premiums may differ slightly due to rounding. The rates above reflect the total cost. Rates vary by age and may be subject to change in the future. Benefits will reduce based on age (see Benefits Reduction Schedule for details).

How to Calculate Your Semi-Monthly Cost:

Step 1: Use the chart above to find your **Semi-Monthly** rate based on your age as of your effective date.
Step 2: Multiply this rate by your desired coverage amount, in units. Reference the table above to find the appropriate unit amounts for employee and/or dependents.
Step 3: The result is the **Semi-Monthly** cost.

Important Definitions and Policy Provisions:

When Your Coverage Begins and Ends – Coverage becomes effective on the later of the program's effective date, the date you become eligible, the date your enrollment elections are received if applicable, or the date you authorize any necessary payroll deductions if applicable. Your coverage will not begin unless you are actively at work on the effective date. Dependent coverage, if applicable, will not begin for any spouse or child who on the effective date is an inpatient in a facility or is home confined and under the care of a physician. Coverage will end on the earliest of the date you are eligible for coverage under a plan intended to replace this coverage, you or your dependents if applicable, are no longer eligible, the group policy is no longer in force, or required premiums are not paid.

Benefit Reductions, Exclusions and Limitations:

Benefit Reduction Schedule - If you are still employed, your benefits and your spouse's benefits will reduce to 75% at age 70, 50% at age 75, 50% at age 80, 50% at age 85, 50% at age 90 and 50% at age 95.

Exclusions - Voluntary life insurance will not be paid if you commit suicide, while sane or insane, within the first two years of coverage.

Waiver of Premium – After premiums have been waived for 12 months, they will be waived for future periods of 12 months if you remain Disabled. This benefit will remain active until age 70 subject to proof of continuing disability each year.

Guaranteed Issue:

If you are a new hire and you apply within 31 days after you are eligible to elect coverage for yourself, you are entitled to choose any coverage offered up to the Guaranteed Issue Amount, without providing proof of good health. If you apply for an amount of coverage greater than the Guaranteed Issue Amount, coverage in excess of the Guaranteed Issue Amount will not be issued until the insurance company approves acceptable proof of good health. If you apply for coverage for yourself more than 31 days from the date you become eligible to elect coverage under this plan, the Guaranteed Issue Amount will not apply, unless Guaranteed Issue has been approved by your employer for a specific period of time. Coverage will not be issued until the insurance company approves acceptable proof of good health.

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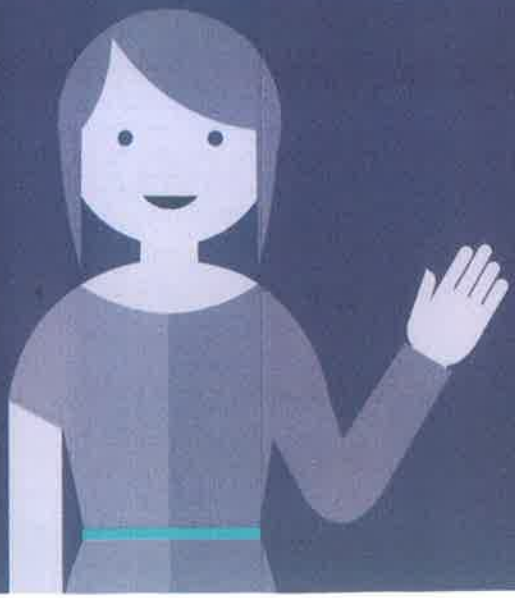
THIS POLICY PROVIDES LIMITED COVERAGE. IT PAYS A FIXED BENEFIT AND DOES NOT COVER MEDICAL EXPENSES AS INCURRED. THIS IS NOT A SUBSTITUTE FOR COMPREHENSIVE OR MAJOR MEDICAL HEALTH INSURANCE. THIS COVERAGE DOES NOT SATISFY THE INDIVIDUAL MANDATE OF THE AFFORDABLE CARE ACT BECAUSE THE COVERAGE DOES NOT MEET THE REQUIREMENTS OF MINIMUM ESSENTIAL COVERAGE.

Terms and conditions of coverage for Term Life insurance are set forth in Group Policy No. FLX 969760. This is not intended as a complete description of the insurance coverage offered. This is not a contract. Complete coverage details, including premiums, eligible conditions, their respective payments and policy exclusions and limitations are contained in the Policy. Please see your Plan Sponsor to obtain a copy of the Policy. If there are any differences between this summary and the group policy, the information in the group policy takes precedence. Product availability, costs, benefits, riders, covered conditions and/or features may vary by state. Please keep this material as a reference. Insurance coverage is issued on group policy form number: Policy Form TL-004700. Coverage is underwritten by Life Insurance Company of North America, 1601 Chestnut St. Philadelphia, PA 19192.



