SUMMARY PLAN DESCRIPTION

2026-2027

for Postdocs

UAW/ UMass HEALTH & WELFARE TRUST FUND

August 1, 2026

Dear Plan Participant,

Your Trust Fund provides a wide range of benefits for you and your family.

Benefits for the Post-Doctoral Unit Health & Welfare Plan (PHWP) include:

- a dental plan with Altus Dental
- a vision plan with EyeMed Vision
- a wellness reimbursement of up to $240 per year against your gym/fitness receipts
- family dental plan with a participant contribution
- free family vision coverage
- a childcare reimbursement for on or off-campus childcare receipts
- access to Grow Therapy
- basic term life insurance policy and optional supplementary life insurance
- a prepaid legal plan

This booklet is designed to make it easier for you to find the information you need and to understand your rights and responsibilities under the Plans.

It is important that you read the entire booklet so that you know what benefits you are eligible to receive, what policies and procedures need to be followed to get your benefits and how to use your benefits wisely.

If you have any questions or concerns about any of your benefits or coverage, contact the Director of Benefit Programs at (413) 200-0423 or uwdental@umass.edu The Trust Fund's website also has detailed information about all aspects of the Plans: www.hwtf.org.

Sincerely,
The Board of Trustees of the UAW/UMass Health & Welfare Trust Fund

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About
Your Trust Fund

The UAW/UMass Health & Welfare Trust Fund is the plan sponsor for the Post-Doctoral Unit Health & WelfarePlan. The UAW/UMassHealth & WelfareTrust Fund is a self-administered, joint labor-management, employer-funded Taft-Hartley Trust Fund. Your coverage is provided as a result of a collective bargaining agreement between the University of Massachusetts Board of Trustees and the United Auto Workers, Local 2322 (GEO-UAW Local 2322 & PRO-UAW Local 2322). The UAW/UMass Health & Welfare Trust Fund's EIN is 04-3538613.

Self-administered means that the Trust Fund staff is responsible for the day-to-day administration of the Trust Fund, including addressing your questions and performing other administrative operations. Employer funded means that the Trust Fund is entirely funded by the University.

All of the money the University pays to the Trust Fund goes directly to providing your benefits and administering the Trust Fund. The Trust Fund does not exist to make profits, like an insurance company. Its purpose is to provide you, other bargaining unit members and your families with quality health and welfare benefits.

Joint labor-management means that the Trust Fund is run by an equal number of trustees appointed by your union, UAW Local 2322, and by your employer, the University of Massachusetts Amherst.

Taft-Hartley is the name of the federal law that allows these labor-management trust funds to be established.

About
Your Trust Fund

Employer Pays for Your Benefits.
Your union contract—the collective bargaining agreement between the University and UAW Local 2322—requires that your employer make contributions to the Trust Fund on your behalf for health and welfare benefits. These contributions go into a large pool of money (the Fund) which is used to pay for all the benefits for all participants and their families covered by the Plans.

Important Phone Numbers:
Trust Fund Director of Benefit Programs: (413) 345-2156
Altus Dental: (877) 223-0588
EyeMed Vision: (866) 723-0154
UAW Local 2322: (413) 534-7600
Center for Early Education & Care: (413) 545-1566

You can also visit our website, www.hwtf.org, for forms and other resources.

What is a Summary **Plan Description?**

This booklet serves as both a Summary Plan Description and Plan Document for those employed by the University of Massachusetts Amherst and participating in the plans provided by UAW/UMass Health & Welfare Trust Fund. The plans administered by the UAW/UMass Health & Welfare Trust Fund are the GEO Unit Health & Welfare Plan (the "GHWP") and the Post-Doctoral Unit Health & Welfare Plan (the "PHWP").

The Plans are administered by the Board of Trustees (the "Trustees") of the UAW/UMass Health & Welfare Trust Fund. No individual or entity, other than the Trustees (including any duly authorized designee thereof) has any authority to interpret the provisions of this Plan Document or to make any promises to you about the Plans.

The Trustees reserve the right to amend, modify, discontinue or terminate all or part of this Plan for any reason and at any time when, in their judgment, it is appropriate to do so. These changes may be made by formal amendments to the Plans, resolutions of the Board of Trustees, actions by the Trustees when not in session by telephone or in writing, and/or any other methods allowed for Trustee actions.

What is a Summary **Plan Description? (cont.)**

If the Plans are amended or terminated, you and other employees may not receive benefits as described in this Plan Document. This may happen at any time if the Trustees decide to terminate the Plans or your coverage under the Plans. In no event will any employee become entitled to any vested or otherwise nonforfeitable rights under the Plans.

The Trustees (including any duly authorized designee of the Trustees) reserve the complete authority and discretion to construe the terms of the Plans (and any related Plan documents) including, without limitation, the authority to determine the eligibility for, and the amount of, benefits payable under the Plans. These decisions shall be final and binding upon all parties affected by such decisions.

This booklet and the Trust Fund's Director of Benefit Programs are your sources of information on the Plans. You cannot rely on information from co-workers, union or employer representatives, dental offices or eyecare providers. If you have any questions about the Plans and how the coverages work, the Trust Fund's Director of Benefit Programs will be glad to help you. Since telephone conversations and other oral statements can easily be misunderstood, they cannot be relied upon if they are in conflict with what is stated in this Plan Document.

Overview of **PHWP**

The benefit plan year for the PHWP is August 1 to July 31 of each year.

The current plan year is 8/1/26-7/31/27.

The benefit application is available online at portal.hwtf.org/login and opens July 15 of each year.

To complete the application, submit all of the information requested and make sure to complete the final step of the process, which is to electronically sign your benefits authorization form according to the online instructions. Without this e-signed form on file, we cannot verify your eligibility or complete the processing of your application.

Your dental, vision, wellness and childcare benefits, administered by the Trust Fund, are completely separate from your employee health plan, administered by Blue Cross Blue Sheild.

Your plan elections for Trust Fund benefits are completely separate from your health plan elections. Though not administered by the Trust Fund, you can find more information regarding your health plan at https://member.bluecrossma.com/

Eligibility
PHWP

Individual Eligibility
You are eligible to participate in the PHWP if:

- You're working in a University of Massachusetts Amherst PRO Unit position that is at least a 50% full-time equivalent (FTE).

You may also be eligible for benefits if:
You are eligible to receive COBRA continuation coverage and you comply with the Notice Requirements and make the monthly payments required to keep this coverage (see section on COBRA continuation coverage).

Eligibility for Your Spouse, Same-Sex or Opposite-Sex Domestic Partner
Your spouse, same-sex or opposite sex domestic partner is eligible for dental and vision coverage under the GHWP as long as they are legally married to you, in the case of a spouse; or are in a committed, long-term relationship, which is similar to marriage and live together at the same address and intend to do so indefinitely, in the case of a partner.

If you and your spouse are legally divorced or legally separated, your spouse is not covered by the GHWP benefits, unless required by court order.

The Trustees reserve the right, in their sole and absolute discretion, to determine all questions relating to the eligibility of partners.

Eligibility
PHWP (cont.)

Eligibility for Your Spouse, Same-Sex or Opposite-Sex Domestic Partner (continued)
Changes within your family that relate to eligibility must be reported to the Trust Fund immediately and in no case more than thirty (30) days from the date of the event. Such changes include:

- separation or divorce of a spouse,
- termination of a domestic partnership,
- failure to continue to meet the eligibility conditions set forth above, and/or
- change in status of your dependent children.

Except as provided by court order, Trust Fund coverage of a spouse or partner ends upon separation or divorce, termination or change in status of a domestic partnership such that it no longer meets the eligibility conditions set forth by the Fund.

Enrollment for spouses, same and opposite sex domestic partners is also subject to any prevailing premiums established by the Trustees for a given plan year. For plan year 2026-27, the monthly premium for single+1 dental coverage is $10 and for family dental coverage is $20, due upon application. There is no premium due for single+1 or family vision coverage. Trustees reserve the right to terminate the family portion of any participant's coverage due to lack of payment of the applicable family premiums, retroactive to the start of coverage date or retroactive to the last month that was paid in full.

Eligibility
PHWP (cont.)

Eligibility for Your Children
Your children are eligible up to their 26th birthday for Altus Dental benefits and up to their 19th birthday for EyeMed Vision benefits if all the following conditions are met:

- They're your biological children; or
- They're your legally adopted children (coverage starts from placement); or
- They're your stepchildren (including the child of a domestic partner); or
- They're a child who resides with you and is fully supported by you; or You're their legal parent identified on their birth certificate; and
- They're not eligible to enroll in another employer-sponsored dental/vision plan (excluding parent coverage) and they are not married.

Your foster children and grandchildren are not covered by the PHWP.

After your Child Ages Out of Eligibility
Your child's Altus Dental coverage may be continued up to his or her 26th birthday if:

- Your child is unmarried; and
- They're not eligible to enroll in another employer-sponsored dental/vision plan (excluding parent coverage).

Your child's EyeMed Vision coverage may not be continued beyond the age of 19, with the exception that they would be eligible to continue coverage under the COBRA extension plan (see COBRA continuation coverage section).

Eligibility
PHWP (cont.)

Children with Disabilities
If your child is disabled, as described in the list immediately below, it may be possible for Altus Dental coverage for your child to continue after age 26 if all of the following additional conditions are met:

- There is no other coverage available from either a government agency or through a special organization; and
- Your child is not married; and
- Your child became handicapped before age 19; and
- You file a properly completed Disability Certification Form with the Trust Fund each year after your child reaches age 26.

Your child is disabled if the Trustees determine in their discretion that your child lacks the ability to engage in any substantial gainful activity due to any physical or mental impairment that is verified by a physician and is expected to last for a continuous period of not less than 12 months or to result in death.

The Trust Fund will comply with the terms of any Qualified Medical Child Support Order (QMCSO) as the term is defined in the Employee Retirement Income Security Act (ERISA) of 1974, as amended.

AQMCSO may require the Trust Fund to make coverage available to your child even though the child is not, for income tax purposes or Fund purposes, your legal dependent, because of separation or divorce.

Eligibility
PHWP (cont.)

Children with Disabilities (continued)
In order to be a qualified order, the medical child support order must:

- Be issued by a court or authorized state agency; Clearly specify the alternate recipient;
- Reasonably describe the type of coverage to be provided to such alternate recipient; Clearly state the period to which such order applies; and
- Indicate the name and last known address of the member who is required to provide the coverage and the name and mailing address of each child covered by the order.

The Director of Benefits will determine the qualified status of a medical child support order in accordance with the Trust Fund's above written procedures.

Benefits of PHWP **Dental+Vision**

The benefit plan descriptions for the dental and vision plans can be found below. Our dental plan is the Altus Dental Plan (Connection Dental and DenteMax Networks). The benefits follow a plan year of 8/1 to 7/31 of each year. Each 8/1, the dental plan year maximum amount availble to you & deductible requirement renew. Our vision plan is the EyeMed Select Plan. The benefits follow a plan year of 8/1 to 7/31 of each year, meaning the allowances available to you renew each 8/1. Both of our plans have nationwide networks of providers. You can locate providers at www.hwtf.org.

Appeals

Both insurers have internal appeals processes for claims. These processes are completely separate from the Trust Fund. If an Altus claim is denied, you can request an appeal by writing to Altus within 180 days of receiving their decision. For urgent or emergency services, you may call Customer Service to start an appeal. Send your appeal to: Altus Dental Insurance Company, Inc., Attn: Appeals, P.O. Box 1557, Providence, RI, 02901-1557.

To appeal an EyeMed decision, you should submit your request in writing to: Member Appeals Coordinator, EyeMed Vision Care, 4000 Luxottica Place, Mason, OH 45040. Your request for a review of the adverse benefit determination must be submitted within 180 days of the date of the Explanation of Benefits.

Benefits of PHWP
Dental+Vision (cont.)

Subscriber Certificates/Member Guides
Subscriber certificates are included in this document and member guides are available at www.hwtf.org.

Pre-Treatment Estimates
Ask your dentist to submit a pre-treatment estimate to Altus before having anything other than preventative or diagnostic procedures done. Altus will send you an estimate of the dental insurance benefits available for the service. Please request a pre-treatment estimate in the case of all fillings, crowns, bridges and implants.

Second Opinion Exams
For Altus: Please contact Altus customer service at (877) 223-0588. For EyeMed: Submit a Second Opinion Request Form. Once completed, it should be sent to the Quality Assurance team for consideration at Vision Care Services (Fax: (513) 492-4999), or Attn: Quality Assurance, 4000 Luxottica Place, Mason, OH 45040

Declining Benefits
To decline benefits, please go to portal.hwtf.org/login. This decision cannot be changed until the next open enrollment period. If you wish to enroll later during an open enrollment period, return to the website and complete the enrollment application.

GRAD EMPLOYEE & POSTDOC DENTAL PLAN

Grad Group Number :3001-0001 **Postdoc Group Number:** 3001-0002

Altus Dental Preferred Point of Service Option - Includes Connection Dental and DenteMax Networks

Benefits Summary

Plan Year 8/1/2026-7/31/2027

Exams, cleanings, perio maintenance, bitewing x-rays, single x-rays, fluorides, sealants and complete x-ray series/Panoramic film don't count against your policy year maximum

Annual Maximum

$2,350

Elective Orthodontic Lifetime Maximum

$1,500

Maximum Lifetime Cap

Unlimited

TMJ Lifetime Maximum

$500

In-Network Deductible

Individual $0

Family $0

Out-of-Network Deductible

Individual $75

Family $225

Dependent Coverage

Dependent children are covered under these benefits up until the end of the month that they turn 26.

Teeth whitening once per arch every 60 months covered at 65%. Athletic mouth guards – For dependent children under age 19, once every 24 months covered at 65%. Biopsy of oral tissue when not covered by a patient's medical plan covered at 80%.

P Pre-treatment Estimate Recommended

A Prior Authorization Required

In Network: Plan pays 100%; Member Coinsurance 0%
Out of Network: Plan pays 100%; Member Coinsurance 0%

- Oral exam, problem or focused visit twice per policy year
- Cleaning four per policy year
- Fluoride treatment for children under age 19 or fluoride varnish for all covered members twice per policy year. For qualifying SmileMore patients, 2 additional fluoride treatments per policy year for members of all ages.
- Bitewing x-rays one set every 6 months
- Complete x-ray series or panoramic film once every 36 months.
- Single x-rays as required
- Sealants for children under age 18 once every 36 months on unrestored permanent molars. For qualifying SmileMore patients, sealants are covered for unrestored primary molars or unrestored permanent bicuspids and molars. One sealant per tooth every 36 months for all ages.
- Space maintainers unilateral space maintainers once per lifetime for lost deciduous (baby) teeth. Bilateral space maintainers once every 60 months for lost deciduous (baby) teeth
- Consultations twice per policy year
- Periodontal maintenance following active therapy four per policy year
- Nutritional counseling or Oral hygiene instruction for qualifying SmileMore patients. One nutritional counseling OR one oral hygiene instruction once every 36 months
- Tobacco counseling for qualifying SmileMore patients. Once every 12 months

In Network: Plan pays 90%; Member Coinsurance 10%
Out of Network: Plan pays 90%; Member Coinsurance 10% - (Deductible Applies)

- Amalgam (silver) fillings and composite (white) fillings

In Network: Plan pays 80%; Member Coinsurance 20%
Out of Network: Plan pays 80%; Member Coinsurance 20% - (Deductible Applies)

- Palliative treatment (minor procedures necessary to relieve acute pain) twice per policy year
- Extractions and other routine oral surgery when not covered by a patient's medical plan
- General anesthesia or intravenous (I.V.) sedation for certain complex surgical procedures
- Root canal therapy on permanent teeth. Retreatments are covered upon review. one procedure per tooth per lifetime

P • Root planing and scaling once per quadrant every 24 months

P • Osseous (bone) surgery once per quadrant every 24 months

P • Gingivectomies once per site every 24 months

P • Soft tissue grafts once per site every 36 months

P • Crown lengthening once per site every 60 months

P • Guided tissue regeneration and bone replacement graft once per site every 24 months

- Repairs to existing partial or complete dentures once per policy year
- Recementing crowns, onlays or bridges once every 60 months
- Rebasing or relining of partial or complete dentures once every 60 months
- Drugs and medicaments for qualifying SmileMore patients. Must be dispensed from the dental office (not Rx) twice per policy year. Includes items like Peridex and prescription strength fluoride

Continued on next page ›

P Pre-treatment Estimate Recommended

A Prior Authorization Required

In Network: Plan pays 65%; Member Coinsurance 35%
Out of Network: Plan pays 65%; Member Coinsurance 35% - (Deductible Applies)

P • Crowns over natural teeth, build ups, posts and cores replacement limited to once every 60 months

P • Bridges and crowns over implants replacement limited to once every 60 months

P • Partial and complete dentures replacement limited to once every 60 months

• Occlusal guards replacement limited to once every 36 months. Occlusal adjustments.

P • Surgical placement of endosteal implant and abutment replacement limited to once every 60 months

• Non-surgical and surgical procedures for temporomandibular (TMJ) disorders subject to a $500 lifetime maximum

In Network: Plan pays 50%; Member Coinsurance 50%
Out of Network: Plan pays 50%; Member Coinsurance 50%

P • Elective braces and related services for all covered members. Subject to a lifetime maximum. No pre-approval required

This is a summary of benefits. The information shown here is not a guarantee of payment. Refer to the Certificate of Coverage for the full plan terms. The Certificate includes any limitations or exclusions not seen here. For a complete listing of frequencies and limitations go to www.altusdental.com/el. To be covered, services must be dentally necessary and appropriate as per our review guidelines.

Note: This plan does not include a missing tooth clause. In addition, if covered, crowns, bridges, partials and complete dentures are paid when the permanent structure is inserted (seated) by the dentist. Member coverage must be active on the date that the permanent structure is inserted and payment is based on benefits available on that day — for example, if the member's annual maximum has been paid prior to the insertion of the permanent structure, the service will not be paid.

* Time limits on services (e.g. 6, 12, 24, 36, or 60 months) are figured to the exact day. Services are then covered the following day. For example, when a service is covered once every 12 months, if the service was done on July 1, it will not be covered again until the following year on July 2 or after.

Out-of-Network Coverage

You have the freedom to choose any dentist, but it is important to know that your out-of-pocket costs may be higher when you visit a dentist who does not participate in our network. Non-participating dentists have not agreed to accept the Altus Dental allowance as payment in full, so services from an out-of-network dentist may cost you more. You may also have to pay the dentist at the time of service and file a claim yourself. To be eligible, all claims must be filed within one year of the date of service. To find a participating dentist near you, use our Find A Dentist tool at www.altusdental.com.

How to Find a Dentist

Choose from Altus Dental's extensive network of dentists, you're sure to find one that's right for you. Visit www.altusdental.com to use our online Find A Dentist tool. You can see if your current dentist participates with us or look for a new dentist by searching by name, location or specialty. Enter your address or other criteria important to you (extended hours, languages spoken, etc.), and our tool will return a list of dentists that meet your needs – as well as maps and driving directions.

Beyond Benefits

When you visit us at www.altusdental.com, you can access a wealth of important dental health information and manage your plan by:

- Checking your benefits and claims
- Reviewing your deductibles and maximums
- Using our Find A dentist tool to find a dentist in your area

Notice of Nondiscrimination and Accessibility Policy

Altus Dental does not discriminate on the basis of race, color, national origin, age, disability, or sex.
Español (Spanish): ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-223-0588.
Português (Portuguese): ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-877-223-0588.

UAW/UMass Health & Welfare Trust Vision Plan Summary of Benefits

2026-2027

Group #s: Grad Employees 9794348 / Postdocs 9878760 / COBRA 1052222

	Primary		Secondary
Vision Service	**Your Benefit** @ In-Network Providers	**Your Reimbursement** @ Out-of-Network Providers OON benefits are now administered through the portal. Submit your receipts at portal.hwtf.org/ login	**Vision Supplement Benefit (VSB)** Reimbursement The VSB is an allowance @ UHS, a reimbursement used anywhere else. It's only available once you've exhausted your primary vision benefit.
Exam Services Exam ..... Retinal Imaging	Your cost: $0* Your cost: up to $39	You'll be reimbursed up to $57 Not covered	Not covered* Not covered
Contact Lens Fit & Follow-up Standard ..... Premium	Your cost: up to $40 You receive 10% off retail price	Not covered Not covered	Not covered Not covered
Frames	Up to $185 is covered & you'll receive 20% off remaining balance	You'll be reimbursed up to $120	**@ the UHS Eye Clinic,** up to $170 is covered after the 40% discount for 2nd pairs is applied toward glasses package: lens, frame and lens options for glasses purchased @ **any other provider,** you'll be reimbursed up to $120
Standard Plastic Lenses Single Vision..... Bifocal ..... Trifocal ..... Lenticular ..... Progressive Standard ..... - Premium Tier 1-3..... - Premium Tier 4	Your cost: $10 copay $10 copay $10 copay $10 copay $10 copay $30-55 copay $10 copay / 20% off retail after $120 allowance	You'll be reimbursed Up to $47 Up to $79 Up to $130 Up to $130 Up to $78 Up to $100 Up to $95	

there is an additional, separate $0 eye exam benefit under the Wellfleet student health plan

Find an eye doctor
(Select Network)

- 866.299.1358
- eyemed.com
- EyeMed Members App
- For LASIK, call 1.800.988.4221

Heads Up
You may have additional benefits. Log into eyemed.com/member to see all plans included with your benefits.

Full VSR Benefit Details are at hwtf.org/vision

- available when your primary vision benefit is exhausted
- once per plan year for glasses OR contacts
- cannot be used to defray the cost of a purchase your primary vision benefit was already applied to
- not a running total, but rather a one-time use benefit and does not carry over
- when buying mutiple pairs of glasses or contact orders a separate transaction is preferred, but an invoice showing a detailed breakdown and clearly indicating insurance was only applied to one item is acceptable

EyeMed reserves the right to make changes to the products available on each tier. All providers are not required to carry all brands on all tiers. For current listing of brands by tier, call 866.939.3633. No benefits will be paid for services or materials connected with or charges arising from: medical or surgical treatment, services or supplies for the treatment of the eye, eyes or supporting structures; Refraction, when not provided as part of a Comprehensive Eye Examination; services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; any Vision Examination or any corrective Vision Materials required by a Policyholder as a condition of employment; safety eyewear; solutions, cleaning products or frame cases; non-prescription sunglasses; plano (non-prescription) lenses; plano (non-prescription) contact lenses; two pair of glasses in lieu of bifocals; electronic vision devices; services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order; or lost or broken lenses, frames, glasses, or contact lenses that are replaced before the next Benefit Frequency when Vision Materials would next become available. Fees charged by a Provider for services other than a covered benefit and any local, state or Federal taxes must be paid in full by the Insured Person to the Provider. Such fees, taxes or materials are not covered under the Policy. Allowances provide no remaining balance for future use within the same Benefit Frequency. Some provisions, benefits, exclusions or limitations listed herein may vary by state. Plan discounts cannot be combined with any other discounts or promotional offers. In certain states members may be required to pay the full retail rate and not the negotiated discount rate with certain participating providers. Please see online provider locator to determine which participating providers have agreed to the discounted rate.

Vision Service	Your Benefit @ In-Network Providers	Your Reimbursement @ Out-of-Network Providers OON benefits are now administered through the portal. Submit your receipts at portal.hwtf.org/login	Vision Supplement Benefit (VSB) Reimbursement The VSB is an allowance @ UHS, a reimbursement used anywhere else. It's only available once you've exhausted your primary vision benefit.
Lens Options			
Anti Reflective Coating	Your cost:		*see above*
-Standard	$45	Not covered	
-Premium Tier 1-2	$57 - 68	Not covered	
-Premium Tier 3	you receive 20% off retail price	Not covered	
Photochromic (non glass)	you receive 20% off retail price	Not covered	
Polycarbonate (standard)	$40	Not covered	
Scratch coating (standard plastic)	$15	Not covered	
Tint (solid & gradient)	$0	You'll be reimbursed up to $5	
UV treatments	$15	Not covered	
All other lens options	you receive 20% off retail price	Not covered	
Contact Lenses			
Conventional	Up to $150 is covered & you'll receive 15% off remaining balance	You'll be reimbursed up to $120	**@ the UHS Eye Clinic**, up to $170 is covered (all types)
Disposable	Up to $150 is covered	You'll be reimbursed up to $120	**@ any other provider**, you'll be reimbursed up to $120 (all types)
Medically Necessary	Your cost: $0	You'll be reimbursed up to $300	
Other			
Hearing Care from Amplifon Network	Up to 66% off hearing aids; call (877) 203-0675	Not covered	Not covered
LASIK or PRK from US Laser Network	15% off retail or 5% off promo price; call (800) 988-4221	Not covered	Not covered
Frequencies			
Exam	1x per plan year (8/1-7/31)		1x use at UHS or anywhere else **for either glasses or contacts** per plan year (8/1-7/31)
Frame	1x per plan year (8/1-7/31)		
Lenses	1x per plan year (8/1-7/31)		
Contact Lenses	1x per plan year (8/1-7/31)		



40% OFF
additional complete pair of prescription eyeglasses

20% OFF
non-covered items, including non-prescription sunglasses

Create a member account at eyemed.com/member

INDEPENDENT PROVIDER NETWORK
+
LENSCRAFTERS
+
PEARLE VISION
+
TARGET OPTICAL

and online @

LENSCRAFTERS
TARGET OPTICAL
Ray-Ban
OAKLEY
GLASSES.COM
contactsdirect
+ MORE

UAW/UMass Health & Welfare Trust Fund

EyeMed Vision Care Diabetic Product

SUMMARY OF BENEFITS

DIABETIC CARE SERVICES	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER REIMBURSEMENT
For Type 1 or Type 2 Diabetes with Diabetic Retinopathy		
Medical Follow Up Eye Examination	$0 copay	Up to $77
Fundus Photography Examination	$0 copay	Up to $50
Extended Ophthalmoscopy (initial and subsequent)	$0 copay	Up to $15
Gonioscopy	$0 copay	Up to $15
Scanning Laser	$0 copay	Up to $33
Benefit Frequency: All Diabetic Care Services are covered once every 6 months*		

DEFINITIONS

Medical Follow-Up Examination means an office visit for diabetic vision care after the initial Comprehensive Eye Examination.

Some or all of the diagnostic services described below will be provided as deemed appropriate, subject to provider determination and the benefit frequency limitations referenced above. More comprehensive descriptions of these services are available in the Certificate of Insurance.

Fundus Photography Examination means photographing portion(s) of or the complete retina surface and structures, with interpretation and report. (*The Fundus Photography Examination is not covered if an Extended Ophthalmoscopy was provided within the previous six-month period.)

Extended Ophthalmoscopy means an examination of the interior of the eye, focusing on the posterior segment of the eye, including the lens, retina, and optic nerve, by direct or indirect ophthalmoscopy, and includes a retinal drawing with interpretation and report. (*The Extended Ophthalmoscopy is not covered if Fundus Photography Examination was provided within the previous six-month period.)

Gonioscopy means an eye examination of the front part of the eye (anterior chamber) to check the angle where the iris meets the cornea with a gonioscope or with a contact prism lens.

Scanning Laser means a computerized ophthalmic diagnostic imaging, posterior segment, with interpretation.

EXCLUSIONS

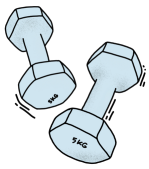
In addition To the Exclusions In the Policy/Certificate, no benefits are payable For services connected With Or charges arising from any Vision Materials; orthoptic Or vision training, subnormal vision aids And any associated supplemental testing; medical, pathological And/Or surgical treatment Of the eye, eyes Or supporting structures; any Vision Examination required by a Policyholder As a condition Of employment; Or services, supplies, prescription medication Or treatment For diabetes, except As specifically included.

R-03080

What healthy habits look like

Diabetes and eye wellness are linked by healthy choices. Full of advice from vision experts, **eyesiteonwellness.com** is a collection of videos, quizzes, articles, recipes and tools to help you make those choices.

INDEPENDENT PROVIDER NETWORK + LENSCRAFTERS PEARLE VISION TARGET OPTICAL



Benefits of PHWP **Wellness Reimbursement**

Wellness Reimbursement Benefits
Eligible Postdoc employees can be reimbursed for up to $240 per plan year towards expenses for wellness and fitness. The eligible employee's receipts are eligible as are the expenses of family members who are enrolled on the employee's dental and/or vision plans. Family members don't receive their own $240 reimbursement benefit, but instead share the total $240 benefit with the eligible employee.

The wellness reimbursement application is accessed through the same online enrollment process as the dental & vision plans, except that you must include a copy of a valid receipt demonstrating your payment of membership fees/fees/tuition to a gym, physical fitness institution or organization. This benefit follows the same plan year of September 1-August 31 of each year. If you are eligible for dental & vision benefits, you are eligible for a maximum reimbursement of $240 per plan year.

Reimbursements are made for receipts dated during our plan year, 8/1 to 7/31 of each year. If you pay on a monthly basis, charges dated after 8/1 are eligible. If you purchase semester or yearly plans, the period of the receipt must include a majority of the plan year to be eligible (i.e. though dated in August, UMass Fall 2026 gym receipts are eligible; receipts for the previous summer are not). **Receipts are due annually by July 14th at 5 pm.**

Benefits of PHWP **Wellness Reimbursement (cont.)**

Wellness Reimbursement: Eligible Wellness Activities

Eligible activities & equipment support fitness, well-being, stress reduction, and physical exercise.

- gym memberships
- yoga, dance, aerobics and martial arts classes
- golf, ski and skate fees, marathon, road race and endurance course fees, swim fees, intramural sport fees, tennis/squash court fees and ice rental fees for related sport.
- Weight loss programs, workout program DVDs
- personal fitness coaching
- fitness tracking devices (all brands, excludes accessories and only 1 per person/plan year), fitness and personal training apps
- mental health apps and out-of-pocket mental health costs, not covered by insurance
- nutritionist, chiropractic, acupuntcure, and physical therapy visit costs not covered by insurance
- program fees for UMass Cojourn
- state & national park passes, camping & fishing fees
- weights, dumbbells, resistance bands, yoga mats and blocks
- treadmills, ellipticals, rowing machines
- sport equipment like balls and rackets
- camping and backpacking equipment, skis, snowshoes
- ergonomic desks and chairs
- face masks and other PPE
- therapeutic massage
- durable medical equipment
- gender affirming items not covered by insurance
- sleep aids (sound machines, weighted blankets, orthopedic pillows)
- office lighting to reduce eye strain or to assist with seasonal affective disorder
- programs/classes that support new parents (prenatal yoga, Lamaze, parenting skills, breastfeeding classes, doula fees)
- electric toothbrushes, waterpics and other ADA recommended devices
- subscription fees/copays to health organizations offering reproductive, fertility & midlife/menopause related services
- prescription swim goggles
- mobility aids
- adaptive sport/outdoors programs for those with disabilities
- stress management devices & wearables
- headphones/earbuds
- smoking cessation programs
- financial planning, counseling & education with a certified professional
- clothing and shoes specifically designed for and required to do an eligible sport or activity (limit 1 pair of specialized shoes per person per plan year)

Final approval is per the decision of the Trustees.

Benefits of PHWP **Wellness Reimbursement (cont.)**

Eligible Wellness Activities (continued)
Both on campus and off-campus programs are eligible. Yearly membership fees, monthly service fees, locker fees and on-site equipment rentals required for the activity are eligible; late fees are not.

Activities & items that aren't eligible include: general medical & pharmacy costs (unless specifically named as eligible above), out-of-pocket dental and vision costs, spa treatments, cosmetic procedures, tips, facials, food, vitamins and supplements, clothing and shoes that are not specifically required to do an eligible sport or activity (i.e. rock climbing shoes or a ballet leotard would be eligible) and receipts from anyone other than a spouse or child actively enrolled on your benefit plans.

Wellness Reimbursement: Special Circumstances
Individuals who have special medical or disability needs and have requests that certain adaptive programs be deemed eligible may submit requests on a case by case basis. Documentation supporting the request must be provided and need not disclose personal information. A letter from a medical professional stating that the adaptive program or item would benefit you is all that is required. Final approval is per the decision of the Trustees.

Benefits of PHWP **Wellness Reimbursement (cont.)**

Pre-Paid Memberships

For the 2026-27 plan year, the Trust Fund will offer a limited quantity of pre-paid, 4-month gym memberships at Central Rock Gym (CRG) in Hadley, MA, 5-packs of 30 minutes massages at The Healing ZONE (THZ) in Hadley, MA, 20-class yoga cards for Cadence Yoga in Sunderland, MA and $240 gift cards for Adventure East (AE) in Sunderland, MA. Prepaid memberships are awarded on a first-come, first-served basis to an eligible Postdoc employee who has completed the online benefits application and completed the separate Prepaid User Waiver Agreement which can be found on your dashboard at https://portal.hwtf.org/

Benefits of PHWP **Wellness Reimbursement (cont.)**

Pre-Paid Daily Burn Subscriptions
For the 2026-27 plan year, The Trust Fund is offering prepaid 12-month subscriptions to the online fitness platform, Daily Burn. These subscriptions are limited and are available on a first- come first-served basis. Daily Burn subscriptions are separate from the wellness reimbursement and do not count against the reimbursement you are otherwise eligible for. Daily Burn subscriptions may be claimed on the dashboard of your Trust Fund benefits account at portal.hwtf.org/login.

Calm Subscriptions
Eligible employees can access Calm, an app for meditation, sleep and relaxation, for free. Each subscription is 12 monthslong and subscriptions may be claimed on the dashboard of your Trust Fund benefits account at portal.hwtf.org/login, where you will find a code to be used on the Calm website.

How & When You'll Receive a Wellness Reimbursement
We use the electronic payment processor, Checkbook. Checkbook will email you a check with instructions for deposit into your bank account. Reimbursement generally takes 4 to 6 weeks from the date you submit your receipts.

Benefits of PHWP **Wellness Reimbursement (cont.)**

How to Submit Your Wellness Receipt
Even if you are declining dental & vision benefits, you still need to submit an application using our enrollment portal at portal.hwtf.org/login in order to access the wellness reimbursement.

Once you complete the application, submit your receipt by uploading it with your application into our system or providing it by email.

The Trust Fund is unable to issue a wellness reimbursement without an electronically signed application on file for you.

Benefits of PHWP **Childcare Reimbursement**

Childcare Reimbursement Benefit
The Trust Fund will distribute approx. $90,000 during the 2026-27 plan year in reimbursements across eligible Postdoc employees for their costs for on or off-campus licensed childcare.

Eligibility for the Childcare Reimbursement
To be eligible you must be:

To be eligible you must be
- working in a University of Massachusetts Amherst PRO Unit position that is at least a 50% FTE and
- use licensed or otherwise eligible childcare

Trust Fund Trustees reserve the right to ultimately determine eligibility. Eligible childcare includes:

- state-licensed (or equivalent) infant, toddler, or preschool care in center-based and group home-based settings
- before and after school-based care
- summer camp
- organizational/center-based extracurricular activities (i.e. excludes private lessons)
- Family, Friends and Neighbor (FFN) informal care when needed by the family due to one of the criteria below
- Tutoring, homework assistance and online instructional programming costs for school-aged children

Benefits of PHWP **Childcare Reimbursement (cont.)**

How we Distribute Childcare Reimbursement Funds
The Trust Fund sorts eligible applicants by family size & income according to a modified version of the MA EEC Financial Assistance Parent Co-Payment Table that can be found at hwtf.org/family.

The Trust Fund relies on the most recent year's federal tax returns for all adults in your family to establish your adjusted gross income and we rely on actual receipts to establish your childcare cost. If a recent tax return is not available, due to a filed extension or no history of tax filings, the Trust Fund utilizes documentation from UMass HR, an income certification form, or the previous year’s return with proof of an IRS tax filing extension.

The most recent year's tax return is assumed to be the return due by April 15 of the current year; if aplying during spring, either the previous year's return or an early return filed in advance of the April 15th deadline is acceptable; during the summer, the most recent year's tax return is assumed to be the return due by April 15 of the current year.

Benefits of PHWP **Childcare Reimbursement (cont.)**

How We Distribute Childcare Funds (continued)

The Trust Fund's first priority is to provide the highest possible reimbursement of childcare expenses to applicants who fall in the lowest income levels (levels 1-11 on the Parent Co-Payment Table). The Trust Fund then applies any remaining funds across applicants with incomes higher than level 11, again prioritizing funding those from lowest to highest income.

The Trust Fund crosschecks receipts provided for care at the Center for Early Education and Care (CEEC) with CEEC records from the same period. In addition, the Trust Fund receives information from the Graduate Student Senate (GSS) and the CCAMPIS grant administrator for childcare awards families receive from GSS, Student Affairs or CCAMPIS for the same period and reduces reported costs accordingly. If an applicant family has received a GEO childcare subsidy for the same period, this will likewise reduce the possible reimbursement.

Benefits of PHWP **Childcare Reimbursement (cont.)**

How we Distribute Childcare Funds (continued)

The Trust Fund first asks applicants to complete a childcare planning document to provide esimates for their expected care for the plan year. The Trust Fund will accept receipts & estimates for months for which receipts are not yet available. On that basis, trustees review and approve a proposed payment amount for the period. Receipts will be accepted on a rolling basis, and payments distributed as receipts are provided by applicants. If provided receipts do not match earlier estimates, the reimbursement payout will be adjusted accordingly.

Additional guidelines:

Eligible FFN providers must not be a permanent resident of the applicant's household or be part of their immediate family (child or spouse)

Significant changes in income (job loss, divorce, death in the family) can be documented and used to adjust the last tax return's adjusted gross income.

Benefits of PHWP **Childcare Reimbursement (cont.)**

How we Distribute Childcare Funds (continued)
The Trust Fund can't guarantee that any applicant will receive funds, nor can the Trust Fund guarantee any particular reimbursement levels for any particular income bracket. There's a finite pool of money and no way to predict how many eligible applicants will apply during each period. The Trust Fund strives to reimburse applicants at the highest level possible with a priority toward funding those at the lowest income level first. Reimbursement is usually within 6 weeks of the application deadline, via personal check.

Maximum Annual Reimbursement
There is a $6,000 per child (for whom receipts are submitted) annual cap on the amount a family can be reimbursed. Of that amount, only up to $3000 per child (for whom receipts are submitted) may be reimbursed for informal FFN care.

Benefits of PHWP **Childcare Reimbursement (cont.)**

Deadlines for the Childcare Reimbursement
The Trust Fund uses the following submission timeframes:

- ·Deadline to submit fall childcare receipts (Aug-Dec) is December 31st annually.
- Deadline to submit spring childcare receipts (Jan-May receipts) is May 31st annually.
- Deadline to submit summer childcare receipts (June-July receipts) is July 31st annually.

Further Notes on Provider Eligibility
You can find out if your provider is licensed at www.eec.state.ma.us/ChildCareSearch/EarlyEduMap.aspx Although please check with your provider as well, as some are exempt under the EEC guidelines.

How to Apply
The application is part of the Trust Fund's regular online benefits application, available at portal.hwtf.org/login if you've enrolled for dental & vision, log in to your existing application, following prompts for the childcare section only. If you are new to our system, you can start a new application.

Benefits of PHWP **Childcare Reimbursement (cont.)**

Outschool Benefit

The Trust Fund will Outschool classes gift cards to families with children through high school age up to $250 per child per plan year. No online classes other than Outschool will be honored in this way. This reimbursement is separate from the general childcare reimbursement. Outschool gift cards can be requested by eligible families at www.hwtf.org/family.

Income Ranking Chart

based on and adapted from the EEC Parent Co-Payment Chart

How to Use this Chart

Step 1: Find your family's adjusted gross income (AGI) on your most recent Federal Tax Return(s) (usually line 11) .

Step 2: Divide your AGI by 12 months and locate that amount in the column corresponding to your family size below.

Step 3: Move to the right from your monthly gross income to the corresponding fee level

Step 4: Find your family's fee level on the charts of recent reimbursement levels below to see what similar families have received in previous rounds of reimbursement.

**we cannot make guarantees about what reimbursement amount you will receive in the future because that is based on a number of variables including the number of families who apply during each round and their total childcare costs, which do fluctuate.*

Once you submit a complete childcare reimbursement application, we'll email you with the percentage reimbursement amount you can expect to receive.

Family of Two	Family Of Three	Family of Four	Family of Five	Family of Six	Family of Seven	Income Level
$0 - $971	$0 - $1180	$0 - $1421	$0 - $1663	$0 - $1905	$0 - $2146	Level 1
$972 - $1095	$1181 - $1260	$1422 - $1499	$1664 - $1739	$1906 - $1980	$2147 - $2205	Level 2
$1096 - $1219	$1261 - $1340	$1500 - $1575	$1740 - $1825	$1981 - $2080	$2206 - $2315	Level 3
$1220 - $1380	$1341 - $1420	$1576 - $1675	$1826 - $1900	$2081 - $2180	$2316 - $2550	Level 4
$1381 - $1457	$1421 - $1529	$1676 - $1799	$1901 - $2087	$2181 - $2380	$2551 - $2675	Level 5
$1458 - $1540	$1530 - $1675	$1800 - $1900	$2088 - $2150	$2381 - $2500	$2676 - $2800	Level 6
$1541 - $1634	$1676 - $1760	$1901 - $2000	$2151 - $2260	$2501 - $2650	$2801 - $2900	Level 7
$1635 - $1725	$1761 - $1850	$2001 - $2175	$2261 - $2435	$2651 - $2800	$2901 - $3000	Level 8
$1726 - $1843	$1851 - $1931	$2176 - $2250	$2436 - $2550	$2801 - $3000	$3001 - $3100	Level 9
$1844 - $1986	$1932 - $2414	$2251 - $2874	$2551 - $3333	$3001 - $3793	$3101 - $3879	Level 10
$1987 - $2186	$2415 - $2476	$2875 - $3130	$3334 - $3550	$3794 - $3900	$3880 - $4030	Level 11
$2187 - $2286	$2477 - $2676	$3131 - $3340	$3551 - $3800	$3901 - $4000	$4031 - $4132	Level 12
$2287 - $2429	$2677 - $2876	$3341 - $3550	$3801 - $4100	$4001 - $4199	$4133 - $4350	Level 13
$2430 - $2573	$2877 - $3076	$3551 - $3760	$4101 - $4363	$4200 - $4500	$4351 - $4700	Level 14
$2574 - $2717	$3077 - $3277	$3761 - $3970	$4364 - $4607	$4501 - $4966	$4701 - $4998	Level 15
$2718 - $2860	$3278 - $3477	$3971 - $4180	$4608 - $4851	$4967 - $5444	$4999 - $5549	Level 16
$2861 - $3004	$3478 - $3677	$4181 - $4490	$4852 - $5095	$5445 - $5939	$5550 - $6074	Level 17
$3005 - $3132	$3678 - $3869	$4491 - $4606	$5096 - $5342	$5940 - $6079	$6075 - $6217	Level 18
$3133 - $3322	$3870 - $4104	$4607 - $4885	$5343 - $5667	$6080 - $6433	$6218 - $6595	Level 19
$3323 - $3410	$4105 - $4210	$4886 - $5012	$5668 - $5812	$6434 - $6615	$6596 - $6765	Level 20
$3411 - $3549	$4211 - $4380	$5013 - $5214	$5813 - $6047	$6616 - $6883	$6766 - $7039	Level 21
$3550 - $3685	$4381 - $4551	$5215 - $5418	$6048 - $6285	$6884 - $7153	$7040 - $7314	Level 22
$3686 - $3908	$4552 - $4828	$5419 - $5747	$6286 - $6666	$7154 - $7586	$7315 - $7758	Level 23
$3909 - $4885	$4829 - $6035	$5748 - $7184	$6667 - $8333	$7587 - $9483	$7759 - $9698	Level 24
$4886 - $5150	$6036 - $6325	$7185 - $7550	$8334 - $8750	$9484 - $9950	$9699 - $10,300	Level 25
$5151 - $5400	$6326 - $6625	$7551 - $7900	$8751 - $9200	$9951 - $10400	$10,301 - $10,750	Level 26
$5401 - $5650	$6626 - $6925	$7901 - $8250	$9201 - $9550	$10,401 - $10,950	$10,751 - $11,150	Level 27
$5651 - $11697	$6925 - $14,449	$8251 - $17201	$9551 - $19,955	$10,951 - $22,705	$11,151 - $23,221	Level 28
$11,698 and above	$14,450 and above	$17,202 and above	$19,956 and above	$22,706 and above	$23,222 and above	200% of Level 28

Benefits of PHWP
MetLife Legal

MetLife | Legal Plans

MetLife Prepaid Legal Benefit
Eligible Postdocs who have submitted a benefits application can opt into the MetLife prepaid group legal plan at no cost.

MetLife Legal can save employees hundreds of dollars in attorney fees for common legal services like these (see attached for benefit definitions):

- Estate planning documents, including Wills and Trusts
- Real estate matters
- Identity theft defense
- Financial matters, such as debt-collection defense
- Traffic offenses
- Document review
- Family Law, including adoption and name change
- Advice and consultation on personal legal matters

Effective 8/1/26, the MetLife Legal Benefit includes immigration representation.

How to Apply for the MetLife Legal Benefit
This is a section of the regular online enrollment portal at portal.hwtf.org/login

Benefits of PHWP
MetLife Legal (cont.)

Using the MetLaw Benefit
You can go to www.legalplans.com to learn about the plan and to log in and you can also search for attorneys at www.members.legalplans.com/Home. Enrollees are free to use an attorney outside the network; when your legal matter has concluded you can contact the Client Service Center (800-821-6400) to apply for fee reimbursement up to set dollar limits. A schedule of these limits is attached.

Portability of the MetLife Legal Plan
If you wish to continue your legal plan benefit after retiring or terminating employment, MetLife may allow you continue on as a legal plan member for 12 months through a portable plan. To apply for portable enrollment: Call the Client Service Center at (800) 821-6400, Monday-Friday (8am - 8pm ET) to enroll in your portable plan. A Client Service Center Representative will assist you in the enrollment process. You must enroll within 30 days of your last day of employment. Enrollment is prepaid via remittance of a lump sum payment equal to the legal plan's monthly rate times 12 months.

MetLife | Legal Plans

MetLife Legal Plans Fact Sheet

UAW UMass Health & Welfare Trust Fund

How To Get Legal Services

To use your Legal Plan, create an account online at www.members.legalplans.com or call MetLife Legal Plans' Client Service Center at 1-800-821-6400.

Employees enrolled in the plan must remain in the plan for the benefit plan year.

If you call the Client Service Center, the Client Service Representative will:

- Verify your eligibility
- Make an initial determination of whether and to what extent your case is covered (the Plan Attorney will make the final determination of coverage)
- Give you the telephone number of the Plan Attorney most convenient to you OR schedule an appointment for you with an attorney; and
- Answer any questions you have about your Legal Plan.

Then you can call the Plan Attorney and identify yourself as a legal Plan Member referred to them by MetLife Legal Plans. You should request an appointment for a consultation. You should be prepared to provide the name of the legal plan you belong to and the type of legal matter you are calling about. You may choose to work with an out-of-network attorney. In a few areas, where there are no Participating Law Firms, you will be asked to select your own attorney. In both circumstances, MetLife Legal Plans will reimburse you for these non-Plan attorneys' fees based on a set fee schedule. To obtain a fee schedule, call our Client Service Center.

What Services Are Covered

You and your eligible dependents are entitled to receive certain personal legal services. The available benefits are very comprehensive, but there are limitations and other conditions that must be met. Please take time to read the description of benefits carefully. All benefits are available to you and your spouse and dependents, who are referred to below as Participant(s), unless otherwise noted or you are enrolled in a Single or Employee Only plan.

Advice And Consultation

Office Consultation And Telephone Advice

This service provides the opportunity to discuss with an attorney any personal legal problems that are not specifically excluded. The Plan Attorney will explain the Participant's rights, point out his or her options and recommend a course of action. The Plan Attorney will identify any further coverage available under the Plan, and will undertake representation if the Participant so requests. If representation is covered by the Plan, the Participant will not be charged for the Plan Attorney's services. If representation is recommended, but is not covered by the Plan, the Plan Attorney will provide a written fee statement in advance. The Participant may choose whether to retain the Plan Attorney at his or her own expense, seek outside counsel, or do nothing. There are no restrictions on the number of times per year a Participant may use this service; however, for a non-covered matter, this service is not intended to provide the Participant with continuing access to a Plan Attorney in order to seek advice that would allow the Participant to undertake his or her own representation.

Consumer Protection

Consumer Protection Matters
This service covers the Participant as a plaintiff, for representation, including trial, in disputes over consumer goods and services where the amount being contested exceeds the small claims court limit in that jurisdiction and is documented in writing. This service does not include disputes over real estate, construction, insurance or collection activities after a judgment.

Small Claims Assistance
This service covers counseling the Participant on prosecuting a small claims action; helping the Participant prepare documents; advising the Participant on evidence, documentation and witnesses; and preparing the Participant for trial. The service does not include the Plan Attorney's attendance or representation at the small claims trial, collection activities after a judgment or any services relating to post-judgment actions.

Personal Property Protection
This service covers counseling the Participant over the phone or in the office on any personal property issue such as consumer credit reports, contracts for the purchase of personal property, consumer credit agreements or installment sales agreements. Counseling on pursuing or defending small claims actions is also included. The service also includes reviewing any personal legal documents and preparing promissory notes, affidavits and demand letters.

Debt Matters

Debt Collection Defense
This service provides Participants with an attorney's services for negotiation with creditors for a repayment schedule and to limit creditor harassment, and representation in defense of any action for personal debt collection, tax agency debt collection, foreclosure, repossession or garnishment, up to and including trial if necessary. It includes a motion to vacate a default judgment. It does not include counter, cross or third party claims; bankruptcy; any action arising out of family law matters, including support and post-decree issues; or any matter where the creditor is affiliated with the Sponsor or Employer.

Personal Bankruptcy Or Wage Earner Plan
This service covers the Plan Member and spouse in pre-bankruptcy planning, the preparation and filing of a personal bankruptcy or Wage Earner petition, and representation at all court hearings and trials. This service is not available if a creditor is affiliated with the Sponsor or Employer, even if the Plan Member or spouse chooses to reaffirm that specific debt.

Tax Audits
This service covers reviewing tax returns and answering questions the IRS or a state or local taxing authority has concerning the Participant's tax return; negotiating with the agency; advising the Participant on necessary documentation; and attending an IRS or a state or local taxing authority audit. The service does not include prosecuting a claim for the return of overpaid taxes or the preparation of any tax returns.

Identity Theft Defense
This service provides the Participant with consultations with an attorney regarding potential creditor actions resulting from identity theft and attorney services as needed to contact creditors, credit bureaus and financial institutions. It also provides defense services for specific creditor actions over disputed accounts. The defense services include limiting creditor harassment and representation in defense of any action that arises out of the identity theft such as foreclosure, repossession or garnishment, up to and including trial if necessary. The service also provides the Participant with online help and information about identity theft and prevention. It does not include counter, cross or third party claims; bankruptcy; any action arising out of family law matters, including support and post-decree issues; or any matter where the creditor is affiliated with the Sponsor or Employer.

Identity Restoration Services
Identity restoration services from U.S. - based Restoration Specialists are available via click or call to support you and your family. If you are a victim of fraud, White Glove Resolution Specialists will work with you to navigate bureaus and government institutions and to resolve your fraud incident quickly. Whether you lose your wallet or learn your personal information has been breached, experienced agents will take care of all the heavy lifting to make sure your identity is restored and your information is secure.

Defense Of Civil Lawsuits

Administrative Hearing Representation
This service covers Participants in defense of civil proceedings before a municipal, county, state or federal administrative board, agency or commission. It includes the hearing before an administrative board or agency over an adverse governmental action. It does not apply where services are available or are being provided by virtue of an insurance policy. It does not include family law matters, post judgment matters or litigation of a job-related incident.

Incompetency Defense
This service covers the Participant in the defense of any incompetency action, including court hearings when there is a proceeding to find the Participant incompetent.

Civil Litigation Defense
This service covers the Participant in defense of an arbitration proceeding or civil proceeding before a municipal, county, state or federal administrative board, agency or commission, or in a trial court of general jurisdiction. It does not apply where services are available or are being provided by virtue of an insurance policy. It does not include family law matters, post judgment matters, matters with criminal penalties or litigation of a job-related incident. Services do not include bringing counterclaims, third party or cross claims.

Document Preparation

Affidavits
This service covers preparation of any affidavit in which the Participant is the person making the statement.

Deeds
This service covers the preparation of any deed for which the Participant is either the grantor or grantee.

Demand Letters
This service covers the preparation of letters that demand money, property or some other property interest of the Participant, except an interest that is an excluded service. It also covers mailing them to the addressee and forwarding and explaining any response to the Participant. Negotiations and representation in litigation are not included.

Document Review
This service covers the review of any personal legal document of the Participant, such as letters, leases or purchase agreements.

Elder Law Matters
This service covers counseling the Participant over the phone or in the office on any personal issues relating to the Participant's parents as they affect the Participant. The service includes reviewing documents of the parents to advise the Participant of the effect on the Participant. The documents include Medicare or Medicaid materials, prescription plans, leases, nursing home agreements, powers of attorney, living wills and wills. The service also includes preparing deeds involving the parents when the Participant is either the grantor or grantee; and preparing promissory notes involving the parents when the Participant is the payor or payee.

Mortgages
This service covers the preparation of any mortgage or deed of trust for which the Participant is the mortgagor. This service does not include documents pertaining to business, commercial or rental property.

Promissory Notes
This service covers the preparation of any promissory note for which the Participant is the payor or payee.