Welcome!

We're so glad you're here.

There's a retirement plan waiting for you! In just a few steps, you'll be on your way. Here's what to expect.

Get your account set up

Visit **principal.com/Welcome** or complete the enclosed forms to get started.

Begin by:

- Setting security preferences
- Reading important plan notices

Review your contribution

Your organization has set a contribution rate for you. Log in, take a look and make changes to your contribution rate if you want, or visit **principal.com/MatchEnrollmentWebinar.**

Check out the plan's investments

Each one is different and you can choose based on your goals and how you feel about risk. You can also pick from the plan's investment options later. But by picking it later, you understand that until you make a new investment selection, you're directing contributions to the plan's default.*

For a full listing, refer to the **Investment Option Summary.**

Principal®

*The plan's participant level default is: RetireView Risk: Moderate. See Investment Option Summary for important information. If the default is a target date fund series, the applicable target date fund will be based on the plan's normal retirement date.

EMPLOYEE BENEFITS

As you read through this guide, use the election worksheet below to keep track of your elections and make the actual enrollment process quick & easy!

Medical	**Dental**	**Life Insurance - Cigna**
__ Single __ Employee + Child __ Employee + Spouse __ Family __ Option 1 - EPO __ Option 2 - PPO (PPO - Only offered to Ohio residents) __ I do not want medical insurance. Are you currently under a court order to provide medical coverage to any dependents? __ Yes __ No	__ Single __ Employee + Child __ Employee + Spouse __ Family __ I do not want dental insurance.	__ Single __ Employee + Child __ Employee + Spouse __ Family __ I do not want voluntary life insurance. You will automatically have coverage for yourself as a free benefit from Miller for 2x your annual salary. This section is asking if you want the voluntary life insurance.
Accident Coverage Allstate	**Critical Illness Coverage Allstate**	**Cancer Coverage Allstate**
__ Single __ Employee + Child __ Employee + Spouse __ Family __ I do not want the accident benefit.	__ Single __ Employee + Child __ Employee + Spouse __ Family __ Low Option - $10K __ High Option - $20K __ I do not want critical illness benefit.	__ Single __ Employee + Child __ Employee + Spouse __ Family __ Low Option __ Median Option __ High Option __ I do not want cancer benefit.

Payroll Deduction Calculator

Health Insurance Premium: _____

Dental Insurance Premium: + _____

Voluntary Life Premium: + _____

Accident Coverage: + _____

Critical Illness Coverage: + _____

Cancer Coverage: + _____

Total Insurance Deductions Per Paycheck: _____

UPMC HEALTH PLAN

Employee Benefit Election & Change Form

For groups with 51 or more employees

For employer use only:	Medical Plan Details	Dental and/or Vision Plan Details
Employee Name: _____	Group #: _____	Group #: _____
Employer Group Name: _____	Subgroup #: _____	Subgroup #: _____
	Effective Date: _____	Effective Date: _____

1. Reason for Application

☐ Open Enrollment ☐ COBRA ☐ Qualifying Event

☐ New Hire

2. Plan Description Name

Medical: _____

UPMC Dental *Advantage*: _____

UPMC Vision Care: _____

UPMC Vision *Advantage*: _____

3. Change of Status/Coverage

☐ Select/Change PCP

☐ Change Address

☐ Change Name

Former Name: _____

☐ COBRA

☐ Add Dependent

☐ Drop Dependent

☐ Birth

☐ Marriage

☐ Other: _____

☐ Date of Qualifying Event: _____

4. Employee Information

Employee Name: _____

Street Address: _____

City: _____ State: _____ ZIP Code: _____ Home Phone Number: _____

Work Phone Number: _____ First Day of Employment: _____ Retiree: ☐ Yes ☐ No

5. Other Group Health Insurance

Name of covered member: _____ Name of other health insurance company: _____

Policy number: _____ Effective date: _____

If you need additional space, attach a separate sheet of paper.