Family Law

Adoption And Legitimization (Contested And Uncontested)
This service covers all legal services and court work in a state or federal court for an adoption for the Plan Member and spouse. Legitimization of a child for the Plan Member and spouse, including reformation of a birth certificate, is also covered.

Guardianship Or Conservatorship (Contested And Uncontested)
This service covers establishing a guardianship or conservatorship over a person and his or her estate when the Plan Member or spouse is being appointed as guardian or conservator. It includes obtaining a permanent and/or temporary guardianship or conservatorship, gathering any necessary medical evidence, preparing the paperwork, attending the hearing and preparing the initial accounting. This service does not include representation of the person over whom guardianship or conservatorship is sought, any annual accountings after the initial accounting, or terminating the guardianship or conservatorship once it has been established.

Name Change
This service covers the Participant for all necessary pleadings and court hearings for a legal name change.

Prenuptial Agreement
This service covers representation of the Plan Member and includes the negotiation, preparation, review and execution of a Prenuptial Agreement between the Plan Member and his or her fiance/partner prior to their marriage or legal union (where allowed by law). It does not include subsequent litigation arising out of a prenuptial agreement. The fiance/partner must either have separate counsel or waive his/her right to representation.

Protection From Domestic Violence
This service covers the Plan Member only, not the spouse or dependents, as the victim of domestic violence. It provides the Plan Member with representation to obtain a protective order, including all required paperwork and attendance at all court appearances. The service does not include representation in suits for damages, defense of any action, or representation for the offender.

Immigration

Immigration Assistance
This service covers advice and consultation, preparation of affidavits and powers of attorney, review of any immigration documents and helping the Participant prepare for hearings.
Effective 8/1/26, plan includes immigration representation.

Personal Injury

Personal Injury (25% Network Maximum)
Subject to applicable law and court rules, Plan Attorneys will handle personal injury matters (where the Participant is the plaintiff) at a maximum fee of 25% of the gross award. It is the Participant's responsibility to pay this fee and all costs.

Real Estate Matters

Boundary Or Title Disputes
This service covers negotiations and litigation arising from boundary or real property title disputes involving a Participant's residence, where coverage is not available under the Participant's homeowner or title insurance policies. The service includes filing to remove a mechanic's lien.

Eviction And Tenant Problems (Tenant Only)
This service covers the Participant as a tenant for matters involving leases, security deposits or disputes with a residential landlord. The service includes eviction defense, up to and including trial. It does not include representation in disputes with other tenants or as a plaintiff in a lawsuit against the landlord, including an action for return of a security deposit.

Home Equity Loans
This service covers the review or preparation of a home equity loan on the Participant's residence.

Property Tax Assessment
This service covers the Participant for review and advice on a property tax assessment on the Participant's residence. It also includes filing the paperwork; gathering the evidence; negotiating a settlement; and attending the hearing necessary to seek a reduction of the assessment.

Refinancing Of Residence
This service covers the review or preparation, by an attorney representing the Participant, of all relevant documents (including the refinance agreement, mortgage and deed, and documents pertaining to title, insurance, recordation and taxation), which are involved in the refinancing of or obtaining a home equity loan on a Participant's residence. The benefit also includes attendance of an attorney at closing. This benefit includes obtaining a permanent mortgage on a newly constructed home. It does not include services provided by any attorney representing a lending institution or title company. The benefit does not include the refinancing of a property that is held for any rental, business, investment or income purpose.

Sale Or Purchase Of Residence
This service covers the review or preparation, by an attorney representing the Participant, of all relevant documents (including the construction documents for a new home, the purchase agreement, mortgage and deed, and documents pertaining to title, insurance, recordation and taxation), which are involved in the purchase or sale of a Participant's residence or of a vacant property to be used for building a residence. The benefit also includes attendance of an attorney at closing. It does not include services provided by any attorney representing a lending institution or title company. The benefit does not include the sale or purchase of a rental property, property held for business or investment or leases with an option to buy.

Zoning Applications
This service provides the Participant with the services of a lawyer to help get a zoning change or variance for the Participant's residence. Services include reviewing the law, reviewing the surveys, advising the Participant, preparing applications, and preparing for and attending the hearing to change zoning.

Security Deposit Assistance (Tenant Only)
This service covers counseling the Participant as a tenant in recovering a security deposit from the Participant's residential landlord; reviewing the lease and other relevant documents; and preparing a demand letter to the landlord for the return of the deposit. It also covers assisting the Participant in prosecuting a small claims action; helping prepare documents; advising on evidence, documentation and witnesses; and preparing the Participant for the small claims trial. This service does not include the Plan Attorney's attendance or representation at the small claims trial, collection activities after a judgment or any services relating to post-judgment actions.

Traffic And Criminal Matters

Juvenile Court Defense
This service covers the defense of Plan Member and/or Spouse and their dependent child in any juvenile court matter, provided there is no conflict of interest between the Plan Member and the dependent child. When a conflict exists, or where the court requires separate counsel for the child, this service provides an attorney for the Plan Member only, including services for Parental Responsibility.

Restoration Of Driving Privileges
This service covers the Participant with representation in proceedings to restore the Participant's driving license.

Traffic Ticket Defense (No Dui)
This service covers representation of the Participant in defense of any traffic ticket including traffic misdemeanor offenses, except driving under influence or vehicular homicide, including court hearings, negotiation with the prosecutor and trial.

Will And Estate Matters

Trusts
This service covers the preparation of revocable and irrevocable living trusts for the Participant. It does not include tax planning or services associated with funding the trust after it is created.

Advanced Healthcare Directive
This service covers the preparation of a living will for the Participant.

Powers Of Attorney
This service covers the preparation of any power of attorney when the Participant is granting the power.

Probate (10% Network Discount)
Subject to applicable law and court rules, Plan Attorneys will handle probate matters at a fee 10% less than the Plan Attorney's normal fee. It is the Participant's responsibility to pay this reduced fee and all costs.

Wills And Codicils
This service covers the preparation of a simple or complex will for the Participant. The creation of any testamentary trust is covered. The benefit includes the preparation of codicils and will amendments. It does not include tax planning.

Miscellaneous

Attorney Services For Non-Covered Matters- 4 Hours

For non-covered matters that are not otherwise excluded, this benefit provides four hours of attorney time and services per year. The Participant is responsible to pay fees beyond the 4 hours. No more than a combined maximum total of four hours of attorney time and service are provided for the member.

Exclusions

Excluded services are those legal services that are not provided under the plan. No services, not even a consultation, can be provided for the following matters:

- Employment-related matters, including company or statutory benefits
- Matters involving the company, MetLife and affiliates, and Plan Attorneys
- Matters in which there is a conflict of interest between the employee and spouse or dependents in which case services are excluded for the spouse and dependents
- Appeals and class actions
- Farm matters, business or investment matters, matters involving property held for investment or rental, or issues when the Participant is the landlord
- Patent, trademark and copyright matters
- Costs or fines
- Frivolous or unethical matters
- Matters for which an attorney-client relationship exists prior to the Participant becoming eligible for plan benefits

IF YOU HAVE ANY QUESTIONS, PLEASE VISIT OUR WEBSITE AT WWW.LEGALPLANS.COM OR CALL METLIFE LEGAL PLANS AT 1-800-821-6400.

MetLife | Legal Plans

Benefit Definitions & Reimbursements

Advice and Consultation	In-Network	Out-of-Network
Office Consultation: This service provides the opportunity to discuss with an attorney any personal legal problems that are not specifically excluded. The plan attorney will explain the participant's rights, point out his or her options and recommend a course of action. The plan attorney will identify any further coverage available under the plan, and will undertake representation if the participant so requests. If representation is covered by the plan, the participant will not be charged for the plan attorney's services. If representation is recommended, but is not covered by the plan, the plan attorney will provide a written fee statement in advance. The participant may choose whether to retain the plan attorney at his or her own expense, seek outside counsel, or do nothing. There are no restrictions on the number of times per year a participant may use this service, although it is not intended to provide the participant with continuing access to a plan attorney in order to undertake his or her own representation.	Fully Covered	$70
Telephone Advice (see Office Consultation definition)	Fully Covered	$70
Consumer Protection Matters	**In-Network**	**Out-of-Network**
Consumer Protection Matters: This service covers the participant as plaintiff for representation, including trial, in disputes over consumer goods and services where the amount being contested exceeds the small claims court limit in that jurisdiction and is documented in writing. This service does not include disputes over real estate, construction, insurance or collection activities after a judgment.		
• Correspondence and Negotiation	Fully Covered	$500
• Filing of Suit, Ending in Settlement or Judgment	Fully Covered	$2,000
• Plus Trial Supplement for Out-of-Network Service*		$100,000
Personal Property Protection: This service covers counseling the participant over the phone or in the office on any personal property issue such as consumer credit reports, contracts for the purchase of personal property, consumer credit agreements or installment sales agreements. Counseling on pursuing or defending small claims actions is also included. The service also includes reviewing any personal legal documents and preparing promissory notes, affidavits and demand letters.	Fully Covered	$125
Small Claims Assistance: This service covers counseling the participant on prosecuting a small claims action; helping the participant prepare documents; advising the participant on evidence, documentation and witnesses; and preparing the participant for trial. The service does not include the plan attorney's attendance or representation at the small claims trial, collection activities after a judgment or any services relating to post-judgment actions.	Fully Covered	$200
Defense of Civil Lawsuits	**In-Network**	**Out-of-Network**
Administrative Hearing Representation: This service covers participants in defense of civil proceedings before a municipal, county, state or federal administrative board, agency or commission. It includes the hearing before an administrative board or agency over an adverse government action. It does not apply where services are available or are being provided by virtue of a homeowner or vehicle insurance policy. It does not include family law matters, post judgment matters or litigation of a job-related incident.		
• Negotiation and Settlement	Fully Covered	$500
• Contested Hearings Ending in Settlement or Judgment	Fully Covered	$1,800
• Plus Trial Supplement for Out-of-Network Service*		$100,000

Benefit Definitions & Reimbursements (Continued)

Civil Litigation Defense: This service covers the participant in defense of an arbitration proceeding or civil proceeding before a municipal, county, state or federal administrative board, agency or commission, or in a trial court of general jurisdiction. It does not apply where services are available or are being provided by virtue of an insurance policy. It does not include family law matters, post judgment matters, matters with criminal penalties or litigation of a job-related incident. Services do not include bringing counter, third party or cross claims.		
• Negotiation and Settlement	Fully Covered	$650
• Filing Answer, Litigation Ending in Settlement or Judgment	Fully Covered	$2,000
• Plus Trial Supplement for Out-of-Network Service*		$100,000
Incompetency Defense: This service covers the participant in the defense of any incompetency action, including court hearings when there is a proceeding to find the participant incompetent.		
• Negotiation and Settlement	Fully Covered	$500
• Trial	Fully Covered	$1,800
• Plus Trial Supplement for Out-of-Network Service*		$100,000
Document Preparation and Review	**In-Network**	**Out-of-Network**
Affidavits: This service covers preparation of any affidavit in which the participant is the person making the statement.	Fully Covered	$75
Deeds: This service covers the preparation of any deed for which the participant is either the grantor or grantee.	Fully Covered	$100
Demand Letters: This service covers the preparation of letters that demand money, property or some other property interest of the participant, except an interest that is an excluded service. It also covers mailing them to the addressee, and forwarding and explaining any response to the participant.	Fully Covered	$75
Document Review: This service covers the review of any personal legal document of the participant, such as letters, leases or purchase agreements.	Fully Covered	$100
Elder Law Matters: This service covers counseling the participant over the phone or in the office on any personal issues relating to the participant's parents as they affect the participant. The service includes reviewing documents of the parents to advise the participant on the effect on the participant. The documents include Medicare or Medicaid materials, prescription plans, leases, nursing home agreements, powers of attorney, living wills and wills. The service also includes preparing deeds involving the parents when the participant is either the grantor or grantee, and preparing promissory notes involving the parents when the participant is the payor or payee.	Fully Covered	$140
Mortgages: This service covers the preparation of any mortgage or deed of trust for which the participant is the mortgagor.	Fully Covered	$70
Promissory Notes: This service covers the preparation of any promissory note for which the participant is the payor or payee.	Fully Covered	$70
Estate Planning Documents	**In-Network**	**Out-of-Network**
Living Wills: This service covers the preparation of a living will for the participant.		
• Individual	Fully Covered	$75
• Member and Spouse	Fully Covered	$80
Powers of Attorney: This service covers the preparation of any power of attorney when the participant is granting the power.		
• Individual	Fully Covered	$65
• Member and Spouse	Fully Covered	$75
Trusts: This service covers the preparation of revocable and irrevocable living trusts for the participant. It does not include tax planning or services associated with funding the trust after it is created.		
• Individual	Fully Covered	$325
• Member and Spouse	Fully Covered	$450

Benefit Definitions & Reimbursements (Continued)

Wills and Codicils (Including Simple Support Trust for Minor Children): This service covers the preparation of a simple or complex will for the participant. The creation of any testamentary trust is covered. The benefit includes the preparation of codicils and will amendments. It does not include tax planning.		
• Individual	Fully Covered	$150
• Member and Spouse	Fully Covered	$200
Family Law	**In-Network**	**Out-of-Network**
Adoption and Legitimization: This service covers all legal services and court work in a state or federal court for an adoption for the plan member and spouse. Legitimization of a child for the plan member and spouse, including reformation of a birth certificate, is also covered.		
• Uncontested	Fully Covered	$650
• Contested	Fully Covered	$1,500
• Plus Trial Supplement for Out-of-Network Service*		$100,000
Guardianship or Conservatorship: This service covers establishing a guardianship or conservatorship over a person and his or her estate when the plan member or spouse is being appointed as guardian or conservator. It includes obtaining a permanent and/or temporary guardianship or conservatorship, gathering any necessary medical evidence, preparing the paperwork, attending the hearing and preparing the initial accounting. This service does not include representation of the person over whom guardianship or conservatorship is sought, any annual accountings after the initial accounting, or terminating the guardianship or conservatorship once it has been established.		
• Uncontested	Fully Covered	$650
• Contested	Fully Covered	$1,500
• Plus Trial Supplement for Out-of-Network Service*		$100,000
Name Change: This service covers the participant for all necessary pleadings and court hearings for a legal name change.	Fully Covered	$400
Prenuptial Agreement: This service covers representation of the participant and includes the negotiation, preparation, review and execution of a prenuptial agreement between the participant and his or her fiancé/partner prior to their marriage or legal union (where allowed by law). It does not include subsequent litigation arising out of a prenuptial agreement. The fiancé/partner must either have separate counsel or waive his/her right to representation.	Fully Covered	$750
Protection from Domestic Violence: This service covers the participant only, not the spouse or dependents, as the victim of domestic violence. It provides the participant with representation to obtain a protective order, including all required paperwork and attendance at all court appearances. The service does not include representation in suits for damages, defense of any action or representation for the offender.	Fully Covered	$425
Financial Matters	**In-Network**	**Out-of-Network**
Debt Collection Defense: This benefit provides participants with an attorney's services for negotiation with creditors for a repayment schedule and to limit creditor harassment, and representation in defense of any action for personal debt collection, tax agency debt collection, foreclosure, repossession or garnishment, up to and including trial if necessary. It includes a motion to vacate a default judgment. It does not include counter, cross or third party claims, bankruptcy, any action arising out of family law matters including support and post decree issues or any matter where the creditor is affiliated with the sponsor or employer.		
Debt Collection Defense (Consumer Debts)		
• Negotiation and Settlement	Fully Covered	$350
• Negotiation and Settlement after Complaint and Answer Filed	Fully Covered	$600
• Trial	Fully Covered	$1,050
• Plus Trial Supplement for Out-of-Network Service*		$100,000

Benefit Definitions & Reimbursements (Continued)

Debt Collection Defense (Foreclosures)		
• Negotiation	Fully Covered	$500
• Complaint and Answer Filed, Settlement Negotiations	Fully Covered	$850
• Trial	Fully Covered	$1,500
• Plus Trial Supplement for Out-of-Network Service*		$100,000
Identity Theft Defense: This service provides the participant with consultations with an attorney regarding potential creditor actions resulting from identity theft and attorney services as needed to contact creditors, credit bureaus and financial institutions. It also provides defense services for specific creditor actions over disputed accounts. The defense services include limiting creditor harassment and representation in defense of any action that arises out of the identity theft such as foreclosure, repossession or garnishment, up to and including trial if necessary. The service also provides the participant with online help and information about identity theft and prevention. It does not include counter, cross or third party claims, bankruptcy, any action arising out of family law matters, including support and post-decree matters or any matter where the creditor is affiliated with the sponsor or employer.	Fully Covered	$250
LifeStages Identity Management Services: This benefit provides the Participant with access to LifeStages Identity Management Services provided by Cyberscout, LLC. It includes both Proactive Services when the Participant believes their personal data has been compromised as well as Resolution Services to assist the Participant in recovering from account takeover or identity theft with unlimited assistance to fix issues, handle notifications, and provide victims with credit and fraud monitoring. Theft Support, Fraud Support, Recovery, and Replacement services are covered by this benefit.	Fully Covered	
Personal Bankruptcy or Wage Earner Plan: This service covers the participant and spouse in pre-bankruptcy planning, the preparation and filing of a personal bankruptcy or Wage Earner petition, and representation at all court hearings and trials. This service is not available if a creditor is affiliated with the sponsor or employer, even if the participant or spouse chooses to reaffirm that specific debt.		
• Chapter 7 Individual or Member/Spouse	Fully Covered	$850
• Chapter 13 Individual or Member/Spouse	Fully Covered	$1,400
Tax Audit Representation: This service covers reviewing tax returns and answering questions the IRS or a state or local taxing authority has concerning the participant's tax return, negotiating with the agency advising the participant on necessary documentation, and attending an IRS or a state or local taxing authority audit. The service does not include prosecuting a claim for the return of overpaid taxes or the preparation of any tax returns.		
• Negotiation and Settlement	Fully Covered	$500
• Audit Hearing	Fully Covered	$1,200
Immigration	**In-Network**	**Out-of-Network**
Immigration Assistance: This service covers advice and consultation, preparation of affidavits and powers of attorney, review of any immigration documents and helping the participant prepare for hearings. Effective 8/1/26, plan includes immigration representation.	Fully Covered	$500
Juvenile Matters	**In-Network**	**Out-of-Network**
Juvenile Court Defense: This service covers the defense of a participant and a participant's dependent child in any juvenile court matter, provided there is no conflict of interest between the participants and the dependent child. In that event, this service provides an attorney for the plan member only including services for Parental Responsibility.		
• Negotiation and Settlement	Fully Covered	$500
• Trial	Fully Covered	$1,200
• Plus Trial Supplement for Out-of-Network Service*		$100,000
Personal Injury	**In-Network**	**Out-of-Network**
Personal Injury (25% Network Maximum): Subject to applicable law and court rules, plan attorneys will handle personal injury matters (where the participant is the plaintiff) at a maximum fee of 25% of the gross award. It is the participant's responsibility to pay this fee and all costs.		

Benefit Definitions & Reimbursements (Continued)

Probate	In-Network	Out-of-Network
Probate (10% Network Reduced Fee): Subject to applicable law and court rules, plan attorneys will handle probate matters at a fee of 10% less than the plan attorney's normal fee. It is the participant's responsibility to pay this reduced fee and all costs.		
Real Estate Matters	**In-Network**	**Out-of-Network**
Boundary or Title Disputes: This service covers negotiations and litigation arising from boundary or real property title disputes involving a participant's primary residence, where coverage is not available under the participant's homeowner or title insurance policies. The service includes filing to remove a mechanic's lien.		
• Negotiation and Settlement	Fully Covered	$500
• Trial	Fully Covered	$1,500
• Plus Trial Supplement for Out-of-Network Service*		$100,000
Eviction and Tenant Problems: This service covers the participant as a tenant for matters involving leases, security deposits or disputes with a residential landlord. The service includes eviction defense, up to and including trial. This service covers matters involving the participant's primary residence only. It does not include representation in disputes with other tenants or as a plaintiff in a lawsuit against the landlord, including an action for return of a security deposit.		
• Correspondence and Negotiations	Fully Covered	$280
• Eviction Trial Defense	Fully Covered	$840
• Plus Trial Supplement for Out-of-Network Service*		$100,000
Home Equity Loan: This service covers the review or preparation of a home equity loan on the Participant's primary, second or vacation home.	Fully Covered	$350
Property Tax Assessments: This service covers the Participant for review and advice on a property tax assessment on the Participant's residence. It also includes filing the paperwork, gathering the evidence, negotiating a settlement and attending the hearing necessary to seek a reduction of the assessment.		
• Negotiation and Settlement	Fully Covered	$270
• File Request for Hearing with Attendance at Hearing	Fully Covered	$620
• Plus Trial Supplement for Out-of-Network Service*		$100,000
Refinancing of Home: This service provides the Covered Person with counsel in the refinancing of or obtaining a home equity loan on the Covered Person's primary or secondary residence. It includes the review or preparation of all relevant documents, including the mortgage, deed, and documents pertaining to title, insurance, recordation and taxation. It does not include:services provided by an attorney representing a lending institution or title company; the sale or purchase of a home; or the refinancing of or obtaining a home equity loan on: rental property; or property held for business or investment.	Fully Covered	$350
Sale or Purchase of Home: This service provides the Covered Person with counsel for the purchase and sale of the Covered Person's primary or secondary residence or of vacant property to be used for building a primary or secondary residence. It includes the review or preparation of all relevant documents, including the construction documents for a new home, purchase agreement, mortgage, deed and documents pertaining to title, insurance, recordation, and taxation. The service also includes attendance of a Plan Attorney at closing in cities where it is the custom to do so. It does not include: services provided by an attorney representing a lending institution or title company; refinancing a home; home equity loans; or the sale or purchase of: rental property; or property held for business or investment.	Fully Covered	$500
Security Deposit Assistance (Primary Residence – Tenant only): This service covers counseling the Participant as a tenant in recovering a security deposit from the Participant's residential landlord for the Participant's primary residence; reviewing the lease and other relevant documents; and preparing a demand letter to the landlord for the return of the deposit. It also covers assisting the Participant in prosecuting a small claims action; helping prepare documents; advising on evidence, documentation and witnesses; and preparing the Participant for the small claims trial. This service does not include the Plan Attorney's attendance or representation at the small claims trial, collection activities after a judgment or any services relating to post-judgment actions.		
• Demand Letter/Negotiations	Fully Covered	$250
• Counseling on Preparing Small Claims Complaint and Trial Preparation	Fully Covered	$150

Benefit Definitions & Reimbursements (Continued)

Zoning Applications: This service provides the participant with the services of a lawyer to help get a zoning change or variance for the participant's primary residence. Services include reviewing the law, reviewing the surveys, advising the participant, preparing applications, and preparing for and attending the hearing to change zoning.		
• Preparation of Documentation	Fully Covered	$250
• Documentation/Attending Hearing	Fully Covered	$500
Traffic Matters	**In-Network**	**Out-of-Network**
Restoration of Driving Privileges: This service covers the participant with representation in proceedings to restore the participant's driving license.	Fully Covered	$385
Traffic Ticket Defense (No DUI): This service covers representation of the participant in defense of any traffic ticket including traffic misdemeanor offenses, except driving under the influence or vehicular homicide, including court hearings, negotiation with the prosecutor and trial.		
• Plea or Trial at Court	Fully Covered	$250
• Plea or Trial at Court for serious moving violations resulting in jail time or license suspension	Fully Covered	$500
• Plus Trial Supplement for Out-of-Network Service*		$100,000

* Trial Supplement — In addition to fees indicated, we will pay the attorney's fees for representation in trial beyond the third day of trial up to a maximum of $800 per day up to $100,000 total trial supplement maximum.

Exclusions: No service, including advice and consultations, will be provided for 1) employment-related matters, including company or statutory benefits; 2) matters involving the employer, MetLife® and affiliates, and plan attorneys; 3) matters in which there is a conflict of interest between the employee and spouse or dependents in which case services are excluded for the spouse and dependents; 4) appeals and class actions; 5) farm and business matters, including rental issues when the participant is the landlord; 6) patent, trademark and copyright matters; 7) costs and fines; 8) frivolous or unethical matters; 9) matters for which an attorney-client relationship exists prior to the participant becoming eligible for plan benefits. For all other personal legal matters, an advice and consultation benefit is provided. Additional representation is also included for certain matters listed above.

Get expert guidance for confident decisions
Contact your MetLife representative today.

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MetLife | Legal Plans



U.S. Immigration

Convenient professional legal guidance for various matters

Frequently Asked Questions about legal plan immigration services

Immigration Assistance

What is covered?

This service is designed to assist a member in handling their own personal immigration matters.

There are two sub-categories within Immigration Assistance matters.
- Counseling and *review* of immigration documents or forms
- Counseling and *preparation* of specific documents and forms

Immigration Services covered within both assistance categories:
- Advice and consultation
- Review of any immigration documents
- Affidavits and powers of attorney
- Preparation of immigration, naturalization forms
- Helping the member prepare for hearings
- Preparing forms regarding *employment status* and *work visas*

Forms signed by enrolled member or their spouse or dependant are covered.

What is not covered under immigration assistance?

The service does not include attending any type of immigration hearing or legal services beyond the review and preparation assistance of the documents.

Have other questions?

To learn more about your coverage or find a Network Attorney, create your account at **members.legalplans.com** or call our Client Service Center at **800-821-6400**
Monday—Friday
8:00 a.m. to 8:00 p.m., ET

Immigration Representation

What is covered?

This service covers same as above: advice and consultation, preparation of immigration forms, affidavits, powers of attorney, review of any immigration documents, helping the member prepare for hearings — **plus attorney representation attendance at hearings.**

Legal plans are administered by MetLife Legal Plans, Inc., Cleveland, Ohio. In California, this entity operates under the name MetLife Legal Insurance Services. In certain states, legal plans are provided through insurance coverage underwritten by Metropolitan General Insurance Company, Warwick, RI. For costs and complete details of the coverage, call or write the company.

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MetLife | Legal Services

New portability procedures

If you wish to continue your legal plan benefit after retiring or terminating employment, we offer you the opportunity to continue on as a legal plan member for 12 months through a portable plan.



To apply for portable enrollment:

- Call our Client Service Center at **800.821.6400**, Monday-Friday (8am - 8pm ET) to enroll in your portable plan. A Client Service Center Representative will assist you in the enrollment process. You must enroll within 30 days of your last day of employment.
- Enrollment is prepaid via remittance of a lump sum payment equal to the legal plan's monthly rate times 12 months.
- Upon receipt and approval of payment, we will send you verification of the portable enrollment.
- Portable enrollments will remain effective for a 12 month period and refunds will not be issued.
- Under portable enrollment, dependent definitions are the same as those for active Employees.
- The covered services and exclusions are the same as those under your current plan. Please visit **members.legalplans.com** or call **800.821.6400** for plan details.

Count on us for an exceptional service experience.

Group legal plans are provided by Hyatt Legal Plans, Inc., a MetLife company, Cleveland, OH. In certain states, group legal plans are provided through insurance coverage underwritten by Metropolitan Property and Casualty Insurance Company, Warwick, RI.

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Benefits of PHWP
New York Life Life Insurance

No Cost Basic Term Life Insurance
Eligible Postdoc employees who work at least 20 hours per week can apply for a $20,000 individual basic term life insurance and accidental death & dismemberment (AD&D) and a $5000 individual supplemental life insurance policy at no cost. This policy is portable when you end your Postdoc employment according to the terms established by New York Life. You can opt out of this benefit if you so choose using the enrollment portal at portal.hwtf.org/login This is the only benefit that requires your SSN. The portal will prompt you to provide your SSN and to name beneficiaries for your policy. If we do not receive a beneficiary information from you, there is a legal sequence of legal spouse, kids, parents, siblings, estate. This sequence would be followed if no beneficiary is designated or if the designated beneficiary is not alive at the time of a claim.

OPTIONAL SUPPLEMENTAL LIFE INSURANCE
Postdocs working at least 20 hours per week can apply to purchase additional, supplementary life insurance at affordable rates through New York Life. This benefit is 100% employee paid. Highlights of the policy include:

- Your first $100,000 of coverage is guaranteed issues, without medical evidence ($25,000 for spouse)

Benefits of PHWP
New York Life Life Insurance

- Coverage is portable at group rates when you leave
- Includes will preparation assistance
- Rates are based on age (see the chart in the following pages)

How to apply
Log in to our enrollment portal at portal.hwtf.org/login and complete the life insurance portion of the application. Any applicant applying for coverage of over $100,000 must also complete New York Life's electronic Evidence of Insurability form which should be accessed from your dashboard at portal.hwtf.org/login

Payment of Premiums for Supplemental Policies
Premium payments must be paid via credit card or debit card using Stripe's automatic, recurring payment feature. Recurring payments may be ended at any time by either the participant or the Trust Fund.

Porting your Life Insurance When you Leave Employment
You can take your policy with you when you leave UMass—although your rates may change, they will likely be less expensive that a non-group policy. Email uwdental@umass.edu right away when you leave employment to receive timely information on porting your life insurance. Information about porting the policy is in the pages that follow.

Offered by Life Insurance Company of North America

Employer-Paid Term Life Insurance

Summary of Benefits **Prepared for:** UAW/UMASS HEALTH & WELFARE TRUST
Class 1

Eligibility:
All active Employees of the Employer, who are United States citizens or United States permanent residents working in the United States, or non-United States citizens living and working in the United States under an active and appropriate visa or work authorization, who are classified as Postdoctoral Researcher Employees and their Spouse and Dependent Children residing in the United States regularly working a minimum of 20 hours per week.
Employee: You will be eligible for coverage immediately.

Available Coverage:

	Benefit Amount	Maximum	Guaranteed Issue Amount
Employee	$20,000	$20,000	$20,000

Additional Features:
Extended Death Benefit with Waiver of Premium – Life insurance for you and your dependents can be continued for up to 12 months while you are disabled or receiving benefits under your employer's disability plan. If you become totally disabled before reaching age 60, life insurance for you and your dependents can be continued, without payment of premium, until age 65, subject to proof of disability (inability to work in any occupation).
Accelerated Death Benefit – Terminal Illness – If two unaffiliated doctors diagnose you as terminally ill while the coverage is active, with a life expectancy of 12 months or less, the benefit for Terminal Illness provides up to:
Employee: 75% of your Term Life Insurance coverage amount or $13,000, whichever is less.

Portability – If your employment is terminated, you can continue your life insurance on a direct-bill basis. 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.

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 65% at age 65 and 50% at age 70. Your premiums will also reduce to match your benefits.
Limitations: The Accelerated Death Benefit is payable only once. Using this benefit reduces the life insurance death benefit. The amount payable under the Accelerated Death Benefit may be reduced by the amount of other benefits already paid to the insured under the policy. See your certificate for details. Benefits will be extended without premium payment until the earlier of the date you are no longer disabled, or the date you fail to qualify for Waiver of Premium or fail to provide proof of Disability.

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. FLX0971099. 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, 51 Madison Avenue New York, NY 10010.

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Offered by Life Insurance Company of North America

Employer-Paid Accidental Death and Dismemberment

Summary of Benefits **Prepared for:** UAW/UMASS HEALTH & WELFARE TRUST
Class 1

Eligibility:
All active Employees of the Employer, who are United States citizens or United States permanent residents working in the United States, or non-United States citizens living and working in the United States under an active and appropriate visa or work authorization, who are classified as Postdoctoral Researcher Employees and their Spouse and Dependent Children residing in the United States regularly working a minimum of 20 hours per week.
Employee: You will be eligible for coverage immediately.

	Benefit Amount	Maximum
Employee	$20,000	$20,000

Benefit Details:

If, within 365 days of a Covered Accident, bodily injuries result in:	We'll pay this % of the Benefit Amount:
Loss of life; Quadriplegia; Loss of two or more hands or feet; Loss of sight in both eyes; Loss of speech and hearing (both ears)	100%
Paraplegia	75%
Hemiplegia; Loss of one hand or foot; Loss of sight in one eye; Loss of speech; Loss of hearing (both ears); Severance & Reattachment of one hand or foot	50%
Uniplegia; Loss of all four fingers of the same hand; Loss of thumb & index finger of the same hand	25%
Loss of all toes of the same foot	20%

Additional Features:
For Wearing a Seatbelt & Protection by an Airbag – You will receive an additional 10% benefit but not more than $2,000 if the covered person dies in a Covered Automobile Accident and law enforcement-certified to be wearing a seatbelt or approved child restraint. We will increase the benefit by an additional 5% but not more than $1,000 if the insured person was also positioned in a seat protected by a properly-functioning and properly deployed Supplemental Restraint System (Airbag).

For Comas – You will receive 1% of the full benefit amount each month, for up to a maximum of 11 months, if you or an insured family member are in a coma for 30 days or more as a result of a Covered Accident. If the covered person is still in a coma after 11 months, or dies, the full benefit amount will be paid.
For Exposure & Disappearance – Benefits are payable if you or an insured family member suffer a covered loss due to unavoidable exposure to the elements as a result of a Covered Accident. If you or an insured family member's body is not found within one year of the disappearance, wrecking or sinking of the conveyance in which you or an insured family member were riding, on a trip otherwise covered, it will be presumed that you sustained loss of life as a result of a Covered Accident.
For a Loss Resulting from a Common Carrier – If you or an insured family member suffer a covered loss while riding as a passenger in, or being struck by, a common carrier, we will pay an additional 100% of the benefit amount, to a maximum of $20,000.
For Child Care Expenses – If you die as a result of a Covered Accident, we will pay a benefit for a surviving child under 13 who is enrolled in a licensed child care center at the time of the accident or within 90 days afterwards. This benefit is 3% of your benefit amount per year, but not more than $600 per year for 4 years or until the child turns 13, whichever occurs first, for each covered child.

Conversion – If group accident coverage ends (except due to nonpayment of premium), your employment is terminated, membership in an eligible class is terminated, or insurance coverage is reduced based on attained age, you can convert to an individual non-term policy. To convert, you must apply for the conversion policy and pay the first premium payment within 31 days after your group coverage ends. Dependents may convert their coverage as well if applicable. Premiums may change at this time, and terms of coverage will be subject to change. You can also convert to an individual policy of up to $10,000 if you have been insured for at least 5 years and the policy is terminated or amended, provided coverage is not replaced and you are not covered under a different conversion policy issued by Life Insurance Company of North America. Refer to your certificate for details.

Important Definitions and Policy Provisions:
When your coverage begins: Coverage begins on the later of the program's effective date, the date you become eligible, the date we receive your completed enrollment form 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 dependent who on the effective date is hospital or home confined; receiving chemotherapy or radiation treatment; or disabled and under the care of a physician.
When your coverage ends: Coverage ends on the earliest of the date you or your dependents , if applicable, are no longer eligible, the date the group policy is no longer in force, or the date for the last period for which required premiums are paid. (Under certain circumstances, your coverage may be continued if you stop working. Be sure to read the Continuation of Insurance provisions in your Certificate.)

Benefit Reductions, Exclusions and Limitations:
Benefit Reduction Schedule: If you are still employed, your benefits will reduce to 65% at age 65 and 50% at age 70. Your premiums will also reduce to match your benefits.
Exclusions: Self-inflicted injuries or suicide while sane or insane • commission or attempt to commit a felony or an assault • any act of war, declared or undeclared • any active participation in a riot, insurrection or terrorist act • bungee jumping • parachuting • skydiving • parasailing • hang-gliding • sickness, disease, bodily or mental infirmity, bacterial or viral infection or medical or surgical treatment thereof, except for any bacterial infection resulting from an accidental external cut or wound or accidental ingestion of contaminated food• voluntarily using any drug, narcotic, poison, gas or fumes except one prescribed by a licensed physician and taken as prescribed • operating any type of vehicle while under the influence of alcohol or any drug, narcotic or other intoxicant including any prescribed drug for which the covered person has been provided a written warning against operating a vehicle while taking it • a Covered Accident that occurs while the covered person is engaged in the activities of active duty service in the military, navy or air force of any country or international organization (this does not include Reserve or National Guard training, unless it extends beyond 31 days) • traveling in an aircraft that is owned, leased or controlled by the sponsoring organization or any of its subsidiaries or affiliates • air travel, except as a passenger on a regularly scheduled commercial airline or in an aircraft being used by the Air Mobility Command or its foreign equivalent • flight in, boarding or alighting from an aircraft or any craft designed to fly above the Earth's surface being flown by the covered person or in which the covered person is a member of the crew.
Limitations: For multiple covered losses, benefits are paid for the single largest benefit available. For loss of life, the benefit amount shown will be reduced by the amount of any dismemberment benefits that were previously paid or payable.

THIS POLICY PROVIDES LIMITED ACCIDENT-ONLY COVERAGE. IT PAYS A FIXED BENEFIT AND DOES NOT COVER MEDICAL EXPENSES AS INCURRED. IT DOES NOT COVER LOSSES CAUSED BY SICKNESS. THIS IS NOT A SUBSTITUTE FOR COMPREHENSIVE OR MAJOR MEDICAL HEALTH INSURANCE.

Terms and conditions of coverage for Accidental Death and Dismemberment insurance are set forth in Group Policy No. OK0972455. This is not intended as a complete description of the insurance coverage offered. This is not a contract. Complete coverage details, including premiums, eligible injuries, their respective payments and policy exclusions and limitations are contained in the Policy Certificate. If there are any differences between this summary and the group policy, the information in the group policy takes precedence. Product availability 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 GA-00-1000.00. Coverage is underwritten by Life Insurance Company of North America, 51 Madison Avenue New York, NY 10010.

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Offered by Life Insurance Company of North America

Employee-Paid Term Life Insurance

Summary of Benefits **Prepared for:** UAW/UMASS HEALTH & WELFARE TRUST
Class 1

Eligibility:
All active, Full-Time Employees of the Employer regularly working a minimum of 30 hours per week in the United States, who are citizens or permanent resident aliens of the United States.
Employee: You will be eligible for coverage immediately.
Spouse/Domestic Partner*: Up to age 70, as long as you apply for and are approved for coverage yourself.
Child(ren): Birth to age 26, as long as you apply for and are approved for coverage yourself.

*Domestic Partner is defined in the Group Policy. For purposes of this brochure, wherever the term Spouse appears, it shall also include Domestic Partner registered under any state which legally recognizes Domestic Partnerships or Civil Unions. Additional information is available from your Benefit Services Representative.

Available Coverage:

	Benefit Amount	Maximum	Guaranteed Issue Amount
Employee	Units of $5,000	$500,000	$100,000
Spouse	Units of $5,000	$100,000, not to exceed 50% of the Employee's benefit	$25,000
Child(ren)	Units of $1,000	$10,000; under 6 months old $500	All Amounts

Ongoing Annual Enrollment Event Option: All eligible employees that are currently insured under this Voluntary Life Policy, may increase their Voluntary Life Insurance Benefit up to the Case Level Guaranteed Issue as long as the total benefit does not exceed the Guaranteed Issue Amount without completing Evidence of Insurability. You may also increase the Spouse Voluntary Life Benefit up to the Case Level Guaranteed Issue if your spouse is currently insured, as long as the total benefit does not exceed the Guaranteed Issue Amount without completing Evidence of Insurability.

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:
Extended Death Benefit with Waiver of Premium – Life insurance for you and your dependents can be continued for up to 12 months while you are disabled or receiving benefits under your employer's disability plan. If you become totally disabled before reaching age 60, life insurance for you and your dependents can be continued, without payment of premium, until age 65, subject to proof of disability (inability to work in any occupation).
Accelerated Death Benefit – Terminal Illness – If two unaffiliated doctors diagnose you or your spouse as terminally ill while the coverage is active, with a life expectancy of 12 months or less, the benefit for Terminal Illness provides up to:
Employee: 75% of your Term Life Insurance coverage amount or $375,000, whichever is less.
Spouse: 75% of your Term Life Insurance coverage amount or $375,000, whichever is less.

Portability – If your employment is terminated, you can continue your life insurance, and life insurance for your insured spouse and dependent children, on a direct-bill basis. Your spouse and dependent children may also continue their life insurance, following your death, following divorce, or when the child reaches the age

limit. 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.

Your Monthly Cost of Coverage:

Age	Employee Cost Per $1,000	Age	Employee Cost Per $1,000
0-19	$0.080	60-64	$0.550
20-24	$0.080	65-69	$0.920
25-29	$0.080	70-74	$1.730
30-34	$0.080	75-79	$1.730
35-39	$0.100	80-84	$1.730
40-44	$0.120	85-89	$1.730
45-49	$0.160	90-94	$1.730
50-54	$0.250	95-99	$1.730
55-59	$0.370		

Age	Spouse Cost Per $1,000	Age	Spouse Cost Per $1,000
0-19	$0.080	45-49	$0.160
20-24	$0.080	50-54	$0.250
25-29	$0.080	55-59	$0.370
30-34	$0.080	60-64	$0.550
35-39	$0.100	65-69	$0.920
40-44	$0.120		

Child Cost Per $1,000 = $0.190

Actual per pay period premiums may differ slightly due to rounding. All spouse rates are based on spouse age. 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 Monthly Cost:
Step 1: Find the appropriate cost for employee and/or dependents above.
Step 2: Take the coverage amount you choose and divide it by 1,000 to get the number of units.
Step 3: Multiply the rate by your desired coverage amount in units.
Step 4: The result is the **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 will reduce to 65% at age 65 and 50% at age 70. Your premiums will also reduce to match your benefits.
Exclusions: Voluntary life insurance will not be paid if you commit suicide, while sane or insane, within the first two years of coverage.
Limitations: The Accelerated Death Benefit is payable only once. Using this benefit reduces the life insurance death benefit. The amount payable under the Accelerated Death Benefit may be reduced by the amount of other

benefits already paid to the insured under the policy. See your certificate for details. Benefits will be extended without premium payment until the earlier of the date you are no longer disabled, or the date you fail to qualify for Waiver of Premium or fail to provide proof of Disability.

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 yourself more than 31 days from the date you become eligible to elect coverage under this plan, the Guaranteed Issue Amount will not apply. 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. FLX0971099. 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, 51 Madison Avenue New York, NY 10010.

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Offered by Life Insurance Company of North America

Employee-Paid Accidental Death and Dismemberment

Summary of Benefits **Prepared for:** UAW/UMASS HEALTH & WELFARE TRUST
Class 1

Eligibility:
All active, Full-Time Employees of the Employer regularly working a minimum of 30 hours per week in the United States, who are citizens or permanent resident aliens of the United States.
Employee: You will be eligible for coverage immediately.
Spouse/Domestic Partner*: Up to age 70, as long as you apply for and are approved for coverage yourself.
Child(ren): Are eligible as long as you apply for and are approved for coverage yourself.

*Domestic Partner is defined in the Group Policy. For purposes of this brochure, wherever the term Spouse appears, it shall also include Domestic Partner registered under any state which legally recognizes Domestic Partnerships or Civil Unions. Additional information is available from your Benefit Services Representative.

	Benefit Amount	Maximum
Employee	Units of $5,000	$500,000
Spouse	Units of $5,000	$100,000, not to exceed 50% of the Employee's benefit
Child(ren)	Units of $1,000	$10,000

Benefit Details:

If, within 365 days of a Covered Accident, bodily injuries result in:	We'll pay this % of the Benefit Amount:
Loss of life; Quadriplegia; Loss of two or more hands or feet; Loss of sight in both eyes; Loss of speech and hearing (both ears)	100%
Paraplegia	75%
Hemiplegia; Loss of one hand or foot; Loss of sight in one eye; Loss of speech; Loss of hearing (both ears); Severance & Reattachment of one hand or foot	50%
Uniplegia; Loss of all four fingers of the same hand; Loss of thumb & index finger of the same hand	25%
Loss of all toes of the same foot	20%

Additional Features:
For Wearing a Seatbelt & Protection by an Airbag – You will receive an additional 10% benefit but not more than $25,000 if the covered person dies in a Covered Automobile Accident and law enforcement-certified to be wearing a seatbelt or approved child restraint. We will increase the benefit by an additional 5% but not more than $10,000 if the insured person was also positioned in a seat protected by a properly-functioning and properly deployed Supplemental Restraint System (Airbag).

For Comas – You will receive 1% of the full benefit amount each month, for up to a maximum of 11 months, if you or an insured family member are in a coma for 30 days or more as a result of a Covered Accident. If the covered person is still in a coma after 11 months, or dies, the full benefit amount will be paid.
For Exposure & Disappearance – Benefits are payable if you or an insured family member suffer a covered loss due to unavoidable exposure to the elements as a result of a Covered Accident. If you or an insured family member's body is not found within one year of the disappearance, wrecking or sinking of the conveyance in which you or an insured family member were riding, on a trip otherwise covered, it will be presumed that you sustained loss of life as a result of a Covered Accident.

Conversion – If group accident coverage ends (except due to nonpayment of premium), your employment is terminated, membership in an eligible class is terminated, or insurance coverage is reduced based on attained age, you can convert to an individual non-term policy. To convert, you must apply for the conversion policy and pay the first premium payment within 31 days after your group coverage ends. Dependents may convert their coverage as well if applicable. Premiums may change at this time, and terms of coverage will be subject to change. You can also convert to an individual policy of up to $10,000 if you have been insured for at least 5 years and the policy is terminated or amended, provided coverage is not replaced and you are not covered under a different conversion policy issued by Life Insurance Company of North America. Refer to your certificate for details.

Your Monthly Cost of Coverage:
Employee Cost Per $1,000 = $0.020
Spouse Cost Per $1,000 = $0.016
Child Cost Per $1,000 = $0.046

Actual per pay period premiums may differ slightly due to rounding. Rates may be subject to change in the future. Benefits will reduce based on age (see Benefits Reduction Schedule for details).

How to Calculate Your Monthly Cost:
Step 1: Find the appropriate cost for employee and/or dependents above.
Step 2: Take the coverage amount you choose and divide it by 1,000 to get the number of units.
Step 3: Multiply the rate by your desired coverage amount in units.
Step 4: The result is the **Monthly** cost.

Important Definitions and Policy Provisions:
When your coverage begins: Coverage begins on the later of the program's effective date, the date you become eligible, the date we receive your completed enrollment form 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 dependent who on the effective date is hospital or home confined; receiving chemotherapy or radiation treatment; or disabled and under the care of a physician.
When your coverage ends: Coverage ends on the earliest of the date you or your dependents , if applicable, are no longer eligible, the date the group policy is no longer in force, or the date for the last period for which required premiums are paid. (Under certain circumstances, your coverage may be continued if you stop working. Be sure to read the Continuation of Insurance provisions in your Certificate.)

Benefit Reductions, Exclusions and Limitations:
Benefit Reduction Schedule: If you are still employed, your benefits will reduce to 65% at age 65 and 50% at age 70. Your premiums will also reduce to match your benefits.
Exclusions: Self-inflicted injuries or suicide while sane or insane • commission or attempt to commit a felony or an assault • any act of war, declared or undeclared • any active participation in a riot, insurrection or terrorist act • bungee jumping • parachuting • skydiving • parasailing • hang-gliding • sickness, disease, bodily or mental infirmity, bacterial or viral infection or medical or surgical treatment thereof, except for any bacterial infection resulting from an accidental external cut or wound or accidental ingestion of contaminated food• voluntarily using any drug, narcotic, poison, gas or fumes except one prescribed by a licensed physician and taken as prescribed • operating any type of vehicle while under the influence of alcohol or any drug, narcotic or other intoxicant including any prescribed drug for which the covered person has been provided a written warning against operating a vehicle while taking it • a Covered Accident that occurs while the covered person is engaged in the activities of active duty service in the military, navy or air force of any country or international organization (this does not include Reserve or National Guard training, unless it extends beyond 31 days) • traveling in an aircraft that is owned, leased or controlled by the sponsoring organization or any of its subsidiaries or affiliates • air travel, except as a passenger on a regularly scheduled commercial airline or in an aircraft being used by the Air Mobility Command or its foreign equivalent • flight in, boarding or alighting from an aircraft or any craft designed to fly above the Earth's surface being flown by the covered person or in which the covered person is a member of the crew.
Limitations: For multiple covered losses, benefits are paid for the single largest benefit available. For loss of life, the benefit amount shown will be reduced by the amount of any dismemberment benefits that were previously paid or payable.

THIS POLICY PROVIDES LIMITED ACCIDENT-ONLY COVERAGE. IT PAYS A FIXED BENEFIT AND DOES NOT COVER MEDICAL EXPENSES AS INCURRED. IT DOES NOT COVER LOSSES CAUSED BY SICKNESS. THIS IS NOT A SUBSTITUTE FOR COMPREHENSIVE OR MAJOR MEDICAL HEALTH INSURANCE.

Terms and conditions of coverage for Accidental Death and Dismemberment insurance are set forth in Group Policy No. OK0972455. This is not intended as a complete description of the insurance coverage offered. This is not a contract. Complete coverage details, including premiums, eligible injuries, their respective payments and policy exclusions and limitations are contained in the Policy Certificate. If there are any differences between this summary and the group policy, the information in the group policy takes precedence. Product availability 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 GA-00-1000.00. Coverage is underwritten by Life Insurance Company of North America, 51 Madison Avenue New York, NY 10010.

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Group Benefit Solutions

Understanding Your Options to Continue Life Insurance Coverage

Life Insurance Company of North America (LINA)

- You know that life insurance is an important part of your overall financial planning package. Now that your group insurance benefit eligibility has changed and your life insurance coverage has ended, you have options to continue your current life insurance coverage and maintain your family's financial health.
- There are important decisions to make about continuing your life insurance benefits with New York Life Group Benefit Solutions (NYL GBS). You may be able to continue term life coverage for yourself and your family through Portability of your group coverage or by Conversion of your group coverage to an individual whole life insurance policy and paying premiums directly to NYL GBS for either option. Please refer to your Certificate of Insurance for details. Here is some information about the differences between these two options to help you make this important decision.

	Portability (Port)	**Conversion (Convert)**
What is the difference between ported coverage and converted coverage?	• When you port your coverage, you can keep the **group term life coverage** offered through a NYL GBS group insurance contract along with some, but not all of the optional benefits that were included. • Benefits not available on ported coverage include Accidental Death and Dismemberment and Waiver of Premium. • Term life insurance provides coverage for a specific term (such as, up to a certain age). It pays only the death benefit in the event you die during the term of the coverage; it has no accumulated cash value or benefit should you outlive the contract term. • Please read your Certificate of Insurance for more details.	• Conversion of coverage for you, your spouse and any children is converting to **individual whole life (or permanent life)** insurance policies. • The converted policy only provides life insurance and does not include any optional benefits. • Whole life insurance builds cash value that you can borrow against or use to pay future premiums. • Please read your Certificate of Insurance for more details.
Will the rates be different from the rates I paid while I was working?	• The premium rates are typically higher than what you paid under the group contract. • The premium rates increase with age and are not guaranteed. • With ported coverage, you will enter a pool of other individuals who have ported their coverage. Rates are then based on the experience of this group.	• The rates for conversion policies are normally higher. • The premium rate will not change as you age. • The rate is based on your age at the time you convert. Your coverage is guaranteed for life (i.e., to age 100), as long as premiums are paid and no changes to the coverage are made.

GBS P&C Admin - LINA
123887 Revised 07/2026

	Portability (Port)	Conversion (Convert)
Does coverage reduce or terminate because of age?	• **Employee and Spouse:** Coverage amount will reduce if there is an age reduction schedule in the group contract. • The coverage will remain in force as long as premiums are paid, up to the age specified in your Certificate of Insurance. As a standard, Portability ends at age 70. • **Spouse:** Coverage may also terminate for your spouse upon reaching a certain age and conversion will be offered. • **Child(ren):** Upon reaching ineligibility as a dependent, as specified in your group Certificate of Insurance, ported coverage terminates for that child. • Please read your Certificate of Insurance for more details on Spouse and Child eligibility and options.	• Coverage can be maintained up to age 100, as long as premiums are paid. • There is no age reduction schedule on the individual whole life policy. • Conversion may be available for coverage lost under the Portability Option due to an age reduction. • Please read your Certificate of Insurance for more details.
Will I have to answer medical questions?	• Proof of good health is not required for initial enrollment. • There may be a requirement if you later add a spouse.	• Proof of good health is not required.
What is the maximum amount of coverage that can be continued?	• You may continue all or a portion of the insurance you had in force upon termination of coverage under the group contract. • You may also select a portion for Portability and convert a portion. • The Employee will elect coverage for Dependent Spouse and/or Children on a single application. • Please read your Certificate of Insurance for more details.	• You may convert all or a portion of the insurance you had in force upon termination of coverage under the group contract. • The Employee, Spouse and Child(ren) will each complete their own application. • Please read your Certificate of Insurance for more details.
Can I increase, decrease or cancel coverage amounts after the initial application period?	• Coverage increases are not permitted. • Coverage decreases are allowed within applicable limits outlined in your Certificate of Insurance. • Yes, you can cancel coverage at any time.	• Coverage increases are not permitted. • Coverage decreases are allowed; an updated rate will be provided based on your age at the time of the request. • Yes, you can cancel coverage at any time.

	Portability (Port)	Conversion (Convert)
When must I enroll/apply for coverage?	• You will have the later of • 62 days from your coverage end date Or • 31 days from the date of your notification letter. • In no event, will the 31-day extension be more than 105 days from your group coverage end date.	• You will have the later of • 62 days from your coverage end date Or • 31 days from the date of your notification letter. • In no event, will the 31-day extension be more than 105 days from your group coverage end date.
How do I enroll/ apply for coverage?	• You will receive a notification letter with an 800# to call to obtain the applications required, which will be sent upon your request. • The application will include contact information if you have additional questions on the products. • Your ported coverage will take effect the first of the month following the coverage end date.	• You will receive a notification letter with an 800# to call to obtain the applications required, which will be sent upon your request. • The application will include contact information if you have additional questions on the products. • A separate Conversion application must be completed for each insured and a separate policy is issued to each insured. • The converted policy will take effect on the 32nd day following your coverage end date.