Disclosure of Personal Health Information

By acceptance of coverage and upon signing this application, for so long as I am enrolled in UPMC Health Plan, I understand, on behalf of myself and my eligible dependents and spouse, if any, that all of my/our health care, dental, and/or vision providers will release to UPMC Health Plan or its authorized agents all information related to my/our medical, dental, and/or vision history and treatment, including mental health, substance abuse treatment/conditions, and AIDS-related information, if any, for all lawful purposes relating to the administration of my health/dental/vision benefits, including determining or reviewing coverage claims, quality assurance, clinical resource management, and utilization review for services that I/we request or receive. I further understand that UPMC Health Plan will release such information to health care, dental, and/or vision entities for such purposes. My right to revoke this consent in writing at any time will not apply to the extent that UPMC Health Plan or any other provider already has acted in reliance on this statement. The term "UPMC Health Plan" collectively refers to UPMC Health Plan Inc., UPMC Health Coverage Inc., UPMC Health Options Inc., and UPMC Health Benefits Inc.

I further understand that information will be released by, to, or among the various UPMC Insurance Services Division entities for all lawful purposes, including administration of workers' compensation and short-term disability, medical management, and implementation of health/wellness initiatives.

(Continued on back)

6. Covered Family Members and Benefit Enrollment Selection

Name (Last, First, MI)	SSN (Required)	Sex (M or F)	Birth Date (Month/Day/Year)	Dependent Code*	Email Address	PCP & Practice #**
Primary (Self)						
Medical: ☐ Enroll ☐ Waive	Dental: ☐ Enroll ☐ Waive		Vision: ☐ Enroll ☐ Waive		Reason for Waiving: _____	
Spouse ☐ Domestic Partner†						
Medical: ☐ Enroll ☐ Waive	Dental: ☐ Enroll ☐ Waive		Vision: ☐ Enroll ☐ Waive		Reason for Waiving: _____	
Dependent Children						
1						
Medical: ☐ Enroll ☐ Waive	Dental: ☐ Enroll ☐ Waive		Vision: ☐ Enroll ☐ Waive		Reason for Waiving: _____	
2						
Medical: ☐ Enroll ☐ Waive	Dental: ☐ Enroll ☐ Waive		Vision: ☐ Enroll ☐ Waive		Reason for Waiving: _____	
3						
Medical: ☐ Enroll ☐ Waive	Dental: ☐ Enroll ☐ Waive		Vision: ☐ Enroll ☐ Waive		Reason for Waiving: _____	
4						
Medical: ☐ Enroll ☐ Waive	Dental: ☐ Enroll ☐ Waive		Vision: ☐ Enroll ☐ Waive		Reason for Waiving: _____	
5						
Medical: ☐ Enroll ☐ Waive	Dental: ☐ Enroll ☐ Waive		Vision: ☐ Enroll ☐ Waive		Reason for Waiving: _____	

**FTS = Full-Time Student; DD = Disabled Dependent (certification required) **Required for HMO plans only.*

†Not all employer groups offer domestic partner coverage. Please contact your employer group if you have questions.

Employee Name: _____

Authorization/Signature

I have read and agree with the terms as stated on this Employee Benefit Election & Change Form. Subject to revocation by me by written notice to my employer, I authorize the required deduction (if any) of applicable contributions from my wages.

I agree that all information on this Employee Benefit Election & Change Form is true and correct to the best of my knowledge and belief. I understand that this Election Form is the basis upon which coverage may be issued under the plan.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. I UNDERSTAND THAT PROVIDING FALSE INFORMATION OR OMITTING RELEVANT INFORMATION IN THIS APPLICATION MAY RESULT IN THE DENIAL OF CLAIM(S) OR CANCELLATION OF COVERAGE.

UPMC Health Plan administers benefit plans underwritten by UPMC Health Plan Inc., UPMC Health Benefits Inc., UPMC Health Coverage Inc., and UPMC Health Options Inc. This managed care plan may not cover all your health care expenses. Read your contract carefully to determine which health care services are covered.

_____ _____

Signature of Employee — Date

_____ _____

Signature of Spouse/Domestic Partner (if to be covered) — Date

_____ _____ _____

Signature of Employer or Employer's Agent/Authorized Representative — Title — Date

Detatch before submission

3831

UNITED CONCORDIA® Dental Enrollment Form

For New Enrollment, please complete ALL sections of this form. For Enrollment Changes, please select the applicable "Type of Activity" in Section A and provide the identification number and employee name in Section C (also complete Section D for dependent changes).

Fill in circles completely: ● Correct ⊗ Incorrect

For best results, print in capital letters and avoid contact with edge of box.

Example: A B C

SECTION A: GENERAL INFORMATION

1. TYPE OF PROGRAM

- ○ **FFS—Indemnity, Active PPO, Passive PPO** (Please specify)
  - ○ Concordia Access
  - ○ Concordia Choice
  - ○ Concordia Flex
  - ○ Concordia Preferred
  - ○ Concordia Select
  - ○ Other_____
- ○ **DHMO** (Please specify)
  - ○ Concordia Plus
  - ○ Other_____

Provider Number (DHMO only)

2. TYPE OF ACTIVITY

- ○ **New Enrollment**
- ○ **Cancel Coverage**
  - ○ Cancel All Coverage (Employee & All Dependents)
  - ○ Cancel Dependent(s) Only (List dependents to be cancelled in Section D)
  - ○ Cancel Spouse Only (List spouse to be cancelled in Section D)
- ○ **Change (Include Group Number in Section B)**
  - ○ Add Dependent (e.g., spouse, domestic partner, child, etc.)
  - ○ Change Address
  - ○ Reinstate Coverage
  - ○ Change Group Number
  - ○ Change Provider
  - ○ Change Name
  - ○ To COBRA Group
  - ○ Other_____

Effective Date (mm/dd/yyyy) / /

SECTION B: EMPLOYER USE ONLY

Employer Name

Group Number (9 digits)

UCCI Payroll Location

SECTION C: EMPLOYEE INFORMATION—Please print clearly to expedite your request.

Identification Number (Social Security Number) | **Date of Birth** (mm/dd/yyyy) / / | **Gender** | **Original Employment Date** (mm/dd/yyyy) / /

First Name | **M.I.** | **Last Name**

Home Address

City | **State** | **ZIP Code**

SECTION D: DEPENDENT INFORMATION—Please list the added/cancelled dependents in this section. For more than six dependent children, complete and attach an additional form. If dependent children listed in this section are disabled or full-time student age 19 or over, please see your group administrator for a Dependent Certification Form, which should be completed and returned with the Dental Enrollment Form.

#1 Spouse/Domestic Partner

Identification Number (Social Security Number) | **Date of Birth** (mm/dd/yyyy) / / | **Gender** | **Provider Number** (DHMO only)

First Name | **M.I.** | **Last Name**

#2 Dependent

Identification Number (Social Security Number) | **Date of Birth** (mm/dd/yyyy) / / | **Gender** | **Provider Number** (DHMO only)

First Name | **M.I.** | **Last Name**

#3

Dependent Identification Number (Social Security Number) | **Date of Birth** (mm/dd/yyyy) | **Gender** | **Provider Number** (DHMO only)

First Name | **M.I.** | **Last Name**

#4

Dependent Identification Number (Social Security Number) | **Date of Birth** (mm/dd/yyyy) | **Gender** | **Provider Number** (DHMO only)

First Name | **M.I.** | **Last Name**

#5

Dependent Identification Number (Social Security Number) | **Date of Birth** (mm/dd/yyyy) | **Gender** | **Provider Number** (DHMO only)

First Name | **M.I.** | **Last Name**

#6

Dependent Identification Number (Social Security Number) | **Date of Birth** (mm/dd/yyyy) | **Gender** | **Provider Number** (DHMO only)

First Name | **M.I.** | **Last Name**

SECTION E: OTHER DENTAL COVERAGE

—Do you or your dependent(s) have other Group Dental Coverage? Yes ◯ No ◯

If your answer is yes, please complete the following information.

Policyholder Name (First, M.I., Last)	**Insurance Company**
Policy/Identification Number	**Effective Date** (mm/dd/yyyy)

I represent that all information supplied in this application is true and correct. Any person who knowingly, and with intent to defraud any insurance company or other person, files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

Employee Signature | **Phone Number** | **Email Address** | **Date**

Employer Signature | **Phone Number** | **Date**

AMERICAN HERITAGE LIFE INSURANCE COMPANY (AHL)
1776 AMERICAN HERITAGE LIFE DRIVE
JACKSONVILLE, FL 32224

Allstate. BENEFITS

Group Enrollment Form

☒ Check if custom form

Account No.	Employee ID	Requested Effective Date	First Deduction Date	Account	Location	Situs State
						TN

Deduction Mode: ☐ Semi-Monthly ☐ Weekly

AHL home office use only	*Remarks*	Dep Code ☐ E ☐ S ☐ C ☐ F

General Information

All references to spouse include civil union and domestic partner relationships.