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Group Benefit Solutions

APPLICATION FOR PORTABILITY OF TERM LIFE INSURANCE

FOR FORMER EMPLOYEES & THEIR DEPENDENTS

Underwritten by
Life Insurance Company of North America (LINA)

Section A of this Application is to be completed by the Employer, all other sections are to be completed by the Former Employee*, for themselves, their Spouse and Children, as applicable, to elect to continue the Term Life Insurance coverage they had under a group policy.

Important Notes

- **A Former Employee is an Employee who has lost coverage under the group through Retirement, Termination of Employment, or other means, and is no longer an Active Employee with this group.*
- *The term `Spouse' used throughout this application will include Domestic Partners as defined in the group policy.*
- *Depending on the facts and circumstances of your unique situation, as well as the terms and conditions of the applicable policy(ies), the options outlined in the application may not all be available to you, your Spouse or your Children. Please refer to your certificate(s) of insurance for further details.*

How Much Time Do I Have to Submit My Application?

You have limited time. You must apply within the later of 62 days from your coverage end date or 31 days from the date of your notification, provided by your Employer in the Employer Section of your application.

However, under no circumstances will the 31 day extension go beyond 105 days from your coverage end date.

Your date of notification is the date entered by your Former Employer in the Verification box in Section A of this application. If Section A is left blank, you should still submit your otherwise completed application.

The effective date of coverage issued, will be the first day of the month following your group coverage end date.

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GBS ADMIN ER-LINA
874261 Revised 07/2026

Employee Name _____ **Social Security Number** _____

CLEAR FORM

Section A: Employer Verification

INSTRUCTIONS: *Employer must complete this section.*

If the group coverage cancelled because of group cancellation of contract, Portability is not an option.

Please print (preferably in black ink)

Employer Name	**Group Policy Number**	**Group Class Number**
Name of Employee	**Date of Hire**	**Last Date Worked**

Employment Termination Date	**Coverage End Date**	**Salary** (as of Last Date Worked)

Effective Date of Salary	**Reason for Loss of Coverage**
	☐ Retirement ☐ Termination of Employment ☐ Disability ☐ Other (Describe):

Basic Life Coverage	**Employee**	**Spouse**	**Child**
Group Coverage Effective Date (month/day/year)			
Premium Paid Through Date (month/day/year)			
Basic Life Coverage Amount			
Has a Terminal Illness benefit been paid?	☐ Yes ☐ No	☐ Yes ☐ No	N/A
If the Coverage has been reduced due to age, please enter the reduced amount.			N/A
Voluntary Life Coverage	**Employee**	**Spouse**	**Child**
Group Coverage Effective Date (month/day/year)			
Premium Paid Through Date (month/day/year)			
Voluntary Life Coverage Amount			
Has a Terminal Illness benefit been paid?	☐ Yes ☐ No	☐ Yes ☐ No	N/A
If the Coverage has been reduced due to age, please enter the reduced amount.			N/A

Verification of the Information Above was provided by:

Employer/Policyholder Signature:	Date: (Month/Day/Year)

Email Address:	Telephone Number:

Employee Name _____ **Social Security Number** _____

Section B: Insured Information

INSTRUCTIONS: *Sections B, C, D & E should be completed by the Former Employee.*
Please print (preferably in black ink)

Employer Name		**Group Policy Number**	**Group Class Number**
Employee Name (First)	(Last)		(Middle)
Address	**City**	**State**	**Zip Code**
Date of Birth	**Social Security Number**	**Phone Number and/or Email Address**	
Reason for Loss of Coverage ☐ Retirement ☐ Termination of Employment ☐ Disability ☐ Other (Describe): _____		**Were You Disabled on Your Coverage End Date?** ☐ Yes ☐ No	
Spouse's Name (First)	(Last)		(Middle)
Date of Birth	**Social Security Number**	**Phone Number and/or Email Address**	

Children will be eligible if they meet the definition of a Dependent Child in the policy.

If you have at least one eligible child you intend to request coverage for, please complete the information below. If you need more space, please complete a separate page using this format and include your name, the date and your signature.

Child's Name	Date of Birth	Social Security Number
1.		
2.		

Section C: Coverage Elections

INSTRUCTIONS: *In this section, the Former Employee must elect the coverage amounts (Basic and/or Voluntary Life) they want to continue under the Portability option in the group policy. Basic coverage is coverage that the Employer provided at no cost and Voluntary coverage is `supplemental' coverage the Employee was paying for through payroll deductions.*

Portability on the Basic and/or Voluntary coverage varies by Employer and may not be one of your options. Age and Policy Plan limitations may exist which could limit your and/or your Dependent's eligibility to continue coverage with Portability. If you or your Dependents do not meet the age, or other requirements for Portability, you may be able to convert this coverage to an individual whole life policy offered by New York Life Group Benefit Solutions (NYL GBS) at the time. Please consult your Certificate of Insurance.

Each person coverage is being elected for, must have had coverage under the group policy.

Employee Basic Life	☐ Continue Current Amount	☐ Other Amount: $ _____
Employee Voluntary Life	☐ Continue Current Amount	☐ Other Amount: $ _____
Spouse Basic Life	☐ Continue Current Amount	☐ Other Amount: $ _____
Spouse Voluntary Life	☐ Continue Current Amount	☐ Other Amount: $ _____
Child Voluntary Life	☐ Continue Current Amount	☐ Other Amount: $ _____

Have you applied for any of the following benefits, either now or previously? (check all that apply)

☐ Conversion to an Individual Policy	☐ Waiver of Premium (if disabled)	☐ Terminal Illness Benefit
Application date:	Application date:	Application date:

Employee Name _____ **Social Security Number** _____

IMPORTANT COVERAGE NOTES:

You may keep your coverages the same, decrease or increase, as available in the policy. If increases are available in the policy, they are subject to proof of good health and approval by the insurance carrier.

If a Terminal Illness Benefit (TI) was paid under the group policy for any coverage listed for an insured, the full amount of group coverage without the TI reduction must be completed on this application to receive the remaining balance of coverage.

Any age-related reduction provisions that were in the group policy, may continue to apply. The Conversion Privilege related to any partial loss of coverage remains subject to the terms of the group policy.

Please check your Certificate of Insurance or contact us at the number located at the end of this application to help with any of these questions.

Section D: Beneficiary Designations

INSTRUCTIONS: *Any beneficiary designations which you made under the group life insurance policy will not automatically carry forward.*

Primary and Contingent Beneficiaries - Unless you designate a percentage, proceeds are paid to primary surviving beneficiaries in equal shares. Proceeds are paid to contingent beneficiaries only when there are no surviving primary beneficiaries.

If you designate contingent beneficiaries and do not designate percentages, proceeds are paid to the surviving contingent beneficiaries in equal shares.

Unless otherwise provided, the share of a beneficiary who dies before the insured will be divided proportionately among the surviving beneficiaries in the respective category (primary or contingent).

If electing two or more beneficiaries for one Insured, the percentages must equal 100%.

Please print (preferably in black ink)

Beneficiary Name (For Employee Coverage)	**Percentage** *Total 100%*	**Social Security Number**	**Date of Birth**	**Relationship**
	%			
	%			
Beneficiary Name (For Dependent Spouse Coverage)	**Percentage** *Total 100%*	**Social Security Number**	**Date of Birth**	**Relationship**
	%			
	%			
Beneficiary Name (For Dependent Children Coverage)	**Percentage** *Total 100%*	**Social Security Number**	**Date of Birth**	**Relationship**
	%			
	%			

If you need additional space to indicate your beneficiary designations, attach a separate page using the above format including the appropriate policy number, the date, and your signature.

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, payments of benefits may be delayed or disputed unless your spouse provides their signature in the space provided below.

Spouse's Signature: _____ **Date:** (Month/Day/Year) _____

Employee Name _____ **Social Security Number** _____

Section E: Agreements & Authorization

INSTRUCTIONS: *If the ownership of this coverage had been previously assigned to someone other than the insured, it is the Owner that should sign below accordingly and provide the assignment documentation with the application.*

Your signature and date attest to your agreement of the following information.

To the best of my knowledge and belief all written, telephonic and electronic information I gave is true and complete. The conditions for the requested insurance to be effective are described in the policy and certificate. The approval of this request by the Insurance Company is one of those conditions**.**

Employee/Owner's Signature:	**Date:** (Month/Day/Year)
_____	_____

Section F: Portability Rate Table

Note: *The Portability Rate for Dependent Children is the same rate as it was under the group.*

This chart is intended as a guide to provide an estimated cost of the coverage.

Portability Rates

Rates shown below are per $1,000 of coverage per month

(Employee and Spouse)

Attained Age	Rate per $1,000
Under 20	$.153
20 to 24	$.144
25 to 29	$.153
30 to 34	$.177
35 to 39	$.190
40 to 44	$.243
45 to 49	$.384
50 to 54	$.726
55 to 59	$1.347
60 to 64	$2.461
65 to 69	$4.065
70 to 74	$6.143
75 to 79	$9.792
80 to 84	$15.523
85 to 89	$24.106
90 to 94	$36.119
95 to 99	$51.278

While this table of rates shows premium rates through age 99, eligibility for continuance of coverage will be as provided under the terms of the policy under which life insurance is being continued, including any age limits contained in the policy.

CLICK TO PRINT

How Do I Get Billed?

Portability has standard due dates on the first of January, April, July or October. If your effective date does not align with one of these months, your initial bill may be higher. Thereafter, you will receive your bill approximately 30 days in advance of the due date. To keep your coverage in force, you must pay your premiums as required. Electronic Fund Transfer (EFT) for monthly payments is also available once your certificate is current. Online payments are available once your certificate has been established.

When Does This Coverage End?

Coverage will end as provided in the Portability Option of the group policy. Age-related termination of coverage may apply. When your coverage under the Portability Option ceases (for reasons other than non-payment of premium), you may be able to convert this coverage within a specified timeframe to an individual whole life policy then offered by the Insurance Company (see your Certificate of Insurance for details).

How Do I Apply and/or Ask Questions?

Mail your completed & signed application to:

AMBA Administrators, Inc.
P.O. Box 152501
Irving, TX 75015-2501

Fax Number: 469-417-1675
E-Mail: policyservice@getamba.com

For Questions, please call 1-800-423-1282, 8:00 a.m. to 4:30 p.m., CST.

Benefits of PHWP
Grow Therapy

Starting August 1, 2026, eligible postdocs and their dependents now have access to three free mental health care sessions with Grow

How to Access Grow Therapy

1. You'll gain access to Grow Therapy via a link on your dashboard at portal.hwtf.org/login, which will appear once we've confirmed your eligibility for benefits.
2. Choose your provider. Filter by provider specialty, identity, language, and availability to meet your needs.
3. Schedule online. Most UMass Trust Fund members can schedule an appointment in less than two days.
4. Connect your way. See your provider virtually or in person. Fit your schedule with evening and weekend times.

Coverage for your Family

UMass employees and their eligible dependents each have access to 3 covered therapy sessions per benefit year. That means that you get three free sessions, your spouse gets three, and each of your children get three, as long as they are signed up for benefits with you. Note that no-shows count against your three covered sessions, so be sure to cancel ahead of time if your plans change.

Benefits of PHWP
Grow Therapy (con't)

Using Grow Therapy with Insurance

After your covered sessions, you may be able to continue care with your private health insurance (subject to your plan's terms and network participation) or through self-pay. The Wellfleet student health plan is accepted by Grow Therapy providers. Grow can assist with billing your preferred payment method. The average cost per session with insurance is around $21, and you'll get a personalized cost estimate before deciding to continue.

GROW | UAW/UMass HEALTH & WELFARE TRUST FUND

Therapy that's covered by your UMass benefits

UMass has partnered with Grow Therapy to make mental health care more affordable, accessible, and personalized to your needs.

LEARN MORE

From day-to-day stress to deeper emotional challenges, Grow connects you with licensed providers who specialize in:

Anxiety, Depression, and Stress | Grief, Trauma, and PTSD | Family Changes and Parenting Support | ADHD and Focus Challenges | Identity and Self-esteem | Many other specialties

Your UMass benefit

You get 3 covered therapy sessions per benefit year, for each member. No-shows count against your 3 covered sessions, so cancel ahead of time if your plans change.

Available to UMass employees and their eligible dependents. Household members are not included.

How to get started on Grow Therapy

01

Choose your provider

Filter by provider specialty, identity, language, and availability to meet your needs.

02

Schedule time online instantly

Most UMass members can schedule an appointment in less than two days.

03

Sessions built for you

See your provider virtually or in person, including evening and weekend times that work around your schedule.

The right therapist for you is already on Grow Therapy

Most UMass members schedule care in less than two days with one of Grow's 29,000+ providers, with virtual or in-person care and evening and weekend availability.

What happens after your 3 covered sessions?

After your covered UMass sessions, you may be able to continue care with your private health insurance (subject to your plan's terms and network participation) or through self-pay. The Wellfleet student health plan and the Postdoc Blue Cross Blue Shield plan are accepted by Grow Therapy providers. Grow can assist with billing your preferred payment method. The average cost per session with insurance is around $21, and you'll get a personalized cost estimate before deciding to continue.

How to Apply
For PHWP Benefits

How to Apply for Benefits
You must complete the online application form and electronically sign the benefits authorization form before you will be enrolled. The online application is available at portal.hwtf.org/login If you have any difficulty with the online application, please contact the Director of Benefits at uwdental@umass.edu or (413) 200-0423.

The online form will ask for information about you and your family, including:

- Your name;
- Your address;
- Your birth date;
- The names and birth dates of each member of your family you wish to enroll.

The Trust Fund will not be able to process your online enrollment form if you do not electronically sign the benefits authorization form or childcare form, or if you do not include all the information and documents required. That means you will not be eligible to receive benefits.

How to Apply
For PHWP Benefits

How to Apply for Benefits
Your claims will be processed faster and you will receive your benefits more quickly if the Trust Fund has up-to-date information for you and your family.

You must notify the Trust Fund when:

- You move;
- Your email address changes;
- You get married;
- You are divorced or legally separated, or end your domestic partnership; You have a new baby or legally adopt a child;
- Your child reaches age 19;
- A family member covered by the Benefit Fund dies.

If any of these situations occurs, please contact the Director of Benefit Programs at uwdental@umass.edu or (413) 200-0423 so that your records can be updated.

How to Apply
For PHWP Benefits

Your Benefits Authorization Form
Electronically signing your benefits authorization form certifies that all information you submit to the UAW/UMass Health & Welfare Trust Fund is true and correct to the best of your knowledge.

By esigning the form, you agree to and understand the following:

- the effective date and termination date of your membership and benefits will be determined by your employer and/or the Trustees of the UAW/UMass Health & Welfare Trust Fund and/or plan sponsor in accordance with the underwriting of any and all vendors employed by the Trust for the purpose of providing benefits;
- the email address and campus mail address you provide to the Trust Fund will be the primary methods used to communicate with you about your benefits;
- you release to the administrative employees and Trustees of the UAW/UMass Health & Welfare Trust Fund, to UAW Local 2322, and to any and all vendors employed by the Trust Fund for the purpose of providing benefits, information necessary to provide you with, and to verify your eligibility for, any and all benefits offered by the Trust Fund (including but not limited to dental, vision, wellness, and childcare assistance).

All information appearing on your online enrollment form is for Trust Fund use only and will not be released to any third party, except where necessary for the administration and operation of the Trust Fund and the provision of your benefits, or where otherwise required by law.

When Your **Coverage Begins**

The timing of when you can start receiving benefits from the PHWP is dependent on several factors: when your status as an employee starts, when you complete your application, and the dates of our open enrollment periods.

If You Are a New Employee
New employees should enroll within 30 days of their employment start date to enroll to avoid possible waiting periods and if their application is completed within this period, their coverage start date will mirror their employment start date.

If You Are an Existing Employee
If you missed the 30 day window,contact us—we can attempt to enroll you without waiting periods.

Open Enrollment
When you enroll as a Postdoc, you enroll for the entire term of your employment and do not need to re-enroll each year. If you need to make changes to your plans, you can do so during the annual open enrollment periods (see following page).

When Your **Coverage Begins (cont.)**

Open Enrollment Periods
Each year, there are several open enrollment periods during which you can submit a benefits application. For plan year 2026-27, open enrollment occurs according to the following schedule:

- July 15-Sept 15, 2026, for a coverage start date of 8/1/26
- Oct 15-Oct 31, 2026, for a coverage start date of 10/1/26
- Nov 15-Nov 30, 2026 for a coverage start date of 11/1/26
- Jan 15-Jan 31, 2027, for a coverage start date of 1/1/27
- March 15-March 31, 2027, for a coverage start date of 3/1/27
- May 15-May 31, 2027; for a coverage start date of 5/1/27

You must fully complete your application and electronically sign your authorization form in order to meet the enrollment deadlines above.

When Your **Coverage Begins (cont.)**

If You Return to Work After a Leave
If you are approved for a Family Medical Leave, the time you are out on the leave will not negatively affect your eligibility for PHWP benefits if you would have been eligible prior to the leave.

You must notify the Trust Fund in writing that you have been approved for an FMLA leave in order to avoid any interruption in your coverage.

If You Have Family Coverage
Coverage for your spouse, partner and/or your children starts at the same time your coverage begins as long as they are eligible to receive benefits and as long as you have completed the family information section of the application, including providing the names and dates of birth of your dependents to the Trust Fund via the application.

Your PHWP **ID Cards**

If you are eligible for benefits and have completed the online application, you will first receive an email confirming your eligibility and enrollment. Then, within 10 days of your first date of enrollment you should receive an ID card directly from Altus Dental and EyeMed Vision if you have opted into benefits. You can also download a digital ID by registering at www.altusdental.com or eyemed.com

You will need your unique Altus ID number which can be requested by emailing uwdental@umass.edu or by checking your dashboard at portal.hwtf.org/login.

You don't need ID cards to access your coverage. You can simply supply your provider with your name, date of birth and the following group numbers:

Altus Group #: 3001-0001
EyeMed Group #: 9878760

For both the dental and the vision plans, your member ID is made up of your UMass employee ID number +0.

Call the Director of Benefits if you have any problems with your ID cards, including:

- You did not receive your card(s);
- Your card is lost or stolen;
- Your name is not spelled correctly.

Your PHWP
ID Cards (cont.)

ID Cards for Dependents and Expired ID Cards
Altus and EyeMed do not issue ID cards in the names of dependents enrolled on your plan. This is not an indication that they are not covered. Your dependents should use your ID cards and your Member ID numbers and providers should be able to find their enrollment under the main subscriber's enrollment (you).

If you are no longer eligible for benefits, you may not use any ID card from the Trust Fund, regardless of any expiration date that may appear on the card. If you do, you will be personally responsible for all charges. Your ID cards are for use by you and your eligible dependents only. You should not allow anyone else to use your ID cards to obtain Trust Fund benefits. If you do, the Trust Fund will deny payment and you may be personally responsible to the provider for the charges. If the Trust Fund has already paid for these benefits, you will be required to reimburse the Trust Fund. The Trust Fund may deny benefits to you and your eligible dependents and/or may initiate civil or criminal actions against you until you repay the Benefit Fund. If you suspect that someone is using an ID card fraudulently, contact the Trust Fund.

When Your **Eligibility Ends**

When Do You Lose Eligibility?
You will lose your eligibility 30 days after your official end of employment date. You can waive this additional 30 days if you so choose.

Cobra Continuation of Coverage
Federal law requires that most group health plans (including the dental & vision plans offered by UAW/UMass Health & Welfare Trust Fund) give employees and their families the opportunity to continue their coverage when there is a "qualifying event" that would result in a loss of coverage under an employer's plan. Depending on the type of qualifying event, "qualified beneficiaries" can include the employee or retired employee covered under the plan, the covered employee's spouse, and the dependent children of the covered employee.

COBRA Continuation **Coverage**

Cobra Continuation of Coverage (continued)
Once your PHWP eligibility is lost, employees are eligible to apply for COBRA continuation coverage, where you can maintain dental and/or vision coverage for up to eighteen months by paying the premium yourself. No benefits other than the dental & vision plans offered under the PHWP are subject to COBRA continuation coverage.

Continuation coverage is the same coverage that the PHWP gives to other participants or beneficiaries under the PHWP who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the PHWP as other participants or beneficiaries covered under the PHWP. Be sure to share the information in this COBRA notice with all qualified beneficiaries in your household, including spouses/partners & dependents, as they may have COBRA rights under the law.

How Can You Elect COBRA Continuation of Coverage?
To elect continuation coverage, you must complete the Election Form and furnish it according to the directions on the form. The form is available at www.hwtf.org/cobra. Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee's spouse may elect continuation coverage even if the employee does not.

COBRA Continuation **Coverage (cont.)**

How Can You Elect COBRA Continuation of Coverage?
Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children. The employee or the employee's spouse can elect continuation coverage on behalf of all of the qualified beneficiaries. In considering whether to elect continuation coverage, you should take into account that a failure to continue group health coverage will affect your future rights under Federal law.

First, you can lose the right to avoid having preexisting condition exclusions applied to you by other group health plans if you have a 63-day gap in health coverage, and election of continuation coverage may help prevent such a gap. Second, you will lose the guaranteed right to purchase individual health coverage that does not impose a preexisting condition exclusion if you do not elect continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under Federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible, such as a plan sponsored by your spouse’s employer within 30 days after your group health coverage ends because of the qualifying event. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

COBRA Continuation **Coverage (cont.)**

How Much Does COBRA Continuation Coverage Cost?
Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage, not to exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent of the cost to the group plan), including both employer and employee contributions for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. The required payment for each continuation coverage period for each option is available at www.hwtf.org/cobra

Length of COBRA Coverage
In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage generally may be continued only for up to a total of 18 months. In the case of losses of coverage due to an employee's death, divorce or legal separation, the employee's becoming entitled to Medicare benefits or a dependent child ceasing to be a dependent under the terms of the plan, coverage may be continued for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. This notice shows the maximum period of continuation coverage available to the qualified beneficiaries.

COBRA Continuation **Coverage (cont.)**

Length of COBRA Coverage (continued)
Continuation coverage will be terminated before the end of the maximum period if:

- any required premium is not paid in full on time,
- a qualified beneficiary first becomes covered, after electing continuation coverage, under another plan that does not impose any preexisting condition exclusion for a preexisting condition of the qualified beneficiary,
- a qualified beneficiary first becomes entitled to Medicare benefits(under Part A, Part B, or both) after electing continuation coverage, or
- the employer ceases to provide any plan for its employees.

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud). When a COBRA continuation coverage participant fails to make their monthly payments in a timely manner, they will receive a series of warning letters via email. After the third of such notices, their coverage will be terminated retroactive to the end of the last month that was paid in full. Reinstatement with no gap in coverage is at the discretion of the Trust Fund. Timely payment of premiums is a condition of maintaining continued and uninterrupted COBRA continuation coverage.

COBRA Continuation **Coverage (cont.)**

Extensions to the Length of COBRA Continuation Coverage
If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify the Director of Benefit Programs at uwdental@umass.edu or (413) 200-0423 of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

Disability COBRA Extension
An 11-month extension of coverage may be available if any of the qualified beneficiaries is determined under the Social Security Act (SSA) to be disabled. The disability has to have started at some time on or before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Notice of said disability must be received by the plan in writing within 30 days of the end of the 18-month period. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined to no longer be disabled under the SSA, you must notify the Plan of that fact within 30 days after that determination.

COBRA Continuation **Coverage (cont.)**

Second Qualifying Event COBRA Extension

An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered employee, divorce or legal separation from the covered employee, the covered employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify the Plan within 60 days after a second qualifying event occurs if you want to extend your continuation coverage.

COBRA Continuation **Coverage (cont.)**

When and How Must Payment For COBRA Continuation Coverage be made?

First payment for continuation coverage: If you elect continuation coverage, you do not have to send any payment with the Election Form. However, you must make your first payment for continuation coverage not later than 45 days after the date of your election. This is the date the Election Notice is post-marked, if mailed. If you do not make your first payment for continuation coverage in full not later than 45 days after the date of your election, you will lose all continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact the Director of Benefit Programs at uwdental@umass.edu or (413) 200-0423 to confirm the correct amount of your first payment or to discuss payment issues related to the ARRA premium reduction.

Your first payment and all periodic payments for continuation coverage must be paid via credit card or debit card using PayPal or Stripe's automatic recurring payment feature. Recurring payments may be ended at any time by either the participant or the Trust Fund. Contact the Director of Benefit Programs to set up recurring automatic payments. You may elect, at your discretion, to make payments in advance, through the end of the current plan year through which rates are guaranteed.

COBRA Continuation **Coverage (cont.)**

When and How Must Payment For COBRA Continuation Coverage be made?

First payment for continuation coverage: If you elect continuation coverage, you do not have to send any payment with the Election Form. However, you must make your first payment for continuation coverage not later than 45 days after the date of your election. This is the date the Election Notice is post-marked, if mailed. If you do not make your first payment for continuation coverage in full not later than 45 days after the date of your election, you will lose all continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact the Director of Benefit Programs at uwdental@umass.edu or (413) 200-0423 to confirm the correct amount of your first payment or to discuss payment issues related to the ARRA premium reduction.

COBRA Continuation **Coverage (cont.)**

Continuous Payments for COBRA

Periodic payments for continuation coverage: After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The amount due for each coverage period for each qualified beneficiary is shown in this notice. The periodic payments can be made on a monthly basis. Under the Plan, each of these periodic payments for continuation coverage is due on the 1st day of the month for that coverage period. If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break. The Plan send periodic notices of payments due for these coverage periods.

Your first payment and all periodic payments for continuation coverage must be paid via credit card or debit card using Stripe's automatic recurring payment feature. Recurring payments may be ended at any time by either the participant or the Trust Fund. Contact the Director of Benefit Programs to set up recurring automatic payments. You may elect, at your discretion, to make payments in advance, through the end of the current plan year through which rates are guaranteed.

COBRA Continuation **Coverage (cont.)**

Continuous Payments for COBRA (continued)
Grace periods for periodic payments: Although periodic payments are due on the dates stated above, you will be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to continuation coverage under the Plan.

Keep Your Plan Informed of Address & Email Address Changes
In order to protect your and your family's rights, you should keep the Plan Administrator informed of any changes in your address, the addresses of family members and your email address. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

For more information, please see www.hwtf.org/cobra or www.dol.gov/dol/topic/health-plans/cobra.htm.

Payment **Policies**

All payments are processed by electronic check using the secure processor, Checkbook, which will email you a check that can be deposited electronically or printed and deposited manually.

If the Trust Fund issued a payment to you via Checkbook, PayPal, or Stripe, we will reissue your payment once with no penalty if you do not receive your check or you do not claim your PayPal or Stripe payment within 30 days and it is subsequently returned to the Trust Fund's account. If you require a second reissue of the same payment, we will deduct a $25 processing fee from the total amount of your reissued payment. No fee deduction shall apply if the reissue is processed via PayPal/Stripe.

The Trust Fund will only reissue payments after:

- the original check has been returned to us in hard copy form and remains uncashed, in the case of damaged checks or checks marked as undeliverable by the Postal Service, or
- the original check's expiration date (90 or 180 days) has passed and the funds have been returned to the Trust Fund's bank account or
- the original payment has been refunded to our PayPal or Stripe account due to not being claimed within 30 days.

If you've elected to be reimbursed electronically and the Trust Fund incurs an additional fee because your email is associated with a non-US account, this additional fee (typically nominal) will be your responsibility, and we will reduce your reimbursement by this fee accordingly.

HIPAA Notice
Of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Disclosure and Use of Protected Health Information
What follows is a Notice of Privacy Practices of the UAW/UMass Health & Welfare Trust Fund (the "Fund"). The Notice establishes the circumstances under which the Fund may share your protected health information with others in accordance with the Health Insurance Portability and Administrative Accountability Act of 1996 (HIPAA) Privacy Rules.

The Fund may use your protected health information ("PHI") for purposes of making or obtaining payment for your care and conducting health care operations. The Fund has established a policy to guard against unnecessary disclosure of your health information.

YOUR PROTECTED HEALTH INFORMATION MAY BE DISCLOSED OR USED IN THE FOLLOWING CIRCUMSTANCES AND FOR THE FOLLOWING PURPOSES:

To Make or Obtain Payment. The Fund may use or disclose your PHI to make payment to or collect payment from third parties, such as other health plans or providers, for the care you receive. For example, the Fund may provide information regarding your coverage or health care treatment to other health plans to coordinate payment of benefits.

HIPAA Notice **Of Privacy Practices (cont.)**

To Conduct Health Care Operations. The Fund may use or disclose PHI for its own operations to facilitate the administration of the Fund and as necessary to provide coverage and services to all of the Fund's participants and beneficiaries. Health care operations includes such activities as:

a. Quality assessment and improvement activities.
b. Activities designed to improve health or reduce health care costs.
c. Clinical guideline and protocol development, case management and care coordination.
d. Contacting health care providers, participants and beneficiaries with information about treatment alternatives and other related functions.
e. Health care professional competence or qualifications review and performance evaluation.
f. Accreditation, certification, licensing or credentialing activities.
g. Underwriting, premium rating or related functions to create, renew or replace health insurance or health benefits.
h. Review and auditing, including compliance reviews, medical reviews, legal services and compliance programs.
i. Business planning and development including cost management and planning related analysis and formulary development. (CONTINUED ON NEXT PAGE)

HIPAA Notice **Of Privacy Practices (cont.)**

j. Business management and general administrative activities of the Fund, including member services and resolution of internal grievances.
k. Certain marketing activities.

For example, the Fund may use your PHI to conduct case management, quality improvement, disease management, utilization review, or to engage in member service and grievance resolution activities. However, in no case will the Fund disclose genetic information as part of any of the above conduct of health care operations.

For Treatment Alternatives. The Fund may use or disclose your PHI to tell you about or recommend possible treatment options or alternatives that may be of interest to you.
For Distribution of Health Related Benefits and Services. The Fund may use or disclose your PHI to provide to you information on health related benefits and services that may be of interest to you.

For Disclosure to Plan Sponsor. The Fund may disclose your PHI to the Plan Sponsor, the Trustees of the Fund, for plan administration functions performed by the Trustees on behalf of the Fund. In addition, the Fund may provide summary health information to the Trustees so that the Trustees may solicit premium bids from health insurers or modify, amend or terminate the plan. The Fund may also disclose to the Trustees information on whether you are participating in the plan.

HIPAA Notice **Of Privacy Practices (cont.)**

Where Required or Permitted by Law. The Fund also may use or disclose your PHI where required or permitted by law. In that regard, HIPAA generally permits health plans to use or disclose PHI for the following purposes: where required by law; for public health activities; to report child or domestic abuse; for governmental oversight activities; pursuant to judicial or administrative proceedings; for certain law enforcement purposes; for a coroner, medical examiner, or funeral director to obtain information about a deceased individual; for organ, eye, or tissue donation purposes; for certain government-approved research activities; to avert a serious threat to an individual's or the public's health or safety; for certain government functions, such as related to military service or national security; or to comply with Workers' Compensation laws.

Authorization to Use or Disclose Protected Health Information

By law, the following types and uses and disclosures of PHI generally require your authorization: use or disclosure of psychotherapy notes, use or disclosure of PHI for marketing purposes, and disclosure of PHI for selling purposes. As stated above, the Fund will not disclose your PHI other than with your written authorization. If you authorize the Fund to use or disclose your PHI, you may revoke that authorization in writing at any time.

HIPAA Notice **Of Privacy Practices (cont.)**

Your Rights With Respect to Your Protected Health Information

You have the following rights regarding your PHI that the Fund maintains:

Right to Request Restrictions. You have the right to request restrictions on certain uses and disclosures of your PHI. You have the right to request a limit on the Fund's disclosure of your PHI to someone involved in the payment of your care. However, the Fund is not required to agree to your request, except if the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law or the PHI pertains solely to a health care item or service for which you, or person other than the Fund on your behalf, has paid the covered entity in full. If you wish to make a request for restrictions, please contact the Fund's Privacy Officer (see Contact Person below).

Right to Receive Confidential Communications. You have the right to request that the Fund communicate with you in a certain way if you feel the disclosure of your PHI could endanger you. For example, you may ask that the Fund only communicate with you at a certain telephone number or by email. If you wish to receive confidential communications, please make your request in writing and mail to the Fund's Privacy Officer (see Contact Person below). The Fund will attempt to honor your reasonable requests for confidential communications.

HIPAA Notice **Of Privacy Practices (cont.)**

Right to Inspect and Copy Your Protected Health Information. You have the right to inspect and copy your PHI, with some limited exceptions. A request to inspect and copy records containing your PHI must be made in writing and mailed to the Fund's Privacy Officer (see Contact Person below). If you request a copy of your PHI, the Fund may charge a reasonable fee for copying, assembly and postage, if applicable, associated with your request.

Right to Amend Your Protected Health Information. You have the right to request an amendment to your PHI records that you believe are inaccurate or incomplete. The request will be considered as long as the information is maintained by the Fund. A request for an amendment of records must be made in writing and mailed to the Fund's Privacy Officer (see Contact Person below). The Fund may deny the request if you do not state why you believe your records to be inaccurate or incomplete. The request also may be denied if your PHI records were not created by the Fund, if the health information you are requesting to amend is not part of the Fund's records, if the health information you wish to amend includes information you are not permitted to change, or if the Fund determines the records containing your PHI are accurate and complete.

HIPAA Notice **Of Privacy Practices (cont.)**

Right to an Accounting. You have the right to obtain a list of disclosures of your PHI made by the Fund for any reason other than for treatment, payment or health care operations, unless you have authorized the disclosure. The request must be made in writing and mailed to the Fund's Privacy Officer (see Contact Person below). The request should specify the time period for which you are requesting the information. The right to an accounting does not extend beyond six (6) years back from the date of your request. The Fund will provide the first accounting you request during any 12- month period without charge. Subsequent accounting requests may be subject to a reasonable cost based fee. The Fund will inform you in advance of the fee, if applicable.

Right to a Copy of this Notice. You have a right to obtain and receive a copy of this Notice at any time, even if you have received this Notice previously. To obtain a copy, please contact the Fund's Privacy Officer (see Contact Person).

HIPAA Notice **Of Privacy Practices (cont.)**

Duties of the Fund

The Fund is required by law to maintain the privacy of your PHI as set forth in this Notice, and to provide to you this Notice of its duties and privacy practices, and to notify affected individuals and relevant government agencies following a breach of unsecured PHI no later than 60 days of the Trust Fund's discovery of such a breach.

The Fund is required to abide by the terms of this Notice, which may be amended from time to time. The Fund reserves the right to change the terms of this Notice by providing you with a copy of a revised Notice within sixty (60) days of the change and by making the new Notice provisions effective for all health information that it maintains. If the Fund changes its policies and procedures, the Fund will revise the Notice and will provide a copy of the revised Notice to you within 60 days of the change. You have the right to express complaints to the Fund and to the Secretary of the United States Department of Health and Human Services if you believe that your privacy rights have been violated.

HIPAA Notice **Of Privacy Practices (cont.)**

Duties of the Fund (continued)
Any complaints to the Fund should be made in writing and mailed to the Fund's Privacy Officer (see Contact Person below). The Fund encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

Contact
The Fund has designated Leslie Edwards Davis as its contact person ("Privacy Officer") for all issues regarding patient privacy and your privacy rights. You may contact this person as follows:

- By mail: UAW/UMass Health & Welfare Trust Fund, 6 University Dr., Suite 206-229, Amherst, MA 01002
- By email: uwdental@umass.edu
- By phone: (413) 200-0423

UAW/UMass Health & Welfare Trust

Vision benefits as you've never seen before

Get the most out of your vision insurance plan with these EyeMed highlights:

- *Ability to use the frame and contact lens allowances in the same benefit year-worth up to an extra $185.00*[1]
- *Separate contact lens fit & follow-up coverage leaving the entire allowance for materials*

Plus, with us, you always get–

NETWORK

The largest network with the right mix of providers

- *America's largest vision network*[2.]
- *In-network options for buying glasses and contacts online at glasses.com, lenscrafters.com, contactsdirect.com, targetoptical.com, oakley.com, nuanceaudio.com and rayban.com – with benefits applied directly in the shopping cart.*
- *The right mix of independent eye doctors and national and regional retail providers – so members can go where they want, when they want.*

BENEFITS

Simple and transparent member experience with an eye on savings

- *The freedom to choose any ophthalmic frame, lens or contact lens without restrictions at any of our retail providers, independent provider locations or online.*
- *Complimentary HealthyEyes wellness program keeps the focus on eye health with exam reminders and leading technology*
- *Members can use their benefit on Nuance Audio glasses – a breakthrough dual hearing and vision solution.*
- *Members enjoy exclusive savings on LASIK, including up to $1000 off at preferred providers or 5% off the in-store promotional price.* [2]

EXPERIENCE

Freedom of choice and maximum value

- *Cost transparency with our Know Before You Go cost estimator.*
- *Digital Tools like online scheduling* [3], *a mobile app and personalized text alerts.*
- *Welcome kits, ID cards and open enrollment support to ensure employees understand their benefits.*

We can't wait to work with you-
Contact Virve Moore at vmoore1@eyemed.com with questions

1 *This document provides highlights of one or more EyeMed plans. Frame allowances may vary by plan. Please consult your EyeMed representative for more information*
2 *Preferred lasik providers include LasikPlus, TLC Laser Eye Centers and The LASIK Vision Institute*
3 *At select locations*

UAW/UMass Health & Welfare Trust

BENEFITS

- *AS IS*
- *Exam & Materials*
- *Select network*
- *ASO (PSPM/PMPM)*
- *Employer Paid*

MONTHLY RATES

- **Per subscriber per month** *$0.93*

SUMMARY OF BENEFITS

VISION CARE SERVICES	IN-NETWORK MEMBER COST	OUT-OF-NETWORK REIMBURSEMENT
EXAM SERVICES *once every plan year*		
Exam	*$0 copay*	*Up to $0*
FRAME *once every plan year*		
Frame	*$0 copay; 20% off balance over $185 allowance*	*Up to $0*
STANDARD PLASTIC LENSES *once every plan year*		
Single Vision	*$10 copay*	*Up to $0*
Bifocal	*$10 copay*	*Up to $0*
Trifocal/Lenticular	*$10 copay*	*Up to $0*
Progressive - Standard	*$10 copay*	*Up to $0*
Progressive – Premium Tier I	*$30 copay*	*Up to $0*
Progressive – Premium Tier II	*$40 copay*	*Up to $0*
Progressive – Premium Tier III	*$55 copay*	*Up to $0*
Progressive – Premium Tier IV	*$10 copay, 20% off retail price less $120 allowance*	*Up to $0*
LENS OPTIONS		
Tint - Solid or Gradient	*$0 copay*	*Up to $0*
CONTACT LENSES *once every plan year*		
Contacts - Conventional	*$0 copay; 15% off balance over $150 allowance*	*Up to $0*
Contacts - Disposable	*$0 copay; 100% of balance over $150 allowance*	*Up to $0*
Contacts - Medically Necessary	*$0 copay; paid-in-full*	*Up to $0*

All plans are based on a 48 month contract and 48 month rate guarantee. Monthly Rate is subject to adjustment even during a rate guarantee period in the event of any of the following events: changes in benefits, employee contributions, the number of eligible employees, or the imposition of any new taxes, fees or assessments by Federal or State regulatory agencies. The Plan reserves the right to make changes to the products available on each tier.

UAW/UMass Health & Welfare Trust

BENEFITS

- *AS IS*
- *Exam & Materials*
- *Select network*
- *ASO (PSPM/PMPM)*
- *Employer Paid*

MONTHLY RATES

- **Per subscriber per month** *$0.93*

Plan Details

Quote for group sitused in the State of MA and will be valid until the 08/01/2026 implementation date. Date Quoted 05/28/2026. Rates are valid only when the quoted plan is the sole stand-alone vision plan offered by the group.

Plan Exclusions/Limitations

No benefits will be paid for services or materials connected with or charges arising from: medical or surgical treatment, services or supplies for the treatment of the eye, eyes or supporting structures; Refraction, when not provided as part of a Comprehensive Eye Examination; services provided as a result of any Workers Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; orthoptic or vision training,subnormal vision aids and associated supplemental testing; Aniseikonic lenses; any Vision Examination or any corrective Vision Materials required by a Policyholder as a condition of employment; safety eyewear; solutions, cleaning products or frame cases; non-prescription sunglasses; plano (non-prescription) lenses; plano (non-prescription) contact lenses; two pair of glasses in lieu of bifocals; electronic vision devices; services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order; or lost or broken lenses, frames, glasses, or contact lenses that are replaced before the next Benefit Frequency when Vision Materials would next become available. Fees charged by a Provider for services other than a covered benefit and any local, state or Federal taxes must be paid in full by the Insured Person to the Provider. Such fees, taxes or materials are not covered under the Policy. Allowances provide no remaining balance for future use within the same Benefit Frequency. Some provisions, benefits, exclusions or limitations listed herein may vary by state.

By signing below, the Group agrees to receive all documents and correspondence electronically and that the Group can access the internet or the email address provided. The Group understands that the Group may revoke this authorization or request specific paper documents without revoking this authorization by contacting EyeMed by mail, email, or telephone. If UAW/UMass Health & Welfare Trust Fund has chosen this benefit design, attach this document to the group application and sign here

	6/9/26
SIGNATURE	**DATE**

Leslie Edwards Davis
Director of Benefit Programs

UAW/UMass Health & Welfare Trust

We're committed to keeping money in our members' pockets

That's why we offer our members additional discounts above the proposed plan benefits

VISION CARE SERVICES	IN-NETWORK MEMBER COST
EXAM SERVICES	
Retinal Imaging	*Up to $39*
CONTACT LENS FIT AND FOLLOW-UP	
Fit and Follow-Up – Standard	*Up to $40*
Fit and Follow-Up – Premium	*10% off retail price*
LENS OPTIONS	
Anti Reflective Coating – Standard	*$45*
Anti Reflective Coating - Prem Tier 1	*$57*
Anti Reflective Coating - Prem Tier 2	*$68*
Anti Reflective Coating - Prem Tier 3	*20% off retail price*
Photochromic – Non-Glass	*20% off retail price*
Polycarbonate – Standard	*$40*
Scratch Coating – Standard Plastic	*$15*
UV Treatment	*$15*
All Other Lens Options	*20% off retail price*

Members can get exclusive additional discounts and deals that are often stackable with their vision benefits at eyemed.com/member[4]

40%OFF

additional pairs of glasses

20%OFF

any item not covered by the plan, including non-prescription sunglasses

15%OFF

retail price or 5% off promotional price for Lasik or PRK from US Laser Network

UP TO 66%OFF

hearing aids, with an extended warranty and free batteries through Amplifon Hearing Health Care Network

DISCOUNT DETAILS

Discounts are not insured benefits. Member receives a 20% discount on items not covered by the insurance plan at EyeMed In-Network locations. Plan discounts cannot be combined with any other discounts or promotional offers. In certain states members may be required to pay the full retail rate and not the negotiated discount rate with certain participating providers. Please see EyeMed's online provider locator to determine which participating providers have agreed to the discounted rate. Discounts on vision materials may not be applicable to certain manufacturers' products. The Plan reserves the right to make changes to the products on each tier and the member out-of-pocket costs. Fixed pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels. Service and amounts listed above are subject to change at any time.

[4] Special offers not valid in the State of Texas.

EyeMed Vision Care – UAW/UMass Health & Welfare Trust Fund
Fifth Amendment to the Fee for Service Agreement

This Fifth Amendment to the Fee for Service Agreement ("Agreement") is effective September 1, 2024, (the "Effective Date") and is entered into by and between EyeMed Vision Care, LLC ("EyeMed") and First American Administrators ("FAA"), with their principal place of business at 4000 Luxottica Place, Mason, OH 45040 and UAW/UMass Health & Welfare Trust Fund with its principal place of business at 6 University Drive, Suite 206-229, Amherst, MA 01002, as Plan Sponsor and Plan Administrator ("Plan Sponsor").

WHEREAS, effective November 1, 2010, the parties entered into a Fee for Service Agreement;

WHEREAS, effective July 1, 2016, the parties entered into a First Amendment to the Fee for Service Agreement;

WHEREAS, effective July 1, 2019, the parties entered into a Second Amendment to the Fee for Service Agreement;

WHEREAS, effective September 1, 2022, the parties entered into a Third Amendment to the Fee for Service Agreement;

WHEREAS, effective September 1, 2023, the parties entered into a Fourth Amendment to the Fee for Service Agreement;

WHEREAS, pursuant to Section XIII, Subsection M of the Fee for Service Agreement the parties reserve the right to modify the Fee for Service Agreement in a writing signed by both parties; and

WHEREAS, the parties now agree to amend the Fee for Service Agreement.

NOW, THEREFORE, in consideration of the foregoing and the mutual covenants and agreements set forth herein, it is agreed as follows:

I. Section I.B Term shall be revised in its entirety as attached hereto:

B. TERM

The Agreement shall commence on the September 1, 2024 for a term of forty-eight (48) months and shall renew for two 1 year renewals unless (i) Plan Sponsor gives written notice to EyeMed at least ninety (90) days prior to the expiration of the initial term or any twelve (12) month renewal term; (ii) EyeMed gives written notice to Plan Sponsor at least one hundred eighty (180) days prior to the expiration of the initial term or any twelve (12) month renewal term; or (iii) the Agreement is otherwise terminated in accordance with Section XII.

II. Exhibit B-Benefit Schedule shall be revised in its entirety as attached hereto.

III. The parties agree that in all other respects the Fee for Service Agreement shall remain unchanged and in full force and effect.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement effective September 1, 2024.

(Signature page to follow)

Exhibit B – Benefit Schedule - Page 1

BENEFITS

UAW/UMass Health & Welfare Trust

Benefits

Renewal
Exam & Materials
Select Network
ASO (PSPM/PMPM)
Employer Paid

Monthly rates

PSPM
$0.93

SUMMARY OF BENEFITS

VISION CARE SERVICES	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER REIMBURSEMENT
EXAM SERVICES once every 12 months		
Exam	*$0 copay*	*Up to $57*
FRAME once every 12 months		
Frame	*$0 copay; 20% off balance over $185 allowance*	*Up to $111*
STANDARD PLASTIC LENSES once every 12 months		
Single Vision	*$10 copay*	*Up to $47*
Bifocal	*$10 copay*	*Up to $79*
Trifocal/Lenticular	*$10 copay*	*Up to $130*
Progressive – Standard	*$10 copay*	*Up to $78*
Progressive – Premium Tier I	*$30 copay*	*Up to $100*
Progressive – Premium Tier II	*$40 copay*	*Up to $100*
Progressive – Premium Tier III	*$55 copay*	*Up to $100*
Progressive – Premium Tier IV	*$10 copay, 20% off retail price less $120 allowance*	*Up to $95*
LENS OPTIONS		
Tint - Solid or Gradient	*$0 copay*	*Up to $5*
CONTACT LENSES once every 12 months		
Contacts – Conventional	*$0 copay; 15% off balance over $150 allowance*	*Up to $120*
Contacts – Disposable	*$0 copay; 100% of balance over $150 allowance*	*Up to $120*
Contacts – Medically Necessary	*$0 copay; paid-in-full*	*Up to $300*

All plans are based on a 48 month contract and 48 month rate guarantee. Monthly Rate is subject to adjustment even during a rate guarantee period in the event of any of the following events: changes in benefits, employee contributions, the number of eligible employees, or the imposition of any new taxes, fees or assessments by Federal or State regulatory agencies. The Plan reserves the right to make changes to the products available on each tier.

Exhibit B – Benefit Schedule - Page 2

RATES, LIMITS AND EXCLUSIONS

UAW/UMass Health & Welfare Trust

Monthly rates

PSPM
$0.93

Plan Details

Quote for group situsued in the State of MA and will be valid until the 09/01/2024 implementation date. Date Quoted 06/28/2024. Rates are valid only when the quoted plan is the sole stand-alone vision plan offered by the group.

Plan Exclusions/Limitations

No benefits will be paid for services or materials connected with or charges arising from: medical or surgical treatment, services or supplies for the treatment of the eye, eyes or supporting structures; Refraction, when not provided as part of a Comprehensive Eye Examination; services provided as a result of any Workers Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; orthoptic or vision training,subnormal vision aids and associated supplemental testing; Aniseikonic lenses; any Vision Examination or any corrective Vision Materials required by a Policyholder as a condition of employment; safety eyewear; solutions, cleaning products or frame cases; non-prescription sunglasses; plano (non-prescription) lenses; plano (non-prescription) contact lenses; two pair of glasses in lieu of bifocals; electronic vision devices; services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order; or lost or broken lenses, frames, glasses, or contact lenses that are replaced before the next Benefit Frequency when Vision Materials would next become available. Fees charged by a Provider for services other than a covered benefit and any local, state or Federal taxes must be paid in full by the Insured Person to the Provider. Such fees, taxes or materials are not covered under the Policy. Allowances provide no remaining balance for future use within the same Benefit Frequency. Some provisions, benefits, exclusions or limitations listed herein may vary by state.

By signing below, the Group agrees to receive all documents and correspondence electronically and that the Group can access the internet or the email address provided. The Group understands that the Group may revoke this authorization or request specific paper documents without revoking this authorization by contacting EyeMed by mail, email, or telephone. If UAW/UMass Health & Welfare Trust Fund has chosen this benefit design, attach this document to the group application and sign here

Docusign Envelope ID: DC139014-2CD2-883F-8285-09EC3EC75267

NOTICE

Benefits paid under the Accelerated Benefits provision will reduce the Death Benefit payable for life insurance.

Benefits payable under the Accelerated Benefits provision may be taxable. If so, the Employee or the Employee's beneficiary may incur a tax obligation. As with all tax matters, an Employee should consult with a personal tax advisor to assess the impact of this benefit. Accelerated Benefits are not payable if life insurance coverage under the Policy is not in force.

TL-004788

Docusign Envelope ID: DC139014-2CD2-883F-8285-09EC3EC75267

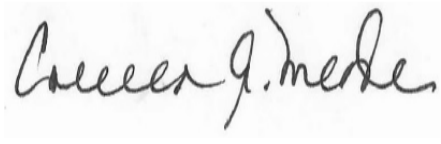
LIFE INSURANCE COMPANY OF NORTH AMERICA
1601 CHESTNUT STREET
PHILADELPHIA, PA 19192-2235
(888) 842-4462 Dial 711 to access telecommunications relay services
A STOCK INSURANCE COMPANY

GROUP POLICY

POLICYHOLDER:	TRUSTEE OF THE GROUP INSURANCE TRUST FOR EMPLOYERS IN THE FINANCE, INSURANCE AND REAL ESTATE INDUSTRY
SUBSCRIBER:	UAW/UMASS Health & Welfare Trust Fund
POLICY NUMBER:	FLX-971099
POLICY EFFECTIVE DATE:	August 1, 2026
POLICY ANNIVERSARY DATE:	August 1

This Policy describes the terms and conditions of coverage. It is issued in Delaware and shall be governed by its laws. The Policy goes into effect on the Policy Effective Date, 12:01 a.m. at the Policyholder's address.

In return for the required premium, the Insurance Company and the Subscriber have agreed to all the terms of this Policy.



Colleen Meade, Corporate Secretary



Scott Berlin, President

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SCHEDULE OF BENEFITS

Premium Due Date: The last day of each month

Classes of Eligible Employees

On the pages following the definition of eligible employees there is a Schedule of Benefits for each Class of Eligible Employees listed below. For an explanation of these benefits, please see the Description of Benefits provision.

If an Employee is eligible under one Class of Eligible Employees and later becomes eligible under a different Class of Eligible Employees, changes in the Employee's insurance due to the class change will be effective on the first date the Employee is in Active Service on or after the date of the change in class.

Class 1	All active full-time and part-time Employees of the Employer who are classified as Postdoctoral Researcher Employees, regularly working a minimum of 20 hours per week in the United States, who are citizens or permanent residents aliens of the United States, or non-United States citizens living and working in the United States under an active and appropriate visa or work authorization.
Class 2	All active full-time and part-time Employees of the Employer who are classified as Graduate Employees who meet the Employer’s established earnings requirement of regularly earning $7835.60 of the equivalent, regularly working a minimum of 20 hours per week in the United States, who are citizens or permanent residents aliens of the United States, or non-United States citizens living and working in the United States under an active and appropriate visa or work authorization.

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SCHEDULE OF BENEFITS FOR CLASS 1

Eligibility Waiting Period

The Eligibility Waiting Period is the period of time the Employee must be in Active Service to be eligible for coverage. It will be extended by the number of days the Employee is not in Active Service.

For Employees hired on or before the Policy Effective Date:	No Waiting Period
For Employees hired after the Policy Effective Date:	No Waiting Period

LIFE INSURANCE BENEFITS

Employee Benefits

Amount of Insurance	$20,000
Guaranteed Issue Amount:	$20,000
Maximum Benefit:	$20,000
Age Based Reductions	Life Insurance Benefit for an Employee age 65 and over will reduce to the percentage shown below: 65% of the Life Insurance Benefit at age 65 50% of the Life Insurance Benefit at age 70 Benefit reductions will be effective on the Policy Anniversary Date coinciding with or next following the Employee's attainment of age as specified in schedule above.
Continuation Options	
For Family Medical Leave	
Maximum Benefit Period:	the later of the period of the approved FMLA leave or the leave period required by the laws of the state in which the Employee is employed
For Disability for Employees over Age 60	
Maximum Benefit Period:	12 months
Applicable Coverages:	Life Insurance Benefits for the Employee

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Extended Death Benefit with Waiver of Premium	
Extended Death Benefit	
Applicable Coverages	Life Insurance Benefits for the Employee
Waiver of Premium	
Waiver Waiting Period	9 months from the date the Employee's Active Service ends
Maximum Benefit Period	To Age 65
Applicable Coverages	Life Insurance Benefits for the Employee
Portability Options	
For Employees	See the Former Employee sections in this Schedule of Benefits for the amounts of insurance an Insured is eligible to continue under this option.
Terminal Illness Benefit	The Insured can elect up to 75% of Life Insurance Benefits in force on the date the Insured is determined by the Insurance Company to be Terminally Ill, subject to a Maximum Benefit of $13,000.

Former Employee Benefits

Amount of Insurance	An amount elected subject to the Maximum Benefit amount for Life Insurance Benefits allowable to an Employee, less any amount of conversion insurance issued under the Conversion Privilege for Life Insurance. Any amount elected in excess of the Life Insurance Benefits in effect on the date he or she no longer qualifies as an Employee will be effective on the date the Insurance Company agrees in writing to insure him or her.
Maximum Benefit Period	To Age 70
Terminal Illness Benefit	The insured can elect up to 75% of Life Insurance Benefits in force on the date the Insured is determined by the Insurance Company to be Terminally Ill, subject to a Maximum Benefit of $13,000.

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SCHEDULE OF BENEFITS FOR CLASS 2

Eligibility Waiting Period

The Eligibility Waiting Period is the period of time the Employee must be in Active Service to be eligible for coverage. It will be extended by the number of days the Employee is not in Active Service.

For Employees hired on or before the Policy Effective Date:	No Waiting Period
For Employees hired after the Policy Effective Date:	No Waiting Period

LIFE INSURANCE BENEFITS

Employee Benefits

Amount of Insurance	$10,000
Guaranteed Issue Amount:	$10,000
Maximum Benefit:	$10,000
Age Based Reductions	Life Insurance Benefit for an Employee age 65 and over will reduce to the percentage shown below: 65% of the Life Insurance Benefit at age 65 50% of the Life Insurance Benefit at age 70 Benefit reductions will be effective on the Policy Anniversary Date coinciding with or next following the Employee's attainment of age as specified in schedule above.
Continuation Options	
For Family Medical Leave	
Maximum Benefit Period:	the later of the period of the approved FMLA leave or the leave period required by the laws of the state in which the Employee is employed
For Disability for Employees over Age 60	
Maximum Benefit Period:	12 months
Applicable Coverages:	Life Insurance Benefits for the Employee

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Extended Death Benefit with Waiver of Premium	
Extended Death Benefit	
Applicable Coverages	Life Insurance Benefits for the Employee
Waiver of Premium	
Waiver Waiting Period	9 months from the date the Employee's Active Service ends
Maximum Benefit Period	To Age 65
Applicable Coverages	Life Insurance Benefits for the Employee
Portability Options	
For Employees	See the Former Employee sections in this Schedule of Benefits for the amounts of insurance an Insured is eligible to continue under this option.
Terminal Illness Benefit	The Insured can elect up to 75% of Life Insurance Benefits in force on the date the Insured is determined by the Insurance Company to be Terminally Ill, subject to a Maximum Benefit of $7,500.

Former Employee Benefits

Amount of Insurance	An amount elected subject to the Maximum Benefit amount for Life Insurance Benefits allowable to an Employee, less any amount of conversion insurance issued under the Conversion Privilege for Life Insurance. Any amount elected in excess of the Life Insurance Benefits in effect on the date he or she no longer qualifies as an Employee will be effective on the date the Insurance Company agrees in writing to insure him or her.
Maximum Benefit Period	To Age 70
Terminal Illness Benefit	The insured can elect up to 75% of Life Insurance Benefits in force on the date the Insured is determined by the Insurance Company to be Terminally Ill, subject to a Maximum Benefit of $7,500.

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ELIGIBILITY FOR INSURANCE

Classes of Eligible Persons
A person may be insured only once under the Policy as an Employee, even though he or she may be eligible under more than one class.

Employee
An Employee in one of the Classes of Eligible Employees shown in the Schedule of Benefits is eligible to be insured on the Policy Effective Date or the day after he or she completes the applicable Eligibility Waiting Period, if later.

If a person has previously converted his or her insurance under the Policy, he or she will not become eligible until the converted policy is surrendered. This does not apply to any amount of insurance that was previously converted under the Policy due to a reduction in the Employee's Life Insurance Benefits based on age or a change in class unless those conditions no longer affect the amount of coverage available to the Employee.

Except as noted in the Reinstatement Provision, if an Employee terminates coverage and later wishes to reapply, or if a former Employee is rehired, a new Eligibility Waiting Period must be satisfied. An Employee is not required to satisfy a new Eligibility Waiting Period, if insurance ends because he or she is no longer in a Class of Eligible Employees, but continues to be employed by the Employer, and within one year becomes a member of an eligible class.

TL-004710-1

EFFECTIVE DATE OF INSURANCE

An Employee will be insured for an amount not to exceed the Guaranteed Issue Amount on the date he or she becomes eligible, if the Employee is not required to contribute to the cost of this insurance.

If an eligible Employee is not in Active Service on the date insurance would otherwise be effective, it will be effective on the date he or she returns to Active Service.

TL-004712

Takeover Provision
Special Terms Applicable to Previously Insured Employees Not in Active Service

Coverage will not go into effect for an Employee unless the Employee is in Active Service on the date the Employee would have first become eligible to be insured under the Policy.

However:
1. if such Employee was insured under a Prior Plan on the date immediately prior to the date the Employee would have first become eligible to be insured under this Policy had the Employee satisfied the Active Service requirement, and
2. if such Employee dies, the Insurance Company agrees to provide a Death Benefit only equal to the lesser of:

a. the amount due under this Policy (had the Employee satisfied the Active Service requirement), or
b. the amount that would have been due under the Prior Plan had it remained in force.

The benefit amount will be reduced by any amount paid by the Prior Plan, or that would have been paid had this Policy not been issued and had timely filing of the claim been made under the Prior Plan.

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These special terms will end on the earliest of the following dates:
1. the date the Employee meets the Active Service requirements;
2. the date insurance terminates for one of the reasons stated in the Termination of Insurance provision;
3. 12 months after the date the Employee first becomes eligible under this Policy; or
4. the last day the Employee would have been covered under the Prior Plan if coverage of the Employee under that plan was still in force.

TL-009020-1

TERMINATION OF INSURANCE

An Insured's coverage will end on the earliest of the following dates:
1. the date the Employee is eligible for coverage under a plan intended to replace this coverage;
2. the date the Policy is terminated by the Insurance Company;
3. the date the Insured is no longer in an eligible class;
4. the date coinciding with the end of the last period for which premiums are paid;
5. the date an Employee is no longer in Active Service; and
6. for an Employee, the date the Employer cancels participation under the Policy.

TL-004714-1

CONTINUATION OF INSURANCE

If an Employee is no longer in Active Service, he or she may be eligible to continue insurance. The following provisions explain the continuation options available under the Policy. Please see the Schedule of Benefits to determine the applicability of these benefits on a class level.

Continuation for Family Medical Leave
If an Employee's Active Service ends due to a family medical leave of absence, insurance will continue for up to the Maximum Benefit Period shown in the Schedule of Benefits, if the required premium is paid.

Continuation for Disability for Employees over Age 60
If an Employee becomes Disabled and is age 60 or over, the Life Insurance Benefits shown in the Schedule of Benefits will be continued, provided premiums are paid, until the earlier of the following dates:
1. The date the Employee is no longer Disabled.
2. The date following the Maximum Benefit Period shown in the Schedule of Benefits.
3. The date coinciding with the end of the last period for which premiums are paid.
4. The date the Policy is terminated.

Amount of Insurance
If an Employee dies while he or she is Disabled and coverage is continued under this provision, the Insurance Company will pay a Death Benefit equal to the amount in effect on the date the Employee became Disabled. However, the Life Insurance Benefit will be subject to the provisions of the Policy that reduce the coverage amount because of age, retirement, payment of an Accelerated Benefit or a change in class. Automatic increases in Life Insurance Benefits will end while coverage is continued under this provision. The Insurance Company will pay benefits only if due proof of the Employee's continuous Disability is received within one year of the date of the loss.

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"Disability"/"Disabled" means because of Injury or Sickness the Employee is unable to perform all the material duties of his or her Regular Occupation; or is receiving disability benefits under the Employer's plan.

"Regular Occupation" means the occupation the Employee routinely performs at the time the Disability begins. The Insurance Company will consider the duties of the occupation as it is normally performed in the general labor market in the national economy.

Extended Death Benefit with Waiver of Premium

Extended Death Benefit

If an Employee becomes Disabled and is less than age 60, the Life Insurance Benefits shown in the Schedule of Benefits will be extended without premium payment until the earlier of the following dates:

1. The date the Employee is no longer Disabled; or
2. 12 months after the end of Active Service.

Amount of Insurance

If an Employee dies while he or she is Disabled and coverage is extended under this provision, the Insurance Company will pay a Death Benefit equal to the amount in effect on the date the Employee became Disabled. However, the Life Insurance Benefit will be subject to the provisions of the Policy that reduce the coverage amount because of age, retirement, payment of an Accelerated Benefit or a change in class. Automatic increases in Life Insurance Benefits will end while premiums are waived. The Insurance Company will pay benefits only if due proof of the Employee's continuous Disability is received within one year of the date of the loss.

"Disability"/"Disabled" means because of Injury or Sickness the Employee is unable to perform the material duties of his or her Regular Occupation; or is receiving disability benefits under the Employer's plan.

"Regular Occupation" means the occupation the Employee routinely performs at the time the Disability begins. The Insurance Company will consider the duties of the occupation as it is normally performed in the general labor market in the national economy.

Waiver of Premium

If such an Employee submits satisfactory proof that he or she has been continuously Disabled for the Waiver Waiting Period shown in the Schedule of Benefits, coverage will be extended up to the Maximum Benefit Period shown in the Schedule of Benefits.

Such proof must be submitted to the Insurance Company no later than 3 months after the date the Waiver Waiting Period ends. Premiums will be waived from the date the Insurance Company agrees in writing to waive premiums for that Employee.

After premiums have been waived for 12 months, they will be waived for future periods of 12 months, if the Employee remains Disabled and submits satisfactory proof that Disability continues. Satisfactory proof must be submitted to the Insurance Company 3 months before the end of the 12-month period.

Amount of Insurance

If an Employee dies while he or she is Disabled and coverage is continued under this provision, the Insurance Company will pay a Death Benefit equal to the amount in effect on the date the Employee became Disabled. However, the Life Insurance Benefit will be subject to the provisions of the Policy that reduce the coverage amount because of age, retirement, payment of an Accelerated Benefit or a change in class. Automatic increases in Life Insurance Benefits will end while premiums are waived. The Insurance Company will pay benefits only if due proof of the Employee's continuous Disability is received within one year of the date of the loss.

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Termination of Waiver
Insurance will end for any Employee whose premiums are waived on the earliest of the following dates.
1. The date he or she is no longer Disabled;
2. The date he or she refuses to submit to any physical examination required by the Insurance Company;
3. The date he or she refuses to participate in a Rehabilitation Plan for which the Insurance Company determines him or her to be eligible;
4. The last day of the 12-month period of Disability during which he or she fails to submit satisfactory proof of continued Disability;
5. The date following the end of the Maximum Benefit Period shown in the Schedule of Benefits.

“Disability/Disabled" means because of Injury or Sickness an Employee is unable to perform the material duties of his or her Regular Occupation, or is receiving disability benefits under the Employer's plan, during the initial 9 months of Disability. Thereafter, the Employee must be unable to perform all of the material duties of any occupation which he or she may reasonably become qualified based on education, training or experience, or is subject to the terms of a Rehabilitation Plan approved by the Insurance Company.

“Regular Occupation” means the occupation the Employee routinely performs at the time the Disability begins. The Insurance Company will consider the duties of the occupation as it is normally performed in the general labor market in the national economy.

Rehabilitation During a Period of Disability
If the Insurance Company determines that a Disabled Employee is a suitable candidate for rehabilitation, the Insurance Company may require the Employee to participate in an assessment and Rehabilitation Plan, not to exceed 18 months, at our expense. The Insurance Company has the sole discretion to approve the Employee's participation in a Rehabilitation Plan and to approve a program as a Rehabilitation Plan. If an Employee fails to fully cooperate in all required phases of the Rehabilitation Plan and assessment without Good Cause, insurance under the Policy will end.

“Good Cause” means a medical reason preventing participation, in whole or in part, in the Rehabilitation Plan. Satisfactory proof of Good Cause must be provided to the Insurance Company.

“Rehabilitation Plan” means a written plan designed to enable the Employee to return to work. The Rehabilitation Plan will consist of one or more of the following phases:
1. Rehabilitation, under which the Insurance Company may provide, arrange or authorize educational, vocational or physical rehabilitation or other appropriate services;
2. Work, which may include modified work and work on a Part-time basis.

“Part-time” means regularly working less than the number of full time hours set by the Employer as a regular work day for Employees in an Eligible Class of Employees in the Policy.

TL-009745 as modified by TL-009745-1

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Portability Options
For Employees

If an Employee's coverage under the Policy ends prior to age 70, for any of the following reasons:
a. termination of employment; or
b. termination of membership in an eligible class under the Policy;
Life Insurance Benefits may be continued up to the Maximum Benefit shown in the Schedule of Benefits for this option.

The Employee must apply to the Insurance Company and pay the required premium. The application must be submitted:
a. within 31 days of the Employee's termination of employment or membership in an eligible class under the Policy; or
b. during the time that the Employee has to exercise the Conversion Privilege.
Coverage under this option may not be elected at a later date.

When applying for this option, the Employee must name a beneficiary. Any beneficiary named previously under the Policy is no longer in effect. If there is no named or surviving beneficiary, Death Benefits will be paid to the first surviving class of the following living relatives:
a. spouse;
b. child or children;
c. mother or father;
d. brothers or sisters; or
e. the executors or administrators of the Insured's estate.

When coverage is continued under this option, the Employee becomes a Former Employee.

Coverage will end on the earliest of the following dates.
a. The date the Insurance Company cancels coverage for all Former Employees.
b. The end of the period for which premiums are paid.
c. The date an Insured reaches age 70.
d. The date the Maximum Benefit Period shown in the Schedule of Benefits for this option ends.

TL-004716 as modified by TL-009330

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DESCRIPTION OF BENEFITS

The following provisions explain the benefits available under the Policy. Please see the Schedule of Benefits for the applicability of these benefits on a class level.

LIFE INSURANCE BENEFITS

Death Benefit

If an Insured dies, the Insurance Company will pay the Life Insurance Benefit in force for that Insured on the date of his or her death.

Accelerated Benefits

Any benefits payable under this and under any similar Accelerated Benefits provision accelerated under a Prior Plan will reduce the Death Benefit payable for Life Insurance. We will deduct from any Death Benefit payable under this Policy, the amount of any similar accelerated benefit paid under a Prior Plan.

Any automatic increases in Life Insurance Benefits will end when benefits are payable under this provision, unless the Insured is determined by the Insurance Company not to be eligible for Accelerated Benefits.

Terminal Illness Benefit

The Insurance Company will pay a Terminal Illness Benefit to an Insured who has incurred a Terminal Illness while insured under this provision.

The Terminal Illness Benefit is shown on the Schedule of Benefits.

A claim for a similar terminal illness benefit under a Prior Plan or group policy intended to replace this Policy shall be deemed payable until such time as it is finally determined not to be payable.

Determination of Terminal Illness

For the purpose of determining the existence of a Terminal Illness, the Insurance Company will require the Insured submit the following proof:

1. A written diagnosis and prognosis by a licensed Physician; and
2. Supportive evidence satisfactory to the Insurance Company, including but not limited to, radiological, histological or laboratory reports documenting the Terminal Illness.

The Insurance Company may require, at its expense, an examination of the Insured and a review of the documented evidence by a Physician of its choice.

Such proofs must be submitted to the Insurance Company within the period of time provided in the *Proof of Loss* section of the Policy. For purposes of this Benefit, the date of loss shall be the date of first prognosis of Terminal Illness.

"Terminal Illness" means that, due to an Injury or Sickness, the Insured has a prognosis of 12 months or less to live without reasonable prospect of recovery, as determined by the Insurance Company.

Payment of Terminal Illness Benefit

The Terminal Illness Benefit will be payable in accordance with the provisions of the *To Whom Payable* section of the Policy.

The Terminal Illness Benefit is payable only once under the Policy in an Insured's lifetime.

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Conditions Applicable to Coverage
Unless the Insured qualifies for waiver of premium, premium payments must continue to be paid on the full amount of group life insurance, including during any Continuation of Insurance under the Policy, in accordance with the *Premium* section in the *Administrative Provisions.*

The amount of Life Insurance which may be converted under the *Conversion Privilege* cannot exceed the amount of the reduced death benefit payable under the Policy.

Before a Terminal Illness Benefit is paid in a Community Property state, the Insurance Company may require the written consent of the Insured's Spouse.

Exclusions Applicable to Terminal Illness Benefit
A Terminal Illness Benefit will not be payable:
1. when the Insured has irrevocably assigned group life insurance under this Policy;
2. when all or a portion of group life insurance benefits under this Policy are to be paid to a former spouse as part of a qualified domestic relations order;
3. for any intentionally self-inflicted Injury or Sickness, or suicide attempt;
4. if the Insured's coverage ends under the *Termination of Insurance* provision prior to the prognosis of Terminal Illness;
5. if the required premium is due and unpaid;
6. if this Policy terminates prior to the prognosis of Terminal Illness;
7. if the Employee or Insured is only provided coverage under the Takeover provision of the Policy (Employees Not in Active Service on the Policy Effective Date); or
8. if the date of first prognosis of Terminal Illness occurs more than 12 months before the submission of the Terminal Illness claim.

TL-004748a

Conversion Privilege for Life Insurance
Each Insured may convert all or any portion of his or her Life Insurance that would end under the Policy due to:
1. termination of employment;
2. termination of membership in an eligible class under the Policy;
3. termination of the Policy.

The Insured may apply for any type of life insurance the Insurance Company offers to persons of the same age in the amount applied for, except the Insured may not:
1. choose term insurance;
2. apply for an amount of insurance greater than the coverage amount terminating under the Policy (also, the conversion policy will not provide accident, disability or other benefits); or
3. apply for more than $10,000 of insurance if the Policy is terminated or amended to terminate the insurance for any class of Insureds, or the Employer cancels participation under the Policy. Conversion in these cases is only permitted if the Insured has been covered by the Policy or, any group life insurance policy issued to the Employer which the Policy replaced, for at least 3 years.

If the Insured becomes eligible for coverage under any group life policy within 31 days of termination of coverage under this Policy, the Insured may not convert an amount of insurance greater than the amount of coverage terminating under the Policy less the amount for which he or she may be covered under the other policy.

To apply for conversion insurance, the Insured must, within 31 days after coverage under the Policy ends:
1. submit an application to the Insurance Company; and
2. pay the required premium.

Evidence of insurability is not required.

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Premium for the conversion insurance will be based on the age and class of risk of the Insured and the type and amount of coverage issued.

If the Insured has assigned ownership of his group coverage, the owner/assignee must apply for the individual policy.

Conversion insurance will become effective on the 31st day after the date coverage under the Policy ends provided the application is received by the Insurance Company and the required premium has been paid.

If the Insured dies during the 31-day conversion period, the Life Insurance benefits will be paid under the Policy regardless of whether he or she applied for conversion insurance. If a conversion policy is issued, it will be in exchange for any further benefits for that type and amount of insurance from this Policy.

Extension of Conversion Period
If an Insured is eligible for conversion insurance and is not notified of this right at least 15 days prior to the end of the 31-day conversion period, the conversion period will be extended. The Insured will have 15 days from the date notice is given to apply for conversion insurance. In no event will the conversion period be extended beyond 90 days. Notice, for the purpose of this section, means written notice presented to the Insured by the Employer or mailed to the Insured's last known address as reported by the Employer.

If the Insured dies during the extended conversion period, but more than 31 days after his or her coverage under the Policy terminates, Life Insurance benefits:

1. will not be paid under the Policy; and
2. will be payable under the conversion insurance; provided:
    a. the Insured's application for conversion insurance has been received by the Insurance Company; and
    b. the required premium has been paid.

Prior Conversion Limitation
If an Insured is covered under a life insurance conversion policy previously issued by the Insurance Company, he or she will not be eligible for this Conversion Privilege unless the prior coverage has ended.

TL-009740

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CLAIM PROVISIONS

Notice of Claim
Written notice, or notice by any other electronic/telephonic means authorized by the Insurance Company, must be given to the Insurance Company within 31 days after a covered loss occurs or begins or as soon as reasonably possible. If written notice, or notice by any other electronic/telephonic means authorized by the Insurance Company, is not given in that time, the claim will not be invalidated or reduced if it is shown that notice was given as soon as was reasonably possible. Notice can be given at our home office in Philadelphia, Pennsylvania or to our agent. Notice should include the Employer's Name, the Policy Number and the claimant's name and address.

Written notice or any other electronic/telephonic means authorized by the Insurance Company of a diagnosis of a Terminal Illness on which claim is based must be given to us within 60 days after the diagnosis. If notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written notice or any other electronic/telephonic means authorized by the Insurance Company was given as soon as reasonably possible.

Claim Forms
When the Insurance Company receives notice of claim, the Insurance Company will send claim forms for filing proof of loss. If claim forms are not sent within 15 days after notice is received by the Insurance Company, the proof requirements will be met by submitting, within the time required under the "Proof of Loss" section, written proof, or proof by any other electronic/telephonic means authorized by the Insurance Company, of the nature and extent of the loss.

Claimant Cooperation Provision
Failure of a claimant to cooperate with the Insurance Company in the administration of the claim may result in termination of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

Insurance Data
The Employer is required to cooperate with the Insurance Company in the review of claims and applications for coverage. Any information the Insurance Company provides in these areas is confidential and may not be used or released by the Employer if not permitted by applicable privacy laws.

Proof of Loss
Written proof of loss, or proof by any other electronic/telephonic means authorized by the Insurance Company, must be given to the Insurance Company within 90 days after the date of the loss for which a claim is made. If written proof of loss, or proof by any other electronic/telephonic means authorized by the Insurance Company, is not given in that 90 day period, the claim will not be invalidated nor reduced if it is shown that it was given as soon as was reasonably possible. In any case, written proof of loss, or proof by any other electronic/telephonic means authorized by the Insurance Company, must be given not more than one year after that 90 day period. If written proof of loss, or proof by any other electronic/telephonic means authorized by the Insurance Company, is provided outside of these time limits, the claim will be denied. These time limits will not apply while the person making the claim lacks legal capacity.

Written proof, or any other electronic/telephonic means authorized by the Insurance Company, of loss for Accelerated Benefits must be furnished 90 days after the date of diagnosis. This proof must describe the occurrence, character and diagnosis for which claim is made.

In case of claim for any other loss, proof must be furnished within 90 days after the date of such loss.

If it is not reasonably possible to submit proof of loss within these time periods, the Insurance Company will not deny or reduce any claim if proof is furnished as soon as reasonably possible. Proof must, in any case, be furnished not more than a year later, except for lack of legal capacity.

Time of Payment
Benefits due under the Policy for a loss, other than a loss for which the Policy provides installment payments, will be paid immediately upon receipt of due written proof of such loss.

Subject to the receipt of satisfactory written proof of loss, all accrued benefits for loss for which the Policy provides installments will be paid monthly; any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof, unless otherwise stated in the Description of Benefits.

Manner of Payment of Claims
The Subscriber authorizes that any benefit payment due as a lump sum of $5,000 or more shall be credited to a draft account with the Insurance Company, in the name of the beneficiary. The beneficiary may withdraw the entire proceeds at any time by issuing one or more drafts, or may withdraw lesser amounts, subject to a minimum account balance set by the Insurance Company from time to time. Interest shall be credited to such account at rates as determined from time to time by the Insurance Company.
To Whom Payable
Employee Death Benefits will be paid to the named beneficiary on file with the Employer. The Employer shall receive and maintain records of beneficiaries designated by Employees. This shall include designations made in writing.

If there is no named beneficiary that survives the Employee, Death Benefits will be paid to the first surviving class of the following living relatives of the Employee: (i) spouse; (ii) child or children; (iii) mother and father; (iv) brothers and sisters; or (v) the Employee's estate.

All other benefits, including death benefits for dependents, will be payable to the Employee, or the certificate owner if other than the Employee. Any other benefits which are unpaid at the Employee's death may, at the Insurance Company's option, be paid either to the Employee's beneficiary or to the executor or administrator of the Employee's estate.

If the Insurance Company pays benefits to the executor or administrator of the Employee's estate, or to a minor or other person who is incapable of giving a valid release, the Insurance Company may pay up to $1,000 to a relative by blood or marriage whom it believes is equitably entitled. This good faith payment satisfies the Insurance Company's legal duty to the extent of that payment.

Change of Beneficiary
The Employee may change the beneficiary at any time by giving written notice to the Employer. The beneficiary's consent is not required unless the existing beneficiary designation is irrevocable.

A change made by the Employee before death will be honored if it is received by the Insurance Company from the Employer before payment is made. The Insurance Company will not be liable for any payment that it makes in good faith before receiving actual notice of the change.

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Physical Examination and Autopsy
The Insurance Company, at its expense, will have the right to examine any person for whom a claim is pending as often as it may reasonably require. The Insurance Company may, at its expense, require an autopsy unless prohibited by law.

Legal Actions
No action at law or in equity may be brought to recover benefits under the Policy less than 60 days after written proof of loss, or proof by any other electronic/telephonic means authorized by the Insurance Company, has been furnished as required by the Policy. No such action shall be brought more than 3 years after the time satisfactory proof of loss is required to be furnished.

Time Limitations
If any time limit stated in the Policy for giving notice of claim or proof of loss, or for bringing any action at law or in equity, is less than that permitted by the law of the state in which the Employee lives when the Policy is issued, then the time limit provided in the Policy is extended to agree with the minimum permitted by the law of that state.

Physician/Patient Relationship
The Insured will have the right to choose any Physician who is practicing legally. The Insurance Company will in no way disturb the Physician/patient relationship.

TL-004724 as modified by TL-009370

ADMINISTRATIVE PROVISIONS

Premiums
The premiums for this Policy will be based on the rates currently in force, the plan and the amount of insurance in effect.

If the Insured's coverage amount is reduced due to acceleration of his or her Death Benefit, his or her premium will be based on the amount of coverage he or she has in force on the day before the reduction took place. If the Insured's coverage amount is reduced due to his or her attained age, premium will be based on the amount of coverage in force on the day after the reduction took place.

Changes in Premium Rates
The premium rates may be changed by the Insurance Company from time to time with at least 31 days advance written notice. No change in rates will be made until 36 months after the Policy Effective Date. An increase in rates will not be made more often than once in a 12 month period. However, the Insurance Company reserves the right to change the rates even during a period for which the rate is guaranteed if any of the following events take place.

1. The terms of the Policy change.
2. A division, subsidiary, affiliated company or eligible class is added or deleted from the Policy.
3. There is a change in the factors bearing on the risk assumed.
4. Any federal or state law or regulation is amended to the extent it affects the Insurance Company's benefit obligation.
5. The Insurance Company determines that the Employer has failed to promptly furnish any necessary information requested by the Insurance Company, or has failed to perform any other obligations in relation to the Policy.

If an increase or decrease in rates takes place on a date that is not a Premium Due Date, a pro rata adjustment will apply from the date of the change to the next Premium Due Date.

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Reporting Requirements
The Employer must, upon request, give the Insurance Company any information required to determine who is insured, the amount of insurance in force and any other information needed to administer the plan of insurance.

Payment of Premium
The first premium is due on the Policy Effective Date. After that, premiums will be due monthly unless the Employer and the Insurance Company agree on some other method of premium payment.

If any premium is not paid when due, the plan will be canceled as of the Premium Due Date, except as provided in the Policy Grace Period section.

Notice of Cancellation
The Employer or the Insurance Company may cancel the Policy as of any Premium Due Date by giving 31 days advance written notice. If a premium is not paid when due, the Policy will automatically be canceled as of the Premium Due Date, except as provided in the Policy Grace Period section.

Policy Grace Period
A Policy Grace Period of 31 days will be granted for the payment of the required premiums under this Policy. This Policy will be in force during the Policy Grace Period. The Employer is liable to the Insurance Company for any unpaid premium for the time this Policy was in force.

Draft Accounts
The Insurance Company shall be entitled to retain, as part of its compensation, any earnings on draft accounts created in connection with benefit claims, in excess of interest credited under the terms of the policy.

Reinstatement of Insurance
Coverage may be reinstated without satisfying the Insurability Requirement, if an Employee's insurance ends because he or she is on an unpaid leave of absence and he or she applies for Reinstatement within 31 days of his return to Active Service.

After an Insured's coverage has ceased, it may be reinstated at any date prior to five years after the date of termination if the following conditions are met:
1. The Policy is still in force.
2. The Insured is eligible under the Policy.
3. A written request for reinstatement and a new enrollment form are sent to the Insurance Company.
4. The required premium is paid.
5. The Insurability Requirement, if any, is satisfied.

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SCHEDULE OF RATES

The following monthly rates apply to all Classes of Eligible Persons unless otherwise indicated.

FOR EMPLOYEE BENEFITS

Basic Life Insurance $.05 Per $1,000

FOR FORMER EMPLOYEE BENEFITS

Monthly Rates are based on units of $1,000.

Under Age 20	$.153	Age 45 - 49	$.384
Age 20 - 24	$.144	Age 50 - 54	$.726
Age 25 - 29	$.153	Age 55 - 59	$1.347
Age 30 - 34	$.177	Age 60 - 64	$2.461
Age 35 - 39	$.190	Age 65 - 69	$4.065
Age 40 - 44	$.243		

A change in rates due to a change in the Former Employee's age will become effective on the Policy Anniversary coinciding with or following the Former Employee's birthday.

TL-004718

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GENERAL PROVISIONS

Entire Contract
The entire contract will be made up of the Policy, the application of the Employer, a copy of which is attached to the Policy, and the applications, if any, of the Insureds.

Incontestability
All statements made by the Employer or by an Insured are representations not warranties. No statement will be used to deny or reduce benefits or as a defense to a claim, unless a copy of the instrument containing the statement has been furnished to the claimant. In the event of death or legal incapacity, the beneficiary or representative must receive the copy.

After two years from an Insured's effective date of insurance, or from the effective date of any added or increased benefits, no such statement will cause insurance to be contested except for fraud or eligibility for coverage.

Misstatement of Age
If an Insured's age has been misstated, the Insurance Company will adjust all benefits to the amounts that would have been purchased for the correct age.

Policy Changes
No change in the Policy will be valid until approved by an executive officer of the Insurance Company. This approval must be endorsed on, or attached to, the Policy. No agent may change the Policy or waive any of its provisions.

Workers' Compensation Insurance
The Policy is not in lieu of and does not affect any requirements for insurance under any Workers' Compensation Insurance Law.

Certificates
A certificate of insurance will be delivered to the Employer for delivery to Insureds. Each certificate will list the benefits, conditions and limits of the Policy. It will state to whom benefits will be paid.

Assignment of Benefits
The Insurance Company will not be affected by the assignment of an Insured's certificate until the original assignment or a certified copy of the assignment is filed with the Insurance Company. The Insurance Company will not be responsible for the validity or sufficiency of an assignment. An assignment of benefits will operate so long as the assignment remains in force provided insurance under the Policy is in effect. This insurance may not be levied on, attached, garnisheed, or otherwise taken for a person's debts. This prohibition does not apply where contrary to law.

Clerical Error
A person's insurance will not be affected by error or delay in keeping records of insurance under the Policy. If such an error is found, the premium will be adjusted fairly.

Agency
The Employer and Plan Administrator are agents of the Employee for transactions relating to insurance under the Policy. The Insurance Company is not liable for any of their acts or omissions.

Ownership of Records
All records maintained by the Insurance Company are, and shall remain, the property of the Insurance Company.

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DEFINITIONS

Please note, certain words used in this document have specific meanings. These terms will be capitalized throughout this document. The definition of any word, if not defined in the text where it is used, may be found either in this Definitions section or in the Schedule of Benefits.

Accident
An Accident is a sudden, unforeseeable external event that causes bodily Injury to an Insured while coverage is in force under the Policy.

Active Service
An Employee will be considered in Active Service with the Employer on a day which is one of the Employer's scheduled work days if either of the following conditions are met.

1. He or she is actively at work. This means the Employee is performing his or her regular occupation for the Employer on a Full-time basis, either at one of the Employer's usual places of business or at some location to which the Employer's business requires the Employee to travel.
2. The day is a scheduled holiday, vacation day or period of Employer approved paid leave of absence, other than disability or sick leave after 7 days.

An Employee is considered in Active Service on a day which is not one of the Employer's scheduled work days only if he or she was in Active Service on the preceding scheduled work day.

Employee
For eligibility purposes, an Employee is an employee of the Employer in one of the "Classes of Eligible Employees." Otherwise, Employee means an employee of the Employer who is insured under the Policy.

Employer
The Employer who has subscribed to the Policyholder and for the benefit of whose Employees this policy has been issued. The Employer, named as the Subscriber on the front of this Policy, includes any affiliates or subsidiaries covered under the Policy. The Employer is acting as an agent of the Insured for transactions relating to this insurance. The actions of the Employer shall not be considered the actions of the Insurance Company.

Full-time
Full-time means the number of hours set by the Employer as a regular work day for Employees in the Employee's eligibility class.

Injury
Any accidental loss or bodily harm which results directly and independently of all other causes from an Accident.

Insurability Requirement
An eligible person will satisfy the Insurability Requirement for an amount of coverage on the day the Insurance Company agrees in writing to accept him or her as insured for that amount. To determine a person's acceptability for coverage, the Insurance Company will require evidence of good health and may require it be provided at the Employee's expense.

Insurance Company
The Insurance Company underwriting the Policy is named on the Policy cover page.

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Insured
A person who is eligible for insurance under the Policy, for whom insurance is elected, the required premium is paid and coverage is in force under the Policy.

Physician
Physician means a licensed doctor practicing within the scope of his or her license and rendering care and treatment to an Insured that is appropriate for the condition and locality. The term does not include an Employee, an Employee's spouse, the immediate family (including parents, children, siblings or spouses of any of the foregoing, whether the relationship derives from blood or marriage), of an Employee or spouse, or a person living in an Employee's household.

Policy Anniversary
A Policy Anniversary is the date stated on the policy cover and the same date that follows every 12 months for as long as the Policy is in effect.

Policy Effective Date
The Policy Effective Date is the date stated on the policy cover.

Prior Plan
The Prior Plan refers to the plan of insurance providing similar benefits sponsored by the Employer in effect directly prior to the Policy Effective Date. A Prior Plan will include the plan of an employer in effect on the day prior to:

1. That employer's addition to this policy; or
2. With the approval of the Insurance Company, the addition of all employees, or all of a defined group of employees, of an employer, as a result of an agreement to which that employer (or a parent or shareholder of that employer) is a party.

To be covered under the Policy, required premium must be paid for all covered Employees.

Sickness
Any physical or mental illness.

Subscriber
Any participating organization that subscribes to the trust to which this Policy is issued, and which is insured under this Policy.

TL-004708-1

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AMENDATORY RIDER

Subscriber: UAW/UMASS Health & Welfare Trust Fund

Policy No : FLX-971099 Effective Date : August 1, 2026

Applicable to Class(es): All Classes

This Amendatory Rider is attached to and made part of the Policy specified above.

The Company and the Subscriber hereby agree that the Policy is amended to include the following provision:

The Insurance Company may provide, or arrange for third parties to provide their Eligible Participants services that are related to the benefits provided by the Policy, including services that would help to mitigate losses for which claims are paid, or their effects on Eligible Participants. These programs may be extended, modified or terminated at our discretion. The Insurance Company will provide the Subscriber with detailed information regarding these services and notice of any changes to these services. Services are the responsibility of the service providers the Insurance Company has retained. Some services may include discounts on additional services for which a charge may be made. Participation and use of services is voluntary and does not affect benefits under the Policy.

These services include but are not limited to the following:

Employee Assistance Program

The Insurance Company has arranged for a third party provider to provide access to a Employee Assistance Program (EAP) to Eligible Participants. This program includes confidential consultation and referral services for issues involving mental health, substance abuse, and other problems of daily living, by telephone, 24 hours a day, seven days a week. In an emergency, trained clinicians will be available to address the situation and make a referral to a local counselor or crisis intervention center.

Eligible Participants may receive up to three in-person or virtual visits per issue per calendar year. Fees for clinical services other than assessment, referral and clinical visits in excess of three visits per person per issue per year will be the Eligible Participant's responsibility.

"Eligible Participants" mean an insured Employee and their family members or beneficiaries.

TL-010091

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Money Coaching Services

The Insurance Company will provide or will arrange for a third party provider to make available a 30 day money coaching program to Eligible Participants. This program will consist of (1) performing a financial needs analysis and creating a short-term plan to address the most severe financial needs; (2) working with the Eligible Participants to develop mid-term and longer-term financial goals; and (3) helping the Eligible Participants develop good money management habits. No financial products or services will be offered or sold to Eligible Participants in connection with this money coaching program.
In addition, we will make available web-based educational resources, including resources to assist Eligible Participants with the preparation of wills and similar legal documents, and discounted tax preparation services by a third party provider.

"Eligible Participants" mean an insured Employee and their household members or beneficiaries.

Post-Death Assistance

The Insurance Company will provide or will arrange for a third party provider to make available the following assistance services to Eligible Participants:

1. Providing a library of information and step-by-step assistance for Eligible Participants to manage the affairs of a deceased person, including such activities as arranging a funeral; publishing an obituary; establishing an estate; closing accounts; marshaling home, other assets, and documents; receiving benefits; and payment of taxes.

2. Providing resources to assist with the management of grief and stress.

3. Providing an application to manage a personalized checklist and to store relevant documents.

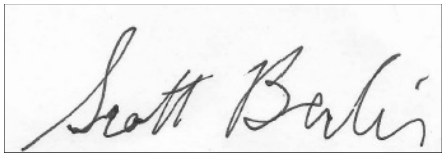
The Insurance Company will provide the Subscriber with information to enable Eligible Participants to access the services.

The services do not include legal, financial or tax advice, and are not intended to replace the services of an attorney, financial or tax advisor where those professional services are required. The service can help assist the Eligible Participant in locating local professionals who can provide those services. The services are not a substitute for mental health care or professional grief counseling.

"Eligible Participants" mean the Employee or Spouse with respect to any deceased family member, or the Beneficiary with respect to an insured Employee, Spouse or Dependent Child.

Except as provided above, this Rider does not amend the terms of the Policy.

LIFE INSURANCE COMPANY OF NORTH AMERICA



Scott Berlin, President

TL-010091

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LIFE INSURANCE COMPANY OF NORTH AMERICA
1601 CHESTNUT STREET
PHILADELPHIA, PA 19192-2235

STATE MODIFYING PROVISIONS AMENDMENT RIDER

Subscriber: UAW/UMASS Health & Welfare Trust Fund
Policy No. FLX-971099
Amendment Effective Date: August 1, 2026

This amendment is attached to and made part of the Policy/Certificate specified above. Its provisions are intended to conform this Policy/Certificate to the laws of the state in which the insured resides.

The Policy delivered under the Group Policy are amended as follows:

APPLICABLE TO CALIFORNIA RESIDENTS:

1. **Conversion Privilege for Life Insurance**
   Insured Employees and Insured Spouses may convert to an individual policy of life insurance for an amount not greater than the Conversion Amount shown below when the Policy ends, without regard to any requirement that the person be insured under the policy for a specified period of time, if all of the following apply.

   a. The Insured became Totally Disabled while covered for the Life Benefit of the Policy. Totally Disabled means the person is unable to perform all the material duties of any occupation for which he or she may reasonably be qualified based on training, education and experience.
   b. The Insured remained Totally Disabled until the Policy ended while covered for the Life Benefit of this Policy.
   c. The Policy does not provide a Waiver of Premium, Extended Death Benefit Provision or monthly payments to Totally Disabled Insureds for the Life Benefit.
   d. The person meets all other conditions for converting the insurance.

   Conversion Amount - Insured's life insurance amount under the Policy on the date the Policy ends minus the amount for which the Insured is insured under a group policy that provides life coverage to employees of the Insured Employee's Employer covered under this Policy. The dollar limit that applies to the amount for conversion at Policy termination does not apply.

   The requirement that the Insured be covered under the Policy for the stated number of years in order to convert life insurance does not apply.

APPLICABLE TO FLORIDA RESIDENTS:

The benefits of the policy providing your coverage are governed primarily by the law of a state other than Florida.

APPLICABLE TO MARYLAND RESIDENTS:

The Group Insurance Policy was issued in a jurisdiction other than Maryland and may not provide all of the benefits required by Maryland law.

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APPLICABLE TO MINNESOTA RESIDENTS:

1. The following Continuation of Life Insurance is available to any Employee residing in Minnesota, unless the Policy otherwise provides for continuation of all life insurance coverage for a minimum of 18 months following termination of eligibility under the Policy.

   Continuation Of Life Insurance – This provision shall not apply to the extent that the Policy provides for the right of Employees to continue insurance on a direct billed basis following termination of employment (Portability).

   This provision shall apply with respect to Employees whose coverage under the Policy is terminated due to: (i) voluntary or involuntary termination or layoff from employment, for any reason other than gross misconduct; or (ii) reduction in hours such that the Employee is not eligible for insurance under the Policy. This provision shall only apply to Employees who, on such date, are Minnesota residents.

   This provision shall also apply with respect to Employees whose coverage under the Policy's Takeover Provision ends, for any reason other than the Employee meeting the Policy's Active Service requirement.

   For those *Employees subject to* this provision, life insurance coverage may be continued under the Policy for 18 months or until the date that the Employee becomes covered under another group policy, whichever is shorter. Coverage provided under this provision will also end if the Policy is terminated.

   The premium required for continued coverage shall be the premium under the Policy applicable to the Employee's class and amount of coverage. The Employer may charge an additional amount, not to exceed 2% of such premium, for collecting premium contributions from former Employees. The Employer shall notify the Employee of the right to continue and the required premium contribution. The Employee may elect to continue within 60 days of termination by paying the required premium, and may continue coverage in force by paying the required premium, without demand, on a monthly basis, as of the first of each month, to the Employer. Coverage will end at the end of any month in which the Employee has failed to pay premium to the Employer.

   If continued coverage remains in force at the end of the 18 month period, or on termination of the Policy, the Employee may choose any conversion right then available under the Policy.

   In the event the Employee dies during the 60 day right to elect period without having become insured under another group policy, or dies while continued coverage is in force, the death benefit will be paid to the beneficiary chosen by the Employee under the terms of the Policy.

   Continued coverage will include eligible dependents who were covered on the Employee's date of termination, provided the dependent remains eligible as a dependent of the Employee. In the event that the dependent ceases to be eligible, the dependent may choose any conversion right then available under the Policy.

APPLICABLE TO NORTH DAKOTA RESIDENTS:

The Suicide exclusion, if any, is limited to one year from the effective date of insurance. The suicide exclusion with respect to any increase in death benefits which results from an application of the Employee subsequent to the effective date, if any, is limited to one year from the effective date of the increase.

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APPLICABLE TO VERMONT RESIDENTS:

To the extent the Policy provides insurance coverage to a spouse, the identical consideration must be applied to same sex marriages and civil unions. The language is as follows:

1. Civil Union Partner means:
   a. A person with whom the Employee has a registered civil union under Vermont law which imposes obligations on the parties substantially similar to marriage. Such person will continue to be recognized as a Civil Union Partner unless and until:
      (1) the civil union is dissolved under applicable law; or
      (2) either the Employee or the Civil Union Partner marries another person.

2. Spouse means:
   a. "Lawful spouse" and includes a lawful spouse of the same sex.
   b. This also includes a partner to a civil union recognized under Vermont Law.

APPLICABLE TO WASHINGTON RESIDENTS:

1. The following *Continuation of Insurance* provision is added to the Policy:

   Continuation of Life Coverage During Labor Disputes
   If an Employee's Active Service ends because of a Labor Dispute and his or her premium for Life Insurance Benefits under the Policy is paid either by the Employer, in whole or in part, or by the Employee through payroll deductions, then the Employee may continue his or her Life Insurance Benefits. The Employer will send written notice of the right to continue coverage to each insured Employee at his or her most recent address as on file with the Employer.

   To continue coverage, the Employee must pay premiums directly to the Employer, who will remit the premiums to the Insurance Company. Premiums must be paid by the date they are due, subject to the 31 day grace period. Policy coverages and premiums will stay the same during a Labor Dispute; however, the Insurance Company may make normal changes in premium rates when the Policy is renewed, under the terms set forth in the Policy.

   Coverage continued in this manner will end on the earliest of the following dates.
   a. The date the Labor Dispute has ended.
   b. The date coverage has been continued for 6 months.

   If the Labor Dispute continues beyond 6 months, the Employee may apply for an individual insurance policy, as set forth in detail under "Conversion Privilege for Life Insurance."

   "Labor Dispute," as used here, means a strike, lockout, or other labor dispute between the Employer and its Employees, during which time the Employee is not paid by the Employer.

2. To the extent the policy includes *Accelerated Benefits,* the following resolution of disputes requirements are added to the Policy.

   - For Terminal Illness – *Determination of Terminal Illness*

     In the event the Physician representing the Insurance Company disputes the existence of a Terminal Illness, and the dispute cannot be resolved, the Insured has the right to mediation and binding arbitration in accordance with Washington Administrative Code 284-23-730.

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3. The *Incontestability Provision* is replaced as follows:

   Incontestability
   All statements made by the Employer or by an Insured are representations not warranties. No statement will be used to deny or reduce benefits or as a defense to a claim, unless a copy of the instrument containing the statement has been furnished to the claimant. In the event of death or legal incapacity, the beneficiary or representative must receive the copy.

   After two years from an Insured's effective date of insurance, or from the effective date of any added or increased benefits, no such statement will cause insurance to be contested.

4. If the term "*Accident*" is defined in the Policy, it is replaced by the following:

   Accident
   An Accident is a sudden, unforeseeable event that causes bodily Injury to an Insured while coverage is in force under the Policy.

Signed for the
Life Insurance Company of North America



Scott Berlin, President

TL-00-3000.00

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RECEIPT ACKNOWLEDGEMENT FORM
LIFE INSURANCE COMPANY OF NORTH AMERICA
PHILADELPHIA, PA 19192-2235

We, UAW/UMASS Health & Welfare Trust Fund, whose main office address is Amherst, MA, hereby approve and accept the terms of Group Policy Number FLX-971099 issued by the LIFE INSURANCE COMPANY OF NORTH AMERICA to the TRUSTEE OF THE GROUP INSURANCE TRUST FOR EMPLOYERS IN THE FINANCE, INSURANCE AND REAL ESTATE INDUSTRY.

This application is to be signed.

UAW/UMASS Health & Welfare Trust Fund

Signature: DocuSigned by: Leslie Edwards-Davis 35FD572DE03C443... Date: 8/4/2026

Title: Director of Benefit Programs

Docusign Envelope ID: DC139014-2CD2-883F-8285-09EC3EC75267

Life Insurance Company of North America

1601 Chestnut Street, Philadelphia, Pennsylvania 19192-2235

A Stock Insurance Company

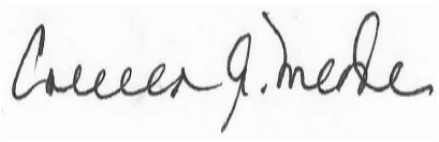
GROUP ACCIDENT POLICY

POLICYHOLDER:	Trustee of the Group Insurance Trust for Employers in the Finance, Insurance and Real Estate Industry
POLICY NUMBER:	OK 972455
POLICY EFFECTIVE DATE:	August 1, 2026
POLICY ANNIVERSARY DATE:	August 1
STATE OF ISSUE:	Delaware

This Policy describes the terms and conditions of insurance. This Policy goes into effect subject to its applicable terms and conditions at 12:01 AM on the Policy Effective Date shown above at the Policyholder's address. The laws of the State of Issue shown above govern this Policy.

We and the Policyholder agree to all of the terms of this Policy.

THIS IS A GROUP ACCIDENT ONLY INSURANCE POLICY.
IT DOES NOT PAY BENEFITS FOR LOSS CAUSED BY SICKNESS.
THIS IS A LIMITED POLICY.
PLEASE READ IT CAREFULLY.



Colleen Meade, Corporate Secretary



Scott Berlin, President

Countersigned_____
Where Required By Law

GA-00-1000.00

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SCHEDULE OF AFFILIATES

The following affiliates are covered under this Policy on the effective dates listed below.

AFFILIATE NAME	LOCATION	EFFECTIVE DATE
None		

GA-00-1000.00

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SCHEDULE OF BENEFITS

This Policy is intended to be read in its entirety. In order to understand all the conditions, exclusions and limitations applicable to its benefits, please read all the policy provisions carefully.

The *Schedule of Benefits* provides a brief outline of the coverage and benefits provided by this Policy. Please read the *Description of Coverages and Benefits* Section for full details.

Subscriber: UAW/UMASS Health & Welfare Trust Fund

Effective Date of Subscriber Participation: August 1, 2026

Covered Classes:

Class 1	All active full-time and part-time Employees of the Employer who are classified as Postdoctoral Researcher Employees, regularly working a minimum of 20 hours per week in the United States, who are citizens or permanent residents aliens of the United States, or non-United States citizens living and working in the United States under an active and appropriate visa or work authorization.
Class 2	All active full-time and part-time Employees of the Employer who are classified as Graduate Employees who meet the Employer's established earnings requirement of regularly earning $7835.60 of the equivalent, regularly working a minimum of 20 hours per week in the United States, who are citizens or permanent residents aliens of the United States, or non-United States citizens living and working in the United States under an active and appropriate visa or work authorization.

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SCHEDULE OF BENEFITS FOR CLASS 1

This *Schedule of Benefits* shows maximums, benefit periods and any limitations applicable to benefits provided in this Policy for each Covered Person unless otherwise indicated. Principal Sum, when referred to in this Schedule, means the Employee's Principal Sum in effect on the date of the Covered Accident causing the Covered Injury or Covered Loss unless otherwise specified.

Eligibility Waiting Period
The Eligibility Waiting Period is the period of time the Employee must be in a Covered Class to be eligible for coverage.

For Employees hired on or before the Policy Effective Date:	No Waiting Period
For Employees hired after the Policy Effective Date:	No Waiting Period

Time Period for Loss:
Any Covered Loss must occur within: 365 days of the Covered Accident

Maximum Age for Insurance: None

BASIC ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Employee Principal Sum: $20,000

SCHEDULE OF COVERED LOSSES

Covered Loss	Benefit
Loss of Life	100% of the Principal Sum
Loss of Two or More Hands or Feet	100% of the Principal Sum
Loss of Sight of Both Eyes	100% of the Principal Sum
Loss of One Hand or One Foot and Sight in One Eye	100% of the Principal Sum
Loss of Speech and Hearing (in both ears)	100% of the Principal Sum
Quadriplegia	100% of the Principal Sum
Paraplegia	75% of the Principal Sum
Hemiplegia	50% of the Principal Sum
Uniplegia	25% of the Principal Sum
Coma	
Monthly Benefit	1% of the Principal Sum
Number of Monthly Benefits	11
When Payable	At the end of each month during which the Covered Person remains comatose
Lump Sum Benefit	100% of the Principal Sum
When Payable	Beginning of the 12th month
Loss of One Hand or Foot	50% of the Principal Sum
Loss of Sight in One Eye	50% of the Principal Sum
Severance and Reattachment of One Hand or Foot	50% of the Principal Sum
Loss of Speech	50% of the Principal Sum
Loss of Hearing (in both ears)	50% of the Principal Sum
Loss of all Four Fingers of the Same Hand	25% of the Principal Sum
Loss of Thumb and Index Finger of the Same Hand	25% of the Principal Sum
Loss of all the Toes of the Same Foot	20% of the Principal Sum

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Age Reductions
A Covered Person's Principal Sum will be reduced to the percentage of his Principal Sum in effect on the date preceding the first reduction, as shown below.

Age	Percentage of Benefit Amount
65 but less than 70	65%
70 or over	50%

Benefit reductions will be effective on the Covered Person's attainment of age as specified in schedule above.

ADDITIONAL ACCIDENTAL DEATH AND DISMEMBERMENT COVERAGES
Accidental Death and Dismemberment benefits are provided under the following coverages. Any benefits payable under them are as shown in the S*chedule of Covered Losses* and are not paid in addition to any other Accidental Death and Dismemberment benefits.

EXPOSURE AND DISAPPEARANCE COVERAGE — Principal Sum multiplied by the percentage applicable to the Covered Loss, as shown in the *Schedule of Covered Losses*.

ADDITIONAL ACCIDENT BENEFITS
Any benefits payable under these *Additional Accident Benefits* shown below are paid in addition to any other Accidental Death and Dismemberment benefits payable.

CHILD CARE CENTER BENEFIT

Benefit Amount	3% of the Employee's Principal Sum subject to a maximum of $600 per year
Maximum Benefit Period	the earlier of 4 years or until the child turns 13 for each surviving Dependent Child

COMMON CARRIER BENEFIT — 50% multiplied by the percentage of the Principal Sum applicable to the Covered Loss, as shown in the *Schedule of Covered Losses*, subject to a maximum of $10,000

SEATBELT AND AIRBAG BENEFIT

Seatbelt Benefit	10% of the Principal Sum subject to a Maximum Benefit of $2,000
Airbag Benefit	5% of the Principal Sum subject to a Maximum Benefit of $1,000
Default Benefit	$1,000

INITIAL PREMIUM RATES

Premium Rate:	Basic Insurance Employee Rate: $0.02 per $1,000
Mode of Premium Payment:	Monthly
Contributions:	The cost of the coverage is paid by the Subscriber
Premium Due Dates:	The Policy Effective Date and the first day of each succeeding modal period

Premium rates are subject to change in accordance with the *Changes in Premium Rates* section contained in the *Administrative Provisions* section of this Policy.

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SCHEDULE OF BENEFITS FOR CLASS 2

This *Schedule of Benefits* shows maximums, benefit periods and any limitations applicable to benefits provided in this Policy for each Covered Person unless otherwise indicated. Principal Sum, when referred to in this Schedule, means the Employee's Principal Sum in effect on the date of the Covered Accident causing the Covered Injury or Covered Loss unless otherwise specified.

Eligibility Waiting Period
The Eligibility Waiting Period is the period of time the Employee must be in a Covered Class to be eligible for coverage.

For Employees hired on or before the Policy Effective Date:	No Waiting Period
For Employees hired after the Policy Effective Date:	No Waiting Period

Time Period for Loss:
Any Covered Loss must occur within: 365 days of the Covered Accident

Maximum Age for Insurance: None

BASIC ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Employee Principal Sum: $10,000

SCHEDULE OF COVERED LOSSES

Covered Loss	Benefit
Loss of Life	100% of the Principal Sum
Loss of Two or More Hands or Feet	100% of the Principal Sum
Loss of Sight of Both Eyes	100% of the Principal Sum
Loss of One Hand or One Foot and Sight in One Eye	100% of the Principal Sum
Loss of Speech and Hearing (in both ears)	100% of the Principal Sum
Quadriplegia	100% of the Principal Sum
Paraplegia	75% of the Principal Sum
Hemiplegia	50% of the Principal Sum
Uniplegia	25% of the Principal Sum
Coma	
Monthly Benefit	1% of the Principal Sum
Number of Monthly Benefits	11
When Payable	At the end of each month during which the Covered Person remains comatose
Lump Sum Benefit	100% of the Principal Sum
When Payable	Beginning of the 12th month
Loss of One Hand or Foot	50% of the Principal Sum
Loss of Sight in One Eye	50% of the Principal Sum
Severance and Reattachment of One Hand or Foot	50% of the Principal Sum
Loss of Speech	50% of the Principal Sum
Loss of Hearing (in both ears)	50% of the Principal Sum
Loss of all Four Fingers of the Same Hand	25% of the Principal Sum
Loss of Thumb and Index Finger of the Same Hand	25% of the Principal Sum
Loss of all the Toes of the Same Foot	20% of the Principal Sum

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Age Reductions
A Covered Person's Principal Sum will be reduced to the percentage of his Principal Sum in effect on the date preceding the first reduction, as shown below.

Age	Percentage of Benefit Amount
65 but less than 70	65%
70 or over	50%

Benefit reductions will be effective on the Covered Person's attainment of age as specified in schedule above.

ADDITIONAL ACCIDENTAL DEATH AND DISMEMBERMENT COVERAGES
Accidental Death and Dismemberment benefits are provided under the following coverages. Any benefits payable under them are as shown in the S*chedule of Covered Losses* and are not paid in addition to any other Accidental Death and Dismemberment benefits.

EXPOSURE AND DISAPPEARANCE COVERAGE — Principal Sum multiplied by the percentage applicable to the Covered Loss, as shown in the *Schedule of Covered Losses*.

ADDITIONAL ACCIDENT BENEFITS
Any benefits payable under these *Additional Accident Benefits* shown below are paid in addition to any other Accidental Death and Dismemberment benefits payable.

CHILD CARE CENTER BENEFIT

Benefit Amount	3% of the Employee's Principal Sum subject to a maximum of $300 per year
Maximum Benefit Period	the earlier of 4 years or until the child turns 13 for each surviving Dependent Child

COMMON CARRIER BENEFIT — 50% multiplied by the percentage of the Principal Sum applicable to the Covered Loss, as shown in the *Schedule of Covered Losses*, subject to a maximum of $10,000

SEATBELT AND AIRBAG BENEFIT

Seatbelt Benefit	10% of the Principal Sum subject to a Maximum Benefit of $1,000
Airbag Benefit	5% of the Principal Sum subject to a Maximum Benefit of $500
Default Benefit	$500

INITIAL PREMIUM RATES

Premium Rate:	Basic Insurance Employee Rate: $0.02 per $1,000
Mode of Premium Payment:	Monthly
Contributions:	The cost of the coverage is paid by the Subscriber
Premium Due Dates:	The Policy Effective Date and the first day of each succeeding modal period

Premium rates are subject to change in accordance with the *Changes in Premium Rates* section contained in the *Administrative Provisions* section of this Policy.

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GENERAL DEFINITIONS

Please note that certain words used in this Policy have specific meanings. The words defined below and capitalized within the text of this Policy have the meanings set forth below.

Active Service

An Employee will be considered in Active Service with his employer on any day that is either of the following:

1. one of the Employer's scheduled work days on which the Employee is performing his regular duties on a full-time basis, either at one of the Employer's usual places of business or at some other location to which the Employer's business requires the Employee to travel;
2. a scheduled holiday, vacation day or period of Employer-approved paid leave of absence, other than sick leave, only if the Employee was in Active Service on the preceding scheduled workday.

Age

A Covered Person's Age, for purposes of initial premium calculations, is his Age attained on the date coverage becomes effective for him under this Policy. Thereafter, it is his Age attained on his last birthday.

Aircraft

A vehicle which:

1. has a valid certificate of airworthiness; and
2. is being flown by a pilot with a valid license to operate the Aircraft.

Covered Accident

A sudden, unforeseeable, external event that results, directly and independently of all other causes, in a Covered Injury or Covered Loss and meets all of the following conditions:

1. occurs while the Covered Person is insured under this Policy;
2. is not contributed to by disease, Sickness, mental or bodily infirmity;
3. is not otherwise excluded under the terms of this Policy.

Covered Injury

Any bodily harm that results directly and independently of all other causes from a Covered Accident.

Covered Loss

A loss that is all of the following:

1. the result, directly and independently of all other causes, of a Covered Accident;
2. one of the Covered Losses specified in the Schedule of Covered Losses;
3. suffered by the Covered Person within the applicable time period specified in the Schedule of Benefits.

Covered Person

An eligible person, as defined in the *Schedule of Benefits*, for whom an enrollment form has been accepted by Us and required premium has been paid when due and for whom coverage under this Policy remains in force.

Employee

For eligibility purposes, an Employee of the Employer who is in one of the Covered Classes.

Employer

The Subscriber and any affiliates, subsidiaries or divisions shown in the *Schedule of Covered Affiliates* and which are covered under this Policy on the date of issue or subsequently agreed to by Us.

He, His, Him

Refers to any individual, male or female.

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Hospital

An institution that meets all of the following:
1. it is licensed as a Hospital pursuant to applicable law;
2. it is primarily and continuously engaged in providing medical care and treatment to sick and injured persons;
3. it is managed under the supervision of a staff of medical doctors;
4. it provides 24-hour nursing services by or under the supervision of a graduate registered nurse (R.N.);
5. it has medical, diagnostic and treatment facilities, with major surgical facilities on its premises, or available on a prearranged basis;
6. it charges for its services.

The term Hospital does not include a clinic, facility, or unit of a Hospital for:
1. rehabilitation, convalescent, custodial, educational or nursing care;
2. the aged, drug addicts or alcoholics;
3. a Veteran's Administration Hospital or Federal Government Hospital unless the Covered Person incurs an expense.

Inpatient

A Covered Person who is confined for at least one full day's Hospital room and board. The requirement that a person be charged for room and board does not apply to confinement in a Veteran's Administration Hospital or Federal Government Hospital and in such case, the term 'Inpatient' shall mean a Covered Person who is required to be confined for a period of at least a full day as determined by the Hospital.

Nurse

A licensed graduate Registered Nurse (R.N.), a licensed practical Nurse (L.P.N.) or a licensed vocational Nurse (L.V.N.) and who is not:
1. employed or retained by the Subscriber;
2. living in the Covered Person's household; or
3. a parent, sibling, spouse or child of the Covered Person.

Outpatient

A Covered Person who receives treatment, services and supplies while not an Inpatient in a Hospital.

Physician

A licensed health care provider practicing within the scope of his license and rendering care and treatment to a Covered Person that is appropriate for the condition and locality and who is not:1. employed or retained by the Subscriber;
2. living in the Covered Person's household;
3. a parent, sibling, spouse or child of the Covered Person.

Prior Plan

The plan of insurance providing similar benefits, sponsored by the Employer in effect immediately prior to this Policy's Effective Date.

Sickness

A physical or mental illness.

Subscriber

Any participating organization that subscribes to the trust to which this Policy is issued.

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Totally Disabled or Total Disability	Totally Disabled or Total Disability means either: 1. inability of the Covered Person who is currently employed to do any type of work for which he is or may become qualified by reason of education, training or experience; or 2. inability of the Covered Person who is not currently employed to perform all of the activities of daily living including eating, transferring, dressing, toileting, bathing, and continence, without human supervision or assistance.
We, Us, Our	Life Insurance Company of North America.

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ELIGIBILITY AND EFFECTIVE DATE PROVISIONS

Subscriber Effective Date
Accident Insurance Benefits become effective for each Subscriber in consideration of the Subscriber's application, Subscription Agreement and payment of the initial premium when due. Insurance coverage for the Subscriber becomes effective on the Effective Date of Subscriber Participation.

Eligibility
An Employee becomes eligible for insurance under this Policy on the date he meets all of the requirements of one of the Covered Classes and completes any Eligibility Waiting Period, as shown in the *Schedule of Benefits.*

Effective Date for Individuals
Insurance becomes effective for an eligible Employee, subject to the *Deferred Effective Date* provision below, on the latest of the following dates:
1. the effective date of this Policy;
2. the date the Employee becomes eligible.

DEFERRED EFFECTIVE DATE
Active Service
The effective date of insurance will be deferred for any Employee who is not in Active Service on the date coverage would otherwise become effective. Coverage will become effective on the later of the date he returns to Active Service and the date coverage would otherwise have become effective.

Effective Date of Changes
Any increase or decrease in the amount of insurance for the Covered Person resulting from:
1. a change in benefits provided by this Policy; or
2. a change in the Employee's Covered Class will take effect on the date of such change.

Increases will take effect subject to any Active Service requirement.

TERMINATION OF INSURANCE
The insurance on a Covered Person will end on the earliest date below:
1. the date this Policy or insurance for a Covered Class is terminated;
2. the next premium due date after the date the Covered Person is no longer in a Covered Class or satisfies eligibility requirements under this Policy;
3. the last day of the last period for which premium is paid;
4. the next premium due date after the Covered Person attains the maximum Age for insurance under this Policy.

Termination will not affect a claim for a Covered Loss or Covered Injury that is the result, directly and independently of all other causes, of a Covered Accident that occurs while coverage was in effect.

CONTINUATION OF INSURANCE
Continuation for Family Medical Leave
Insurance for an Employee may be continued until the earliest of the following dates if: (a) an Employee is on an Employer-approved family medical leave; and (b) required premium contributions are paid when due.
1. for an Employer-approved family medical leave: up to the later of the period of the approved FMLA leave or the leave period required by law in the state in which the Employee is employed.

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COMMON EXCLUSIONS

In addition to any benefit-specific exclusions, benefits will not be paid for any Covered Injury or Covered Loss which, directly or indirectly, in whole or in part, is caused by or results from any of the following unless coverage is specifically provided for by name in the *Description of Benefits* Section:

1. intentionally self-inflicted injury, suicide or any attempt thereat while sane or insane;
2. commission or attempt to commit a felony or an assault;
3. commission of or active participation in a riot or insurrection;
4. bungee jumping; parachuting; skydiving; parasailing; hang-gliding;
5. declared or undeclared war or act of war;
6. flight in, boarding or alighting from an Aircraft or any craft designed to fly above the Earth's surface:
    a. except as a passenger on a regularly scheduled commercial airline;
    b. being flown by the Covered Person or in which the Covered Person is a member of the crew;
    c. being used for:
        i. crop dusting, spraying or seeding, giving and receiving flying instruction, fire fighting, sky writing, sky diving or hang-gliding, pipeline or power line inspection, aerial photography or exploration, racing, endurance tests, stunt or acrobatic flying; or
        ii. any operation that requires a special permit from the FAA, even if it is granted (this does not apply if the permit is required only because of the territory flown over or landed on);
    d. designed for flight above or beyond the earth's atmosphere;
    e. an ultra-light or glider;
    f. being used for the purpose of parachuting or skydiving;
    g. being used by any military authority, except an Aircraft used by the Air Mobility Command or its foreign equivalent;
7. Sickness, disease, bodily or mental infirmity, bacterial or viral infection or medical or surgical treatment thereof, except for any bacterial infection resulting from an accidental external cut or wound or accidental ingestion of contaminated food;
8. travel in any Aircraft owned, leased or controlled by the Subscriber, or any of its subsidiaries or affiliates. An Aircraft will be deemed to be "controlled" by the Subscriber if the Aircraft may be used as the Subscriber wishes for more than 10 straight days, or more than 15 days in any year;
9. a Covered Accident that occurs while engaged in the activities of active duty service in the military, navy or air force of any country or international organization. Covered Accidents that occur while engaged in Reserve or National Guard training are not excluded until training extends beyond 31 days;
10. operating any type of vehicle while under the influence of alcohol or any drug, narcotic or other intoxicant including any prescribed drug for which the Covered Person has been provided a written warning against operating a vehicle while taking it. Under the influence of alcohol, for purposes of this exclusion, means intoxicated, as defined by the law of the state in which the Covered Accident occurred;
11. voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage;
12. in addition, benefits will not be paid for services or treatment rendered by a Physician, Nurse or any other person who is:
    a. employed or retained by the Subscriber;
    b. providing homeopathic, aroma-therapeutic or herbal therapeutic services;
    c. living in the Covered Person's household;
    d. a parent, sibling, spouse or child of the Covered Person.

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CLAIM PROVISIONS

Notice of Claim
Written or authorized electronic/telephonic notice of claim must be given to Us within 31 days after a Covered Loss occurs or begins or as soon as reasonably possible. If written or authorized electronic/telephonic notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written or authorized electronic/telephonic notice was given as soon as was reasonably possible. Notice can be given to Us at Our Home Office in Philadelphia, Pennsylvania, such other place as We may designate for the purpose, or to Our authorized agent. Notice should include the Subscriber's name and policy number and the Covered Person's name, address, policy and certificate number.

Claim Forms
We will send claim forms for filing proof of loss when We receive notice of a claim. If such forms are not sent within 15 days after We receive notice, the proof requirements will be met by submitting, within the time fixed in this Policy for filing proof of loss, written or authorized electronic proof of the nature and extent of the loss for which the claim is made.

Claimant Cooperation Provision
Failure of a claimant to cooperate with Us in the administration of the claim may result in termination of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

Proof of Loss
Written or authorized electronic proof of loss satisfactory to Us must be given to Us at Our office, within 90 days of the loss for which claim is made. If (a) benefits are payable as periodic payments and (b) each payment is contingent upon continuing loss, then proof of loss must be submitted within 90 days after the termination of each period for which We are liable. If written or authorized electronic notice is not given within that time, no claim will be invalidated or reduced if it is shown that such notice was given as soon as reasonably possible. In any case, written or authorized electronic proof must be given not more than one year after the time it is otherwise required, except if proof is not given solely due to the lack of legal capacity.

Time of Payment of Claims
We will pay benefits due under this Policy for any loss other than a loss for which this Policy provides any periodic payment immediately upon receipt of due written or authorized electronic proof of such loss. Subject to due written or authorized electronic proof of loss, all accrued benefits for loss for which this Policy provides periodic payment will be paid monthly unless otherwise specified in the benefits descriptions and any balance remaining unpaid at the termination of liability will be paid immediately upon receipt of proof satisfactory to Us.

Manner of Payment of Claims
The Subscriber authorizes that any benefit payment due as a lump sum of $5,000 or more shall be credited to a draft account with the Insurance Company, in the name of the beneficiary. The beneficiary may withdraw the entire proceeds at any time by issuing one or more drafts, or may withdraw lesser amounts, subject to a minimum account balance set by the Insurance Company from time to time. Interest shall be credited to such account at rates as determined from time to time by the Insurance Company.

Payment of Claims
All benefits will be paid in United States currency. Benefits for loss of life will be payable in accordance with the Beneficiary provision and these Claim Provisions. All other proceeds payable under this Policy, unless otherwise stated, will be payable to the covered Employee or to his estate.

If We are to pay benefits to the estate or to a person who is incapable of giving a valid release, We may pay $1,000 to a relative by blood or marriage whom We believe is equitably entitled. Any payment made by Us in good faith pursuant to this provision will fully discharge Us to the extent of such payment and release Us from all liability.

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Payment of Claims to Foreign Employees
The Subscriber may, in a fiduciary capacity, receive and hold any benefits payable to covered Employees whose place of employment is other than the United States of America.

We will not be responsible for the application or disposition by the Subscriber of any such benefits paid. Our payments to the Subscriber will constitute a full discharge of Our liability for those payments under this Policy.

Physical Examination and Autopsy
We, at Our own expense, have the right and opportunity to examine the Covered Person when and as often as We may reasonably require while a claim is pending and to make an autopsy in case of death where it is not forbidden by law.

Legal Actions
No action at law or in equity may be brought to recover under this Policy less than 60 days after written or authorized electronic proof of loss has been furnished as required by this Policy. No such action will be brought more than three years after the time such written proof of loss must be furnished.

Beneficiary
The beneficiary is the person or persons the Employee names or changes on a form executed by him and satisfactory to Us. This form may be in writing or by any electronic means agreed upon between Us and the Subscriber. Consent of the beneficiary is not required to affect any changes, unless the beneficiary has been designated as an irrevocable beneficiary, or to make any assignment of rights or benefits permitted by this Policy.

A beneficiary designation or change will become effective on the date the Employee executes it. However, We will not be liable for any action taken or payment made before We record notice of the change at our Home Office.

If more than one person is named as beneficiary, the interests of each will be equal unless the Employee has specified otherwise. The share of any beneficiary who does not survive the Covered Person will pass equally to any surviving beneficiaries unless otherwise specified.

If there is no named beneficiary or surviving beneficiary, or if the Employee dies while benefits are payable to him, We may make direct payment to the first surviving class of the following classes of persons:
1. spouse;
2. child or children;
3. mother or father;
4. sisters or brothers;
5. estate of the Covered Person.

Recovery of Overpayment
If benefits are overpaid, We have the right to recover the amount overpaid by either of the following methods.
1. A request for lump sum payment of the overpaid amount.
2. A reduction of any amounts payable under this Policy.

If there is an overpayment due when the Covered Person dies, We may recover the overpayment from the Covered Person's estate.

GA-00-1600.00 as modified by RA-GA-1000.00

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ADMINISTRATIVE PROVISIONS

Premiums
All premium rates are expressed in, and all premiums are payable in, United States currency. The premiums for this Policy will be based on the rates set forth in the *Schedule of Benefits*, the plan and amounts of insurance in effect. If a Covered Person's insurance amounts are reduced due to age, premium will be based on the amounts of insurance in force on the day after the reduction took place.

Changes in Premium Rates
We may change the premium rates from time to time with at least 31 days advance written notice to the Subscriber. No change in rates will be made until 36 months after the Policy Effective Date. An increase in rates will not be made more often than once in a 12-month period. However, We reserve the right to change rates at any time if any of the following events take place:
1. the terms of this Policy change;
2. the terms of the Subscriber's participation change;
3. a division, subsidiary, affiliated company or eligible class is added or deleted from this Policy;
4. there is a change in the factors bearing on the risk assumed;
5. any federal or state law or regulation is amended to the extent it affects Our benefit obligation.

Draft Accounts
The Insurance Company shall be entitled to retain, as part of its compensation, any earnings on draft accounts created in connection with benefit claims, in excess of interest credited under the terms of the policy.

Payment of Premium
The first premium is due on the Subscriber's effective date of participation under this Policy. Thereafter, premiums are due on the Premium Due Dates agreed upon between Us and the Subscriber. If any premium is not paid when due, the Subscriber's participation under this Policy will be terminated as of the Premium Due Date on which premium was not paid.

Grace Period
A Grace Period of 31 days will be granted to each Subscriber for payment of required premiums under this Policy. A Subscriber's participation under this Policy will remain in effect during the Grace Period. The Subscriber is liable to Us for any unpaid premium for the time its participation under this Policy was in force.

GA-00-1701.00 as modified by RA-GA-1000.00

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GENERAL PROVISIONS

Entire Contract; Changes
This Policy, including the endorsements, amendments and any attached papers constitutes the entire contract of insurance. No change in this Policy will be valid until approved by one of Our executive officers and endorsed on or attached to this Policy. No agent has authority to change this Policy or to waive any of its provisions.

Subscriber Participation Under This Policy
An organization may elect to participate under this Policy by submitting a signed Subscriber participation agreement to the Policyholder. No participation by an organization is in effect until approved by Us.

Misstatement of Fact
If the Covered Person has misstated any fact, all amounts payable under this Policy will be such as the premium paid would have purchased had such fact been correctly stated.

Certificates
Where required by law, We will provide a certificate of insurance for delivery to the Covered Person. Each certificate will list the benefits, conditions and limits of this Policy. It will state to whom benefits will be paid.

30 Day Right To Examine Certificate
If a Covered Person does not like the Certificate for any reason, it may be returned to Us within 30 days after receipt. We will return any premium that has been paid and the Certificate will be void as if it had never been issued.

Multiple Certificates
The Covered Person may have in force only one certificate at a time under this Policy. If at any time the Covered Person has been issued more than one certificate, then only the largest shall be in effect. We will refund premiums paid for the others for any period of time that more than one certificate was issued.

Assignment
We will be bound by an assignment of a Covered Person's insurance under this Policy only when the original assignment or a certified copy of the assignment, signed by the Covered Person and any irrevocable beneficiary, is filed with Us. The assignee may exercise all rights and receive all benefits assigned only while the assignment remains in effect and insurance under this Policy and the Covered Person’s certificate remains in force.

Incontestability
1. Of This Policy or Participation Under This Policy
All statements made by the Subscriber to obtain this Policy or to participate under this Policy are considered representations and not warranties. No statement will be used to deny or reduce benefits or be used as a defense to a claim, or to deny the validity of this Policy or of participation under this Policy unless a copy of the instrument containing the statement is, or has been, furnished to the Subscriber.

After two years from the Policy Effective Date, no such statement will cause this Policy to be contested except for fraud.

2. Of A Covered Person's Insurance
All statements made by a Covered Person are considered representations and not warranties. No statement will be used to deny or reduce benefits or be used as a defense to a claim, unless a copy of the instrument containing the statement is, or has been, furnished to the claimant.

After two years from the Covered Person’s effective date of insurance, or from the effective date of increased benefits, no such statement will cause insurance or the increased benefits to be contested except for fraud or lack of eligibility for insurance.

In the event of death or incapacity, the beneficiary or representative shall be given a copy.

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Policy Termination
We may terminate coverage on or after the first anniversary of the policy effective date. The Subscriber may terminate coverage on any premium due date. Written or authorized electronic notice must be given at least 31 days prior to such premium due date.

Termination will not affect a claim for a Covered Loss that is the result, directly and independently of all other causes, of a Covered Accident that occurs while coverage was in effect.

Reinstatement
This Policy may be reinstated if it lapsed for nonpayment of premium. Requirements for reinstatement are written application of the Subscriber satisfactory to Us and payment of all overdue premiums. Any premium accepted in connection with a reinstatement will be applied to a period for which premium was not previously paid.

Clerical Error
A Covered Person's insurance will not be affected by error or delay in keeping records of insurance under this Policy. If such error or delay is found, We will adjust the premium fairly.

Conformity with Statutes
Any provisions in conflict with the requirements of any state or federal law that apply to this Policy are automatically changed to satisfy the minimum requirements of such laws.

Policy Changes
We may agree with the Subscriber to modify a plan of benefits without the Covered Person’s consent.

Workers’ Compensation Insurance
This Policy is not in place of and does not affect any requirements for coverage under any Workers’ Compensation law.

Examination of the Policy
This Group Policy will be available for inspection at the Subscriber's office during regular business hours.

Examination of Records
We will be permitted to examine all of the Subscriber's records relating to this Group Policy. Examination may occur at any reasonable time while the Group Policy is in force; or it may occur:
1. at any time for two years after the expiration of this Group Policy; or, if later,
2. upon the final adjustment and settlement of all Group Policy claims.

The Subscriber is acting as an agent of the Covered Person for transactions relating to this insurance. The actions of the Subscriber will not be considered Our actions.

Ownership of Records
All records maintained by the Insurance Company are, and shall remain, the property of the Insurance Company.

GA-00-1800.00

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DESCRIPTION OF COVERAGES AND BENEFITS

This *Description of Coverages and Benefits* Section describes the Accident Coverages and Benefits provided by this Policy. Benefit amounts, benefit periods and any applicable aggregate and benefit maximums are shown in the *Schedule of Benefits.* Certain words capitalized in the text of these descriptions have special meanings within this Policy and are defined in the *General Definitions* section. Please read these and the *Common Exclusions* sections in order to understand all of the terms, conditions and limitations applicable to these coverages and benefits.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Covered Loss

We will pay the benefit for any one of the Covered Losses listed in the *Schedule of Benefits,* if the Covered Person suffers a Covered Loss resulting directly and independently of all other causes from a Covered Accident within the applicable time period specified in the *Schedule of Benefits*.

If the Covered Person sustains more than one Covered Loss as a result of the same Covered Accident, benefits will be paid for the Covered Loss for which the largest available benefit is payable. If the loss results in death, benefits will only be paid under the Loss of Life benefit provision. Any Loss of Life benefit will be reduced by any paid or payable Accidental Dismemberment benefit. However, if such Accidental Dismemberment benefit equals or exceeds the Loss of Life benefit, no additional benefit will be paid.

Definitions

Loss of a Hand or Foot means complete Severance through or above the wrist or ankle joint.

Loss of Sight means the total, permanent loss of all vision in one eye which is irrecoverable by natural, surgical or artificial means.

Loss of Speech means total and permanent loss of audible communication which is irrecoverable by natural, surgical or artificial means.

Loss of Hearing means total and permanent loss of ability to hear any sound in both ears which is irrecoverable by natural, surgical or artificial means.

Loss of a Thumb and Index Finger of the Same Hand or Four Fingers of the Same Hand means complete Severance through or above the metacarpophalangeal joints of the same hand (the joints between the fingers and the hand).

Loss of Toes means complete Severance through the metatarsalphalangeal joint.

Paralysis or Paralyzed means total loss of use of a limb. A Physician must determine the loss of use to be complete and irreversible.

Quadriplegia means total Paralysis of both upper and both lower limbs.

Hemiplegia means total Paralysis of the upper and lower limbs on one side of the body.

Paraplegia means total Paralysis of both lower limbs or both upper limbs.

Uniplegia means total Paralysis of one upper or one lower limb.

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Coma means a profound state of unconsciousness which resulted directly and independently from all other causes from a Covered Accident, and from which the Covered Person is not likely to be aroused through powerful stimulation. This condition must be diagnosed and treated regularly by a Physician. Coma does not mean any state of unconsciousness intentionally induced during the course of treatment of a Covered Injury unless the state of unconsciousness results from the administration of anesthesia in preparation for surgical treatment of that Covered Accident.

Severance means the complete and permanent separation and dismemberment of the part from the body.

Exclusions The exclusions that apply to this benefit are in the *Common Exclusions* section.

GA-00-2100.00

ADDITIONAL ACCIDENTAL DEATH AND DISMEMBERMENT COVERAGES

Accidental Death and Dismemberment benefits are provided under the following coverages. Any benefits payable under them are shown in the *Schedule of Covered Losses* and will not be paid in addition to any other Accidental Death and Dismemberment benefits payable.

EXPOSURE AND DISAPPEARANCE COVERAGE

Benefits for Accidental Death and Dismemberment, as shown in the *Schedule of Covered Losses,* will be payable if a Covered Person suffers a Covered Loss which results directly and independently of all other causes from unavoidable exposure to the elements following a Covered Accident.

If the Covered Person disappears and is not found within one year from the date of the wrecking, sinking or disappearance of the conveyance in which the Covered Person was riding in the course of a trip which would otherwise be covered under this Policy, it will be presumed that the Covered Person's death resulted directly and independently of all other causes from a Covered Accident.

Exclusions The exclusions that apply to this coverage are in the *Common Exclusions* Section.

GA-00-2202.00

ADDITIONAL ACCIDENT BENEFITS

Accidental Death and Dismemberment benefits are provided under the following Additional Benefits. Any benefits payable under them will be paid in addition to any other Accidental Death and Dismemberment benefit payable.

CHILD CARE CENTER BENEFIT

We will pay benefits shown in the *Schedule of Benefits* for the care of each surviving Dependent Child in a Child Care Center if death of the covered Employee results directly and independently of all other causes from a Covered Accident and all of the following conditions are met:

1. one or more surviving Dependent Children is under Age 13 and:
    a. was enrolled in a Child Care Center on the date of the Covered Accident; or
    b. enrolls in a Child Care Center within 90 days from the date of the Covered Accident.

This benefit will be payable to the Surviving Spouse if the Spouse has custody of the child. If the Surviving Spouse does not have custody of the child, benefits will be paid to the child's legally appointed guardian. Payments will be made at the end of each 12 month period that begins after the date of the covered Employee's death. A claim must be submitted to Us at the end of each 12 month period. A 12 month period begins:

1. when the Dependent Child enters a Child Care Center for the first time, within the period specified in (1b) above, after the covered Employee's death; or
2. on the first of the month following the covered Employee's death, if the Dependent Child was enrolled in a Child Care Center before the covered Employee's death.

Each succeeding 12 month period begins on the day immediately following the last day of the preceding period. Pro rata payments will be made for periods of enrollment in a Child Care Center of less than 12 months.

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Definitions For purposes of this benefit:

Child Care Center is a facility which:

1. is licensed and run according to laws and regulations applicable to child care facilities; and
2. provides care and supervision for children in a group setting on a regular, daily basis.

A Child Care Center does not include any of the following:

1. a Hospital;
2. the child's home;
3. care provided during normal school hours while a child is attending grades one through twelve.

Dependent Child(ren) will include:

A covered Employee's child who is unmarried and a:

1. natural child;
2. adopted child, beginning with any waiting period pending finalization of the child's adoption;
3. stepchild who resides with the Employee;
4. child for whom the Employee is legal guardian, as long as the child resides with the Employee and depends on the Employee for financial support. Financial support means that the Employee is eligible to claim the dependent for purposes of Federal and State income tax returns.

Surviving Spouse will include the Spouse.

Spouse will include the Employee's lawful spouse.

Exclusions The exclusions that apply to this benefit are in the *Common Exclusions* Section.

GA-00-2222a.00

COMMON CARRIER BENEFIT

We will pay the benefit shown in the *Schedule of Benefits* if the Covered Person suffers a Covered Loss that results directly and independently of all other causes from a Covered Accident that occurs while riding as a fare-paying passenger in, or being struck by, a Common Carrier. Riding includes getting into and out of the Common Carrier.

Definition For purposes of this benefit:

Common Carrier means:

1. a public conveyance, including Aircraft, licensed for hire to carry fare-paying passengers; or
2. a transport Aircraft operated by the Air Mobility Command or a similar air transport service of another country.

Exclusions The exclusions that apply to this benefit are in the *Common Exclusions* Section.

GA-00-2225.00

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SEATBELT AND AIRBAG BENEFIT

We will pay the benefit shown in the *Schedule of Benefits,* subject to the conditions and exclusions described below, when the Covered Person dies directly and independently of all other causes from a Covered Accident while wearing a seatbelt and operating or riding as a passenger in an Automobile. An additional benefit is provided if the Covered Person was also positioned in a seat protected by a properly-functioning and properly deployed Supplemental Restraint System (Airbag).

Verification of proper use of the seatbelt at the time of the Covered Accident and that the Supplemental Restraint System properly inflated upon impact must be a part of an official police report of the Covered Accident or be certified, in writing, by the investigating officer(s) and submitted with the Covered Person's claim to Us.

If such certification or police report is not available or it is unclear whether the Covered Person was wearing a seatbelt or positioned in a seat protected by a properly functioning and properly deployed Supplemental Restraint System, We will pay a default benefit shown in the *Schedule of Benefits* to the Covered Person's beneficiary.

Definitions For purposes of this benefit:
Supplemental Restraint System means an airbag that inflates upon impact for added protection to the head and chest areas.

Automobile means a self-propelled, private passenger motor vehicle with four or more wheels which is a type both designed and required to be licensed for use on the highway of any state, province or country. Automobile includes, but is not limited to, a sedan, station wagon, sport utility vehicle, or a motor vehicle of the pickup, van, camper, or motor-home type. Automobile does not include a mobile home or any motor vehicle which is used in mass or public transit.

Exclusions The exclusions that apply to this benefit are in the *Common Exclusions* Section.

GA-00-2251.00

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LIFE INSURANCE COMPANY OF NORTH AMERICA

AMENDATORY RIDER
TRAVEL ASSISTANCE SERVICES

Subscriber: UAW/UMASS Health & Welfare Trust Fund
Policy No.: OK 972455 Effective Date: August 1, 2026

This rider amends the Policy and Certificate to which it is attached. It is effective on the Effective Date shown above, and expires when the Policy expires.

Travel Assistance Services

We will pay the cost of the Covered Services described below, subject to all applicable conditions and exclusions, resulting, directly and independently of all other causes, from a Covered Medical Emergency. The Covered Medical Emergency must occur and Covered Services must be incurred during the course of travel or other activities covered by the Policy, and while the Covered Person is either more than 100 miles from his permanent residence or outside of his country of permanent residence.

To obtain services, the Covered Person must contact Us or our authorized service provider at the phone number provided by the Subscriber. All services must be provided by our authorized service provider unless authorized by Us.

Covered Services

Covered Services includes the reasonable costs for medically necessary services provided by Us or by our authorized service provider, and which are provided by our authorized service provider unless authorized by Us, for any of the following.

Emergency Medical Evacuation

Medically necessary expenses for Transportation of the Covered Person to the nearest adequate medical facility, if adequate medical care is not available at the Covered Person's location.

Cost of any medically necessary services or equipment that the Covered Person receives during transportation covered under this provision.

Cost of transporting qualified and licensed medical professional(s) or an Immediate Family Member or a Travel Companion if medically required to escort the Covered Person during transportation covered under this provision.

Transportation will be provided by medically equipped specialty aircraft, commercial airline, train or ambulance depending upon the medical needs and available transportation specific to each case.

Return Transportation

Any increase in the cost of the Covered Person's return transportation to his or her home or work location following emergency medical evacuation covered under this benefit, above the cost of the Covered Person's original scheduled return transportation.

Any increased cost of the transportation for an Immediate Family Member or Travel Companion of the Covered Person to return to his or her primary residence, if he or she accompanied the Covered Person on the trip where the emergency occurred, and was as a result not able to return to his or her primary residence when originally scheduled.

Unless it is medically necessary for another means of transportation to be provided, such return transportation costs will be covered for the same class of travel as the Covered Person's original transportation.

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In the case of an Immediate Family Members who is a child under age 18, who is left without a parent, guardian or other adult to accompany the child, we will cover the reasonable cost of an escort to accompany the child to the nearest airport. If under the applicable rules of the airline, the child is too young to travel unaccompanied by an adult, we will pay the round trip economy airfare for an adult family member from the child's place of residence to the airport nearest the child.

Immediate Family Member Visit

Expenses for an Immediate Family Member or Friend of the Covered Person to visit the Covered Person during hospitalization away from the Covered Person's primary residence, if the Covered Person is hospitalized or expected to remain hospitalized for 7 or more consecutive days following emergency medical evacuation covered under this benefit. Such expenses shall be limited to one person only, and shall include round-trip economy airfare, and an allowance of $150.00 per day for up to 7 days for meals and lodging.

If a Dependent Child is evacuated, we will pay the expenses of an adult Immediate Family Member who accompanied the Dependent Child on the trip where the emergency occurred, to accompany the Dependent Child during the evacuation and during the Dependent Child's return to his or her place of residence. If the Dependent Child was not accompanied by an adult Immediate Family Member on the trip where the emergency occurred, we will pay expenses described in the preceding paragraph, without regard to the expected duration on the hospitalization.

Repatriation of Remains

If the Covered Person dies as a result of a Covered Medical Emergency, or during a Medical Evacuation covered by this Policy, the following expenses will be covered:

1. Embalming;
2. Cremation in the locality where death occurred and urn for return ashes;
3. A container appropriate for transportation of remains;
4. Autopsy if required by law;
5. Expenses of securing documentation necessary for return of remains;
6. Transportation of the body or remains to the Covered Person's place of permanent residence.

Definitions

"Covered Medical Emergency" means an injury, illness or disease diagnosed by a Physician which causes severe or acute symptoms that, if not provided with immediate care or treatment, would reasonably be expected to result in serious deterioration of the Covered Person's health or place his life in jeopardy; and which first manifests itself suddenly and unexpectedly during the travel or other hazards covered by the Policy.

"Immediate Family Member" means a spouse, parent, child, step-parent, step-child, brother or sister, step-brother or step-sister, grandparent, or Domestic Partner.

"Travel Companion" means an individual, other than an Immediate Family Member, who accompanied the Covered Person on the trip where the emergency occurred.

"Friend" means a person chosen by the Covered Person, other than an Immediate Family Member who is able to visit the Covered Person.

Limitations

Covered Expenses are secondary to, and in excess of, any expenses for medical or transportation services paid or payable under any workers' compensation law.

No payment will be made for services without authorization of those services by Us or the express written approval of Our approved vendor.

If coverage for these services is provided under more than one policy issued by the Insurance Company, we will only provide or pay for these services under one such policy.

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Exclusions

The exclusions listed in the Policy's Common Exclusions section will not apply to Medical Evacuation and Repatriation Expenses, except for exclusions relating to war or acts of war, suicide or intentionally self-inflicted injury. In addition, the following exclusions apply specifically to this coverage:

1. Non-Emergency, routine or minor medical problems, tests and exams where there is no clear or significant risk of death or imminent serious Injury or harm to the Covered Person;
2. a condition which would allow for treatment at a future date convenient to the Covered Person and which does not require Emergency evacuation or repatriation;
3. expenses incurred if a purpose of the Covered Person's trip is to obtain medical treatment;
4. services provided for which no charge is normally made, in the absence of insurance;
5. transportation for the Covered Person's vehicle and/or other personal belongings;
6. Initial transport by ambulance following a Covered Medical Emergency occurring in the United States;
7. services incurred while serving in the armed forces of any country;
8. services required or obtained in any location which, due to war, insurrection, natural disaster or other reasons, is not reasonably accessible to our designated service provider, unless approved in advance by us;
9. claim payments that are illegal under applicable law;
10. expenses which are paid or payable under any workers' compensation law;
11. Medical care or services scheduled for your or your doctor's convenience which are not considered an emergency.

Except for the above this rider does not change the Policy or Certificate to which it is attached.

LIFE INSURANCE COMPANY OF NORTH AMERICA



Scott Berlin, President

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AMENDATORY RIDER

Subscriber: UAW/UMASS Health & Welfare Trust Fund

Policy No.: OK 972455 Effective Date: August 1, 2026

This Amendatory Rider is attached to and made part of the Policy specified above.

The Company and the Subscriber hereby agree that the Policy is amended to include the following provision:

The Insurance Company may provide, or arrange for third parties to provide, their Eligible Participants services that are related to the benefits provided by the Policy, including services that would help to mitigate losses for which claims are paid, or their effects on Eligible Participants. These programs may be extended, modified or terminated at our discretion. The Insurance Company will provide the Subscriber with detailed information regarding these services and notice of any changes to these services. Services are the responsibility of the service providers the Insurance Company has retained. Some services may include discounts on additional services for which a charge may be made. Participation and use of services is voluntary and does not affect benefits under the Policy.

These services include but are not limited to the following:

Post-Death Assistance

The Insurance Company will provide or will arrange for a third-party provider to make available the following assistance services to Eligible Participants:

1. Providing a library of information and step-by-step assistance for Eligible Participants to manage the affairs of a deceased person, including such activities as arranging a funeral; publishing an obituary; establishing an estate; closing accounts; marshaling home, other assets, and documents; receiving benefits; and payment of taxes.

2. Providing resources to assist with the management of grief and stress.

3. Providing an application to manage a personalized checklist and to store relevant documents.

The Insurance Company will provide the Subscriber with information to enable Eligible Participants to access the services.

The services do not include legal, financial or tax advice, and are not intended to replace the services of an attorney, financial or tax advisor where those professional services are required. The service can help assist the Eligible Participant in locating local professionals who can provide those services. The services are not a substitute for mental health care or professional grief counseling.

“Eligible Participants” mean the Employee or Spouse with respect to any deceased family member, or the Beneficiary with respect to an insured Employee, Spouse or Dependent Child.

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Employee Assistance Program

The Insurance Company has arranged for a third-party provider to provide access to an Employee Assistance Program (EAP) to Eligible Participants. This program includes confidential consultation and referral services for issues involving mental health, substance abuse, and other problems of daily living, by telephone, 24 hours a day, seven days a week. In an emergency, trained clinicians will be available to address the situation and make a referral to a local counselor or crisis intervention center.

Eligible Participants may receive up to three in-person or virtual visits per issue per calendar year. Fees for clinical services other than assessment, referral and clinical visits in excess of three visits per person per issue per year will be the Eligible Participant's responsibility.

"Eligible Participants" mean an insured Employee and their family members or beneficiaries

Financial Coaching Services

The Insurance Company will provide or will arrange for a third-party provider to make available a 30-day financial coaching program to Eligible Participants. This program will consist of (1) performing a financial needs analysis and creating a short-term plan to address the most severe financial needs; (2) working with the Eligible Participants to develop mid-term and longer-term financial goals; and (3) helping the Eligible Participants develop good money management habits. No financial products or services will be offered or sold to Eligible Participants in connection with this financial coaching program.

In addition, we will make available web-based educational resources, including resources to assist Eligible Participants with the preparation of wills and similar legal documents, and discounted tax preparation services by a third-party provider.

"Eligible Participants" mean an insured Employee and their household members or beneficiaries.

Except as provided above, this Rider does not amend the terms of the Policy.

LIFE INSURANCE COMPANY OF NORTH AMERICA



Scott Berlin, President

GA-010091

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Life Insurance Company of North America
1601 Chestnut Street
Philadelphia, Pennsylvania 19192-2235

MODIFYING PROVISIONS AMENDMENT

Subscriber: UAW/UMASS Health & Welfare Trust Fund Policy No.: OK 972455

Amendment Effective Date: August 1, 2026

This amendment is attached to and made part of the Policy specified above and the Certificates issued under it. Its provisions are intended to conform this Policy to the laws of the state in which the insured resides.

The Policy and any Certificates delivered under the Group Policy are amended as follows:

Arkansas residents:

1. Under the *General Definitions* section, the definition of Covered Accident does not include reference to an "external" event.

Connecticut residents:

1. The following benefit is added to the *Schedule of Benefits* section:

AMBULANCE BENEFIT	
Basic Benefit	Equal to the lesser of billed charges or rate established by the CT Dept. of Public Health

2. In the *General Definitions* section the definition of Hospital and Totally Disabled are replaced with the following:

Hospital

An institution that meets all of the following:
1. it is licensed as a Hospital pursuant to applicable law;
2. it is primarily and continuously engaged in providing medical care and treatment to sick and injured persons;
3. it is managed under the supervision of a staff of medical doctors;
4. it provides 24-hour nursing services by or under the supervision of a graduate registered nurse (R.N.);
5. it has medical, diagnostic and treatment facilities, with major surgical facilities on its premises, or available on a prearranged basis;
6. it charges for its services.

Hospital shall include a Veteran's Administration Hospital or Federal Government Hospital and the requirement that a patient must incur an expense as an Inpatient shall be waived.

The term Hospital does not include a clinic, facility, or unit of a Hospital for:
1. rehabilitation, convalescent, custodial, educational or nursing care;
2. the aged, drug addicts or alcoholics;
3. a Veteran's Administration Hospital or Federal Government Hospital unless the Covered Person incurs an expense.

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Totally Disabled or Total Disability Totally Disabled or Total Disability means either:

1. inability of the Covered Person who is currently employed to do any type of work for which he is or may become qualified by reason of education, training or experience; or
2. inability of the Covered Person who is not currently employed to perform the normal activities of a person of like age and sex and who is under the regular care of a Physician who certifies that such person is Totally Disabled.

3. In the *Eligibility and Effective Date Provisions*, the Eligibility section is replaced with the following:

Eligibility
An Employee becomes eligible for insurance under this Policy on the date he meets all of the requirements of one of the Covered Classes and completes any Eligibility Waiting Period, as shown in the *Schedule of Benefits.* No person may be eligible for insurance under this Policy as both an Employee and a Spouse or Dependent Child at the same time. However, this limitation will not apply when the Employee and the Spouse are employed by the same Employer and by reason to their employment are both participating in a group insurance plan.

4. In the *General Provisions* section, the following provision is replaced:

Incontestability
1. Of This Policy or Participation Under This Policy
All statements made by the Subscriber to participate under this Policy are considered representations and not warranties. No statement will be used to deny or reduce benefits or be used as a defense to a claim, or to deny the validity of this Policy or of participation under this Policy unless a copy of the instrument containing the statement is, or has been, furnished to the Subscriber.

After two years from the Policy Effective Date, no such statement will cause this Policy to be contested.

2. Of A Covered Person's Insurance
All statements made by a Covered Person are considered representations and not warranties. No statement will be used to deny or reduce benefits or be used as a defense to a claim, unless a copy of the instrument containing the statement is, or has been, furnished to the claimant.

After two years from the Covered Person’s effective date of insurance, or from the effective date of increased benefits, no such statement will cause insurance or the increased benefits to be contested except for lack of eligibility for insurance.

In the event of death or incapacity, the beneficiary or representative shall be given a copy.

5. The following benefit is added to the *Description of Benefits* section:

AMBULANCE BENEFIT
We will pay the benefit shown in the *Schedule of Benefits*, subject to the following conditions and exclusions, if the Covered Person requires ambulance services due to a Covered Injury resulting directly and independently of all other causes from a Covered Accident.

The Covered Person must be transported by ambulance to a Hospital and admitted as an inpatient Any payment will be paid directly to the ambulance provider rendering such service if such provider has not received payment for such service from any other source and includes the following statement on the face of each bill: "NOTICE: This bill subject to mandatory assignment pursuant to Connecticut general statutes."

In the event any Covered Person is covered under more than one policy, the Hospital Policy will be primary and pay benefits.

Exclusions The exclusions that apply to this benefit are in the *Common Exclusions* Section.

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6. The following Conversion Privilege section applies:

   Conversion Privilege

   1. If the Covered Person's insurance or any portion of it ends for a reason other than non-payment of premium, the Covered Person's Age or those reasons described in Paragraph 2 below, the Covered Person may have Us issue converted accident insurance on an individual policy or an individual certificate under a designated group policy. The Covered Person may not apply for an amount greater than his coverage under this Group Policy less the amount of any other group accident insurance for which he becomes eligible within 31 days after the date coverage under this Group Policy terminated. The policy or certificate will not contain disability or other additional benefits. The Covered Person need not show Us that he is insurable.

      The Covered Person must apply for the individual policy within 31 days after his coverage under this Group Policy ends and pay the required premium, based on Our table of rates for such policies, his Age and class of risk.

      The individual policy or certificate will take effect on the day following the date coverage under the Group Policy ended. If the Covered Person dies during this 31-day period as the result of an accident that would have been covered under this Group Policy, We will pay as a claim under this Group Policy the amount of insurance that the Covered Person was entitled to convert. It does not matter whether the Covered Person applied for the individual policy or certificate. If such policy or certificate is issued, it will be in exchange for any other benefits under this Group Policy.

   2. If the Covered Person's insurance ends because this Group Policy is terminated or is amended to terminate insurance for the Covered Person's class, and he has been covered under this Group Policy for at least five years, the Covered Person may have Us issue an individual policy or certificate of accident insurance subject to the same terms, conditions and limitations listed above. However, the amount he may apply for will be limited to the lesser of the following:
      a. coverage under this Group Policy less any amount of group accident insurance for which he is eligible on the date this Group Policy is terminated or for which he became eligible within 31 days of such termination, or
      b. $10,000.

Massachusetts residents:

Under the *Eligibility and Effective Date Provisions* section, the following is added:

Continuation of Insurance after leaving the group
If a Covered Person leaves the group covered under the Policy, insurance for such Covered Person will be continued until the earliest of the following dates:
1. 31 days from the date the Covered Person leaves the group;
2. the date the Covered Person becomes eligible for similar benefits.

Continuation of Insurance due to a Plant Closing or Partial Closing
If an Employee leaves the group due to termination of employment resulting from a Plant Closing or Partial Closing, insurance for such Employee will be continued until the earliest of the following dates:
1. 90 days from the date of the Plant Closing or Partial Closing;
2. the date the Employee becomes eligible for similar benefits.

Definitions: For purposes of this provision:

Plant Closing means a permanent cessation or reduction of business at a facility which results or will result as determined by the director in the permanent separation of at least 90% of the employees of said facility within a period of six months prior to the date of certification or with such other period as the director shall prescribe, provided that such period shall fall within the six month period prior to the date of certification.

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Partial Closing means a permanent cessation of a major discrete portion of the business conducted at a facility which results in the termination of a significant number of the employees of said facility and which affects workers and communities in a manner similar to that of Plant Closings.

Missouri residents:

1. Under the *General Definitions* section, the definition of Covered Accident does not include reference to an "external" event.

2. Under the *General Definitions* section, the definition of *Totally Disabled or Total Disability* means either:
   a) the inability of the Covered Person who is currently employed to perform the material and substantial duties of the Covered Person's occupation for a period of at least twelve months. After the initial benefit period, total disability shall mean the Covered Person's inability to perform the material and substantial duties of any occupation for which the Covered Person is qualified by education, training or experience; or
   b) the inability of the Covered Person who is not currently employed to perform all of the activities of daily living including eating, transferring, dressing, toileting, bathing, and continence, without human supervision or assistance.

Montana residents:

Under the *General Definitions* section, the definition of *Sickness* is replaced with the following:

Sickness A physical or mental illness including pregnancy

New Hampshire residents:

1. Under the *General Definitions* section, the definition of Covered Accident does not include reference to an "external" event.

2. If applicable, the definition of Emergency Room Treatment is replaced with the following:

Emergency Room Treatment Emergency medical services and care given in a Hospital as an out or inpatient, for a sudden, unexpected onset of a medical condition that manifests itself by symptoms of sufficient severity that in the absence of immediate medical attention could be expected to result in any of the following:
1. serious jeopardy to the covered Employee's health;
2. serious impairment to bodily functions; or
3. serious dysfunction of any bodily organ or part.

3. The definition of Hospital is replaced with the following.

Hospital An institution that meets all of the following:
1. it is operated pursuant to applicable law;
2. it is primarily and continuously engaged in providing medical care and treatment to sick and injured persons;
3. it is managed under the supervision of a staff of medical doctors;
4. it provides 24-hour nursing services by or under the supervision of a graduate registered nurse (R.N.);
5. it has medical, diagnostic and treatment facilities, with major surgical facilities on its premises, or available on a prearranged basis;
6. it charges for its services.

Hospital shall include a Veteran's Administration Hospital or Federal Government Hospital and the requirement that a patient must incur an expense as an Inpatient shall be waived.

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The term Hospital does not include a clinic, facility, or unit of a Hospital for:
1. rehabilitation, convalescent, custodial, educational or nursing care;
2. the aged, drug addicts or alcoholics;
3. a Veteran's Administration Hospital or Federal Government Hospitals unless the Covered Person incurs an expense.

South Carolina residents:

1. Under the *General Definitions* section, the definition of Covered Accident does not include reference to an "external" event.

2. Under the *Claim Provisions,* the following changes are made.
   - The *Claimant Cooperation Provision* does not apply.
   - The provision titled *Physical Examination and Autopsy* is replaced with the following:
     Physical Examination and Autopsy
     We, at Our own expense, have the right and opportunity to examine the Covered Person when and as often as We may reasonably require while a claim is pending. If an autopsy is performed, it will be in the State of South Carolina and during the period of contestability unless prohibited by law.
   - The provision titled *Legal Actions* is replaced with the following:
     Legal Actions
     No action at law or in equity may be brought to recover under this Policy less than 60 days after written or authorized electronic proof of loss has been furnished as required by this Policy. No such action will be brought more than six years after the time such written proof of loss must be furnished.

3. Under the *General Provisions,* the following changes are made.
   The *Multiple Certificates* provision does not apply.

South Dakota residents:

Under the *Common Exclusions* section, the following changes are not permitted:
1. the Covered Person being legally intoxicated as determined according to the laws of the jurisdiction in which the Covered Accident occurred;
2. the Covered Person being Intoxicated. "Intoxicated" means having a blood alcohol level of .08 or higher;
3. the Covered Person operating a motorized vehicle while under the influence of alcohol or drugs as defined according to the laws of the jurisdiction in which the Accident occurred;
4. voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a Physician and taken in accordance with the prescribed dosage;
5. occupational injuries for which benefits are not paid under the Workers' Compensation Law or any similar law;
6. operating any type of vehicle while under the influence of alcohol or any drug , narcotic or other intoxicant including any prescribed drug for which the Covered Person has been provided a written warning against operating a vehicle while taking it. Under the influence of alcohol, for purposes of this exclusion, means intoxicated, as defined by the law of the state in which the Covered Accident occurred;
7. the Covered Person was driving a Private Passenger Automobile at the time of the Covered Accident that resulted in the Covered Loss; and he was intoxicated, as that term is defined by the laws of the state in which the Covered Accident occurred.

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Vermont residents:

To the extent the Policy provides insurance coverage to a spouse, the identical consideration must be applied to same sex marriages and civil unions. The language is as follows:

1. Civil Union Partner means:
   a. A person with whom the Employee has a registered civil union under Vermont law which imposes obligations on the parties substantially similar to marriage. Such person will continue to be recognized as a Civil Union Partner unless and until: (1) the civil union is dissolved under applicable law; or (2) either the Employee or the Civil Union Partner marries another person.

2. Spouse means:
   a. "Lawful spouse" and includes a lawful spouse of the same sex.
   b. This also includes a partner to a civil union recognized under Vermont Law.

West Virginia residents:

1. Under the *General Definitions* section, the definition of Covered Accident does not include reference to an "external" event.

2. Under the *General Definitions* section, the definition of Hospital does not require that an institution be licensed as a Hospital pursuant to applicable law, but does require that an institution operate pursuant to applicable law.

3. Under the *General Definitions* section, the definition of Totally Disabled or Total Disability id replaced with the following:

   Totally Disabled or Total Disability
   Totally Disabled or Total Disability means either:
   1. inability of the Covered Person who is currently employed to perform substantially all of the material duties of his job, or any other job for which he is or may become qualified by reason of education, training or experience; or
   2. inability of the Covered Person who is not currently employed to perform all of the activities of daily living including eating, transferring, dressing, toileting, bathing, and continence, without human supervision or assistance.

Washington residents:

1. Under the ***Schedule of Benefits,*** the following changes apply:

   - The ***Time Period for Loss*** must be at least 365 days.
   - Aggregate limits are not permitted.

2. Under **Common Exclusions,** the following changes apply:

   - Terrorism exclusions are not permitted.

   - The Common Exclusion for sickness, disease, bodily or mental infirmity and other disease or illness is replaced by the following:

     Sickness, disease, bodily or mental infirmity, bacterial or viral infection or medical or surgical treatment thereof, except for any bacterial infection resulting from an accidental cut or wound or accidental ingestion of contaminated food.

   - Any exclusion regarding travel or activity outside the United States or Canada is not permitted.

3. Terrorism Coverage is not permitted.

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4. War Risk coverage is not permitted.

5. Under the *General Definitions* section, the eligibility requirements for **Dependent Child** are replaced with the following:

    1. A child from live birth to 25 years old;
    2. A child who is 25 or more years old but less than 26 years old
    3. A child who is 25 or more years old, primarily supported by the Employee, Member and incapable of self-sustaining employment by reason of mental or physical handicap. Proof of the child's condition and dependence must be submitted to Us within 31 day after the date the child ceases to qualify as a Dependent Child for the reasons listed above. During the next two years, We may, from time to time, require proof of the continuation of such condition and dependence. After that, We may require proof no more than once a year.

Signed for the
Life Insurance Company of North America



Scott Berlin, President

GA-00-3000.00b

Docusign Envelope ID: DC139014-2CD2-883F-8285-09EC3EC75267

RECEIPT ACKNOWLEDGEMENT FORM
LIFE INSURANCE COMPANY OF NORTH AMERICA
Philadelphia, PA 19192-2235

We, UAW/UMASS Health & Welfare Trust Fund, whose main office address is Amherst, MA, hereby approve and accept the terms of Group Policy Number OK 972455 issued by the LIFE INSURANCE COMPANY OF NORTH AMERICA to the TRUSTEE OF THE GROUP INSURANCE TRUST FOR EMPLOYERS IN THE FINANCE, INSURANCE AND REAL ESTATE INDUSTRY. We acknowledge that benefits will be provided in accordance with the terms and provisions of the policy, which will be the sole contract under which benefits are paid.

This application is to be signed.

Sign: DocuSigned by: Leslie Edwards Davis 35FD572DE03C443... 8/4/2026

Title: Director of Benefit Programs

UAW/UMASS Health & Welfare Trust Fund



Group Dental Summary
Plan Description

Altus Dental Point of Service Option
Class 1 & Class 2

THE PLAN	**UAW/UMASS HEALTH & WELFARE TRUST FUND-POSTDOC & GEO**
Policy Number	**3001-0001 & 0002**
State of Delivery	**Massachusetts**
Plan Effective Date	**September 1, 2022**
Renewal Date	**August 1**

Effective Date: September 1, 2022
Date of Issue: August 1, 2026

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Altus Dental Insurance Company, Inc.

Certificate of Coverage

Altus Dental Point of Service Plan

Welcome to Altus Dental. This *Certificate* is a means through which *we* at Altus Dental Insurance Company, Inc. in consideration of the application for benefits and payment of applicable fees agree to provide benefits.

This *Certificate*, along with the *Benefits Summary* describes the *Plan*. It describes the dental services covered by *your Plan.* It also explains how each is paid for and tells *you* how to use the *Plan.* If *you* have any questions, please contact Customer Service.

Our **toll free Customer Service number is:**

1-877-223-0588

Customer Service representatives are available Monday – Friday from 8 a.m. to 5 p.m. ET. *Our* automated information line is available 24 hours a day, seven days a week. *You* may also contact *us* on the Internet at **www.altusdental.com.**

Claims and written correspondence should be sent to:

Altus Dental Insurance Company, Inc.
P.O. Box 1557
Providence, R.I. 02901-1557

NOTICE OF NONDISCRIMINATION AND ACCESSIBILITY POLICY

Altus Dental Insurance Co. does not discriminate on the basis of race, color, national origin, age, disability, or sex.

We provide appropriate, free, and timely aids and services, including qualified interpreters, for individuals and information in alternate formats, when such aids and services are necessary to ensure an equal opportunity to participate to individuals with disabilities.

We provide language assistance services, including translated documents and oral interpretation, free of charge and in a timely manner when such services are necessary to provide meaningful access to individuals with limited English proficiency.

If *you* need these services, contact *us* at 1-877-223-0588.

If *you* believe *we* have failed to provide these services or discriminated on the basis of race, color, national origin, disability, or sex, *you* can file a grievance with: Civil Rights Coordinator, Altus Dental Insurance Co., 10 Charles Street, Providence, RI 02904, or by calling 1-877-223-0588. *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 DC 20201; 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-223-0588.

Português (Portuguese): ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-877-223-0588.

繁體中文 (Chinese): 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-223-0588.

Kreyòl Ayisyen (French Creole): ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-877-223-0588.

ែ (Cambodian): ុបយ័ៈ េបើសិន អ កនិ យ ែ, េស ជំនួយែ ក
េយមិនគិតឈ លៃ
គឺ ជ នសំ ក។ ចូរ ទូរស័ព 1-877-223-0588
ប់បំេអ

Français (French): ATTENTION : Si vous parlez français, des services d'aidelinguistique vous sont proposés gratuitement. Appelez le 1-877-223-0588.

Italiano (Italian): ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-877-223-0588.

ພາສາລາວ (Lao): ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-877-223-0588.

ية (Arabic):

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-877-223-0588 (رقم هاتف الصم والبكم: 1-877-223-0588).

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-223-0588.

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-223-0588.

Ɓàsɔ́ɔ̀-wùɖù-po-nyɔ̀ (Bassa): Dè ɖɛ nìà kɛ dyéɖé gbo: Ɔ jǔ ké m̀[Ɓàsɔ́ɔ̀-wùɖù-po-nyɔ̀] jǔ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀ ɓɛ́ìn m̀gbo kpáa. Đá 1-877-223-0588.

Igbo asusu (Ibo): Ige nti: O buru na asu Ibo asusu, enyemaka diri gi site na call 1-877-223-0588.

èdè Yorùbá (Yoruba): AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi 1-877-223-0588.

Polski (Polish): UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-223-0588.

한국어 (Korean): 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-223-0588 번으로 전화해 주십시오.

Tagalog (Tagalog – Filipino): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-223-0588.

हिंदी (Hindi): ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-877-223-0588 पर कॉल करें।

ગુજરાતી (Gujarati): સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-877-223-0588.

λληνικά (Greek): ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-877-223-0588.

SCHEDULE OF BENEFITS
OUTLINE OF COVERAGE

The Insurance for each Insured and each Insured Dependent will be based on the Insured's class shown in this Schedule of Benefits.

Benefit Class	Class Description
Class 1	Post Doctoral Researcher
Class 2	Graduate Employee

Class Number 1-Post Doctoral Researcher

DENTAL EXPENSE BENEFITS

When you select a Participating Provider, a discounted fee schedule is used which is intended to provide you, the Insured, reduced out of pocket costs.

Deductible Amount:
In Network Deductible: $0

Out of Network Deductible: $0 Type 1 & Type 4
$75 Individual/$225 Family Type 2 & Type 3

On the date that three members of one family have satisfied their own Deductible Amounts for that Benefit Period, no Covered Expenses incurred after that date by any other family member will be applied toward the satisfaction of any Deductible Amount for the rest of that Benefit Period. No Covered Expense that was incurred prior to such date, which was used to satisfy any part of a Deductible Amount, will be eligible for reimbursement.

Coinsurance Percentage:	Participating Provider	Non-Participating Provider
Type 1 Procedures*	100%	100%
Type 2 Procedures**	80%	80%
Type 3 Procedures	65%	65%
Type 4 Procedures	65%	65%
Policy Year Maximum		$2,350*+

*Type 1 Procedures do not count toward the Maximum Benefit.
**Fillings are covered at 90%.
+Benefits for Temporomandibular Joint Dysfunction may not exceed $500 per Lifetime.

ORTHODONTIC EXPENSE BENEFITS

Deductible Amount - Once per lifetime	$0
Coinsurance Percentage	50%

Maximum Benefit During Lifetime	$1,500

Class Number 2-Graduate Employee

DENTAL EXPENSE BENEFITS

When you select a Participating Provider, a discounted fee schedule is used which is intended to provide you, the Insured, reduced out of pocket costs.

Deductible Amount:

In Network Deductible: $0

Out of Network Deductible: $0 Type 1 & Type 4
$75 Individual/$225 Family Type 2 & Type 3

On the date that three members of one family have satisfied their own Deductible Amounts for that Benefit Period, no Covered Expenses incurred after that date by any other family member will be applied toward the satisfaction of any Deductible Amount for the rest of that Benefit Period. No Covered Expense that was incurred prior to such date, which was used to satisfy any part of a Deductible Amount, will be eligible for reimbursement.

Coinsurance Percentage:	Participating Provider	Non-Participating Provider
Type 1 Procedures*	100%	100%
Type 2 Procedures**	80%	80%
Type 3 Procedures	65%	65%
Type 4 Procedures	65%	65%
Policy Year Maximum		$2,350*+

*Type 1 Procedures do not count toward the Maximum Benefit.
**Fillings are covered at 90%.
+Benefits for Temporomandibular Joint Dysfunction may not exceed $500 per Lifetime.

ORTHODONTIC EXPENSE BENEFITS

Deductible Amount - Once per lifetime	$0
Coinsurance Percentage	50%
Maximum Benefit During Lifetime	$1,500

PREMIUMS

TABLE OF MONTHLY PREMIUM WORKING RATES

Classes 01 & 02

Dental	$37.38 Subscriber
	$76.20 Subscriber + 1
	$127.88 Family

COBRA 3001-0003 (Classes 01 & 02)

Dental	$37.38 Subscriber
	$76.20 Subscriber + 1
	$127.88 Family

DEFINITIONS

This document contains words used in insurance and dentistry. These words have specific meanings that are described below. Insurance or dental terms used in this document will be in *italics.* If *you* are not clear about the meaning of the words used, please refer back to this page.

- *Adverse Benefit Decision* means a decision by Altus Dental not to pay (in whole or in part) for a *covered service*, including a denial; reduction; termination; or, failure to make a payment based on the imposition of a pre-existing condition exclusion; a source of injury exclusion; retroactive rescission of coverage; or, other limitation on *covered services.*
- *Allowance* means the amount *we* base payment on for a *covered service* or procedure.

  The *Allowance* for an *In-Network Dentist* is the LOWEST of the:
  a) Amount the *in-network dentist* has agreed to accept by contract as payment in full for the service;
  b) Maximum amount *we* will pay any *dentist* for a *covered service* or procedure; or

c) Amount charged by the *dentist*.

In-network dentists cannot charge Altus Dental *members* more than their *allowance.*

The *Allowance* for an *Out-of-Network Dentist* is the LOWEST of the:

a) Usual charge by the *dentist* for the same or similar services or supplies;

b) Average amount *we* determine that most other *dentists* in the same geographic area charge for the same or similar services or supplies; or

c) Actual charge for the services or supplies.

- *Annual Maximum* means the most *we* will pay for *covered services* for a continuous 12-month period (usually a calendar year). The *annual maximum* is stated in the *Benefits Summary.*
- *Benefits Summary* is a summary description of the services covered under this dental Policy; with a schedule that shows *you* how much *we* pay toward a procedure. If a service is not listed in the *Benefits Summary, we* will not pay for it.
- *Certificate* means this document and the applicable *Benefits Summary* pages, including any rider pages. This *Certificate* is *your* policy.
- *Coinsurance/Copayment* means the amount *you* pay for *covered services*, after the *deductible*, if any, is met. *Coinsurance* is usually shown as a percentage and *copayment* as a fixed dollar amount. The amount of *coinsurance/copayment* varies with the type of *covered services.*
- *Coverage Level* means the amount *we* pay for *covered services,* after the *deductible* and/or *copayment,* if any, is met. The *coverage level* varies with the type of *covered services* and is shown in the *Benefits Summary*.
- *Covered Services* means those services and procedures listed in the *Benefits Summary.* All *covered services* must be *dentally necessary* and appropriate to qualify for payment.
- *Date of Service* means the date that the service was done. For services requiring more than one visit, except *orthodontics*, the *Date of Service* is the final completion date (Examples: the insertion date of a denture; the date a permanent crown is cemented).
- *Deductible* (if applicable) means the amount *you* pay toward *covered services* before *we* begin paying benefits. *Deductibles* must be met each *year. Deductibles* may vary by type of benefits or by type of provider (in-network vs. out-of-network) and are specific dollar amounts for each *subscriber* and/or *dependent* per *year.*
- *Dentally Necessary (Dental Necessity)* means that the dental services provided are:
  - appropriate, in terms of type, amount, frequency, level, setting and duration to the *member's* diagnosis or condition;
  - consistent with the symptoms and appropriate and effective for the diagnosis, treatment, or care of the oral condition, disease, or injury for which it is prescribed or performed;

- appropriate with regard to generally accepted standards of dental practice within the dental community or scientific evidence related thereto; AND
- the most appropriate level of service which can safely be provided to the *member.*

We will make a determination whether a service is *dentally necessary* based on the criteria set forth in the utilization review plan and guidelines ("review guidelines") that *we* file with the Rhode Island Office of the Health Insurance Commissioner. A copy of these review guidelines is available on *our* website at: www.altusdental.com. *You* have the right to appeal *our* determination or to take legal action as described in the **Claims Procedures** section of this *Certificate*.

- *Dentist* means any person duly licensed as a Doctor of Dental Medicine (DMD) or Doctor of Dental Surgery (DDS) practicing within the authority of his or her license. The term *dentist* includes an oral surgeon.

- *Dependent* refers to:

a. an Insured's spouse or Domestic Partner.

b. each unmarried child less than 26 years of age, for whom the Insured, the Insured's spouse, or the Insured's Domestic Partner is legally responsible, including natural born children, adopted children from the date of placement for adoption, and children covered under a Qualified Medical Child Support Order as defined by applicable Federal and State laws.

c. each unmarried child age 26 or older who is Totally Disabled and becomes Totally Disabled as defined below while insured as a dependent under b. above. Coverage of such child will not cease if proof of dependency and disability is given within 31 days of attaining the limiting age and subsequently as may be required by us but not more frequently than annually after the initial two-year period following the child's attaining the limiting age. Any costs for providing continuing proof will be at our expense.

- *Total Disability* describes the Insured's Dependent as:

1. Continuously incapable of self-sustaining employment because of mental retardation or physical handicap; and

2. Chiefly dependent upon the Insured for support and maintenance.

- *Dependent Unit* refers to all of the people who are insured as the dependents of

any one Insured.

- *Effective Date* means the date, as shown on *our* records, that *your* coverage begins under this contract or an amendment to it.
- *Emergency Care* means services given to treat a person with a serious medical or health problem. A medical problem includes physical, mental, and dental conditions. *Emergency care* is limited to services which are palliative (to relieve pain) and/or temporary and does not include services such as permanent fillings, crowns or root canals.
- *Endodontics* means a specialty of dentistry that deals with treatment of dental pulp diseases (nerves, blood vessels and other tissues within the tooth). A root canal is an example of *endodontic* treatment.
- *Hygienist* means any person duly licensed as a dental *hygienist* practicing within the authority of his or her license.
- *In-Network Dentist (or Network Dentist) (or Participating Dentist)* means a *dentist* who participates in the *network* available under *your Plan* and has a contractual agreement to accept the *allowance* as payment in full for *covered services.*
- *Late Entrant* refers to any person:
    - whose Effective Date of insurance is more than 31 days from the date the person becomes eligible for insurance; or
    - who has elected to become insured again after canceling a premium contribution agreement.
- *Lifetime Maximum* means the maximum amount of dollars *we* will allow for *covered services* during a *subscriber's* or *dependent's* lifetime. This provision usually applies only to *orthodontic* services and implants if covered by *your plan.*
- *Material Change* means a modification to any of Altus Dental's procedures or documents required by Massachusetts regulation 211 CMR 52.00 that substantially affects the rights or responsibilities of an insured, carrier or health care provider.
- *Member* means a *Subscriber* or *Dependent*.
- *Network* means a group or groups of *participating dentists* providing dental services under this *Plan* who have agreed to accept the *allowance* as payment in full for *covered services.*
- *Non-participating Dentist* – see "out-of-network dentist."
- *Orthodontics* means a specialty of dentistry concerned with prevention and correction of abnormalities in tooth position and their relationship to the jaw (straightening of teeth).
- *Out-of-Network Dentist (or Non-participating Dentist)* means a *dentist* who does not participate in the *network* available under *your Plan* and has not entered into a

contractual agreement to accept the *allowance* as payment in full for *covered services*.

- *Participating Dentist* – see “in-network dentist.”
- *Pedodontics* means a specialty of dentistry concerned with the treatment of children.
- *Periodontics* means a specialty of dentistry concerned with diseases of the gums and other supportive structures of the teeth.
- *Plan* means the terms, conditions and benefits described in this *Certificate* and applicable *Benefits Summary* pages, including any rider pages.
- *Plan Sponsor* means *your* employer or other organization / association that is sponsoring the *Plan.* In the case of a group subject to the Employee Retirement Income Security Act of 1974 (ERISA), as amended, the *Plan Sponsor* is the individual or entity designated under that Act.
- *Policy Year* means the continuous 12-month period under which coverage is offered by *your plan sponsor. Your policy year* is either the calendar year or the timeframe beginning with *your* group’s coverage start date and ending 12 months later.
- *Prosthodontics* means a specialty of dentistry concerned with the replacement of missing teeth by bridges and dentures.
- *Spouse* means *your* legal *spouse.* A *spouse* includes a party to a domestic partner, same sex marriage; civil union; or, similar union entered into under applicable state laws.
- *Subscriber* means someone who has applied for coverage and been approved by *us* and is eligible to receive benefits under this *Certificate*. In the case of a *subscriber* who is less than 18 years of age, the parent or legal guardian must contract on behalf of the dependent child for the benefits described in this *Certificate.* The parent or legal guardian must assure the dependent child’s compliance with any and all terms and conditions outlined in the policy.
- *Usual and Customary Charge* means that charge which is the lowest of: the usual charge by the *dentist* for the same or similar services or supplies; or the average amount *we* determine that most other *dentists* in the same geographic area charge for the same or similar services or supplies; or the actual charge for the services or supplies.
- *Waiting Period* is the amount of time *you* must wait from *your effective date* before a service is covered. If *your plan* has a *waiting period,* it will be shown in the *Benefits Summary* that goes with this *Certificate.*
- *We, Our, Us* and *Altus Dental* means *Altus Dental Insurance Company, Inc.* located at 10 Charles Street, Providence, RI 02904-2208.
- *You* and *Your* means the *subscriber or member covered under this Certificate*.

Conditions For Insurance Coverage

Eligible Class For Members. The members of the eligible class(es) are shown on the Schedule of Benefits. Each member of the eligible class (referred to as "Member") will qualify for such insurance on the day he or she completes the required eligibility period, if any. Members choosing to elect coverage will hereinafter be referred to as “Insured.”

If employment is the basis for membership, a member of the Eligible Class for Insurance is any graduate employee working at least 20 hours per week. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

Eligible Class For Dependent Insurance**. Eac**h Member of the eligible class(es) for dependent coverage is eligible for the Dependent Insurance under the policy and will qualify for this

Dependent Insurance on the latest of:

1. the day he or she qualifies for coverage as a Member;
2. the day he or she first becomes a Member; or
3. the day he or she first has a dependent. For dependent children, a newborn child will be considered an eligible dependent upon reaching their 2nd birthday. The child may be added at birth or within 31 days of the 2nd birthday.

A Member must be an Insured to also insure his or her dependents.

If employment is the basis for membership, a member of the Eligible Class for Dependent Insurance is any graduate employee working at least 20 hours per week and has eligible dependents. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

When a member of the Eligible Class for Dependent Insurance dies and, if at the date of death, has dependents insured, the Policyholder has the option of offering the dependents of the deceased employee continued coverage. If elected by the Policyholder and the affected dependents, the name of such deceased member will continue to be listed as a member of the Eligible Class for Dependent Insurance.

Contribution Requirements**.** Member Insurance: An Insured is not required to contribute to the payment of his or her insurance premiums. An insured may or may

not be required to contribute to the payment of insurance premiums if he or she is both covered under this policy and also covered under another plan.

Dependent Insurance: An Insured is required to contribute to the payment of insurance premiums for his or her dependents.

***Eligibility Period*.** For Members on the Plan Effective Date of the policy, qualification will occur after an eligibility period defined by the Policyholder is satisfied. The same eligibility period will be applied to all members.

For persons who become Members after the Plan Effective Date of the policy, qualification will occur after an eligibility period defined by the Policyholder is satisfied. The same eligibility period will be applied to all members.

XtraLineSpacFix

If employment is the basis for membership in the Eligible Class for Members, an Insured whose eligibility terminates and is established again, may or may not have to complete a new eligibility period before he or she can again qualify for insurance.

***Effective Date*.** Each Member has the option of being insured and insuring his or her Dependents. To elect coverage, he or she must agree in writing to contribute to the payment of the insurance premiums. The Effective Date for each Member and his or her Dependents, will be:

1. the date on which the Member qualifies for insurance, if the Member agrees to contribute on or before that date.

2. the date on which the Member agrees to contribute, if that date is within 31 days after the date he or she qualifies for insurance.

3. the date we accept the Member and/or Dependent for insurance when the Member and/or Dependent is a Late Entrant. The Member and/or Dependent will be subject to any limitation concerning Late Entrants.

How You Join

You join by enrolling online at www.uawumasstrustfund.org through the Enrollment Portal. If your family status changes and you need to add or remove dependents from your plan, contact us or your plan sponsor. We can only accept membership changes from a Subscriber or your plan sponsor.

When Coverage Begins

Coverage generally starts the first of the month after the plan sponsor enrolls you on the portal.

Class 01—You must wait until *your plan sponsor's* next open enrollment period, if *you* or *your dependent(s)* do not enroll when first eligible. *You* may also enroll when there is a qualifying event or subsequent open enrollment period.

Class 02—You must wait until *your plan sponsor's* next open enrollment period, if *you* or *your dependent(s)* do not enroll when first eligible. *You* may also enroll when there is a qualifying event or subsequent open enrollment period.

If *you* marry, *you* may enroll *your spouse* within 60 days of marriage. *You* must wait until *your plan sponsor's* next open enrollment period if *your spouse* does not enroll when first eligible. *Your spouse* may also enroll when there is a qualifying event.

If *you* have family coverage, *your* newborn infant and the newborn infant of a *dependent* child are covered from birth. Adopted children are covered from the date of home placement. Foster children are covered from the date of the petition to adopt. Stepchildren and children are considered dependent children if they: are under *your* own or *your spouse's* legal custody; permanently live in *your* household; and, chiefly depend on *you* for support. *We* do not consider married children *dependents,* regardless of their age.

Coverage generally begins on the first of the month after *we* accept *your* enrollment form. If *you* don't enroll within 60 days, *you* must wait until the next open enrollment period to enroll *dependents. Dependents* may enroll when there is a qualifying event or when the plan sponsor determines eligibility.

Notify *us* and *your plan sponsor* of any changes in *your* or *your dependent's* status. This includes marriage; births; attainment of the *dependent* or student (if applicable) age limits; or, changes in *your* address. This will help us maintain up to date eligibility and billing records.

***Exceptions*.** If employment is the basis for membership, a Member must be in active service on the date the insurance, or any increase in insurance, is to take effect. If not, the insurance will not take effect until the day he or she returns to active service. Active service refers to the performance in the customary manner by an employee of all the regular duties of his or her employment with his or her employer on a full time basis at one of the employer's business establishments or at some location to which the employer's business requires the employee to travel.

A Member will be in active service on any regular non-working day if he or she is not

totally disabled on that day and if he or she was in active service on the regular working day before that day.

If membership is by reason other than employment, a Member must not be totally disabled on the date the insurance, or any increase in insurance, is to take effect. The insurance will not take effect until the day after he or she ceases to be totally disabled.

Termination Dates

Insureds. The insurance for any Insured, will automatically terminate on the **earliest of:**

1. the date the Insured ceases to be a Member;
2. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
3. the date the policy is terminated.

Dependents. The insurance for all of an Insured's dependents will automatically terminate on the **earliest of:**

1. the date on which the Insured's coverage terminates;
2. the date on which the Insured ceases to be a Member;
3. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
4. the date all Dependent Insurance under the policy is terminated.

The insurance for any Dependent will automatically terminate on the day before the date on which the dependent no longer meets the definition of a dependent. See "Definitions."

Continuation Coverage. If coverage ceases according to TERMINATION DATE, some or all of the insurance coverages may be continued. Contact your plan administrator for details.

An employee or dependent whose insurance has stopped may be able to continue some or all of the insurance coverages. The sections below explain when and how insurance may be continued. If insurance is continued, it must be according to a plan which does not allow individual selection.

Thirty-One Day Continuation of Coverage in accordance with M.G.L. c.175, s. 110D

If an employee leaves his/her job for any reason (quit, terminated, laid off, plant closing, etc.) or if a child ceases to be a dependent under this policy, group coverages provided under this policy will be extended for 31 days in accordance with Massachusetts Law, chapter 175, section 110D. The employer/employee contributions will remain the same for the 31-day period as during employment. The 31-day

continuation period begins the date the employee actually terminates employment or the date the child ceases to be considered a dependent under the policy.

This continuation of coverage is in addition to any other continuation periods applicable under Massachusetts law as defined below. This benefit does not extinguish eligibility for benefits available under the Federal Consolidated Omnibus budget Reconciliation Act. (COBRA).

Federally Required Continuation For Employees and/or Dependents

Through the Consolidated Omnibus Budget Reconciliation Act (COBRA) the federal government requires the Policyholder to provide continuation of coverages to employees and/or dependents who would otherwise lose their coverages. There are some groups which are not subject to the law. They are:

1. groups of less than 20 employees.

2. certain church plans.

When a person is eligible for both state benefits and federal COBRA benefits, certain state and federal benefits overlap and run concurrently. Please note the election of continued coverage under certain state laws may extinguish eligibility for benefits under federal law.

For details the employee and/or dependent(s) must contact the person who handles the Policyholder's insurance matters.

Leave of Absence For Employees Only

If membership is because of employment and an Insured's active service terminates because of a leave of absence, the insurance will stay in force for two months only if the Policyholder pays his or her premiums and does not cancel the insurance.

If the Policyholder is subject to COBRA, the rules applicable to COBRA will supersede the continuation due to a leave of absence.

Separation or Divorce For Dependents Only

The Insured's spouse may continue coverage without additional premium (unless the divorce or separation judgment specifies otherwise) if the Insured and the spouse:

a. become legally separated; or

b. dissolve the marriage;

unless the judgment of separation or divorce excludes such continuation. For purposes of this continuation provision such spouse is called "former spouse." The former spouse may also continue to insure his or her dependent children. Coverage may be continued if the judgment of dissolution or separation was entered prior to the effective date of this plan.

Benefits
This continuation applies to all benefits provided under this policy covering the former spouse.

Termination
Such insurance will stop on the earliest of:

1. the last day of the period for which the premium is paid;

2. the date coverage would normally stop under the terms of the policy;

3. the date specified in the judgment of separation or dissolution;

4. the date either party remarries*;

5. the date insurance terminates for the Insured;

6. the date the policy terminates.

*In the event of the remarriage of the Insured, the former spouse shall have the right, if so provided in said judgment, to continue to be covered as a member of the group.

We will send notice of termination of continuation coverage, and any right to reinstate coverage to the former spouse at the last known address.

Premium
We may charge the full premium, i.e., the employee and employer's portion, during the continuation period.

We may change the premium rate at any time the Insured's group plan premium rate is changed. Any part of the premium to be paid by the former spouse should be paid to the employer. The employer may stop coverage if any premium is not received within 30 days following the due date.

Claims
Claims incurred by the former spouse will be paid to the former spouse or the provider. Claims incurred by dependent children not living with the Insured will be paid to the provider or the parent with custody.

Benefits After Cancellation
All services must be complete to qualify for benefits. For example, permanent crowns must be cemented; bridges or dentures must be inserted. Once *your* coverage is cancelled, *you* will not have benefits for services finished after *your* cancellation date. *Your* covered family *members* will not have benefits either.

Dental Expense Benefits

We will determine dental expense benefits according to the terms of the group policy for dental expenses incurred by an Insured. An Insured person has the freedom of choice to receive treatment from any Provider.

Determining Benefits. The benefits payable will be determined by totaling all of the Covered Expenses submitted into each benefit type as shown in the Table of Dental Procedures. This amount is reduced by the Deductible, if any. The result is then multiplied by the Coinsurance Percentage(s) shown in the Schedule of Benefits. Benefits are subject to the Maximum Amount, if any, shown in the Schedule of Benefits.

Benefit Period. Benefit Period refers to the period shown in the Table of Dental Procedures.

Deductible. The Deductible is shown on the Schedule of Benefits and is a specified amount of Covered Expenses that must be incurred and paid by each Insured person prior to any benefits being paid.

Maximum Amount. The Maximum Amount shown in the Schedule of Benefits is the maximum amount that may be paid for the Covered Expenses incurred by an Insured.

Covered Expenses. Covered Expenses include:

1. only those expenses for dental procedures performed by a Provider; and
2. only those expenses for dental procedures listed and outlined on the Table of Dental Procedures.

Covered Expenses are subject to "Limitations." See Limitations and

Table of Dental Procedures. Benefits payable for Covered Expenses

also will be based on the lesser of:

1. the actual charge of the Provider.
2. the usual and customary ("U&C") as covered under your plan, if services are provided by a Non Participating Provider.

Usual and Customary (“U&C”) describes those dental charges that we have determined to be the usual and customary charge for a given dental procedure within a particular ZIP code area. The U&C is based upon a combination of dental charge information taken from our own database as well as from data received from nationally recognized industry databases. From the array of charges ranked by amount, your Policyholder (in most cases your employer) has selected a percentile that will be used to determine the maximum U&C for your plan. The U&C is reviewed and updated periodically. The U&C can differ from the actual fee charged by the provider and is not indicative of the appropriateness of the provider’s fee. Instead, the U&C is simply a plan provision used to determine the extent of benefit coverage purchased by your Policyholder.

In no event will Covered Persons be held liable for payment denials by us for improper utilization of covered services caused by Participating Providers.

Emergency Care. Services provided in or by a hospital emergency facility to a covered person after the development of a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient

severity that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the covered person's or another person's health in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part.

If a covered person receives Emergency Care and cannot reasonably reach a Participating Provider, payment for care related to the emergency shall be made at the same level and in the same manner as if the covered person had been treated by a Participating Provider.

Alternative Procedures. If two or more procedures are considered adequate and appropriate treatment to correct a certain condition under generally accepted standards of dental care, the amount of the Covered Expense will be equal to the charge for the least expensive procedure. This provision is NOT intended to dictate a course of treatment. Instead, this provision is designed to determine the amount of the plan allowance for a submitted treatment when an adequate and appropriate alternative procedure is available. Accordingly, you may choose to apply the alternate benefit amount determined under this provision toward payment of the submitted treatment.

We may request pre-operative dental radiographic images, periodontal charting and/or additional diagnostic data to determine the plan allowance for the procedures submitted. We strongly encourage pre-treatment estimates so you understand your benefits before any treatment begins. Ask your provider to submit a claim form for this purpose.

Expenses Incurred. An expense is incurred at the time the impression is made for an appliance or change to an appliance. An expense is incurred at the time the tooth or teeth

are prepared for a dental prosthesis or prosthetic crown. For root canal therapy, an expense is incurred at the time the pulp chamber is opened. All other expenses are incurred at the time

When You May Rejoin the Plan

A *member* who voluntarily cancels membership in the group *plan* may not re-enroll in that group *plan* until at least one year after the date of cancellation. The re-enrollment must occur during the group's open enrollment period. If *your Benefits Summary* notes that there is a *waiting period* applicable to any services, this *waiting period* begins again with the new *effective date.* No reinstatement of coverage back to the original *effective date* is allowed.

You may rejoin through a different group plan anytime *you* become eligible for that plan. *Lifetime maximums* and claim history accumulated while covered under a previous plan or any other plan may be carried forward to the new plan.

Features of the Plan

Your plan is designed to help *you* maintain good dental health through regular dental care. It will help *you* to pay for dental expenses. *We* describe *your* exact coverage in the *Benefits Summary.*

Utilization Review Guidelines

Our Dental Case Management area performs clinical claims reviews. These reviews help *us* decide if the service meets *our* review guidelines. Analysts who review claims are registered dental *hygienists;* or, dental assistants with clinical experience. The analysts review claims. They can approve services. Only a dental consultant, who is a licensed *dentist,* can deny a claim.

We review claims using written review guidelines. *We* base *our* guidelines on accepted standards of care in the dental profession. They are backed by statistical studies of practice patterns. These guidelines, as well as contract limits, are the basis for review decisions. *We* create clinical guidelines and utilization review standards with guidance from the Dental Director; in-house dental consultants; and, a dental advisory committee. The committee is made up of licensed *dentists. Our* dental consultants and dental advisory committee study trends in dentistry; the proven value of new materials and procedures; treatment longevity; and, local and national practice patterns.

Quality Management Programs

We strive to provide high quality products and services. *We* do this by monitoring, identifying, and tracking key issues over time. *We* deal with these issues as part of *our* review of *our* Quality Program.

Assessment of New Dental Materials and Treatments

We study new dental materials and treatments. *We* also study how effective they are and

the cost. Then, *we* decide if *we* will cover the material or treatment.

Continuity of Care

If *your dentist* moves or ever decides not to participate, *you* can choose a new *dentist* from the network. There will not be any disruption in *your* coverage or benefits. If *you* change from an *in-network dentist* to an *out-of-network dentist,* the treatment or procedure would still be covered. This is true so long as it is a *covered service*; but, *you* will be responsible for any difference between *our* payment and the *dentist's* charge.

Pre-treatment Estimate / Prior Authorization

A pre-treatment estimate / prior authorization is a claim that is filed before *you* have a dental service.

Pre-treatment Estimate

When treatment is likely to cost more than $300, *you* and *your dentist* are strongly encouraged to get an estimate before *you* receive treatment. This includes treatment such as crowns; *periodontic; prosthodontic;* and *orthodontic* services.

After *your dentist* sends a request, *we* will review the treatment plan. After reviewing the treatment plan, *we* will tell *you* and *your dentist* what the estimated payment will be for those services.

NOTE: Estimates are based on available benefits. The patient must be an Altus Dental *member* at the time the service is done. The estimate shows what money is available at the time the estimate is done. Estimates can change because services may no longer be available on the date the service is done. For example, if *you* had other services paid for after the estimate, and *you* reach *your annual maximum,* there will be no money left to pay for the new service. Another example is if *you* lose coverage before the new service is finished.

How to Use Altus Dental

You pay a set dollar amount or a percentage thereof for each *covered service* (or nothing for some services). The amount *we* pay is shown in the *Benefits Summary. You* may go to any *dentist you* choose. You must first pay the *deductible* amount, if applicable, for *covered services* before *we* make any payment. There are advantages to going to a *dentist* that is part of the *network.* When *you* visit a *network dentist,* after the *deductible* is met, *you* pay only the *copayment/coinsurance* amount for *covered services.* However, if *you* visit an *out-of-network dentist,* after *you* pay the *deductible* and any *copayment/coinsurance* amount; *you* also pay the difference between the *out-of-network dentist's* charge and the amount *we* pay. *Our* payment varies. See the *Definitions* section of this *Certificate* for a detailed explanation of how *we* pay claims for

services done by *out-of-network dentists*.

Maximize Your Coverage with In-Network Dentists

If *you* go to an *in-network dentist, your* out-of-pocket expenses will generally be less. The *dentist* will file claims on *your* behalf. *We* will pay *in-network dentists* directly. By choosing an *in-network dentist, you* get the best value from *your* dental *plan*.

You can go to a *dentist* that is not in the *network.* When *you* go to an *out-of-network dentist, you* are responsible for filing the claim; and, for paying the *dentist.* Most *out-of- network dentists* will file the claim on *your* behalf. *Your* out-of-pocket cost will be more; because, after you pay the deductible and any *copayment/coinsurance* amount, *you* also pay the difference between the *out-of-network dentist's* charge and the amount *we* pay.

Finding an In-Network Dentist

To find a *dentist* participating in the *network,* visit *our* website – www.altusdental.com. The Altus Dental *network* includes general *dentists* and specialists throughout Massachusetts and Rhode Island, and in New Hampshire and Vermont border towns.

If *your plan* has access to *network dentists* in other states including Vermont, the additional *network(s)* will be noted on *your* Altus Dental member identification card. In addition to *dentists* in *our* Altus Dental *network, you* can choose a *dentist* from one of these *networks* and get the advantages of visiting an *in-network dentist.* Follow the instructions in *our* "Find a Dentist" tool on *our* website to find a *dentist* in the *network.*

Network dentists will file claims on *your* behalf; and, *we* will pay them directly. They also agree to accept the *allowance* as payment in full for *covered services.*

We do not require *you* or *your dentist* to get referrals to see a specialist; however, not all services done by a specialist may be covered under *your plan.* Check *your Benefits Summary* for a list of *covered services.*

Payments for Services

In-network dentists will accept *your co-pay/coinsurance* plus *our* payment as payment in full for *covered services*. *We* will pay *in-network dentists* directly. When *your network dentist* provides services that are not covered; or, *covered services* that do not meet *dental necessity* criteria as per *our* review guidelines, *you* may be liable for the *dentist's* charge.

Y*our network dentist* may charge *you* more than the *allowance* when:

- *You* or *your dependents* receive *covered services;* and, *you* have gone over the *annual maximum*.

- *You* and *your dentist* decide to use non-covered services; such as, treatments or materials that cost more than those normally given by most *dentists;* or, that are being done to improve *your* appearance. In these cases, *we* may pay an *allowance* suitable for a less costly, generally accepted material or service.

Out-of-network dentists have not agreed to accept *your co-pay/coinsurance* plus *our* payment as payment in full for *covered services. You* will pay more. That's because, after you pay the *deductible* and any *copayment/coinsurance* amount, *you* also pay the difference between the *out-of-network dentist's* charge and the amount *we* pay. *Our* payment varies. See the *Definitions* section of this *Certificate* for a detailed explanation of how *we* pay claims for services done by *out-of-network dentists*.

When an *out-of-network dentist* treats *you, we* will make benefit payments to *you;* unless, *you* and *your dentist* agree to assign benefit payment to *your dentist*. *Your dentist* may not agree to this; and, he/she may request payment from *you.*

Y*our Benefits Summary* indicates *you* have Altus Dental Point of Service, therefore, the Plan will pay for services rendered by *out-of-network dentists* at the Fair Health 95th percentile based on the *usual and customary charge* for *your dentist's* area, less any applicable *deductible(s), copayments* or *coinsurance* that are *your* responsibility. *You* are responsible for any difference between *our* payment and the *out-of-network dentist's* charge.

Emergency Services

If *you or your covered dependents* require *emergency care* and cannotreasonably reach an *in-network dentist*, payment will be made at the same level and in the same manner as if the treating *dentist* was an *in-network dentist*.

We cover services received in a dental facility by a licensed *dentist,* as long as they are covered under *your plan. We* do not cover services received in a hospital; surgi-center; or, urgent care facility.

In the case of a life-threatening emergency, *you* should go to the nearest hospital. Hospital claims must be sent to *your* medical insurance plan. If *you* have an urgent dental condition, *you* should go to the nearest *dentist's* office. *You* do not need prior approval. *We* will only pay for *covered services.* Most dental offices treat existing patients within 24 hours for an urgent appointment. If *you* need help finding a *dentist* participating in the *network,* call *us* at 877-223-0588. *You* may also use *our* online tool at www.altusdental.com.

When Your Benefits May Be Continued

When You Leave the Group

When There is Other Coverage

Right to Receive and Release Needed Information

Certain information, including but not limited to Coordination of Benefits (COB), is needed to accurately process claims. *We* have the right to receive information reasonably related to a claim filed under the *plan*. *We* can get this information from, or give it to, any organization or person with a legitimate interest. When *you* file a claim, *you* must give *us* any information needed to process the claim. *You* must give *us* information regarding other insurance coverage when *you* first enroll. *You* must also let *your dentist* know of other coverage when *you* receive care. *We* will ask *you* for updated information from time to time.

Coordination of Benefits

Your plan is designed to prevent overpayment of benefits when *you* or a *dependent* is covered under more than one Plan. The other Plan may be a dental Plan or a medical plan that covers certain services also covered under this p*lan*.

When *you* are covered by more than one Plan, one Plan is the "primary" Plan and the others are "secondary" Plans. When *you* file a claim, the primary Plan pays benefits first, up to the limits of the Plan. The secondary Plans adjust their benefits so that the total amount paid does not exceed the cost of *covered services*. This process is called "Coordination of Benefits" (COB). If *you,* or a family *member,* are also covered by other medical or dental plans, *we* will coordinate payment with them. *We* use standard

insurance industry guidelines in most cases. The standard guidelines that govern this process are set forth below. If other guidelines apply to *your Plan,* they will be noted on *your Benefits Summary.* As used in these rules, the terms "Plan" and "Allowable Expenses" are defined as follows:

- "Plan" means any plan providing dental benefits or services, including government and insured or self-insured group or group-type coverages through an HMO or other prepayment, group practice or individual practice plan.

- "Allowable Expenses" means a necessary, *usual and customary* item of expense for dental care, all or part of which is covered by at least one Plan covering the person for whom the claim is made. Where a Plan provides dental benefits in the form of services rather than cash payments, the reasonable cash value of each service received will be considered both an Allowable Expense and a benefit paid.

The effect of the COB rules on benefits payable during any particular claim period is as follows: If *you* are covered under more than one Plan, the total payment *you* receive will never be more

than *your* Allowable Expenses.

The National Association of Insurance Commissioners sets the rules that decide which Plan is primary. They are, in part, as follows:

- The Plan without a coordination of benefits provision is primary.
- When another Plan's rules and this *plan's* rules require this *plan* to pay its benefits first, this *plan* is primary.
- The Plan covering the patient directly rather than as an employee's *dependent* is primary.
- If a child is covered under both parents' Plans, the Plan of the parent whose birthday falls earlier in the calendar year is primary (the "birthday" rule) unless the other Plan has a "gender" rule.
- If a child is covered under both parents' Plans and the other Plan has a "gender" rule, the rule in the other Plan determines benefits. (The "gender" rule says that if a child is covered under both parents' Plans, the Plan of the male parent is primary).
- If the "birthday" rule applies, and both parents have the same birthday, the Plan covering a parent longest is primary.
- If the parents are separated or divorced, benefits for the child are determined in this order:

♦ The Plan of the parent with custody.

♦ The Plan of the *spouse* of the parent with custody.

♦ The Plan of the parent not having custody, unless one of the parents is made responsible for the child's health expenses by a court decree.

- If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the dental care expenses of the child, the Plans covering the child shall follow the order of benefit determination rules outlined above.
- If a full-time student is eligible for coverage as a *dependent* under this *Certificate*, the benefits of any other coverage available because of student enrollment (except accident-only type coverage) will be determined before the benefits under this *plan*.
- The benefits of a Plan which covered a person as an employee who is neither laid off nor retired are determined before those of a Plan which covers that person as a laid off or retired employee. The same is true if a person is a *dependent* of a person covered as a retiree and an employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.
- If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another Plan, the benefits are determined in the following order:

♦ First, the benefits of a Plan covering the person as an employee, *member* or *subscriber* (or as that person's *dependent*);

♦ Second, the benefits under the continuation coverage.

- If the other plan does not have the rule described above, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.
- If payment responsibility is still unresolved, the Plan covering the patient longest is primary.

In general, if *you* use more benefits than *you* are covered for during a calendar year, the insurer covering *you* first will cover *you* up to its *allowance.* The secondary insurer will cover any allowable benefit *you* use over that amount. The insurers will never pay more than the total amount of coverage that would have been provided if benefits were not coordinated.

Subrogation

If someone caused *your* illness or injury, *you* may have the legal right to get back some of *your* dental care costs. When *you* have this right, *you* must let *us* use it if *we* decide to recoup any payments *we* made for services related to the illness or injury. If *you* use this right to recoup money from someone else, *you* must repay *us* for the payments *we* made. *Our* right to repayment comes first. It can be reduced only by *our* share of *your* reasonable cost of collecting *your* claim against the other person; or, if the payment received is for other than dental expenses. *You* must give *us* information and assistance and sign documents needed to help *us* receive *our* repayment. *You* must not do anything that might limit *our* repayment.

Facility of Payment

If another Plan pays a benefit that should have been paid under this *plan, we* may reimburse the other Plan for that amount. It will be considered a benefit paid by this *plan*.

Right of Recovery

If *we* pay more than *we* should have paid under the COB provision, *we* have the right to recoup the excess amount *we* paid. This includes recouping from other insurance companies and organizations. The amount that can be recouped includes the reasonable cash value of any benefits provided in the form of services.

When You Have a Claim

When to File a Claim

You should send *us* completed claim forms for services covered under this *Certificate. You* have up to one year from the date *you* get services. All services must be complete to qualify for benefits; e.g., permanent crowns cemented; bridge or denture inserted. *In- network dentists* will send claim forms on *your* behalf. *You* will not be responsible for payment on *covered services* when a *network dentist* sends claims more than one year after the date *you* get the service; except, for any *deductibles; copayments; coinsurance;* or amounts in excess of the *annual dollar maximum. We* will deny claims that an *out-of-network dentist* sends to *us* more than one year after *you* get the services. *You* must pay such claims, unless the failure to send a claim within one year was because of a legal incapacity.

How to File a Claim

In-Network Dentist

When *you* go to a *dentist* who has agreed to participate in the *network, your* claim will be filed for *you*. *Network dentists* are encouraged to file claims within six (6) months from the *date of service.* In no event may a *network dentist* file a claim more than one year after the *date of service.* It must include all necessary supporting information such as x-rays. *We* accept claims from *dentists* on paper and in an electronic, HIPAA compliant format.

Out-of-Network Dentist

When *you* go to a *dentist* who is not participating in the *network,* y*ou* must mail the claim to the following address. *You* don't have to do this if the *dentist* agrees to file it for *you*. Dental claim forms are available by signing into *your* account on *our* website at: **www.altusdental.com** or from *your dentist***.**

Mail Claims To:
Altus Dental Insurance Company, Inc.
P.O. Box 1557
Providence, RI 02901-1557

Claims Procedures

Call Customer Service if *you* have a question about how a claim was paid, or why *we* denied it. The number is 877-223-0588. Customer Service representatives are available Monday – Friday from 8 a.m. to 5 p.m. ET. *You* have a right to request a full and fair review of *your* claim. **To consider a claim for payment, *we* must get it within one year of the date *you* get the service.**

Pre-treatment Estimates

A pre-treatment estimate is a claim that is filed before *you* have a dental service.

Pre-treatment Estimate

When treatment is likely to cost more than $300, *you* and *your dentist* are strongly encouraged to get an estimate before *you* receive treatment. This includes treatment such as crowns; *periodontic; prosthodontic*; and elective *orthodontic* services.

After *your dentist* sends a request, *we* will review the treatment plan. After reviewing the treatment plan, *we* will tell *you* and *your dentist* what the estimated payment will be for those services.

NOTE: Estimates are based on available benefits. The patient must be an Altus Dental *member* at the time the service is done. The estimate shows what money is available at the time the estimate is done. Estimates can change because services may no longer be available on the date the service is done. For example, if *you* had other services paid for after the estimate, and *you* reach *your annual maximum,* there will be no money left to pay for the new service. Another example isif *you* lose coverage before the new service is finished.

We must have all of the information *we* need to review the treatment plan; and, to make a benefit decision. *We* will send *you our* initial decision in writing within 15 calendar days. For urgent or emergency services, *we* will give *you our* decision within 72 hours.

If the service is denied, the notice will explain the reason(s) for the denial. The notice will include the process for filing an appeal. Once a denial is made, *you* have 180 days from the day *you* get *our* notice to file an appeal.

Post-service Claims

A post-service claim is a claim that is filed after dental care has been received. All services must be complete to qualify for benefits; e.g., permanent crowns must be cemented; bridges or dentures must be inserted. *We* will send *you our initial decision in writing* within 30 calendar days of the day *we* receive the claim. *We* will send *you* a notice if *we* can't process a post service claim because information is missing. The notice will be sent to *you* within 30 days. It will tell *you* what additional information *we* need to process the claim. An *in-network dentist* must give *us* the information *we* need to process a claim. If not provided, the *dentist* may not charge the patient for any un- paid amount. Refer to the **Expedited Reviews** section for claims involving urgent or emergency services.

We will provide notice or payment to *you* or *your dentist* within 45 days after receipt of a complete claim. A complete claim has all the supporting documentation *we* need to make a claim decision. If *we* do not notify or pay within this time, *we* will pay interest on the amount not paid. Interest will be paid at a rate of 1 ½ percent per month (not to exceed 18% per year). Interest is paid from the 45th day after *we* received the complete claim.

If the service is denied, the notice will explain the reason(s) for the denial. It will include the process for filing an appeal. Once a denial is made, *you* have 180 days from the day *you* receive *our* notice to file an appeal.

To Appeal an Adverse Benefit Decision

If *you* receive an *adverse benefit decision, you* have the right to have it reviewed. An adverse decision means a decision not to approve a service, in whole or in part. *Adverse benefit decisions* include:

- *Administrative adverse benefit decisions.* These do not require us to use dental judgment or clinical criteria. Examples include decisions not to approve because a *member* is not eligible for coverage, or a decision that a benefit is not a covered benefit under the *Plan,* or that the *waiting period* has not been met, or that the frequency on a service has gone above the limit.

- *Non-administrative adverse benefit decisions.* These require *us* to use dental judgment or clinical criteria to determine if the service is *dentally necessary* and/or appropriate. These decisions are made by *dentists* using *our* review guidelines, which detail the

clinical criteria that must be met for a service to be covered. These guidelines are found at altusdental.com.

For all adverse decisions, follow the process below to file an appeal. If *you* are in Rhode Island and feel that *we* did not follow the appeals process as described in this part, *you* may contact the Rhode Island Resource, Education and Assistance Consumer Helpline (RIREACH) at 300 Jefferson Blvd., Suite 300, Warwick, RI 02888, 1-855-747-3224, www.rireach.org. This is Rhode Island's Health Insurance Consumer Assistance Program.

When to File an Appeal: *You* must file *your* appeal within 180 days of the date *you* receive the original coverage denial.

How and Where You Can File an Appeal: *You* must file an appeal in writing. For urgent or emergency services*, *you* may call Customer Service to start an appeal. **Send *your* appeal to: Altus Dental Insurance Company, Inc., Attn: Appeals, P.O. Box 1557, Providence, RI, 02901-1557.** *Your* appeal should ask *us* to reconsider and tell *us* why *you* believe the service was wrongly denied. It should include a copy of the Explanation of Benefits or Pre-treatment Estimate notice. *You* should include the patient's name; the member identification number; and, a detailed description of *your* concern. Appeals of coverage decisions based on *dental necessity* should also include clinical treatment notes; narratives; photos; x-rays; charting; and, any other necessary clinical documents that support *your* claim. To be covered, services must meet the criteria in *our* review guidelines found at altusdental.com. *Your* appeal will be reviewed based on the material *you* send *us.* If the file is incomplete, *we* might not have all the information *we* need to make an appropriate decision. *You* should add any information that is relevant to considering the appeal.

The Explanation of Benefits or Pre-treatment Estimate notice sent to *you* with the original denial has numbered messages. These messages explain the reason(s) for *our* denial. They also refer to any plan terms the decision was based on; and may refer to any guideline; protocol; or, criteria *we* used to make the denial. *You* have the right to see copies of all documents related to the claim. *We* will also give *you* a copy of any internal rule, guideline, or protocol *we* used. *We* will also explain the scientific or clinical judgment *we* used to make *our* decision. *We* will give *you* this information, if *you* ask for it, at no charge.

Who Will Review Your Appeal: Appeals will be investigated by an Appeals Coordinator in *our* Program Integrity department. He or she will talk with appropriate departments and decisions will be made by individuals who know about the issues involved in *your* appeal. Appeals regarding *non-administrative adverse benefit decisions* will be reviewed by a licensed *dentist* who has not been involved in any prior reviews and who has not been involved in the direct care of the patient.

Response to Your Appeal: *We* will reconsider *our* decision and send *you* a written response within 15 calendar days of receiving *your* appeal (72 hours for urgent or

emergency services). If *we* do not change *our* decision, *you* have 180 days from the date *you* receive *our* notice to continue the appeal process by sending *us* a written request for an appeal. *We* will send *you* a written response within 15 calendar days of receiving *your* request (72 hours for urgent or emergency services). Before *we* make a final internal appeal decision, *you* have the right to inspect the entire appeal file and add information. Additional information must be sent in writing and will be held confidential in accordance with applicable state and federal laws.

External Review Option: If *your* final internal appeal to reverse a *non-administrative adverse benefit decision* is denied, *you* may request an external appeal. External appeals are sent to an independent review agency. *You* have 125 calendar days from the date *you* receive *our* final internal appeal decision to send *your* request to *us* in writing. *You* can add information to the file for review by sending it to *us* in writing within 5 business days after starting the appeal. *We* will send all documentation *we* reviewed to the review agency.

Cost for External Review: *You* must pay $50 (up to a maximum of $150 per *policy year* per *member).* Include a check made payable to Altus Dental Insurance Company, Inc. for *your* share of the cost with *your* request. If *your plan* includes pediatric dental essential health benefits for children under age 19 and the appeal involves a service for a *member* under age 19, the cost of the external review is $25 (up to a maximum of $75 per *policy year* per *member).* The fee may be waived if paying it would cause *you* undue financial hardship.

Response to Your External Appeal: The review agency will notify *you* about the outcome of *your* appeal within 10 calendar days of their receipt of all information needed to complete the review. If the external review agency overturns *our* decision, *we* will reimburse *you* within 60 days of the notice of overturn for *your* share of the fee.

Additional Information: Under certain circumstances, once the internal appeals process is exhausted, the *member* may also have the right to bring a civil action. This right is given under Section 502(a) of the ERISA Act. The *member* does not have this right if he/she is a member of a governmental plan, church plan, or a plan not established or maintained by an employer.

Expedited Reviews

If *your* claim involves urgent or emergency services as defined below, *you* have the right to an expedited review. For expedited reviews, *we* will complete *our* review and make a decision within 72 hours. *We* must receive all of the information needed to review the claim. Call Customer Service to obtain an expedited review.

*"Urgent services" includes those resources necessary to treat a symptomatic health care condition that a prudent layperson, acting reasonably would believe necessitates treatment within a 24-hour period of the onset of such a condition in order that the patient's health status not decline as a consequence. This does not include "emergency services"

as defined below.

“Emergency services” means those resources provided in the event of the sudden onset of a health condition that the absence of immediate medical attention could reasonably be expected, by a prudent layperson, to result in placing the patient’s health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

Resolution of Inquiries and Complaints

Inquiries

If *you* have questions or concerns, send an email to customerservice@altusdental.com. *You* may also call Customer Service toll-free at **1-877-223-0588;** or, mail or fax the inquiry to: **Altus Dental Insurance Company, Inc., P.O. Box 1557, Providence, RI 02901-1557, Fax: 401-457-7260.** *We* will try to resolve it as soon as *we* can. The appeals process above describes how to appeal a claim decision.

Complaints

If *you* have a complaint, send an email to customerservice@altusdental.com; or, call *us* at 1-877-223-0588. *We* settle most complaints on first contact. However, if *your* complaint needs more research (e.g., it involves quality of care; fraud; or, abuse, etc.), *we* will settle it as soon as *we* can. If *you* are not satisfied, *you* may call the Massachusetts Division of Insurance.

Other Provisions

Claims Review

This *Certificate* provides coverage only for *dentally necessary* and appropriate care. The decision whether a service is *dentally necessary* is solely for the purpose of claims payment. It is not a professional dental judgment. *You* have the right to appeal *our* decision. Refer to the **Claims Procedures** section, and the definition of “*dentally necessary”* in the **Definitions** section.

Although *we* may conduct review, *we* do not act as a *dentist. We* do not provide dental care. *We* do not make dental judgments. Nothing here is meant to change; or, affect *your* relationship with *your dentist.*

Access to Records

When *you* file a claim, *you* agree to give *us* the right to get, from any source, all dental records and/or related information that *we* need. *We* will keep *your* information confidential. *We* can also have a licensed *dentist* examine, at *our* expense, any person making a claim. *You* agree that *dentists* may give *us* individually identifiable health information. *You* also agree that *we* may use and disclose such information as described in *our* Notice of Privacy Practices. *You* can find this Notice on *our* website.

You can also call Customer Service for a copy.
In-network dentists must give *us* all of the information *we* need to process *your* claim. They will not charge for this service. If *you* get services from an *out-of-network dentist*, *you* must help *us* get all of the records *we* need. *We* will not pay the *dentist* for giving *us* this information. If the *out-of- network dentist* does not give *us* this information, *we* may not provide benefit payments to *you*.

Office of Patient Protection

The Office of Patient Protection (OPP) in Massachusetts assists consumers with questions regarding health insurance. You may contact the OPP toll-free at 1-800-436-7757, by fax at 617-624-5046, or visit their website at www.mass.gov/hpc/opp.

Document Changes

We or *your plan sponsor* may change a part of *your Certificate*. This is usually done on the anniversary date of *your plan sponsor's* contract with *us.* Any change will have an effective date. The change will apply to all benefits for services *you* receive on or after the effective date. Changes in the *Certificate* are not valid unless approved by an officer of Altus Dental; and, are made a written part of this *Certificate* or the *Benefits Summary*. *We* will give the group representative of *your plan sponsor* at least 60 days advance notice when *we* make any *material changes* to *covered services.* The notice will include any changes in clinical review standards. The notice will also include the effect such changes may have on *your* personal liability for the cost of such changes. *We* will also give *your* group representative an annual notice listing all *in-network dentists.*

We will provide an addendum or supplementary insert for each enrolled *subscriber* residing in Massachusetts for notice of all *material changes* to this *Certificate*.

Notices

To *You*: When *we* send a notice to *your plan sponsor*, *we* will send it by first class mail, e-mail or fax. Once *we* send the notice, *we* are not responsible for its delivery. It will be *your plan sponsor's* responsibility to notify *you* if the notice is sent to *your plan sponsor.* This applies to any notices regarding premium charges as well as to a notice of a change in the premium charge or a change in the *Certificate*. If *your* name or mailing address should change, *you* should notify *us* or *your plan sponsor* at once. Be sure to give *us* or *your plan sponsor* both *your* old name and address as well as *your* new name and address.

To *Us:* Send mail to Altus Dental Insurance Company, Inc., P.O. Box 1557, Providence, RI 02901-1557; or email us at customerservice@altusdental.com. Always include *your* name and *your* ID number.

Acts of Providers

We will not get involved with the relationship between *dentists* and patients. *We* are not responsible if a *dentist* refuses to treat *you. We* are not liable for injuries or damages resulting from the acts or omissions of a *dentist*. *We* are not responsible if *you* are dissatisfied with the treatment or services *your dentist* provides.

Right to Recover Overpayments

If *we* pay more than *we* should, *we* can recoup payment from either *you;* or, the *dentist*. *We* can also deduct any payment *we* have made from any benefits properly paid under this policy if the payment was made:

1. In error; or
2. Due to a misstatement in a proof of loss; or
3. Due to fraud or misrepresentation of a material fact to procure coverage or under the terms of the coverage; or
4. For an ineligible person; or,
5. Due to a claim for which benefits are recoverable under any policy or act of law providing coverage for occupational injury or disease, to the extent that such benefits are recovered.

If *we* have already made claim payments to a covered person; *we* can reduce the payment *we* would make on a future claim to recoup an overpayment.

Conformity with Applicable Laws

We amend any term of this *Certificate* which conflicts with any relevant law. *We* do this to conform to the minimum requirements of such law.

This *Certificate* and the *Benefits Summary,* is a description of *your* benefits; rights; and, obligations under the *plan*.

Your membership ID card identifies *you* as a person with these benefits. Please show the ID card to *your dentist* whenever *you* or *your dependents* receive services.

Preexisting Conditions

There are no preexisting condition limitations in this *plan.*

Services Covered by the Plan

Dental Expense Benefits

- Your benefits are based on a Benefit Year. A Benefit Year runs from August 1 through July 31.
- Benefit Period means the period from August 1 of any year through July 31 of the next year. But during the first year a person is insured, a benefit period means the period from his or her effective date through July 31 of the next year.

  When you select a Participating Provider, a discounted fee schedule is used which is intended to provide you, the Insured, reduced out of pocket costs.

Benefit Class	Class Description
Class 1	Post Doctoral Researcher
Class 2	Graduate Employee

Class Number 1-Post Doctoral Researcher

DENTAL EXPENSE BENEFITS

When you select a Participating Provider, a discounted fee schedule is used which is intended to provide you, the Insured, reduced out of pocket costs.

Deductible Amount:

In Network Deductible: $0

Out of Network Deductible: $0 Type 1 & Type 4
$75 Individual/$225 Family Type 2 & Type 3

On the date that three members of one family have satisfied their own Deductible Amounts for that Benefit Period, no Covered Expenses incurred after that date by any other family member will be applied toward the satisfaction of any Deductible Amount for the rest of that Benefit Period. No Covered Expense that was incurred prior to such date, which was used to satisfy any part of a Deductible Amount, will be eligible for reimbursement.

Coinsurance Percentage:	Participating Provider	Non-Participating Provider
Type 1 Procedures*	100%	100%
Type 2 Procedures**	80%	80%
Type 3 Procedures	65%	65%
Type 4 Procedures	65%	65%
Policy Year Maximum		$2,350*+

*Type 1 Procedures do not count toward the Maximum Benefit.
**Fillings are covered at 90%.
+Benefits for Temporomandibular Joint Dysfunction may not exceed $500 per Lifetime.

Orthodontic Expense Benefits

	$0
Deductible Amount - Once per lifetime	
Coinsurance Percentage	50%
Maximum Benefit During Lifetime	$1,500

Class Number 2-Graduate Employee

Dental Expense Benefits

When you select a Participating Provider, a discounted fee schedule is used which is intended to provide you, the Insured, reduced out of pocket costs.

Deductible Amount:

In Network Deductible: $0

Out of Network Deductible: $0 Type 1 & Type 4
$75 Individual/$225 Family Type 2 & Type 3

On the date that three members of one family have satisfied their own Deductible Amounts for that Benefit Period, no Covered Expenses incurred after that date by any other family member will be applied toward the satisfaction of any Deductible Amount for the rest of that Benefit Period. No Covered Expense that was incurred prior to such date, which was used to satisfy any part of a Deductible Amount, will be eligible for reimbursement.

Coinsurance Percentage:	Participating Provider	Non-Participating Provider
Type 1 Procedures*	100%	100%
Type 2 Procedures**	80%	80%
Type 3 Procedures	65%	65%
Type 4 Procedures	65%	65%
Policy Year Maximum		$2,350*+

*Type 1 Procedures do not count toward the Maximum Benefit.
**Fillings are covered at 90%.
+Benefits for Temporomandibular Joint Dysfunction may not exceed $500 per Lifetime.

Orthodontic Expense Benefits

Deductible Amount - Once per lifetime	$0
Coinsurance Percentage	50%
Maximum Benefit During Lifetime	$1,500

TABLE OF DENTAL PROCEDURES
TYPE 1 PROCEDURES
BENEFIT PERIOD - Benefit Year
For Additional Limitations - See Limitations

ROUTINE ORAL EVALUATION
D0120 Periodic oral evaluation - established patient.
D0160 Detailed and extensive oral evaluation - problem focused, by report.
D0145 Oral evaluation for a patient under three years of age and counseling with primary caregiver.
D0150 Comprehensive oral evaluation - new or established patient.
D0180 Comprehensive periodontal evaluation - new or established patient.
COMPREHENSIVE EVALUATION: D0150, D0180
- Coverage is limited to 1 of each of these procedures per provider.
- In addition, D0150, D0180 coverage is limited to 2 of any of these procedures per 12 month(s).
- D0120, D0145, also contribute(s) to this limitation.
- If frequency met, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency.

ROUTINE EVALUATION: D0120, D0145
- Coverage is limited to 2 of any of these procedures per 12 month(s).
- D0150, D0180, also contribute(s) to this limitation.
- Procedure D0120 will be considered for individuals age 3 and over. Procedure D0145 will be considered for individuals age 2 and under.

LIMITED ORAL EVALUATION
D0140 Limited oral evaluation - problem focused.
D0170 Re-evaluation - limited, problem focused (established patient; not post-operative visit).
LIMITED ORAL EVALUATION: D0140, D0170
- Coverage is allowed for accidental injury only. If not due to an accident, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency.

D9310 Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician.
D9430 Office visit for observation (during regularly scheduled hours) - no other services performed.
D9440 Office visit - after regularly scheduled hours.
D9930 Treatment of complications (post-surgical) - unusual circumstances, by report.

COMPLETE SERIES OR PANORAMIC
D0210 Intraoral - complete series of radiographic images.
D0330 Panoramic radiographic image.
COMPLETE SERIES/PANORAMIC: D0210, D0330
- Coverage is limited to 1 of any of these procedures per 5 year(s).

OTHER XRAYS
D0220 Intraoral - periapical first radiographic image.
D0230 Intraoral - periapical each additional radiographic image.
D0240 Intraoral - occlusal radiographic image.
D0250 Extra-oral - 2D projection radiographic image created using a stationary radiation source, and detector.
D0251 Extra-oral posterior dental radiographic image.
PERIAPICAL: D0220, D0230
- The maximum amount considered for x-ray radiographic images taken on one day will be equivalent to an allowance of a D0210.

BITEWINGS
D0270 Bitewing - single radiographic image.
D0272 Bitewings - two radiographic images.
D0273 Bitewings - three radiographic images.
D0274 Bitewings - four radiographic images.
D0277 Vertical bitewings - 7 to 8 radiographic images.
BITEWINGS: D0270, D0272, D0273, D0274
- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D0277, also contribute(s) to this limitation.
- The maximum amount considered for x-ray radiographic images taken on one day will be equivalent to an allowance of a D0210.

VERTICAL BITEWINGS: D0277
- Coverage is limited to 1 of any of these procedures per 5 year(s).
- The maximum amount considered for x-ray radiographic images taken on one day will be equivalent to an allowance of a D0210.

TYPE 1 PROCEDURES

PRE-DIAGNOSTIC TEST
D0431 Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures.
TESTS: D0431

- Coverage is limited to 1 of any of these procedures per 2 year(s).
- Benefits are considered for persons from age 35 and over.

ORAL PATHOLOGY/LABORATORY
D0472 Accession of tissue, gross examination, preparation and transmission of written report.
D0473 Accession of tissue, gross and microscopic examination, preparation and transmission of written report.
D0474 Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report.
ORAL PATHOLOGY LABORATORY: D0472, D0473, D0474

- Coverage is limited to 1 of any of these procedures per 12 month(s).
- Coverage is limited to 1 examination per biopsy/excision.

PROPHYLAXIS (CLEANING) AND FLUORIDE
D1110 Prophylaxis - adult.
D1120 Prophylaxis - child.
D1206 Topical application of fluoride varnish.
D1208 Topical application of fluoride-excluding varnish.
D9932 Cleaning and inspection of removable complete denture, maxillary.
D9933 Cleaning and inspection of removable complete denture, mandibular.
D9934 Cleaning and inspection of removable partial denture, maxillary.
D9935 Cleaning and inspection of removable partial denture, mandibular.
FLUORIDE: D1206, D1208

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- Benefits are considered for persons age 18 and under.

PROPHYLAXIS: D1110, D1120

- Coverage is limited to 4 of any of these procedures per 12 month(s).
- D4346, D4910, also contribute(s) to this limitation.
- An adult prophylaxis (cleaning) is considered for individuals age 14 and over. A child prophylaxis (cleaning) is considered for individuals age 13 and under. Benefits for prophylaxis (cleaning) are not available when performed on the same date as periodontal procedures.

CLEANING AND INSPECTION OF REMOVABLE DENTURE: D9932, D9933, D9934, D9935

- Coverage is limited to 4 of any of these procedures per 12 month(s).
- Benefits are not available when performed on the same date as prophylaxis (cleaning) or periodontal maintenance.

FULL MOUTH DEBRIDEMENT
D4355 Full mouth debridement to enable comprehensive oral evaluation and diagnosis on a subsequent visit.
FULL MOUTH DEBRIDEMENT: D4355

- Coverage is limited to 1 of any of these procedures per 5 year(s).

SEALANTS AND CARIES MEDICAMENTS
D1351 Sealant - per tooth.
D1352 Preventive resin restoration in a moderate to high caries risk patient-permanent.
D1353 Sealant repair - per tooth.
D1354 Interim caries arresting medicament application-per tooth.
D1355 Caries preventive medicament application - per tooth.
SEALANT: D1351, D1352, D1353

- Coverage is limited to 1 of any of these procedures per lifetime.
- D1354, D1355, also contribute(s) to this limitation.
- Benefits are considered for persons age 18 and under.
- Benefits are considered on permanent molars only, excluding 3rd molars (wisdom teeth).
- Coverage is allowed on the occlusal surface only.

SPACE MAINTAINERS
D1510 Space maintainer-fixed, unilateral-per quadrant.
D1516 Space maintainer - fixed - bilateral, maxillary. D1517 Space maintainer - fixed - bilateral, mandibular.
D1520 Space maintainer-removable, unilateral-per quadrant.
D1526 Space maintainer - removable - bilateral, maxillary.

TYPE 1 PROCEDURES

D1527 Space maintainer - removable - bilateral, mandibular.
D1551 Re-cement or re-bond bilateral space maintainer-maxillary.
D1552 Re-cement or re-bond bilateral space maintainer-mandibular.
D1553 Re-cement or re-bond unilateral space maintainer-per quadrant.
D1556 Removal of fixed unilateral space maintainer-per quadrant.
D1557 Removal of fixed bilateral space maintainer-maxillary.
D1558 Removal of fixed bilateral space maintainer-mandibular.
D1575 Distal shoe space maintainer - fixed, unilateral-per quadrant.

SPACE MAINTAINER: D1510, D1516, D1517, D1520, D1526, D1527, D1575

- Benefits are considered for persons age 13 and under.
- Coverage is limited to space maintenance for unerupted teeth, following extraction of primary teeth. Allowances include all adjustments within 6 months of placement date.

PERIODONTAL MAINTENANCE

D4346 Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation.
D4910 Periodontal maintenance.

PERIODONTAL MAINTENANCE: D4346, D4910

- Coverage is limited to 4 of any of these procedures per 12 month(s).
- D1110, D1120, also contribute(s) to this limitation.
- Benefits are not available if performed on the same date as any other periodontal service. Procedure D4910 is contingent upon evidence of full mouth active periodontal therapy. Procedure D4346 is limited to persons age 14 and over.

APPLIANCE THERAPY

D8210 Removable appliance therapy.
D8220 Fixed appliance therapy.

APPLIANCE THERAPY: D8210, D8220

- Coverage is limited to the correction of thumb-sucking

TYPE 2 PROCEDURES

BENEFIT PERIOD - Benefit Year

For Additional Limitations - See Limitations

AMALGAM RESTORATIONS (FILLINGS)

D2140 Amalgam - one surface, primary or permanent.
D2150 Amalgam - two surfaces, primary or permanent.
D2160 Amalgam - three surfaces, primary or permanent.
D2161 Amalgam - four or more surfaces, primary or permanent.

AMALGAM RESTORATIONS: D2140, D2150, D2160, D2161

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2990, D9911, also contribute(s) to this limitation.

INLAY RESTORATIONS

D2510 Inlay - metallic - one surface.
D2520 Inlay - metallic - two surfaces.
D2530 Inlay - metallic - three or more surfaces.
D2610 Inlay - porcelain/ceramic - one surface.
D2620 Inlay - porcelain/ceramic - two surfaces.
D2630 Inlay - porcelain/ceramic - three or more surfaces.
D2650 Inlay - resin-based composite - one surface.
D2651 Inlay - resin-based composite - two surfaces.
D2652 Inlay - resin-based composite - three or more surfaces.

INLAY: D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652

- Inlays will be considered at an alternate benefit of an amalgam/composite restoration and only when resulting from caries (tooth decay) or traumatic injury.

RESIN RESTORATIONS (FILLINGS)

D2330 Resin-based composite - one surface, anterior.
D2331 Resin-based composite - two surfaces, anterior.
D2332 Resin-based composite - three surfaces, anterior.
D2335 Resin-based composite - four or more surfaces or involving incisal angle (anterior).
D2391 Resin-based composite - one surface, posterior.
D2392 Resin-based composite - two surfaces, posterior.
D2393 Resin-based composite - three surfaces, posterior.
D2394 Resin-based composite - four or more surfaces, posterior. D2410 Gold foil - one surface.
D2420 Gold foil - two surfaces.
D2430 Gold foil - three surfaces.
D2990 Resin infiltration of incipient smooth surface lesions.

COMPOSITE RESTORATIONS: D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2990

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2140, D2150, D2160, D2161, D9911, also contribute(s) to this limitation.
- Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

GOLD FOIL RESTORATIONS: D2410, D2420, D2430

- Gold foils are considered at an alternate benefit of an amalgam/composite restoration.

STAINLESS STEEL CROWN (PREFABRICATED CROWN)

D2390 Resin-based composite crown, anterior.
D2928 Prefabricated porcelain/ceramic crown - permanent tooth.
D2929 Prefabricated porcelain/ceramic crown - primary tooth.
D2930 Prefabricated stainless steel crown - primary tooth.
D2931 Prefabricated stainless steel crown - permanent tooth.
D2932 Prefabricated resin crown.
D2933 Prefabricated stainless steel crown with resin window.
D2934 Prefabricated esthetic coated stainless steel crown - primary tooth.

STAINLESS STEEL CROWN: D2390, D2928, D2929, D2930, D2931, D2932, D2933, D2934

- Replacement is limited to 1 of any of these procedures per 12 month(s).
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

RECEMENT

D2910 Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration. D2915 Re-cement or re-bond indirectly fabricated or prefabricated post and core. D2920 Re-cement or re-bond crown.

TYPE 2 PROCEDURES

D2921 Reattachment of tooth fragment, incisal edge or cusp.
D6092 Re-cement or re-bond implant/abutment supported crown.
D6093 Re-cement or re-bond implant/abutment supported fixed partial denture.
D6930 Re-cement or re-bond fixed partial denture.

D6980 Fixed partial denture repair necessitated by restorative material failure.

CROWN LENGTHENING
D4249 Clinical crown lengthening - hard tissue.
FIXED CROWN AND PARTIAL DENTURE REPAIR
D2980 Crown repair necessitated by restorative material failure.
D2981 Inlay repair necessitated by restorative material failure.
D2982 Onlay repair necessitated by restorative material failure.
D2983 Veneer repair necessitated by restorative material failure.

SEDATIVE FILLING
D2940 Protective restoration.
D2941 Interim therapeutic restoration - primary dentition.

PULP CAP
D3110 Pulp cap - direct (excluding final restoration).

ENDODONTICS MISCELLANEOUS
D3220 Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament.
D3221 Pulpal debridement, primary and permanent teeth.
D3222 Partial Pulpotomy for apexogenesis - permanent tooth with incomplete root development.
D3230 Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration).
D3240 Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration).
D3333 Internal root repair of perforation defects.
D3351 Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.).
D3352 Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.).
D3353 Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.).
D3357 Pulpal regeneration - completion of treatment.
D3430 Retrograde filling - per root.
D3450 Root amputation - per root.
D3920 Hemisection (including any root removal), not including root canal therapy.
ENDODONTICS MISCELLANEOUS: D3333, D3430, D3450, D3920

- Procedure D3333 is limited to permanent teeth only.

ENDODONTIC THERAPY (ROOT CANALS)
D3310 Endodontic therapy, anterior tooth.
D3320 Endodontic therapy, premolar tooth (excluding final restorations).
D3330 Endodontic therapy, molar tooth (excluding final restorations).
D3332 Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth.
D3346 Retreatment of previous root canal therapy - anterior.
D3347 Retreatment of previous root canal therapy - premolar.
D3348 Retreatment of previous root canal therapy - molar.
ROOT CANALS: D3310, D3320, D3330, D3332

- Benefits are considered on permanent teeth only.
- Allowances include intraoperative radiographic images and cultures but exclude final restoration.

RETREATMENT OF ROOT CANAL: D3346, D3347, D3348

- Coverage is limited to 1 of any of these procedures per 12 month(s).
- D3310, D3320, D3330, also contribute(s) to this limitation.
- Benefits are considered on permanent teeth only.
- Coverage is limited to service dates more than 12 months after root canal therapy. Allowances include intraoperative radiographic images and cultures but exclude final restoration.

SURGICAL ENDODONTICS
D3355 Pulpal regeneration - initial visit.
D3356 Pulpal regeneration - interim medication replacement.
D3410 Apicoectomy - anterior.
D3421 Apicoectomy - premolar (first root).
D3425 Apicoectomy - molar (first root).
D3426 Apicoectomy (each additional root).
D3471 Surgical repair of root resorption - anterior.

TYPE 2 PROCEDURES

D3472 Surgical repair of root resorption - premolar.
D3473 Surgical repair of root resorption - molar.
D3501 Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior.
D3502 Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar.
D3503 Surgical exposure of root surface without apicoectomy or repair of root resorption - molar.

SURGICAL PERIODONTICS
D4210 Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant.
D4211 Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant.
D4240 Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant.
D4241 Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant.
D4260 Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant.
D4261 Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant.
D4263 Bone replacement graft - retained natural tooth - first site in quadrant.
D4264 Bone replacement graft - retained natural tooth - each additional site in quadrant.
D4265 Biologic materials to aid in soft and osseous tissue regeneration.
D4270 Pedicle soft tissue graft procedure.
D4273 Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft.
D4274 Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area).
D4275 Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant or edentulous tooth position in graft.
D4276 Combined connective tissue and double pedicle graft, per tooth.
D4277 Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft.
D4278 Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant or edentulous tooth position in same graft site.
D4283 Autogenous connective tissue graft procedure (including donor and recipient surgical sites) - each additional contiguous tooth, implant or edentulous tooth position in same graft site.
D4285 Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) - each additional contiguous tooth, implant or edentulous tooth position in same graft site.
BONE GRAFTS: D4263, D4264, D4265

- Each quadrant is limited to 1 of each of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

GINGIVECTOMY: D4210, D4211

- Each quadrant is limited to 1 of each of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

OSSEOUS SURGERY: D4240, D4241, D4260, D4261

- Each quadrant is limited to 1 of each of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

TISSUE GRAFTS: D4270, D4273, D4275, D4276, D4277, D4278, D4283, D4285

- Each quadrant is limited to 2 of any of these procedures per 3 year(s).
- Coverage is limited to treatment of periodontal disease.

NON-SURGICAL PERIODONTICS
D4341 Periodontal scaling and root planing - four or more teeth per quadrant.
D4342 Periodontal scaling and root planing - one to three teeth, per quadrant.
D4381 Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report.
ANTIMICROBIAL AGENTS: D4381

- Each quadrant is limited to 2 of any of these procedures per 2 year(s).

PERIODONTAL SCALING & ROOT PLANING: D4341, D4342

- Each quadrant is limited to 1 of each of these procedures per 2 year(s).

DENTURE REPAIR
D5511 Repair broken complete denture base, mandibular.
D5512 Repair broken complete denture base, maxillary.
D5520 Replace missing or broken teeth - complete denture (each tooth).
D5611 Repair resin partial denture base, mandibular.
D5612 Repair resin partial denture base, maxillary.
D5621 Repair cast partial framework, mandibular.
D5622 Repair cast partial framework, maxillary.

TYPE 2 PROCEDURES

D5630 Repair or replace broken retentive/clasping materials per tooth.
D5640 Replace broken teeth - per tooth.

ADD TOOTH/CLASP TO EXISTING PARTIAL

D5650 Add tooth to existing partial denture.
D5660 Add clasp to existing partial denture-per tooth.

DENTURE REBASES
D5710 Rebase complete maxillary denture.
D5711 Rebase complete mandibular denture.
D5720 Rebase maxillary partial denture.
D5721 Rebase mandibular partial denture.

DENTURE RELINES
D5730 Reline complete maxillary denture (direct).
D5731 Reline complete mandibular denture (direct).
D5740 Reline maxillary partial denture (direct).
D5741 Reline mandibular partial denture (direct).
D5750 Reline complete maxillary denture (indirect).
D5751 Reline complete mandibular denture (indirect).
D5760 Reline maxillary partial denture (indirect).
D5761 Reline mandibular partial denture (indirect).
DENTURE RELINE: D5730, D5731, D5740, D5741, D5750, D5751, D5760, D5761

- Coverage is limited to service dates more than 6 months after placement date.

TISSUE CONDITIONING
D5850 Tissue conditioning, maxillary.
D5851 Tissue conditioning, mandibular.

NON-SURGICAL EXTRACTIONS
D7111 Extraction, coronal remnants - primary tooth.
D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal).

SURGICAL EXTRACTIONS
D7210 Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated.
D7220 Removal of impacted tooth - soft tissue.
D7230 Removal of impacted tooth - partially bony.
D7240 Removal of impacted tooth – completely bony.
D7241 Removal of impacted tooth - completely bony, with unusual surgical complications.
D7250 Removal of residual tooth roots (cutting procedure).
D7251 Coronectomy-intentional partial tooth removal.

OTHER ORAL SURGERY
D7260 Oroantral fistula closure.
D7261 Primary closure of a sinus perforation.
D7270 Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.
D7272 Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization).
D7280 Exposure of an unerupted tooth.
D7282 Mobilization of erupted or malpositioned tooth to aid eruption.
D7283 Placement of device to facilitate eruption of impacted tooth.
D7310 Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.
D7311 Alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.
D7320 Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.
D7321 Alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.
D7340 Vestibuloplasty - ridge extension (secondary epithelialization).
D7350 Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue).

D7410 Excision of benign lesion up to 1.25 cm.
D7411 Excision of benign lesion greater than 1.25 cm.
D7412 Excision of benign lesion, complicated.

TYPE 2 PROCEDURES

D7413 Excision of malignant lesion up to 1.25 cm.
D7414 Excision of malignant lesion greater than 1.25 cm.
D7415 Excision of malignant lesion, complicated.
D7440 Excision of malignant tumor - lesion diameter up to 1.25 cm.
D7441 Excision of malignant tumor - lesion diameter greater than 1.25 cm.
D7450 Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm.
D7451 Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm.
D7460 Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm.
D7461 Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm.
D7465 Destruction of lesion(s) by physical or chemical method, by report.
D7471 Removal of lateral exostosis (maxilla or mandible).
D7472 Removal of torus palatinus.
D7473 Removal of torus mandibularis.
D7485 Reduction of osseous tuberosity.
D7490 Radical resection of maxilla or mandible.
D7510 Incision and drainage of abscess - intraoral soft tissue.
D7520 Incision and drainage of abscess - extraoral soft tissue.
D7530 Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue.
D7540 Removal of reaction producing foreign bodies, musculoskeletal system.
D7550 Partial ostectomy/sequestrectomy for removal of non-vital bone.
D7560 Maxillary sinusotomy for removal of tooth fragment or foreign body.
D7910 Suture of recent small wounds up to 5 cm.
D7911 Complicated suture - up to 5 cm.
D7912 Complicated suture - greater than 5 cm.
D7961 Buccal/labial frenectomy (frenulectomy).
D7962 Lingual frenectomy (frenulectomy).
D7963 Frenuloplasty.
D7970 Excision of hyperplastic tissue - per arch.
D7972 Surgical reduction of fibrous tuberosity.
D7979 Non-surgical sialolithotomy.
D7980 Surgical sialolithotomy.
D7983 Closure of salivary fistula.

REMOVAL OF BONE TISSUE: D7471, D7472, D7473

- Coverage is limited to 5 of any of these procedures per lifetime.

BIOPSY OF ORAL TISSUE

D7285 Incisional biopsy of oral tissue - hard (bone, tooth).
D7286 Incisional biopsy of oral tissue - soft.
D7287 Exfoliative cytological sample collection. D7288
Brush biopsy - transepithelial sample collection.

PALLIATIVE

D9110 Palliative (emergency) treatment of dental pain - minor procedure.

PALLIATIVE TREATMENT: D9110

- Not covered in conjunction with other procedures, except diagnostic x-ray radiographic images.

ANESTHESIA-GENERAL/IV

D9219 Evaluation for moderate sedation, deep sedation or general anesthesia.
D9222 Deep sedation/general anesthesia - first 15 minutes.
D9223 Deep sedation/general anesthesia - each subsequent 15 minute increment.
D9239 Intravenous moderate (conscious) sedation/analgesia - first 15 minutes.
D9243 Intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment.

GENERAL ANESTHESIA: D9222, D9223, D9239, D9243

- Coverage is only available with a cutting procedure. A maximum of four (D9222, D9223, D9239 or D9243) will be considered.

MISCELLANEOUS

D0486 Laboratory accession of transepithelial cytologic sample, microscopic examination, preparation and transmission of written report.
D2951 Pin retention - per tooth, in addition to restoration.
D9911 Application of desensitizing resin for cervical and/or root surfaces, per tooth.

DESENSITIZATION: D9911

- Coverage is limited to 1 of any of these procedures per 6 month(s).
- D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2990, also contribute(s) to this limitation.
- Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

NON-SURGICAL MISCELLANEOUS

D0320 Temporomandibular joint arthrogram, including injection.
D0321 Other temporomandibular joint radiographic images, by report.

TYPE 3 PROCEDURES
BENEFIT PERIOD - Benefit Year
For Additional Limitations - See Limitations

ONLAY RESTORATIONS
D2542 Onlay - metallic - two surfaces.
D2543 Onlay - metallic - three surfaces.
D2544 Onlay - metallic - four or more surfaces.
D2642 Onlay - porcelain/ceramic - two surfaces.
D2643 Onlay - porcelain/ceramic - three surfaces.
D2644 Onlay - porcelain/ceramic - four or more surfaces.
D2662 Onlay - resin-based composite - two surfaces.
D2663 Onlay - resin-based composite - three surfaces.
D2664 Onlay - resin-based composite - four or more surfaces.

ONLAY: D2542, D2543, D2544, D2642, D2643, D2644, D2662, D2663, D2664

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.
- Benefits will not be considered if procedure D2390, D2928, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

CROWNS SINGLE RESTORATIONS
D2710 Crown - resin-based composite (indirect).
D2712 Crown - 3/4 resin-based composite (indirect).
D2720 Crown - resin with high noble metal.
D2721 Crown - resin with predominantly base metal.
D2722 Crown - resin with noble metal.
D2740 Crown - porcelain/ceramic.
D2750 Crown - porcelain fused to high noble metal.
D2751 Crown - porcelain fused to predominantly base metal.
D2752 Crown - porcelain fused to noble metal.
D2753 Crown-porcelain fused to titanium and titanium alloys.
D2780 Crown - 3/4 cast high noble metal.
D2781 Crown - 3/4 cast predominantly base metal.
D2782 Crown - 3/4 cast noble metal.
D2783 Crown - 3/4 porcelain/ceramic.
D2790 Crown - full cast high noble metal.

TYPE 3 PROCEDURES

D2791 Crown - full cast predominantly base metal.
D2792 Crown - full cast noble metal.
D2794 Crown - titanium and titanium alloys.
CROWN: D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.
- Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.
- Benefits will not be considered if procedure D2390, D2928, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

CORE BUILD-UP
D2950 Core buildup, including any pins when required.
CORE BUILDUP: D2950

- A pretreatment is strongly suggested for D2950. This is reviewed by our dental consultants and benefits are allowed when diagnostic data indicates significant tooth structure loss.

POST AND CORE
D2952 Post and core in addition to crown, indirectly fabricated.
D2954 Prefabricated post and core in addition to crown.

D9120 Fixed partial denture sectioning.

PROSTHODONTICS - FIXED/REMOVABLE (DENTURES)
D5110 Complete denture - maxillary.
D5120 Complete denture - mandibular.
D5130 Immediate denture - maxillary.
D5140 Immediate denture - mandibular.
D5211 Maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth).
D5212 Mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth).
D5213 Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth).
D5214 Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth).
D5221 Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth).
D5222 Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth).
D5223 Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth).

TYPE 3 PROCEDURES

D5224 Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth).
D5225 Maxillary partial denture-flexible base (including retentive/clasping materials, rests, and teeth).
D5226 Mandibular partial denture-flexible base (including retentive/clasping materials, rests, and teeth).
D5282 Removable unilateral partial denture-one piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary.
D5283 Removable unilateral partial denture-one piece cast metal (including retentive/clasping materials, rests, and teeth), mandibular.
D5284 Removable unilateral partial denture-one piece flexible base (including retentive/clasping materials, rests, and teeth)-per quadrant.
D5286 Removable unilateral partial denture-one piece resin (including retentive/clasping materials, rests, and teeth)-per quadrant.
D5670 Replace all teeth and acrylic on cast metal framework (maxillary).
D5671 Replace all teeth and acrylic on cast metal framework (mandibular).
D5810 Interim complete denture (maxillary).
D5811 Interim complete denture (mandibular).
D5820 Interim partial denture (including retentive/clasping materials, rests, and teeth), maxillary.
D5821 Interim partial denture (including retentive/clasping matierals, rests, and teeth), mandibular.
D5863 Overdenture - complete maxillary.
D5864 Overdenture - partial maxillary.
D5865 Overdenture - complete mandibular.
D5866 Overdenture - partial mandibular.
D5876 Add metal substructure to acrylic full denture (per arch).
D6110 Implant/abutment supported removable denture for edentulous arch - maxillary.
D6111 Implant/abutment supported removable denture for edentulous arch - mandibular.
D6112 Implant/abutment supported removable denture for partially edentulous arch - maxillary.
D6113 Implant/abutment supported removable denture for partially edentulous arch - mandibular.
D6114 Implant/abutment supported fixed denture for edentulous arch - maxillary.
D6115 Implant/abutment supported fixed denture for edentulous arch - mandibular. D6116 Implant/abutment supported fixed denture for partially edentulous arch - maxillary.
D6117 Implant/abutment supported fixed denture for partially edentulous arch - mandibular.
D6118 Implant/abutment supported interim fixed denture for edentulous arch - mandibular.
D6119 Implant/abutment supported interim fixed denture for edentulous arch - maxillary.

COMPLETE DENTURE: D5110, D5120, D5130, D5140, D5863, D5865, D5876, D6110, D6111, D6114, D6115

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months after placement date. Procedures D5863, D5865, D6110, D6111, D6114 and D6115 are considered at an alternate benefit of a D5110/D5120. Benefits for procedure D5876 is contingent upon the related denture being covered.

PARTIAL DENTURE: D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5282, D5283, D5284, D5286, D5670, D5671, D5864, D5866, D6112, D6113, D6116, D6117

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D6010, D6040, D6050, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months of placement date. Procedures D5864, D5866, D6112, D6113, D6116 and D6117 are considered at an alternate benefit of a D5213/D5214.

DENTURE ADJUSTMENTS

D5410 Adjust complete denture - maxillary.
D5411 Adjust complete denture - mandibular.
D5421 Adjust partial denture - maxillary.
D5422 Adjust partial denture - mandibular.

DENTURE ADJUSTMENT: D5410, D5411, D5421, D5422

- Coverage is limited to dates of service more than 6 months after placement date.

TYPE 3 PROCEDURES

IMPLANTS
D6010 Surgical placement of implant body: endosteal implant.
D6040 Surgical placement: eposteal implant.
D6050 Surgical placement: transosteal implant.
D6051 Interim abutment.
D6055 Connecting bar-implant supported or abutment supported.
D6056 Prefabricated abutment - includes placement.
D6057 Custom abutment - includes placement.
D6191 Semi-precision abutment-placement.
D6192 Semi-precision attachment-placement.
IMPLANT: D6010, D6040, D6050

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D5211, D5212, D5213, D5214, D5225, D5226, D5282, D5283, D5284, D5286, D6094, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Benefits for procedures D6051, D6055, D6056, D6057, D6191 and D6192 will be contingent upon the implant being covered. Replacement for procedures D6056, D6057, D6191 and D6192 are limited to 1 of any of these procedures in 5 years.

IMPLANT SERVICES
D6080 Implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prostheses and abutments.
D6081 Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure.
D6090 Repair implant supported prosthesis, by report.
D6091 Replacement of replaceable part of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment.
D6095 Repair implant abutment, by report.
D6096 Remove broken implant retaining screw.
D6100 Implant removal, by report.
D6190 Radiographic/surgical implant index, by report.
IMPLANT SERVICES: D6080, D6081, D6090, D6091, D6095, D6096, D6100, D6190

- Coverage for D6080 and D6081 is limited to 2 of any of these procedures in a 12 month period. Coverage for D6090, D6091, D6095 and D6096 is limited to service dates more than 6 months after placement date. Coverage for D6190 is limited to 1 per arch in a 24 month period.

PROSTHODONTICS - FIXED
D6058 Abutment supported porcelain/ceramic crown.
D6059 Abutment supported porcelain fused to metal crown (high noble metal).
D6060 Abutment supported porcelain fused to metal crown (predominantly base metal).
D6061 Abutment supported porcelain fused to metal crown (noble metal).
D6062 Abutment supported cast metal crown (high noble metal).
D6063 Abutment supported cast metal crown (predominantly base metal).
D6064 Abutment supported cast metal crown (noble metal).
D6065 Implant supported porcelain/ceramic crown.
D6066 Implant supported crown - porcelain fused to high noble alloys.
D6067 Implant supported crown - high noble alloys.
D6068 Abutment supported retainer for porcelain/ceramic FPD.
D6069 Abutment supported retainer for porcelain fused to metal FPD (high noble metal).
D6070 Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal).
D6071 Abutment supported retainer for porcelain fused to metal FPD (noble metal).
D6072 Abutment supported retainer for cast metal FPD (high noble metal).
D6073 Abutment supported retainer for cast metal FPD (predominantly base metal).
D6074 Abutment supported retainer for cast metal FPD (noble metal).
D6075 Implant supported retainer for ceramic FPD.
D6076 Implant supported retainer for FPD - porcelain fused to high noble alloys.

TYPE 3 PROCEDURES

D6077 Implant supported retainer for metal FPD - high noble alloy.
D6082 Implant supported crown-porcelain fused to predominantly base alloys.
D6083 Implant supported crown-porcelain fused to noble alloys.
D6084 Implant supported crown-porcelain fused to titanium and titanium alloys.
D6086 Implant supported crown-predominantly base alloys.
D6087 Implant supported crown-noble alloys.
D6088 Implant supported crown-titanium and titanium alloys.
D6094 Abutment supported crown - titanium and titanium alloys.
D6097 Abutment supported crown-porcelain fused to titanium and titanium alloys.
D6098 Implant supported retainer-porcelain fused to predominantly base alloys.
D6099 Implant supported retainer for FPD-porcelain fused to noble alloys. D6120
Implant supported retainer-porcelain fused to titanium and titanium alloys.
D6121 Implant supported retainer for metal FPD-predominantly base alloys.
D6122 Implant supported retainer for metal FPD-noble alloys.
D6123 Implant supported retainer for metal FPD-titanium and titanium alloys. D6194
Abutment supported retainer crown for FPD - titanium and titanium alloys.
D6195 Abutment supported retainer-porcelain fused to titanium and titanium alloys.
D6205 Pontic - indirect resin based composite.
D6210 Pontic - cast high noble metal.
D6211 Pontic - cast predominantly base metal.
D6212 Pontic - cast noble metal.
D6214 Pontic - titanium and titanium alloys. D6240
Pontic - porcelain fused to high noble metal.
D6241 Pontic - porcelain fused to predominantly base metal.
D6242 Pontic - porcelain fused to noble metal.
D6243 Pontic-porcelain fused to titanium and titanium alloys.
D6245 Pontic - porcelain/ceramic.
D6250 Pontic - resin with high noble metal.
D6251 Pontic - resin with predominantly base metal.
D6252 Pontic - resin with noble metal.
D6545 Retainer - cast metal for resin bonded fixed prosthesis.
D6548 Retainer - porcelain/ceramic for resin bonded fixed prosthesis.
D6549 Resin retainer - for resin bonded fixed prosthesis.
D6600 Retainer inlay - porcelain/ceramic, two surfaces.
D6601 Retainer inlay - porcelain/ceramic, three or more surfaces.
D6602 Retainer inlay - cast high noble metal, two surfaces.
D6603 Retainer inlay - cast high noble metal, three or more surfaces.
D6604 Retainer inlay - cast predominantly base metal, two surfaces.
D6605 Retainer inlay - cast predominantly base metal, three or more surfaces.
D6606 Retainer inlay - cast noble metal, two surfaces.
D6607 Retainer inlay - cast noble metal, three or more surfaces.
D6608 Retainer onlay - porcelain/ceramic, two surfaces.
D6609 Retainer onlay - porcelain/ceramic, three or more surfaces.
D6610 Retainer onlay - cast high noble metal, two surfaces.
D6611 Retainer onlay - cast high noble metal, three or more surfaces.
D6612 Retainer onlay - cast predominantly base metal, two surfaces.
D6613 Retainer onlay - cast predominantly base metal, three or more surfaces.
D6614 Retainer onlay - cast noble metal, two surfaces.
D6615 Retainer onlay - cast noble metal, three or more surfaces.
D6624 Retainer inlay - titanium.
D6634 Retainer onlay - titanium.
D6710 Retainer crown - indirect resin based composite.
D6720 Retainer crown - resin with high noble metal.
D6721 Retainer crown - resin with predominantly base metal.
D6722 Retainer crown - resin with noble metal.
D6740 Retainer crown - porcelain/ceramic.
D6750 Retainer crown - porcelain fused to high noble metal.
D6751 Retainer crown - porcelain fused to predominantly base metal.
D6752 Retainer crown - porcelain fused to noble metal.
D6753 Retainer crown-porcelain fused to titanium and titanium alloys.
D6780 Retainer crown - 3/4 cast high noble metal.

TYPE 3 PROCEDURES

D6781 Retainer crown - 3/4 cast predominantly base metal.
D6782 Retainer crown - 3/4 cast noble metal.
D6783 Retainer crown - 3/4 porcelain/ceramic.
D6784 Retainer crown 3/4-titanium and titanium alloys.
D6790 Retainer crown - full cast high noble metal.
D6791 Retainer crown - full cast predominantly base metal.
D6792 Retainer crown - full cast noble metal.
D6794 Retainer crown - titanium and titanium alloys.
D6940 Stress breaker.

FIXED PARTIAL CROWN: D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.
- Benefits will not be considered if procedure D2390, D2928, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL INLAY: D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.
- Benefits will not be considered if procedure D2390, D2928, D2929, D2930, D2931, D2932. D2933 or D2934 has been performed within 12.

FIXED PARTIAL ONLAY: D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.
- Benefits will not be considered if procedure D2390, D2928, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL PONTIC: D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252

TYPE 3 PROCEDURES

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5282, D5283, D5284, D5286, D6010, D6040, D6050, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6082, D6083, D6084, D6086, D6087, D6088, D6094, D6097, D6098, D6099, D6120, D6121, D6122, D6123, D6194, D6195, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

IMPLANT SUPPORTED CROWN: D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6082, D6083, D6084, D6086, D6087, D6088, D6094, D6097

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5282, D5283, D5284, D5286, D6194, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

IMPLANT SUPPORTED RETAINER: D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6098, D6099, D6120, D6121, D6122, D6123, D6194, D6195

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5282, D5283, D5284, D5286, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6082, D6083, D6084, D6086, D6087, D6088, D6094, D6097, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, also contribute(s) to this limitation
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

BONE AUGMENTATION

D6104 Bone graft at time of implant placement.
D7950 Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla - autogenous or nonautogenous, by report.
D7951 Sinus augmentation with bone or bone substitutes via a lateral open approach.
D7952 Sinus augmentation via a vertical approach.
D7953 Bone replacement graft for ridge preservation - per site.

BONE AUGMENTATION: D6104, D7950, D7951, D7952, D7953

- Each quadrant is limited to 1 of any of these procedures per 5 year(s).
- Coverage of D6104, D7950, D7951, D7952 and D7953 is limited to the treatment and placement of endosteal implant D6010, D6040 eposteal implant or D6050 transosteal implant.

OCCLUSAL GUARD

D9944 Occlusal guard - hard appliance, full arch.
D9945 Occlusal guard - soft appliance, full arch.
D9946 Occlusal guard - hard appliance, partial arch.

OCCLUSAL GUARD: D9944, D9945, D9946

- Coverage is limited to 1 of any of these procedures per 3 year(s).
- Benefits will not be available if performed for athletic purposes.

OCCLUSAL ADJUSTMENT

D9951 Occlusal adjustment - limited.
D9952 Occlusal adjustment - complete.

OCCLUSAL ADJUSTMENT: D9951, D9952

- Coverage is considered only when performed in conjunction with periodontal procedures for the treatment of periodontal disease.

BENEFIT PERIOD - Benefit Year

For Additional Limitations - See Limitations

NON-SURGICAL MISCELLANEOUS

D0322	Tomographic survey.
D0340	2D Cephalometric radiographic image - acquisition, measurement and analysis.
D0368	Cone beam CT capture and interpretation for TMJ series including two or more exposures.
D0369	Maxillofacial MRI capture and interpretation.
D0384	Cone beam CT image capture for TMJ series including two or more exposures.
D0385	Maxillofacial MRI image capture.
D0391	Interpretation of diagnostic image by a practitioner not associated with capture of the image, including report.
D0470	Diagnostic casts.
D7880	Occlusal orthotic device, by report.
D7881	Occlusal orthotic device adjustment.
D9130	Temporomandibular joint dysfunction - non-invasive physical therapies.

Services Not Covered by the Plan

Unless otherwise stated in the *Benefits Summary,* the following are not covered:

- Services that are not *dentally necessary* and appropriate according to *our* review guidelines. Services subject to these guidelines include, but are not limited to, root canals; crowns and related services; bridges; periodontal services; *orthodontics;* and, oral surgery. *We* will make a decision whether a service is *dentally necessary* based on these guidelines. A service may not be covered under these guidelines even if it was recommended by a *dentist. Our* guidelines can be found on *our* website at www.altusdental.com. *You* can have *your dentist* send *us* a request for a Pre-treatment Estimate in advance of the service to see if the service meets *our* guidelines.
- Services greater than the *annual maximum.*
- Services received from a dental or medical department maintained by or on behalf of an employer; a mutual benefit association; labor union; trustee; or, similar person or group.
- An illness or injury that *we* decide is employment-related.
- Services *you* would not have to pay for if *you* did not have this Altus Dental coverage.
- Services or supplies that are experimental in terms of generally accepted dental standards.
- Services done by a *dentist* who is a member of *your* immediate family.
- An illness, injury or dental condition for which benefits are, or would have been available, through a government program if *you* did not have this Altus Dental coverage.
- Services done by someone who is not a licensed *dentist* or a licensed *hygienist* working as authorized by applicable law.
- Disorders related to the temporomandibular joints – (TMJ), including night guards and surgery.
- Services to increase the height of teeth or restore occlusion.
- Restorations needed because *you* grind *your* teeth or due to erosion, abrasion, or attrition.
- Services done mainly to change or to improve *your* appearance.
- Splinting and other services to stabilize teeth.
- Laboratory or bacteriological tests or reports.
- Temporary, complete dentures or temporary, fixed bridges or crowns.
- Prescription drugs.
- General anesthesia or intravenous sedation given by anyone other than a *dentist*.
- General anesthesia or intravenous sedation for non-surgical extractions, diagnostic, preventive, or minor restorative services.

We can adopt and apply policies that *we* deem reasonable when *we* approve the eligibility of *subscribers;* and, the appropriateness of treatment plans and related charges.



Certificate of Coverage

Altus Dental Preferred and Altus Dental Plus

Effective Date: January 1, 2026
Date of Issue: January 1, 2026

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Altus Dental Insurance Company, Inc.

Certificate of Coverage

Altus Dental Preferred and Altus Dental Plus

Welcome to Altus Dental. This *Certificate* is a means through which *we* at Altus Dental Insurance Company, Inc. in consideration of the application for benefits and payment of applicable fees agree to provide benefits.

This *Certificate*, along with the *Benefits Summary* describes the *Plan*. It describes the dental services covered by *your Plan.* It also explains how each is paid for and tells *you* how to use the *Plan.* If *you* have any questions, please contact Customer Service.

***Our* toll free Customer Service number is:**

1-877-223-0588

Customer Service representatives are available Monday – Friday from 8 a.m. to 5 p.m. ET. *Our* automated information line is available 24 hours a day, seven days a week. *You* may also contact *us* on the Internet at **www.altusdental.com.**

Claims and written correspondence should be sent to:

Altus Dental Insurance Company, Inc.
P.O. Box 1557
Providence, R.I. 02901-1557

NOTICE OF NONDISCRIMINATION AND ACCESSIBILITY POLICY & AVAILABILITY OF LANGUAGE ASSISTANCE

Altus Dental Insurance Co. does not discriminate on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability, or sex, including characteristics, orientation, identity, stereotypes, and pregnancy and related conditions.

We provide appropriate, free, and timely aids and services, including qualified interpreters, for individuals and information in alternate formats, when such aids and services are necessary to ensure an equal opportunity to participate to individuals with disabilities.

We provide language assistance services, including translated documents and oral interpretation, free of charge and in a timely manner when such services are necessary to provide meaningful access to individuals with limited English proficiency.

If *you* need these services, contact *us* at 1-877-223-0588.

If *you* believe *we* have failed to provide these services or discriminated on the basis of race, color, national origin, age, disability, or sex, *you* can file a grievance with: Civil Rights and Section 1557 Coordinator, Altus Dental Insurance Co., 10 Charles Street, Providence, RI 02904, or by calling 1-877-223-0588, TTY: 711, or fax to: (401) 457-7240, or email to customerservice@altusdental.com. *You* can file a grievance in person or by mail, fax, or email. If *you* need help filing a grievance, *our* Civil Rights and Section 1557 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 DC 20201; 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

English: ATTENTION: If *you* speak another language, free language assistance services are available to *you.* Call 1-877-223-0588.

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-223-0588.

Português (Portuguese): ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-877-223-0588.

繁體中文 (Chinese): 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-223-0588.

Kreyòl Ayisyen (French Creole): ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-877-223-0588.

ខ្មែរ (Cambodian): ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-877-223-0588.

Français (French): ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-223-0588.

Italiano (Italian): ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-877-223-0588.

ພາສາລາວ (Lao): ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງ ຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-877-223-0588.

ية (Arabic):
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-877-223-0588
(رقم هاتف الصم والبكم: 1-877-223-0588).

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-223-0588.

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-223-0588.

Ɓàsɔ́ɔ̀-wùɖù-po-nyɔ̀ (Bassa): Dè ɖɛ nìà kɛ dyéɖé gbo: Ɔ jǔ ké m̀ [Ɓàsɔ́ɔ̀-wùɖù-po-nyɔ̀] jǔ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀ ɓéìn m̀ gbo kpáa. Đá 1-877-223-0588.

Igbo asusu (Ibo): Ige nti: O buru na asu Ibo asusu, enyemaka diri gi site na call 1-877-223-0588.

èdè Yorùbá (Yoruba): AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi 1-877-223-0588.

Polski (Polish): UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-223-0588.

한국어 (Korean): 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-223-0588 번으로 전화해 주십시오.

Tagalog (Tagalog – Filipino): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-223-0588.

हिंदी (Hindi): ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-877-223-0588 पर कॉल करें।

ગુજરાતી (Gujarati): સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-877-223-0588.

λληνικά (Greek): ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-877-223-0588.

Definitions

This document contains words used in insurance and dentistry. These words have specific meanings that are described below. Insurance or dental terms used in this document will be in *italics.* If *you* are not clear about the meaning of the words used, please refer back to this page.

- *Adverse Benefit Decision* means a decision by Altus Dental not to pay (in whole or in part) for a *covered service*, including a denial; reduction; termination; or, failure to make a payment based on the imposition of a pre-existing condition exclusion; a source of injury exclusion; retroactive rescission of coverage; or, other limitation on *covered services.*
- *Allowance* means the amount *we* base payment on for a *covered service* or procedure.

  The *Allowance* for an *In-Network Dentist* is the LOWEST of the:
  a) Amount the *in-network dentist* has agreed to accept by contract as payment in full for the service;
  b) Maximum amount *we* will pay any *dentist* for a *covered service* or procedure; or
  c) Amount charged by the *dentist*.

  In-network dentists cannot charge Altus Dental *members* more than their *allowance.*

  The *Allowance* for an *Out-of-Network Dentist* is the LOWEST of the:
  a) Usual charge by the *dentist* for the same or similar services or supplies;
  b) Average amount *we* determine that most other *dentists* in the same geographic area charge for the same or similar services or supplies; or
  c) Actual charge for the services or supplies.
- *Annual Maximum* means the most *we* will pay for *covered services* for a continuous 12-month period (usually a calendar year). The *annual maximum* is stated in the *Benefits Summary.*
- *Benefits Summary* is a summary description of the services covered under this dental Policy; with a schedule that shows *you* how much *we* pay toward a procedure. If a service is not listed in the *Benefits Summary, we* will not pay for it.
- *Certificate* means this document and the applicable *Benefits Summary* pages, including any rider pages. This *Certificate* is *your* policy.
- *Coinsurance/Copayment* means the amount *you* pay for *covered services*, after the *deductible*, if any, is met. *Coinsurance* is usually shown as a percentage and *copayment* as a fixed dollar amount. The amount of *coinsurance/copayment* varies with the type of *covered services.*
- *Coverage Level* means the amount *we* pay for *covered services,* after the *deductible* and/or *copayment,* if any, is met. The *coverage level* varies with the type of *covered services* and is shown in the *Benefits Summary*.

- *Covered Services* means those services and procedures listed in the *Benefits Summary.* All *covered services* must be *dentally necessary* and appropriate to qualify for payment.
- *Date of Service* means the date that the service was done. For services requiring more than one visit, except *orthodontics*, the *Date of Service* is the final completion date (Examples: the insertion date of a denture; the date a permanent crown is cemented).
- *Deductible* (if applicable) means the amount *you* pay toward *covered services* before *we* begin paying benefits. *Deductibles* must be met each *year. Deductibles* may vary by type of benefits or by type of provider (in-network vs. out-of-network) and are specific dollar amounts for each *subscriber* and/or *dependent* per *year.*
- *Dentally Necessary (Dental Necessity)* means that the dental services provided are:
  - appropriate, in terms of type, amount, frequency, level, setting and duration to the *member's* diagnosis or condition;
  - consistent with the symptoms and appropriate and effective for the diagnosis, treatment, or care of the oral condition, disease, or injury for which it is prescribed or performed;
  - appropriate with regard to generally accepted standards of dental practice within the dental community or scientific evidence related thereto; AND
  - the most appropriate level of service which can safely be provided to the *member.*

  We will make a determination whether a service is *dentally necessary* based on the criteria set forth in the utilization review plan and guidelines ("review guidelines") that *we* file with the Rhode Island Office of the Health Insurance Commissioner. A copy of these review guidelines is available on *our* website at: www.altusdental.com. *You* have the right to appeal *our* determination or to take legal action as described in the **Claims Procedures** section of this *Certificate*.

- *Dentist* means any person duly licensed as a Doctor of Dental Medicine (DMD) or Doctor of Dental Surgery (DDS) practicing within the authority of his or her license. The term *dentist* includes an oral surgeon.
- *Dependent* typically means *your spouse* and *your* unmarried *dependent* children up to a certain age. A *spouse* includes a party to a same sex marriage; civil union; or, similar union entered into under applicable state laws. Refer to *your Benefits Summary* for *dependent* children age limits. ***Your plan sponsor* determines *dependent* eligibility requirements.** If *you* have family coverage, *your* newborn infant and a newborn infant of a *dependent* child are eligible for coverage from birth. Adopted children are covered from the date of placement in the home. Foster children are covered from the date of the filing of the petition to adopt. Stepchildren and children under *your* own or *your spouse's* legal guardianship who permanently live in *your* household and are chiefly dependent on *you* for support, are also considered *dependent* children. Married children are not considered *dependents,* regardless of their age.

- *Effective Date* means the date, as shown on *our* records, that *your* coverage begins under this contract or an amendment to it.
- *Emergency Care* means services given to treat a person with a serious medical or health problem. A medical problem includes physical, mental, and dental conditions. *Emergency care* is limited to services which are palliative (to relieve pain) and/or temporary and does not include services such as permanent fillings, crowns or root canals.
- *Endodontics* means a specialty of dentistry that deals with treatment of dental pulp diseases (nerves, blood vessels and other tissues within the tooth). A root canal is an example of *endodontic* treatment.
- *Hygienist* means any person duly licensed as a dental *hygienist* practicing within the authority of his or her license.
- *In-Network Dentist (or Network Dentist) (or Participating Dentist)* means a *dentist* who participates in the *network* available under *your Plan* and has a contractual agreement to accept the *allowance* as payment in full for *covered services.*
- *Lifetime Maximum* means the maximum amount of dollars *we* will allow for *covered services* during a *subscriber's* or *dependent's* lifetime. This provision usually applies only to *orthodontic* services and implants if covered by *your plan.*
- *Material Change* means a modification to any of Altus Dental's procedures or documents required by Massachusetts regulation 211 CMR 52.00 that substantially affects the rights or responsibilities of an insured, carrier or health care provider.
- *Medically Necessary Orthodontics* means the patient under age 19 must have severe and handicapping malocclusion (faulty contact of upper and lower teeth in biting); as defined by *our* review guidelines.
- *Member* means a *Subscriber* or *Dependent*.
- *Network* means a group or groups of *participating dentists* providing dental services under this *Plan* who have agreed to accept the *allowance* as payment in full for *covered services.*
- *Non-participating Dentist* – see "out-of-network dentist."
- *Orthodontics* means a specialty of dentistry concerned with prevention and correction of abnormalities in tooth position and their relationship to the jaw (straightening of teeth).
- *Out-of-Network Dentist (or Non-participating Dentist)* means a *dentist* who does not participate in the *network* available under *your Plan* and has not entered into a contractual agreement to accept the *allowance* as payment in full for *covered services*.
- *Participating Dentist* – see "in-network dentist."
- *Pedodontics* means a specialty of dentistry concerned with the treatment of children.
- *Periodontics* means a specialty of dentistry concerned with diseases of the gums and other supportive structures of the teeth.

- *Plan* means the terms, conditions and benefits described in this *Certificate* and applicable *Benefits Summary* pages, including any rider pages.
- *Plan Sponsor* means *your* employer or other organization / association that is sponsoring the *Plan.* In the case of a group subject to the Employee Retirement Income Security Act of 1974 (ERISA), as amended, the *Plan Sponsor* is the individual or entity designated under that Act.
- *Policy Year* means the continuous 12 month period under which coverage is offered by *your plan sponsor. Your policy year* is either the calendar year or the timeframe beginning with *your* group's coverage start date and ending 12 months later.
- *Prosthodontics* means a specialty of dentistry concerned with the replacement of missing teeth by bridges and dentures.
- *Spouse* means *your* legal *spouse.* A *spouse* includes a party to a same sex marriage; civil union; or, similar union entered into under applicable state laws.
- *Subscriber* means someone who has applied for coverage and been approved by *us* and is eligible to receive benefits under this *Certificate*. In the case of a *subscriber* who is less than 18 years of age, the parent or legal guardian must contract on behalf of the dependent child for the benefits described in this *Certificate.* The parent or legal guardian must assure the dependent child's compliance with any and all terms and conditions outlined in the policy.
- *Usual and Customary Charge* means that charge which is the lowest of: the usual charge by the *dentist* for the same or similar services or supplies; or the average amount *we* determine that most other *dentists* in the same geographic area charge for the same or similar services or supplies; or the actual charge for the services or supplies.
- *Waiting Period* is the amount of time *you* must wait from *your effective date* before a service is covered. If *your plan* has a *waiting period,* it will be shown in the *Benefits Summary* that goes with this *Certificate.*
- *We, Our, Us* and *Altus Dental* means *Altus Dental Insurance Company, Inc.* located at 10 Charles Street, Providence, RI 02904-2208.
- *You* and *Your* means the *subscriber or member covered under this Certificate*.

When You Join the Plan

Who Can Join

You and/or *your* eligible *dependents* can join the *Plan* if *your Plan Sponsor* agrees and complies with *our* underwriting guidelines. ***Your plan sponsor*** **determines eligibility requirements for *dependents.*** A parent or legal guardian must contract on behalf of a child who is less than 18 years old. The parent or legal guardian is liable for the child's compliance with any and all policy terms and conditions.

Your eligible *dependents* typically are:

- ***Your* legal spouse. A *spouse* includes a party to a same sex marriage; civil union; or, similar union entered into under applicable state laws.** In the event of divorce, *your* ex-spouse will be eligible for continued coverage under the policy without additional premium until either spouse remarries. This is true unless the divorce or separation judgment states otherwise. If *you* remarry, the ex-spouse may, if so stated in the divorce judgment, stay covered as a *member* at additional premium.
- ***Your* unmarried *dependent* children** up to a certain age. Refer to *your Benefits Summary* for age limits.
- ***Your* unmarried children who have reached the *dependent* age limit up to a higher student age limit,** if a full-time student at an accredited secondary school or college and he or she is primarily dependent on *you* for support;

  NOTE: *Your plan sponsor* must agree to purchase a coverage for this extended period of time. If applicable, the student age limit will be noted in *your Benefits Summary.*
- ***Your* unmarried children who have reached the *dependent* age limit; and, who are mentally or physically disabled and cannot earn a living.** To continue coverage, *you* must submit proof of *your* child's disability within 30 days of the child reaching the *dependent* age limit. The proof must be acceptable to *us*. *You* must continue to provide proof of the disability upon request.

How You Join

You join by completing, signing and returning to *us;* or, to *your plan sponsor* an applicable form. Forms are available from *us* or *your plan sponsor,* or *you* may be able to enroll online. If *your* family status changes and *you* need to add or remove *dependents* from *your plan*, contact *us* or *your plan sponsor*. *We* can only accept membership changes from a *Subscriber* or *your plan sponsor*.

When Coverage Begins

Coverage generally starts the first of the month after *we* accept *your* completed and signed enrollment form and payment arrangements. *Your plan sponsor* can tell *you* if a *waiting period* is required.

You must wait until *your plan sponsor's* next open enrollment period, if *you* or *your dependent(s)* do not enroll when first eligible. *You* may also enroll when there is a qualifying event.

If *you* marry, *you* may enroll *your spouse* within 60 days of marriage. *You* must wait until *your plan sponsor's* next open enrollment period if *your spouse* does not enroll when first eligible. *Your spouse* may also enroll when there is a qualifying event.

If *you* have family coverage, *your* newborn infant and the newborn infant of a *dependent* child are covered from birth. Adopted children are covered from the date of home placement. Foster children are covered from the date of the petition to adopt. Stepchildren and children are considered dependent children if they: are under *your* own or *your spouse's* legal custody; permanently live in *your* household; and, chiefly depend on *you* for support. *We* do not consider married children *dependents,* regardless of their age.

Coverage generally begins on the first of the month after *we* accept *your* enrollment form. If *you* don't enroll within 60 days, *you* must wait until the next open enrollment period to enroll *dependents. Dependents* may enroll when there is a qualifying event.

Notify *us* and *your plan sponsor* of any changes in *your* or *your dependent's* status. This includes marriage; births; attainment of the *dependent* or student (if applicable) age limits; or, changes in *your* address. This will help us maintain up to date eligibility and billing records.

The Cost of Your Coverage

You and/or *your plan sponsor* pay the cost of coverage for *you* and *your* eligible *dependents.* The cost of coverage is based on the arrangement agreed to by *your plan sponsor.* This arrangement must comply with *our* underwriting guidelines.

When Coverage Ends

We or *your plan sponsor* may cancel *your* group's contract under the terms of *our* contract with *your* group. If *your* group's contract is cancelled, *your* coverage will also be terminated on the same date. If *your* group's contract is cancelled for nonpayment of premiums, *we* will duly notify *you* of the cancellation in writing. *We* will honor any claims for *covered services* rendered before the written cancellation date.

In addition, *your* coverage may be cancelled for the following reasons (coverage generally ends on the last day of the month):

- Appropriate premium payments are not made;
- *You* or *your plan sponsor* cancel coverage;
- *You* cease being eligible;
- *You* engage in misrepresentation or fraud;
- *You* commit acts of physical or verbal abuse against a provider or other insured *member.*

The voluntary disenrollment rate among insureds of Altus Dental is 0%. The involuntary disenrollment rate among insureds is 0%.

When Your Dependent's Coverage Ends

Your dependent's coverage typically ends:

- When *you* become legally divorced from *your spouse**, *your* former *dependent spouse* will, unless specified in a court judgment, continue to be considered *your dependent* until the earliest of:
  a. the date *you* remarry, unless coverage must be provided as set forth in the divorce judgment. In that case, *your* ex-spouse can continue to be covered as a *member* of the group at an additional premium; or
  b. the date *your* former *dependent spouse* remarries; or
  c. the date when he/she ceases to be eligible for continued coverage as specified in the divorce judgment; or
  d. the date when *you* or *your spouse* cancels coverage; or
  e. the date when *your plan* would have otherwise ended; or
  f. the date when appropriate premium payments are not made.

** A spouse includes a party to a same sex marriage; civil union; or, similar union entered into under applicable state laws.*

- At the end of the month in which an eligible *dependent* child marries; or

- When a *dependent* child reaches the *dependent* age limit as set forth in *your Plan's Benefits Summary.*

NOTE: If *your* unmarried *dependent* child is mentally or physically disabled upon reaching the *dependent* age limit; and, he/she cannot earn a living, *you* may apply for continued coverage through *your plan sponsor.* *You* have 30 days from the date *your* child reaches the *dependent* age limit to apply. *You* must include the medical reason for *your* request. *We* will review *your* application to decide if it meets *our* criteria.

NOTE: If *your plan sponsor* has purchased coverage for students, coverage for a *dependent* child may continue past the *dependent* age limit if enrolled as a full-time student. If *you* have such coverage, the option will be noted in *your Benefits Summary* with a student age limit.

Benefits After Cancellation

All services must be complete to qualify for benefits. For example, permanent crowns must be cemented; bridges or dentures must be inserted. Once *your* coverage is cancelled, *you* will not have benefits for services finished after *your* cancellation date. *Your* covered family *members* will not have benefits either.

When You May Rejoin the Plan

A *member* who voluntarily cancels membership in the group *plan* may not re-enroll in that group *plan* until at least one year after the date of cancellation. The re-enrollment must occur during the group's open enrollment period. If *your Benefits Summary* notes that there is a *waiting period* applicable to any services, this *waiting period* begins again with the new *effective date.* No reinstatement of coverage back to the original *effective date* is allowed.

You may rejoin through a different group plan anytime *you* become eligible for that plan. *Lifetime maximums* and claim history accumulated while covered under a previous plan or any other plan may be carried forward to the new plan.

Features of the Plan

Your plan is designed to help *you* maintain good dental health through regular dental care. It will help *you* to pay for dental expenses. *We* describe *your* exact coverage in the *Benefits Summary.*

Utilization Review Guidelines

Our Dental Case Management area performs clinical claims reviews. These reviews help *us* decide if the service meets *our* review guidelines. Analysts who review claims are registered dental *hygienists;* or, dental assistants with clinical experience. The analysts review claims. They can approve services. Only a dental consultant, who is a licensed *dentist,* can deny a claim.

We review claims using written review guidelines. *We* base *our* guidelines on accepted standards of care in the dental profession. They are backed by statistical studies of practice patterns. These guidelines, as well as contract limits, are the basis for review decisions. *We* create clinical guidelines and utilization review standards with guidance from the Dental Director; in-house dental consultants; and, a dental advisory committee. The committee is made up of licensed *dentists. Our* dental consultants and dental advisory committee study trends in dentistry; the proven value of new materials and procedures; treatment longevity; and, local and national practice patterns.

Quality Management Programs

We strive to provide high quality products and services. *We* do this by monitoring, identifying, and tracking key issues over time. *We* deal with these issues as part of *our* review of *our* Quality Program.

Assessment of New Dental Materials and Treatments

We study new dental materials and treatments. *We* also study how effective they are and the cost. Then, *we* decide if *we* will cover the material or treatment.

Continuity of Care

If *your dentist* moves or ever decides not to participate, *you* can choose a new *dentist* from the network. There will not be any disruption in *your* coverage or benefits. If *you* change from an *in-network dentist* to an *out-of-network dentist,* the treatment or procedure would still be covered. This is true so long as it is a *covered service*; but, *you* will be responsible for any difference between *our* payment and the *dentist's* charge.

Pre-treatment Estimate / Prior Authorization

A pre-treatment estimate / prior authorization is a claim that is filed before *you* have a dental service.

Pre-treatment Estimate

When treatment is likely to cost more than $300, *you* and *your dentist* are strongly encouraged to get an estimate before *you* receive treatment. This includes treatment such as crowns; *periodontic; prosthodontic;* and *orthodontic* services.

Prior Authorization

Prior authorization is required for *medically necessary orthodontic* treatment if covered by *your Plan.* *Medically necessary orthodontics* is covered for *dependent* children under age 19 only if there is an EHB pediatric dental rider with the *Plan.* Refer to the *Benefits Summary* pages of *your Certificate.* The treatment must meet *our* criteria. **No payment will be made if prior authorization is not obtained.**

After *your dentist* sends a request, *we* will review the treatment plan. After reviewing the treatment plan, *we* will tell *you* and *your dentist* what the estimated payment will be for those services.

NOTE: Estimates are based on available benefits. The patient must be an Altus Dental *member* at the time the service is done. The estimate shows what money is available at the time the estimate is done. Estimates can change because services may no longer be available on the date the service is done. For example, if *you* had other services paid for after the estimate, and *you* reach *your annual maximum,* there will be no money left to pay for the new service. Another example is if *you* lose coverage before the new service is finished.

How to Use Altus Dental

You pay a set dollar amount or a percentage thereof for each *covered service* (or nothing for some services). The amount *we* pay is shown in the *Benefits Summary. You* may go to any *dentist you* choose. You must first pay the *deductible* amount, if applicable, for *covered services* before *we* make any payment. There are advantages to going to a *dentist* that is part of the *network.* When *you* visit a *network dentist,* after the *deductible* is met, *you* pay only the *copayment/coinsurance* amount for *covered services.* However, if *you* visit an *out-of-network dentist,* after *you* pay the *deductible* and any *copayment/coinsurance* amount; *you* also pay the difference between the *out-of-network dentist's* charge and the amount *we* pay. *Our* payment varies. See the *Definitions* section of this *Certificate* for a detailed explanation of how *we* pay claims for services done by *out-of-network dentists*.

Maximize Your Coverage with In-Network Dentists

If *you* go to an *in-network dentist, your* out-of-pocket expenses will generally be less. The *dentist* will file claims on *your* behalf. *We* will pay *in-network dentists* directly. By choosing an *in-network dentist, you* get the best value from *your* dental *plan*.

You can go to a *dentist* that is not in the *network.* When *you* go to an *out-of-network dentist, you* are responsible for filing the claim; and, for paying the *dentist.* Most *out-of-network dentists* will file the claim on *your* behalf. *Your* out-of-pocket cost will be more; because, after you pay the deductible and any *copayment/coinsurance* amount, *you* also pay the difference between the *out-of-network dentist's* charge and the amount *we* pay.

Finding an In-Network Dentist

To find a *dentist* participating in the *network,* visit *our* website – www.altusdental.com. The Altus Dental *network* includes general *dentists* and specialists throughout Massachusetts and Rhode Island, and in New Hampshire and Vermont border towns.

If *your plan* has access to *network dentists* in other states including Vermont, the additional *network(s)* will be noted on *your* Altus Dental member identification card. In addition to *dentists* in *our* Altus Dental *network, you* can choose a *dentist* from one of these *networks* and get the advantages of visiting an *in-network dentist.* Follow the instructions in *our* "Find a Dentist" tool on *our* website to find a *dentist* in the *network.*

Network dentists will file claims on *your* behalf; and, *we* will pay them directly. They also agree to accept the *allowance* as payment in full for *covered services.*

We do not require *you* or *your dentist* to get referrals to see a specialist; however, not all services done by a specialist may be covered under *your plan.* Check *your Benefits Summary* for a list of *covered services.*

Payments for Services

In-network dentists will accept *your co-pay/coinsurance* plus *our* payment as payment in full for *covered services*. *We* will pay *in-network dentists* directly. When *your network dentist* provides services that are not covered; or, *covered services* that do not meet *dental necessity* criteria as per *our* review guidelines, *you* may be liable for the *dentist's* charge.

Y*our network dentist* may charge *you* more than the *allowance* when:

- *You* or *your dependents* receive *covered services;* and, *you* have gone over the *annual maximum*.

- *You* and *your dentist* decide to use non-covered services; such as, treatments or materials that cost more than those normally given by most *dentists;* or, that are being done to improve *your* appearance. In these cases, *we* may pay an *allowance* suitable for a less costly, generally accepted material or service.

Out-of-network dentists have not agreed to accept *your co-pay/coinsurance* plus *our* payment as payment in full for *covered services. You* will pay more. That's because, after you pay the *deductible* and any *copayment/coinsurance* amount, *you* also pay the difference between the *out-of-network dentist's* charge and the amount *we* pay. *Our* payment varies. See the *Definitions* section of this *Certificate* for a detailed explanation of how *we* pay claims for services done by *out-of-network dentists*.

When an *out-of-network dentist* treats *you, we* will make benefit payments to *you;* unless, *you* and *your dentist* agree to assign benefit payment to *your dentist*. *Your dentist* may not agree to this; and, he/she may request payment from *you.*

If *your Benefits Summary* indicates *you* have Altus Dental Preferred, *we* will pay for services rendered by *out-of-network dentists* at no less than 80% of the in-network *coverage level* (illustrated in *your Benefits Summary)* for that type of service, based on the *usual and customary charge* for *your dentist's* area, less any applicable *deductible(s), copayments* or *coinsurance* that are *your* responsibility. *You* are responsible for any difference between *our* payment and the *out-of-network dentist's* charge.

Altus Dental Preferred
Example* of How Claims are Paid – *In-Network* v. *Out-of-Network Dentist*

	In-Network Dentist	***Out-of-Network Dentist***
Type of Service	Root Canal	Root Canal
Dentist's Charge	$840	$840
Allowance	$680	N/A
Usual and Customary Charge	N/A	$810
*Coverage Level*** (Refer to *your Benefits Summary)*	80% (in-network)	64% (80% of 80%) (out-of-network)
Altus Payment	$544 (80% of the $680 *allowance*)	$518.40 (64% of the $810 *usual and customary charge*)
You Pay	$136 (the difference between *our* payment and the *allowance)*	$321.60 (the difference between *our* payment and the *dentist's* charge)

***These are examples only. Actual charges and *allowance*s will vary.** All services must be complete to qualify for benefits (e.g., permanent crowns cemented, bridge or denture inserted).

****Some Preferred Plans may have a Point of Service (POS) option.** With this option, some services may be covered at the same *coverage level* in and out of network, while others have higher coverage amounts for services received from an *in-network dentist.*

If *your Benefits Summary* indicates *you* have Altus Dental Plus, *we* will pay for services rendered by *out-of-network dentists* at the *coverage level* (illustrated in *your Benefits Summary*) for that type of service, based on the *usual and customary charge* for *your dentist's* area, less any applicable *deductible(s), copayments* or *coinsurance* that are *your* responsibility. *You* are responsible for any difference between *our* payment and the *out-of-network dentist's* charge.

Altus Dental Plus
Example* of How Claims are Paid – *In-Network* v. *Out-of-Network Dentist*

	In-Network Dentist	***Out-of-Network Dentist***
Type of Service	Root Canal	Root Canal
Dentist's Charge	$840	$840
Allowance	$680	N/A
Usual and Customary Charge	N/A	$810
Coverage Level (Refer to *your Benefits Summary)*	80%	80%
Altus Payment	$544 (80% of the $680 *allowance*)	$648 (80% of the $810 *usual and customary charge*)
You Pay	$136 (the difference between *our* payment and the *allowance*)	$192 (the difference between *our* payment and the *dentist's* charge)

***These are examples only. Actual charges and *allowances* will vary.** All services must be complete to qualify for benefits (e.g., permanent crowns cemented, bridge or denture inserted).

NOTE:

- If *you* see more than one *dentist* for the same service; or, need more than one visit, the total amount of *your* benefits will not be more than the amount *you* would have received if only one *dentist* had given all of the treatment. *You* may be liable for the difference.

- If *you* or *your dependent* has coverage for *orthodontic* treatment, *we* will make periodic payments for covered *orthodontic* services spread over the expected course of the treatment. If *you* or *your dependent* is already in active treatment when *you*/he/she becomes eligible for these services, *we* will prorate *our* payments for the remaining treatment. Should coverage cease during active treatment, *we* will discontinue payments as of the date the coverage ended regardless of whether or not the treatment is complete.

Emergency Services

If *you or your covered dependents* require *emergency care* and cannot reasonably reach an *in-network dentist*, payment will be made at the same level and in the same manner as if the treating *dentist* was an *in-network dentist*.

We cover services received in a dental facility by a licensed *dentist,* as long as they are covered under *your plan. We* do not cover services received in a hospital; surgi-center; or, urgent care facility.

In the case of a life-threatening emergency, *you* should go to the nearest hospital. Hospital claims must be sent to *your* medical insurance plan. If *you* have an urgent dental condition, *you* should go to the nearest *dentist's* office. *You* do not need prior approval. *We* will only pay for *covered services.* Most dental offices treat existing patients within 24 hours for an urgent appointment. If *you* need help finding a *dentist* participating in the *network,* call *us* at 877-223-0588. *You* may also use *our* online tool at www.altusdental.com.

Medically Necessary Orthodontics

Medically necessary orthodontics (braces and related services) is covered for *members* under the age of 19 only if there is an EHB pediatric dental rider with the *Plan.* Refer to the *Benefits Summary* pages of *your Certificate.* This means that the *member* must have severe and handicapping malocclusion (faulty contact of upper and lower teeth in biting) as defined by a specific scoring used in this area of dental specialty that is referred to as the HLD index score. Treatment is also covered if one or more automatic qualifying conditions is met. Guidelines for determining medical necessity are found at altusdental.com. **Before treatment starts, *you* must have *your dentist* send *us* documentation for approval. *Your dentist* may do this by sending *us* a *pre-treatment estimate* form.**

When Your Benefits May Be Continued

When You Leave the Group

If *you* leave the group to which this policy has been issued, *you* may continue coverage, at *your* expense, for the 31-day period after the date such benefits would have ended because *your* employment ended. However, coverage will terminate on the earliest of: the date *you* become eligible for other similar coverage, the day the policy ends or the day any premium payable by *you* is due and unpaid.

Federal Election to Continue Coverage (COBRA)

You and *your dependents* may have the right to continue coverage through *your plan sponsor* under the provision of the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). Contact *your plan sponsor* for information concerning this option.

You and *your dependents* may have the right to continue coverage for limited periods under various state laws even under conditions that would otherwise make *you* ineligible for coverage, so long as the appropriate premium is paid in full. Contact *your plan sponsor* for information concerning these options.

When There is Other Coverage

Right to Receive and Release Needed Information

Certain information, including but not limited to Coordination of Benefits (COB), is needed to accurately process claims. *We* have the right to receive information reasonably related to a claim filed under the *plan*. *We* can get this information from, or give it to, any organization or person with a legitimate interest. When *you* file a claim, *you* must give *us* any information needed to process the claim. *You* must give *us* information regarding other insurance coverage when *you* first enroll. *You* must also let *your dentist* know of other coverage when *you* receive care. *We* will ask *you* for updated information from time to time.

Coordination of Benefits

Your plan is designed to prevent overpayment of benefits when *you* or a *dependent* is covered under more than one Plan. The other Plan may be a dental Plan or a medical plan that covers certain services also covered under this p*lan*.

When *you* are covered by more than one Plan, one Plan is the "primary" Plan and the others are "secondary" Plans. When *you* file a claim, the primary Plan pays benefits first, up to the limits of the Plan. The secondary Plans adjust their benefits so that the total amount paid does not exceed the cost of *covered services*. This process is called "Coordination of Benefits" (COB). If *you,* or a family *member,* are also covered by other medical or dental plans, *we* will coordinate payment with them. *We* use standard

insurance industry guidelines in most cases. The standard guidelines that govern this process are set forth below. If other guidelines apply to *your Plan,* they will be noted on *your Benefits Summary.* As used in these rules, the terms "Plan" and "Allowable Expenses" are defined as follows:

- "Plan" means any plan providing dental benefits or services, including government and insured or self-insured group or group-type coverages through an HMO or other prepayment, group practice or individual practice plan.

- "Allowable Expenses" means a necessary, *usual and customary* item of expense for dental care, all or part of which is covered by at least one Plan covering the person for whom the claim is made. Where a Plan provides dental benefits in the form of services rather than cash payments, the reasonable cash value of each service received will be considered both an Allowable Expense and a benefit paid.

The effect of the COB rules on benefits payable during any particular claim period is as follows: If *you* are covered under more than one Plan, the total payment *you* receive will never be more than *your* Allowable Expenses.

The National Association of Insurance Commissioners sets the rules that decide which Plan is primary. They are, in part, as follows:

- The Plan without a coordination of benefits provision is primary.
- When another Plan's rules and this *plan's* rules require this *plan* to pay its benefits first, this *plan* is primary.
- The Plan covering the patient directly rather than as an employee's *dependent* is primary.
- If a child is covered under both parents' Plans, the Plan of the parent whose birthday falls earlier in the calendar year is primary (the "birthday" rule) unless the other Plan has a "gender" rule.
- If a child is covered under both parents' Plans and the other Plan has a "gender" rule, the rule in the other Plan determines benefits. (The "gender" rule says that if a child is covered under both parents' Plans, the Plan of the male parent is primary).
- If the "birthday" rule applies, and both parents have the same birthday, the Plan covering a parent longest is primary.
- If the parents are separated or divorced, benefits for the child are determined in this order:
    - ♦ The Plan of the parent with custody.
    - ♦ The Plan of the *spouse* of the parent with custody.
    - ♦ The Plan of the parent not having custody, unless one of the parents is made responsible for the child's health expenses by a court decree.

- If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the dental care expenses of the child, the Plans covering the child shall follow the order of benefit determination rules outlined above.
- If a full-time student is eligible for coverage as a *dependent* under this *Certificate*, the benefits of any other coverage available because of student enrollment (except accident-only type coverage) will be determined before the benefits under this *plan*.
- The benefits of a Plan which covered a person as an employee who is neither laid off nor retired are determined before those of a Plan which covers that person as a laid off or retired employee. The same is true if a person is a *dependent* of a person covered as a retiree and an employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.
- If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another Plan, the benefits are determined in the following order:
    - ♦ First, the benefits of a Plan covering the person as an employee, *member* or *subscriber* (or as that person's *dependent*);
    - ♦ Second, the benefits under the continuation coverage.
    - ♦ If the other plan does not have the rule described above, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.
    - ♦ If payment responsibility is still unresolved, the Plan covering the patient longest is primary.

In general, if *you* use more benefits than *you* are covered for during a calendar year, the insurer covering *you* first will cover *you* up to its *allowance.* The secondary insurer will cover any allowable benefit *you* use over that amount. The insurers will never pay more than the total amount of coverage that would have been provided if benefits were not coordinated.

Subrogation

If someone caused *your* illness or injury, *you* may have the legal right to get back some of *your* dental care costs. When *you* have this right, *you* must let *us* use it if *we* decide to recoup any payments *we* made for services related to the illness or injury. If *you* use this right to recoup money from someone else, *you* must repay *us* for the payments *we* made. *Our* right to repayment comes first. It can be reduced only by *our* share of *your* reasonable cost of collecting *your* claim against the other person; or, if the payment received is for other than dental expenses. *You* must give *us* information and assistance and sign documents needed to help *us* receive *our* repayment. *You* must not do anything that might limit *our* repayment.

Facility of Payment

If another Plan pays a benefit that should have been paid under this *plan, we* may reimburse the other Plan for that amount. It will be considered a benefit paid by this *plan*.

Right of Recovery

If *we* pay more than *we* should have paid under the COB provision, *we* have the right to recoup the excess amount *we* paid. This includes recouping from other insurance companies and organizations. The amount that can be recouped includes the reasonable cash value of any benefits provided in the form of services.

When You Have a Claim

When to File a Claim

You should send *us* completed claim forms for services covered under this *Certificate. You* have up to one year from the date *you* get services. All services must be complete to qualify for benefits; e.g., permanent crowns cemented; bridge or denture inserted. *In-network dentists* will send claim forms on *your* behalf. *You* will not be responsible for payment on *covered services* when a *network dentist* sends claims more than one year after the date *you* get the service; except, for any *deductibles; copayments; coinsurance;* or amounts in excess of the *annual dollar maximum. We* will deny claims that an *out-of-network dentist* sends to *us* more than one year after *you* get the services. *You* must pay such claims, unless the failure to send a claim within one year was because of a legal incapacity.

How to File a Claim

In-Network Dentist

When *you* go to a *dentist* who has agreed to participate in the *network, your* claim will be filed for *you*. *Network dentists* are encouraged to file claims within six (6) months from the *date of service.* In no event may a *network dentist* file a claim more than one year after the *date of service.* It must include all necessary supporting information such as x-rays. *We* accept claims from *dentists* on paper and in an electronic, HIPAA compliant format.

Out-of-Network Dentist

When *you* go to a *dentist* who is not participating in the *network,* y*ou* must mail the claim to the following address. *You* don't have to do this if the *dentist* agrees to file it for *you*. Dental claim forms are available by signing into *your* account on *our* website at: **www.altusdental.com** or from *your dentist***.**

MAIL CLAIMS TO: Altus Dental Insurance Company, Inc.
P.O. Box 1557
Providence, RI 02901-1557

Claims Procedures

Call Customer Service if *you* have a question about how a claim was paid, or why *we* denied it. The number is 877-223-0588. Customer Service representatives are available Monday – Friday from 8 a.m. to 5 p.m. ET. *You* have a right to request a full and fair review of *your* claim. **To consider a claim for payment, *we* must get it within one year of the date *you* get the service.**

Pre-treatment Estimates / Prior Authorization

A pre-treatment estimate / prior authorization is a claim that is filed before *you* have a dental service.

Pre-treatment Estimate

When treatment is likely to cost more than $300, *you* and *your dentist* are strongly encouraged to get an estimate before *you* receive treatment. This includes treatment such as crowns; *periodontic; prosthodontic*; and elective *orthodontic* services.

Prior Authorization

Prior authorization is required for *medically necessary orthodontic* treatment if covered by *your Plan.* *Medically necessary orthodontics* is covered for *dependent* children under age 19 only if there is an EHB pediatric dental rider with the *Plan.* Refer to the *Benefits Summary* pages of *your Certificate.* **No payment will be made if prior authorization is not obtained.**

After *your dentist* sends a request, *we* will review the treatment plan. After reviewing the treatment plan, *we* will tell *you* and *your dentist* what the estimated payment will be for those services.

NOTE: Estimates are based on available benefits. The patient must be an Altus Dental *member* at the time the service is done. The estimate shows what money is available at the time the estimate is done. Estimates can change because services may no longer be available on the date the service is done. For example, if *you* had other services paid for after the estimate, and *you* reach *your annual maximum,* there will be no money left to pay for the new service. Another example is if *you* lose coverage before the new service is finished.

We must have all of the information *we* need to review the treatment plan; and, to make a benefit decision. *We* will send *you our* initial decision in writing within 15 calendar days. For urgent or emergency services, *we* will give *you our* decision within 72 hours.

If the service is denied, the notice will explain the reason(s) for the denial. The notice will include the process for filing an appeal. Once a denial is made, *you* have 180 days from the day *you* get *our* notice to file an appeal.

Post-service Claims

A post-service claim is a claim that is filed after dental care has been received. All services must be complete to qualify for benefits; e.g., permanent crowns must be cemented; bridges or dentures must be inserted. *We* will send *you our initial decision in writing* within 30 calendar days of the day *we* receive the claim. *We* will send *you* a notice if *we* can't process a post service claim because information is missing. The notice will be sent to *you* within 30 days. It will tell *you* what additional information *we* need to process the claim. An *in-network dentist* must give *us* the information *we* need to process a claim. If not provided, the *dentist* may not charge the patient for any un-paid amount. Refer to the **Expedited Reviews** section for claims involving urgent or emergency services.

We will provide notice or payment to *you* or *your dentist* within 45 days after receipt of a complete claim. A complete claim has all the supporting documentation *we* need to make a claim decision. If *we* do not notify or pay within this time, *we* will pay interest on the amount not paid. Interest will be paid at a rate of 1 ½ percent per month (not to exceed 18% per year). Interest is paid from the 45th day after *we* received the complete claim.

If the service is denied, the notice will explain the reason(s) for the denial. It will include the process for filing an appeal. Once a denial is made, *you* have 180 days from the day *you* receive *our* notice to file an appeal.

To Appeal an Adverse Benefit Decision

If *you* receive an *adverse benefit decision, you* have the right to have it reviewed. An adverse decision means a decision not to approve a service, in whole or in part. *Adverse benefit decisions* include:

- *Administrative adverse benefit decisions.* These do not require us to use dental judgment or clinical criteria. Examples include decisions not to approve because a *member* is not eligible for coverage, or a decision that a benefit is not a covered benefit under the *Plan,* or that the *waiting period* has not been met, or that the frequency on a service has gone above the limit.

- *Non-administrative adverse benefit decisions.* These require *us* to use dental judgment or clinical criteria to determine if the service is *dentally necessary* and/or appropriate. These decisions are made by *dentists* using *our* review guidelines, which detail the clinical criteria that must be met for a service to be covered. These guidelines are found at altusdental.com.

For all adverse decisions, follow the process below to file an appeal. If *you* are in Rhode Island and feel that *we* did not follow the appeals process as described in this part, *you* may contact the Rhode Island Resource, Education and Assistance Consumer Helpline (RIREACH) at 300 Jefferson Blvd., Suite 300, Warwick, RI 02888, 1-855-747-3224,

www.rireach.org. This is Rhode Island's Health Insurance Consumer Assistance Program.

When to File an Appeal: *You* must file *your* appeal within 180 days of the date *you* receive the original coverage denial.

How and Where You Can File an Appeal: *You* must file an appeal in writing. For urgent or emergency services*, *you* may call Customer Service to start an appeal. **Send *your* appeal to: Altus Dental Insurance Company, Inc., Attn: Appeals, P.O. Box 1557, Providence, RI, 02901-1557.** *Your* appeal should ask *us* to reconsider and tell *us* why *you* believe the service was wrongly denied. It should include a copy of the Explanation of Benefits or Pre-treatment Estimate notice. *You* should include the patient's name; the member identification number; and, a detailed description of *your* concern. Appeals of coverage decisions based on *dental necessity* should also include clinical treatment notes; narratives; photos; x-rays; charting; and, any other necessary clinical documents that support *your* claim. To be covered, services must meet the criteria in *our* review guidelines found at altusdental.com. *Your* appeal will be reviewed based on the material *you* send *us.* If the file is incomplete, *we* might not have all the information *we* need to make an appropriate decision. *You* should add any information that is relevant to considering the appeal.

The Explanation of Benefits or Pre-treatment Estimate notice sent to *you* with the original denial has numbered messages. These messages explain the reason(s) for *our* denial. They also refer to any plan terms the decision was based on; and may refer to any guideline; protocol; or, criteria *we* used to make the denial. *You* have the right to see copies of all documents related to the claim. *We* will also give *you* a copy of any internal rule, guideline, or protocol *we* used. *We* will also explain the scientific or clinical judgment *we* used to make *our* decision. *We* will give *you* this information, if *you* ask for it, at no charge.

Who Will Review Your Appeal: Appeals will be investigated by an Appeals Coordinator in *our* Program Integrity department. He or she will talk with appropriate departments and decisions will be made by individuals who know about the issues involved in *your* appeal. Appeals regarding *non-administrative adverse benefit decisions* will be reviewed by a licensed *dentist* who has not been involved in any prior reviews and who has not been involved in the direct care of the patient.

Response to Your Appeal: *We* will reconsider *our* decision and send *you* a written response within 15 calendar days of receiving *your* appeal (72 hours for urgent or emergency services). If *we* do not change *our* decision, *you* have 180 days from the date *you* receive *our* notice to continue the appeal process by sending *us* a written request for an appeal. *We* will send *you* a written response within 15 calendar days of receiving *your* request (72 hours for urgent or emergency services). Before *we* make a final internal appeal decision, *you* have the right to inspect the entire appeal file and add information. Additional information must be sent in writing and will be held confidential in accordance with applicable state and federal laws.

External Review Option: If *your* final internal appeal to reverse a *non-administrative adverse benefit decision* is denied, *you* may request an external appeal. External appeals are sent to an independent review agency. *You* have 125 calendar days from the date *you* receive *our* final internal appeal decision to send *your* request to *us* in writing. *You* can add information to the file for review by sending it to *us* in writing within 5 business days after starting the appeal. *We* will send all documentation *we* reviewed to the review agency.

Cost for External Review: *You* must pay $50 (up to a maximum of $150 per *policy year* per *member).* Include a check made payable to Altus Dental Insurance Company, Inc. for *your* share of the cost with *your* request. If *your plan* includes pediatric dental essential health benefits for children under age 19 and the appeal involves a service for a *member* under age 19, the cost of the external review is $25 (up to a maximum of $75 per *policy year* per *member).* The fee may be waived if paying it would cause *you* undue financial hardship.

Response to Your External Appeal: The review agency will notify *you* about the outcome of *your* appeal within 10 calendar days of their receipt of all information needed to complete the review. If the external review agency overturns *our* decision, *we* will reimburse *you* within 60 days of the notice of overturn for *your* share of the fee.

Additional Information: Under certain circumstances, once the internal appeals process is exhausted, the *member* may also have the right to bring a civil action. This right is given under Section 502(a) of the ERISA Act. The *member* does not have this right if he/she is a member of a governmental plan, church plan, or a plan not established or maintained by an employer.

Expedited Reviews

If *your* claim involves urgent or emergency services as defined below, *you* have the right to an expedited review. For expedited reviews, *we* will complete *our* review and make a decision within 72 hours. *We* must receive all of the information needed to review the claim. Call Customer Service to obtain an expedited review.

*"Urgent services" includes those resources necessary to treat a symptomatic health care condition that a prudent layperson, acting reasonably would believe necessitates treatment within a 24 hour period of the onset of such a condition in order that the patient's health status not decline as a consequence. This does not include "emergency services" as defined below.

"Emergency services" means those resources provided in the event of the sudden onset of a health condition that the absence of immediate medical attention could reasonably be expected, by a prudent layperson, to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

Resolution of Inquiries and Complaints

Inquiries

If *you* have questions or concerns, send an email to customerservice@altusdental.com. *You* may also call Customer Service toll-free at **1-877-223-0588;** or, mail or fax the inquiry to: **Altus Dental Insurance Company, Inc., P.O. Box 1557, Providence, RI 02901-1557, Fax: 401-457-7260.** *We* will try to resolve it as soon as *we* can. The appeals process above describes how to appeal a claim decision.

Complaints

If *you* have a complaint, send an email to customerservice@altusdental.com; or, call *us* at 1-877-223-0588. *We* settle most complaints on first contact. However, if *your* complaint needs more research (e.g., it involves quality of care; fraud; or, abuse, etc.), *we* will settle it as soon as *we* can. If *you* are not satisfied, *you* may call the Massachusetts Division of Insurance.

Other Provisions

Claims Review

This *Certificate* provides coverage only for *dentally necessary* and appropriate care*.* The decision whether a service is *dentally necessary* is solely for the purpose of claims payment. It is not a professional dental judgment. *You* have the right to appeal *our* decision. Refer to the **Claims Procedures** section, and the definition of "*dentally necessary"* in the **Definitions** section.

Although *we* may conduct review, *we* do not act as a *dentist. We* do not provide dental care. *We* do not make dental judgments. Nothing here is meant to change; or, affect *your* relationship with *your dentist.*

Access to Records

When *you* file a claim, *you* agree to give *us* the right to get, from any source, all dental records and/or related information that *we* need. *We* will keep *your* information confidential. *We* can also have a licensed *dentist* examine, at *our* expense, any person making a claim. *You* agree that *dentists* may give *us* individually identifiable health information*. You* also agree that *we* may use and disclose such information as described in *our* Notice of Privacy Practices. *You* can find this Notice on *our* website. *You* can also call Customer Service for a copy.

In-network dentists must give *us* all of the information *we* need to process *your* claim. They will not charge for this service.

If *you* get services from an *out-of-network dentist*, *you* must help *us* get all of the records *we* need. *We* will not pay the *dentist* for giving *us* this information. If the *out-of-network dentist* does not give *us* this information, *we* may not provide benefit payments to *you*.

Office of Patient Protection

The Office of Patient Protection (OPP) in Massachusetts assists consumers with questions regarding health insurance. You may contact the OPP toll-free at 1-800-436-7757, by fax at 617-624-5046, or visit their website at www.mass.gov/hpc/opp.

Document Changes

We or *your plan sponsor* may change a part of *your Certificate*. This is usually done on the anniversary date of *your plan sponsor's* contract with *us.* Any change will have an effective date. The change will apply to all benefits for services *you* receive on or after the effective date. Changes in the *Certificate* are not valid unless approved by an officer of Altus Dental; and, are made a written part of this *Certificate* or the *Benefits Summary*. *We* will give the group representative of *your plan sponsor* at least 60 days advance notice when *we* make any *material changes* to *covered services.* The notice will include any changes in clinical review standards. The notice will also include the effect such changes may have on *your* personal liability for the cost of such changes. *We* will also give *your* group representative an annual notice listing all *in-network dentists.*

We will provide an addendum or supplementary insert for each enrolled *subscriber* residing in Massachusetts for notice of all *material changes* to this *Certificate*.

Notices

To *You*: When *we* send a notice to *your plan sponsor*, *we* will send it by first class mail, e-mail or fax. Once *we* send the notice, *we* are not responsible for its delivery. It will be *your plan sponsor's* responsibility to notify *you* if the notice is sent to *your plan sponsor.* This applies to any notices regarding premium charges as well as to a notice of a change in the premium charge or a change in the *Certificate*. If *your* name or mailing address should change, *you* should notify *us* or *your plan sponsor* at once. Be sure to give *us* or *your plan sponsor* both *your* old name and address as well as *your* new name and address.

To *Us:* Send mail to Altus Dental Insurance Company, Inc., P.O. Box 1557, Providence, RI 02901-1557; or email us at customerservice@altusdental.com. Always include *your* name and *your* ID number.

Acts of Providers

We will not get involved with the relationship between *dentists* and patients. *We* are not responsible if a *dentist* refuses to treat *you. We* are not liable for injuries or damages resulting from the acts or omissions of a *dentist*. *We* are not responsible if *you* are dissatisfied with the treatment or services *your dentist* provides.

Right to Recover Overpayments

If *we* pay more than *we* should, *we* can recoup payment from either *you;* or, the *dentist*. *We* can also deduct any payment *we* have made from any benefits properly paid under this policy if the payment was made:

1. In error; or
2. Due to a misstatement in a proof of loss; or
3. Due to fraud or misrepresentation of a material fact to procure coverage or under the terms of the coverage; or
4. For an ineligible person; or,
5. Due to a claim for which benefits are recoverable under any policy or act of law providing coverage for occupational injury or disease, to the extent that such benefits are recovered.

If *we* have already made claim payments to a covered person; *we* can reduce the payment *we* would make on a future claim to recoup an overpayment.

Conformity with Applicable Laws

We amend any term of this *Certificate* which conflicts with any relevant law. *We* do this to conform to the minimum requirements of such law.

This *Certificate* and the *Benefits Summary,* is a description of *your* benefits; rights; and, obligations under the *plan*.

Your membership ID card identifies *you* as a person with these benefits. Please show the ID card to *your dentist* whenever *you* or *your dependents* receive services.

Preexisting Conditions

There are no preexisting condition limitations in this *plan.*

Waiting Periods

Some dental plans require *you* to wait a certain amount of time before a particular procedure is covered. This is called a *waiting period.* If *your plan* has a *waiting period,* it will be noted in the *Benefits Summary.*

Services Not Covered by the Plan

Unless otherwise stated in the *Benefits Summary,* the following are not covered:

- Services that are not *dentally necessary* and appropriate according to *our* review guidelines. Services subject to these guidelines include, but are not limited to, root canals; crowns and related services; bridges; periodontal services; *orthodontics;* and, oral surgery. *We* will make a decision whether a service is *dentally necessary*

based on these guidelines. A service may not be covered under these guidelines even if it was recommended by a *dentist. Our* guidelines can be found on *our* website at www.altusdental.com. *You* can have *your dentist* send *us* a request for a Pre-treatment Estimate in advance of the service to see if the service meets *our* guidelines.

- Services greater than the *annual maximum.*
- Services received from a dental or medical department maintained by or on behalf of an employer; a mutual benefit association; labor union; trustee; or, similar person or group.
- An illness or injury that *we* decide is employment-related.
- Services *you* would not have to pay for if *you* did not have this Altus Dental coverage.
- Services or supplies that are experimental in terms of generally accepted dental standards.
- Services done by a *dentist* who is a member of *your* immediate family.
- An illness, injury or dental condition for which benefits are, or would have been available, through a government program if *you* did not have this Altus Dental coverage.
- Services done by someone who is not a licensed *dentist* or a licensed *hygienist* working as authorized by applicable law.
- Exams by specialists except for periodic oral exams.
- Consultations.
- Disorders related to the temporomandibular joints – (TMJ), including night guards and surgery.
- Services to increase the height of teeth or restore occlusion.
- Restorations needed because *you* grind *your* teeth or due to erosion, abrasion, or attrition.
- Services done mainly to change or to improve *your* appearance.
- *Orthodontics.*
- Occlusal guards.
- Implants.
- Bone grafts.
- Splinting and other services to stabilize teeth.
- Laboratory or bacteriological tests or reports.
- Temporary, complete dentures or temporary, fixed bridges or crowns.
- Prescription drugs.
- Guided tissue regeneration.
- General anesthesia or intravenous sedation given by anyone other than a *dentist*.
- General anesthesia or intravenous sedation for non-surgical extractions, diagnostic, preventive, or minor restorative services.

We can adopt and apply policies that *we* deem reasonable when *we* approve the eligibility of *subscribers;* and, the appropriateness of treatment plans and related charges.

UAW/ UMass
HEALTH & WELFARE
TRUST FUND

Contact Us

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