Employee Name *(Last, First, M.I.)*	Birth Date	Social Security No.	☐ Male ☐ Female
Residence Street Address		Phone No.	
City, State, Zip	Email Address		
Employer/Association/Union Miller Industries	Hire Date	Occupation*	

**Occupation with the employer in the General Information section.*

Complete for all other persons you (the employee) are requesting to be insured

Last Name	First Name	Relationship	Gender	Birth Date	Social Security No.

Tobacco Use

If applying for Critical Illness, has the employee used tobacco in the last 12 months? Employee ☐ Yes ☐ No

If applying for Critical Illness, has the employee's spouse used tobacco in the last 12 months? Spouse ☐ Yes ☐ No

Qualifying Life Event

Are you applying for coverage or changing existing coverage due to a qualifying event? ☐ Yes ☐ No

Check the qualifying event: ☐ Marriage/Divorce ☐ Birth/Adoption ☐ Spouse New Job/Job Loss ☐ Termination ☐ Work Status Change ☐ Eligible/Ineligible Child ☐ Spouse/Dependent Child Death ☐ Employee Death

Qualifying event date _____ Current certificate number(s) _____

Termination of Current Coverage

Do you currently have any individual coverages with AHL that you wish to terminate in conjunction with this enrollment for group coverage? ☐ Yes ☐ No

If yes, enter the following information: Effective date of termination _____ Policy Number _____

Select the type of coverage: ☐ Accident ☐ Cancer ☐ Critical Illness

Employee Name _____ Account No. _____

Group Enrollment Form

Selection of Coverage

Answer yes or no and complete for each coverage selected.

Accident (GVAP2 Off the Job Accident)

Section 125 ☒

Do you want this coverage? ☐ Yes ☐ No

Who do you want to cover?

- ☐ Employee Only
- ☐ Employee + Spouse
- ☐ Employee + Child(ren)
- ☐ Family

Total Deduction

Your coverage will consist of:	Units
Base Coverage	3
☒ Benefit Enhancement Option	2
☒ Outpatient Physician's Rider	4

Cancer/Specified Disease (GVCP3)

Section 125 ☒

Do you want this coverage? ☐ Yes ☐ No

Who do you want to cover?

- ☐ Employee Only
- ☐ Employee + Spouse
- ☐ Employee + Child(ren)
- ☐ Family

Total Deduction

Choose coverage:	☐ Plan 1	☐ Plan 2	☐ Plan 3
Hospital	1	2	3
Radiation/Chemotherapy	2	4	4
Surgery Related	1	2	3
Miscellaneous	1	1	1
☒ Cancer Initial Diagnosis Option	2	2	5
☒ Intensive Care Option	2	2	4
☒ Wellness Option	4	4	4

Critical Illness (GVCIP2)

Section 125 ☒

Do you want this coverage? ☐ Yes ☐ No

Who do you want to cover?

- ☐ Employee Only
- ☐ Employee + Spouse
- ☐ Employee + Child(ren)
- ☐ Family

Total Deduction

Choose basic benefit amount ☐ $10,000 ☐ $20,000

Your coverage will consist of:

- ☒ Second Event Initial Critical Illness Option
- ☒ Wellness Option Units 1
- ☒ Supplemental Critical Illness Option II

Beneficiary Designation

Your beneficiary designations will apply to all coverages and riders applied for, including designations for a spouse or covered dependent. For additional beneficiary designation options, complete form ABJ040.

Primary Beneficiary Name *(Last, First, M.I.)*		Social Security No.
Residence Address	Birth Date	Relationship
City, State, Zip	Phone No.	
Contingent Beneficiary Name *(Last, First, M.I.)*		Social Security No.
Residence Address	Birth Date	Relationship
City, State, Zip	Phone No.	

Employee Name _____ Account No. _____

Group Enrollment Form

ACCEPTANCE/AUTHORIZATION. I hereby request all coverage(s) selected for which I am or may become eligible under the group coverages issued by AHL. I AUTHORIZE my employer to deduct from my salary or wages, if applicable, the necessary premium for the coverages requested. EFFECTIVE DATE: I understand that the "effective date" of my elected coverages will be the effective date recorded on my Certificate, not the date this Enrollment is signed. WAIVER/DECLINATION: I understand that if I refuse any coverage for which I am eligible, satisfactory proof of insurability may be required, at my own expense, should I desire to apply for it at a later date. Any such form may be declined on the basis of such proof.

FRAUD NOTICE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Employee Signature _____ Date Signed _____

Home office or producer to complete before issue:

Producer Name	Producer Number	Percentage Credit	Producer Name	Producer Number	Percentage Credit
Servicing Producer					
Robert Huffaker	5EBG1		Robert Huffaker	5EBG1	

INSURANCE ENROLLMENT FORM

Please use this form to apply for coverage. Simply fill in any missing information below. Don't forget to include your Social Security Number, Birthdate, sign your name and enter today's date.

Return completed form to Human Resources, 8503 Hilltop Drive Ooltewah, TN 37363

NEW YORK LIFE GROUP BENEFIT SOLUTIONS

Offered by Life Insurance Company of North America

Employer: Miller Industries, Inc.

ALL ABOUT YOU – THE EMPLOYEE

Your Name _____ **Social Security #** _____ **Birthdate** _____

Address _____ City _____ State _____ Zip _____

Work Phone _____ Home Phone _____ Employee ID # _____ Gender: ____

COMPLETE THIS SECTION ONLY IF YOU WANT COVERAGE FOR YOUR SPOUSE

❑ I am currently married and my date of marriage is: _____

My Spouse's Information

Name _____ **Social Security #** _____

Birthdate _____ Gender _____

YOUR COVERAGE ELECTIONS

View the enclosed Summary of Benefits for full costs and instructions for how to calculate premium.

Employee-Paid (Voluntary) Term Life Insurance Policy # FLX 969760

Applicant	Available Coverage	Choose your desired coverage amount below or enter a different amount in the "Other" field.
Employee	Units of $5,000 up to $1,000,000. Guaranteed Coverage: $400,000	❑ $5,000 ❑ $400,000* ❑ $1,000,000** ❑ Other _____ *Amount must be a multiple of $5,000.* ❑ Decline Coverage
Spouse	Units of $5,000 up to $100,000. Guaranteed Coverage: $30,000	❑ $5,000 ❑ $30,000* ❑ $100,000** ❑ Other _____ *Amount must be a multiple of $5,000. The amount cannot exceed 50% of the employee's coverage.* ❑ Decline Coverage
Child	❑ $10,000	❑ Decline Coverage

**The GI amount is only available between 03/01/2022 and 03/31/2022 or if enrolling within the first 31 days of eligibility. For any coverage that is not Guaranteed Issue, you must complete the Evidence of Insurability Form.*
***This is the maximum amount that you can choose under this plan.*
All coverage elected during this enrollment period will take effect on the latest of 04/01/2022, the date your election form is received by your employer, or if applicable the day your Evidence of Insurability Form is approved by the Insurance Company.

SIGN HERE TO ACCEPT YOUR DEDUCTION FROM YOUR PAYCHECK

I accept the insurance options chosen above. If premiums are to be paid by payroll, I authorize my employer to deduct the necessary amounts from my paycheck. If I did not choose coverage now, and I decide I want coverage at a later date, I may be required to provide evidence of insurability at my own expense. I understand that coverage is subject to New York Life Group Benefit Solutions' approval and that my insurance will not go into effect unless I am actively at work on the effective date. I also understand that coverage for each of my dependents will go into effect only if the person is not confined in a hospital or institution, or receiving certain medical treatment. I understand my information is protected by privacy laws and will be released only in accordance with these laws. Additional information about the rules and conditions around the requested insurance is described in the policy and certificate. Insurance coverage is underwritten by GA: Life Insurance Company of North America.

Please Sign Here ☛ Signature _____ Date _____

Please turn to other side to complete enrollment process.
Be sure to make a copy for your records.

BENEFICIARY SECTION

To specify a beneficiary, complete the section below. You will be the beneficiary for your spouse and child(ren). If you need additional space to indicate your beneficiary designations, attach a separate piece of paper using the below format including the appropriate policy number, the date, and your signature.

Voluntary Life Insurance			Policy No. FLX 969760	
Employee's Primary Beneficiary(ies):	Relationship	Social Security Number	Date of Birth	% (total must equal 100%)
Employee's Contingent Beneficiary(ies):	Relationship	Social Security Number	Date of Birth	% (total must equal 100%)

Community Property Laws—If you are married, reside in a community property state (Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington or Wisconsin), and name someone other than your spouse as beneficiary payment of benefits may be delayed or disputed unless your spouse provides their signature in the space provided below.

Spouse Signature _____ Date ____/____/____

Employee Signature _____ Date ____/____/____

Created on 02/2022.

**Info required for *ALL* children if adding Child Life

Name:

Social:

Birth Date: