

September 1, 2023

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)

- a dental plan with Altus
- a vision plan with EyeMed Vision Care
- family dental plan with a participant contribution
- free family vision coverage
- a childcare reimbursement for on or off-campus childcare receipts
- a basic \$10K 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 Benefits at (413) 345-2156 or uawdental@external.umass.edu The Trust Fund's website also has detailed information about all aspects of the Plans: <https://www.hwtf.org/>

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 & Welfare Plan. The UAW/UMass Health & Welfare Trust 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.

YOUR 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 Benefits: (413) 345-2156

Altus Dental: (877) 223-0588

EyeMed Vision Care: (866) 299-1358

UAW Local 2322: (413) 534-7600

Center for Early Education & Care: (413) 545-1566

You can also visit our website, <https://www.hwtf.org/> for forms and other resources

WHAT IS A SUMMARY PLAN DESCRIPTION (SPD)?

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.

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 Benefits 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 Benefits 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 September 1 to August 31 of each year. The current plan year is 9/1/23-8/31/24.

The benefit application is available online at <https://portal.hwtf.org/> and opens August 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. The online application requests a Social Security Number (SSN) only for those electing life insurance.

Your dental, vision, and childcare benefits, administered by the Trust Fund, are completely separate from your health plan, managed by UMass Human Resources. 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://www.umass.edu/hr/benefits-and-pay/benefits/health-insurance/benefited-postdoctoral-employees>

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 PHWP 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 PHWP 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.

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 2023-24, the monthly premium for single +1 dental coverage is \$10.00 and the monthly premium for family dental coverage is \$20.00, with initial payment due upon application. There is no premium due for single+1 or family vision coverage. Premiums must be paid via credit card or debit card using PayPal or Stripes's automatic, recurring payment feature. Recurring payments may be ended at any time by either the participant or the Trust Fund. 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 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 Care 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 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 Care 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).

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.

A QMCSO 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.

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

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 9/1 to 8/31 of each year. Every September 1, the plan year maximum amount and any deductible responsibility renews. Our vision plan is the EyeMed Select Plan. The vision benefits follow a point of service plan year, meaning that your benefit renews 12 months after the last time you utilized it. Both of our plans have nationwide networks of providers. You can locate providers at <https://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.

Subscriber Certificates/Member Guides

Subscriber certificates are included in this document and member guides are available at <https://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 <https://portal.hwtf.org/> 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.

Benefits Summary

Employee Dental Plan

Plan Year 9/1/2023-8/31/2024

Grad Employee Group #3001-0002/ Postdoc Group #3001-0001
Altus Dental POS - Includes Connection Dental and DenteMax Networks

Exams, cleanings, bitewing x-rays, single x-rays, fluorides, sealants and full mouth/Panorex x-rays don't count against your annual maximum.

Annual Maximum
\$2,250

Elective Orthodontic Lifetime Maximum
\$1,000

Maximum Lifetime Cap
Unlimited

TMJ Lifetime Cap
\$500

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.

P Pre-treatment Estimate Recommended

A Prior Authorization Required

See back page for additional information >

Plan pays 100%; Member Coinsurance 0%

- Oral exam twice per policy year. Problem or focused visit. Specialist consultation.
- Cleaning four per policy year
- Fluoride treatment for children under age 19 or Fluoride varnish for all covered members, for a total of two treatments per policy year.
- Bitewing x-rays one set per 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
- Space maintainers, unilateral space maintainers once per lifetime for lost deciduous (baby) teeth. Bilateral space maintainers once every 60 months for lost baby teeth
- Periodontal maintenance following active therapy four per policy year

Plan pays 80%; Member Coinsurance 20%

- Palliative treatment (minor procedures necessary to relieve acute pain) twice per policy year
- Amalgam (silver) fillings and composite (white) fillings
- 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 one procedure per tooth per lifetime. Retreatment upon review
- Misc-Laboratory and Biopsy
- P** • Root planing and scaling once per quadrant every 24 months
- P** • Osseous (bone) surgery once per quadrant every 24 months
- P** • Guided tissue regeneration and bone replacement graft once per site 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
- Repairs to existing partial or complete dentures once per policy year
- Recementing crowns or bridges once every 60 months
- Rebasing or relining of partial or complete dentures once every 60 months

Plan pays 65%; Member Coinsurance 35%

- P** • Crowns over natural teeth, build ups, posts and cores replacement limited to once 60 months.
- P** • Occlusal guards, replacement limited to once every 36 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
- P** • Surgical placement of endosteal implant and abutment replacement limited to once every 60 months
- Teeth Whitening once per arch every 60 months
- Athletic Mouth Guards for dependent children under age 19, once every 24 months.
- Non-surgical and surgical procedures for temporomandibular (TMJ) disorders subject to a \$500 lifetime maximum

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 Fund

Group # for Grad Employees is 9794348 / Group # for Postdocs is 9878760



40% OFF

additional complete pair of prescription eyeglasses

20% OFF

non-covered items, including non-prescription sunglasses

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.

SUMMARY OF BENEFITS

VISION CARE SERVICES	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER REIMBURSEMENT
EXAM SERVICES		
Exam	\$10 copay	Up to \$57
Retinal Imaging	Up to \$39	Not covered
CONTACT LENS FIT AND FOLLOW-UP		
Fit and Follow-up - Standard	Up to \$40; contact lens fit and two follow-up visits	Not covered
Fit and Follow-up - Premium	10% off retail price	Not covered
FRAME		
Frame	\$0 copay; 20% off balance over \$185 allowance	Up to \$111
STANDARD PLASTIC LENSES		
Single Vision	\$10 copay	Up to \$47
Bifocal	\$10 copay	Up to \$79
Trifocal	\$10 copay	Up to \$130
Lenticular	\$10 copay	Up to \$130
Progressive - Standard	\$10 copay	Up to \$78
Progressive - Premium Tier 1 - 3	\$30 - 55 copay	Up to \$100
Progressive - Premium Tier 4	\$10 copay; 20% off retail price less \$120 allowance	Up to \$95
LENS OPTIONS		
Anti Reflective Coating - Standard	\$45	Not covered
Anti Reflective Coating - Premium Tier 1 - 2	\$57-68	Not covered
Anti Reflective Coating - Premium Tier 3	20% off retail price	Not covered
Photochromic - Non-Glass	20% off retail price	Not covered
Polycarbonate - Standard	\$40	Not covered
Scratch Coating - Standard Plastic	\$15	Not covered
Tint - Solid and Gradient	\$15	Not covered
UV Treatment	\$15	Not covered
All Other Lens Options	20% off retail price	Not covered
CONTACT LENSES		
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
OTHER		
Hearing Care from Amplifon Network	Up to 64% off hearing aids; call 1.877.203.0675	Not covered
LASIK or PRK from U.S. Laser Network	15% off retail or 5% off promo price; call 1.800.988.4221	Not covered
FREQUENCY	ALLOWED FREQUENCY - ADULTS	ALLOWED FREQUENCY - KIDS
Exam	Once every 12 months	Once every 12 months
Frame	Once every 12 months	Once every 12 months
Lenses	Once every 12 months	Once every 12 months
Contact Lenses	Once every 12 months	Once every 12 months

(Plan allows member to receive either contacts and frame, or frames and lens services)

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.

Ready to live your best EyeMed life?

There's so much more to your vision benefits than copays and coverage. Get ready to see the good stuff for yourself.

Your network is the place to start

See who you want, when you want. You have thousands of providers to choose from – independent eye doctors, your favorite retail stores, even online options.

Keep your eyes open for extra discounts

Members already save an average 71% off retail using their EyeMed benefits,¹ but our long list of special offers takes benefits even further.

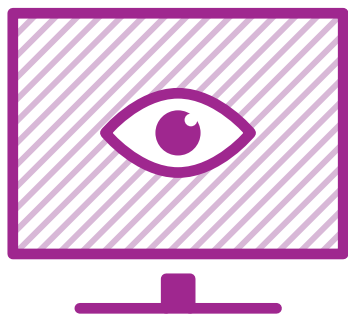
Remember, you're never alone

We're always here to help you use your benefits like a pro. Stay in-the-know with text alerts or healthy vision resources from the experts. If it can make benefits easier for you, we do it.

¹Based on weighted average of sample transactions; EyeMed Insight network/\$10 exam copay/\$10 materials copay/\$120 frame or contact lens allowance.



eye
Med



Create a member account at eyemed.com

Everything is right there in one spot. Check claims and benefits, see special offers and find an eye doctor – search for one with the hours, location and brands you want. For maximum mobility, try the EyeMed Members App (Google Play or App Store).

INDEPENDENT
PROVIDER
NETWORK



LENSCRAFTERS®

PEARLE
VISION

OPTICAL™



UAW/UMass Health & Welfare Trust Fund

EyeMed Vision Care Diabetic Product



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.

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



LENSCRAFTERS



WELLNESS BENEFITS

Pre-Paid Central Rock Gym Memberships and The Healing ZONE therapeutic massage packages

For the 2022-23 plan year, the Trust Fund will offer 20 prepaid, 4-month gym memberships at Central Rock Gym (CRG) in Hadley, MA, and 20 5-packs of 30 minutes massages at The Healing ZONE (THZ) in Hadley, MA, and 3 20 class Yoga passes at Cadence Yoga in Hadley, MA as a pilot program. 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/>

Pre-Paid Daily Burn Subscriptions

For the 2023-24 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 may be claimed on the dashboard of your Trust Fund benefits account at <https://portal.hwtf.org/>

Calm Subscriptions

Eligible Postdoc employees can access ***Calm***, an app for meditation, sleep and relaxation, for free. Each subscription is 12 months long and subscriptions may be claimed using the link on the dashboard of your Trust Fund benefits account at <https://portal.hwtf.org/>

CHILDCARE REIMBURSEMENT BENEFIT

The Trust Fund will distribute at least \$60,000 during the 2023-24 plan year in reimbursements across eligible Postdoc employees for their costs for on or off-campus licensed childcare.

Eligibility

To be eligible you must be 1) working in a University of Massachusetts Amherst PRO Unit position that is at least a 50% FTE and 2) use licensed or otherwise eligible childcare.

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

How we Distribute Funds

The Trust Fund sorts eligible applicants by family size & income according to the MA EEC Financial Assistance Parent Co-Payment Table (see below). The daily fee level on this chart represents the amount a parent can be expected to pay out-of-pocket for childcare.

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.

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

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 determines reimbursements for applicants with incomes higher than level 11 by calculating their expected parent co-pay, which can be calculated using the Flat Fee Expected Parent Copayment Chart (see below). Receipts for any costs in excess of the expected parent co-pay are potentially eligible for reimbursement. 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. If an applicant family has received a GEO, GSS or CCAMPIS childcare subsidy for the same period, this will reduce the possible reimbursement. When considering childcare reimbursement applications, should an applicant claim that their income has changed significantly since their last tax return, which we use for income verification, we will process any eligible reimbursement based on the current tax return and the income level that places the applicant in, per our usual process. However, upon presentation of the next year's tax return, we will re-examine the reimbursement in light of the new return once it is furnished to us.

In order to qualify for a retroactive additional reimbursement, the applicant will need to: 1) provide us with page 1 of the new federal tax return as soon as it is available, but no later than the next IRS established deadline, and 2) the adjusted gross income on the new return will need to be such that it would have changed the percentage reimbursement bracket the applicant occupied when we first reviewed the application. It is the applicant's responsibility to supply the new return once it is available.

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. There is a lower annual cap of \$3000 per child (for whom receipts are submitted) for families submitting receipts for FFN care.

Deadlines

The Trust Fund reimburses childcare costs during three periods annually: fall, spring & summer.

- Application opens Aug 15 & deadline is Sept 15, 2023 for June-August 2023 receipts
- Application opens Dec 15 & deadline is Dec 31, 2023 for Sept-Dec 2023 receipts
- Application opens May 15 & deadline is May 30, 2024 for Jan-May 2024 receipts
- Application opens Aug 15 & deadline is Sept 15, 2024 for June-August 2024 receipts

Further Notes on Provider Eligibility

You can find out if your provider is licensed at <http://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 online benefits application, available at <https://portal.hwtf.org/> If you've enrolled for dental & vision, log in to your existing application, following prompts for the childcare section only. If you're new to our system, start a new application.

Outschool Family Wallet

Effective December 31, 2023, Outschool ended its in-house wallet program. In lieu of the wallet program, the Trust Fund will accept receipts for Outschool classes for reimbursement up to the \$250 per child per year per household maximum. No online classes other than Outschool will be honored in this way. This reimbursement is separate from the general childcare reimbursement. Alternatively, Outschool gift cards can be requested by eligible families at <https://www.hwtf.org/geo-family>



SHERRI KILLINS
COMMISSIONER

Commonwealth of Massachusetts
Department of Early Education and Care (EEC)

EEC FINANCIAL ASSISTANCE

PARENT CO-PAYMENT TABLE

Parent Co-Payment Schedule is used to determine the parent's co-payment once the family is determined to be eligible and is being enrolled in an early education and care program.

Step 2: Use This Form to Determine Parent Co-Payment

1. Find the column with the family's size written at the top.
2. Read down the column until you come to the correct income bracket.
3. Then read directly across to the right until you are under the "Daily Fee" column.

GROSS MONTHLY INCOME							
Family of Two	Family of Three	Family of Four	Family of Five	Family of Six	Family of Seven	Family of Eight	Family of Nine
\$ 0-971	\$ 0-1180	\$ 0-1421	\$ 0-1663	\$ 0-1905	\$ 0-2146	\$ 0-2387	\$ 0-2630
\$ 972-1095	\$ 1181-1260	\$ 1422-1499	\$ 1664-1739	\$ 1906-1980	\$ 2147-2205	\$ 2388-2450	\$ 2631-2675
\$ 1096-1219	\$ 1261-1340	\$ 1500-1575	\$ 1740-1825	\$ 1981-2080	\$ 2206-2315	\$ 2451-2575	\$ 2676-2775
\$ 1220-1380	\$ 1341-1420	\$ 1576-1675	\$ 1826-1900	\$ 2081-2180	\$ 2316-2550	\$ 2576-2700	\$ 2776-2825
\$ 1381-1457	\$ 1421-1529	\$ 1676-1799	\$ 1901-2087	\$ 2181-2380	\$ 2551-2675	\$ 2701-2800	\$ 2826-2940
\$ 1458-1540	\$ 1530-1675	\$ 1800-1900	\$ 2088-2150	\$ 2381-2500	\$ 2676-2800	\$ 2801-2900	\$ 2941-3050
\$ 1541-1634	\$ 1676-1760	\$ 1901-2000	\$ 2151-2260	\$ 2501-2650	\$ 2801-2900	\$ 2901-3000	\$ 3051-3125
\$ 1635-1725	\$ 1761-1850	\$ 2001-2175	\$ 2261-2435	\$ 2651-2800	\$ 2901-3000	\$ 3001-3100	\$ 3126-3242
\$ 1726-1843	\$ 1851-1931	\$ 2176-2250	\$ 2436-2550	\$ 2801-3000	\$ 3001-3100	\$ 3101-3200	\$ 3243-3340
\$ 1844-1986	\$ 1932-2414	\$ 2251-2874	\$ 2551-3333	\$ 3001-3793	\$ 3101-3879	\$ 3201-3966	\$ 3341-4052
\$ 1987-2186	\$ 2415-2476	\$ 2875-3130	\$ 3334-3550	\$ 3794-3900	\$ 3880-4030	\$ 3967-4100	\$ 4053-4125
\$ 2187-2286	\$ 2477-2676	\$ 3131-3340	\$ 3551-3800	\$ 3901-4000	\$ 4031-4132	\$ 4101-4199	\$ 4126-4249
\$ 2287-2429	\$ 2677-2876	\$ 3341-3550	\$ 3801-4100	\$ 4001-4199	\$ 4133-4350	\$ 4200-4499	\$ 4250-4599
\$ 2430-2573	\$ 2877-3076	\$ 3551-3760	\$ 4101-4363	\$ 4200-4500	\$ 4351-4700	\$ 4500-4799	\$ 4600-4899
\$ 2574-2717	\$ 3077-3277	\$ 3761-3970	\$ 4364-4607	\$ 4501-4966	\$ 4701-4998	\$ 4800-5099	\$ 4900-5149
\$ 2718-2860	\$ 3278-3477	\$ 3971-4180	\$ 4608-4851	\$ 4967-5444	\$ 4999-5549	\$ 5100-5650	\$ 5150-5699
\$ 2861-3004	\$ 3478-3677	\$ 4181-4490	\$ 4852-5095	\$ 5445-5939	\$ 5550-6074	\$ 5651-6209	\$ 5700-6344
\$ 3005-3132	\$ 3678-3869	\$ 4491-4606	\$ 5096-5342	\$ 5940-6079	\$ 6075-6217	\$ 6210-6355	\$ 6345-6494
\$ 3133-3322	\$ 3870-4104	\$ 4607-4885	\$ 5343-5667	\$ 6080-6433	\$ 6218-6595	\$ 6356-6743	\$ 6495-6887
\$ 3323-3410	\$ 4105-4210	\$ 4886-5012	\$ 5668-5812	\$ 6434-6615	\$ 6596-6765	\$ 6744-6915	\$ 6888-7066
\$ 3411-3549	\$ 4211-4380	\$ 5013-5214	\$ 5813-6047	\$ 6616-6883	\$ 6766-7039	\$ 6916-7195	\$ 7067-7350
\$ 3550-3685	\$ 4381-4551	\$ 5215-5418	\$ 6048-6285	\$ 6884-7153	\$ 7040-7314	\$ 7196-7477	\$ 7351-7639
\$ 3686-3908	\$ 4552-4828	\$ 5419-5747	\$ 6286-6666	\$ 7154-7586	\$ 7315-7758	\$ 7478-7932	\$ 7640-8103
\$ 3909-4885	\$ 4829-6035	\$ 5748-7184	\$ 6667-8333	\$ 7587-9483	\$ 7759-9698	\$ 7933-9915	\$ 8104-10129
\$ 4886-5150	\$ 6036-6325	\$ 7185-7550	\$ 8334-8750	\$ 9484-9950	\$ 9699-10300	\$ 9916-10400	\$ 10130-10650
\$ 5151-5400	\$ 6326-6625	\$ 7551-7900	\$ 8751-9200	\$ 9951-10400	\$ 10301-10750	\$ 10401-10900	\$ 10651-11150
\$ 5401-5650	\$ 6626-6925	\$ 7901-8250	\$ 9201-9550	\$ 10401-10950	\$ 10751-11150	\$ 10901-11400	\$ 11151-11650
\$ 5651-5849	\$ 6925-7225	\$ 8251-8601	\$ 9551-9978	\$ 10951-11353	\$ 11151-11611	\$ 11401-11869	\$ 11651-12126

PARENT CO-PAYMENT				FEE LEVEL
Daily Fee	Weekly Fee	Daily Fee SACC Blended	Weekly Fee SACC Blended	
\$ -	\$ -	\$ -	\$ -	1
\$ 2.00	\$ 10.00	\$ 1.20	\$ 6.00	2
\$ 3.00	\$ 15.00	\$ 1.80	\$ 9.00	3
\$ 4.50	\$ 22.50	\$ 2.70	\$ 13.50	4
\$ 5.50	\$ 27.50	\$ 3.30	\$ 16.50	5
\$ 6.50	\$ 32.50	\$ 3.90	\$ 19.50	6
\$ 7.50	\$ 37.50	\$ 4.50	\$ 22.50	7
\$ 8.00	\$ 40.00	\$ 4.80	\$ 24.00	8
\$ 8.50	\$ 42.50	\$ 5.10	\$ 25.50	9
\$ 9.00	\$ 45.00	\$ 5.40	\$ 27.00	10
\$ 12.50	\$ 62.50	\$ 7.50	\$ 37.50	11
\$ 15.00	\$ 75.00	\$ 9.00	\$ 45.00	12
\$ 16.50	\$ 82.50	\$ 9.90	\$ 49.50	13
\$ 17.50	\$ 87.50	\$ 10.50	\$ 52.50	14
\$ 19.00	\$ 95.00	\$ 11.40	\$ 57.00	15
\$ 20.50	\$ 102.50	\$ 12.30	\$ 61.50	16
\$ 22.00	\$ 110.00	\$ 13.20	\$ 66.00	17
\$ 23.00	\$ 115.00	\$ 13.80	\$ 69.00	18
\$ 24.00	\$ 120.00	\$ 14.40	\$ 72.00	19
\$ 25.00	\$ 125.00	\$ 15.00	\$ 75.00	20
\$ 26.00	\$ 130.00	\$ 15.60	\$ 78.00	21
\$ 27.00	\$ 135.00	\$ 16.20	\$ 81.00	22
\$ 28.00	\$ 140.00	\$ 16.80	\$ 84.00	23
\$ 29.00	\$ 145.00	\$ 17.40	\$ 87.00	24
\$ 32.00	\$ 160.00	\$ 19.20	\$ 96.00	25
\$ 35.00	\$ 175.00	\$ 21.00	\$ 105.00	26
\$ 38.00	\$ 190.00	\$ 22.80	\$ 114.00	27
\$ 41.00	\$ 205.00	\$ 24.60	\$ 123.00	28



SHERRI KILLINS
COMMISSIONER

Commonwealth of Massachusetts Department of Early Education and Care (EEC)

PARENT CO-PAYMENT TABLE

Step 2: Determining Parent Co-Payment (for families larger than nine)

1. Find the column with the family's size written at the top.
 2. Read down the column until you come to the correct income bracket.
 3. Then read directly across to the right until you are under the "Daily Fee" column.
- This will show you the parent co-pay pertaining to that family size and income.

GROSS MONTHLY INCOME			PARENT CO-PAYMENT				FEE LEVEL
Family of Ten	Family of Eleven	Family of Twelve	Daily Fee	Weekly Fee	Daily Fee SACC Blended	Weekly Fee SACC Blended	
\$ 0-2871	\$ 0-3113	\$ 0-3355	\$ -	\$ -	\$ -	\$ -	1
\$ 2872-2925	\$ 3114-3165	\$ 3356-3425	\$ 2.00	\$ 10.00	\$ 1.20	\$ 6.00	2
\$ 2926-3025	\$ 3166-3275	\$ 3426-3550	\$ 3.00	\$ 15.00	\$ 1.80	\$ 9.00	3
\$ 3026-3125	\$ 3276-3375	\$ 3551-3650	\$ 4.50	\$ 22.50	\$ 2.70	\$ 13.50	4
\$ 3126-3225	\$ 3276-3375	\$ 3651-3750	\$ 5.50	\$ 27.50	\$ 3.30	\$ 16.50	5
\$ 3226-3325	\$ 3376-3475	\$ 3751-3850	\$ 6.50	\$ 32.50	\$ 3.90	\$ 19.50	6
\$ 3326-3425	\$ 3476-3575	\$ 3851-3950	\$ 7.50	\$ 37.50	\$ 4.50	\$ 22.50	7
\$ 3426-3525	\$ 3576-3675	\$ 3951-4050	\$ 8.00	\$ 40.00	\$ 4.80	\$ 24.00	8
\$ 3526-3625	\$ 3676-3775	\$ 4051-4150	\$ 8.50	\$ 42.50	\$ 5.10	\$ 25.50	9
\$ 3626-4138	\$ 3776-4224	\$ 4151-4310	\$ 9.00	\$ 45.00	\$ 5.40	\$ 27.00	10
\$ 4139-4210	\$ 4225-4300	\$ 4311-4400	\$ 12.50	\$ 62.50	\$ 7.50	\$ 37.50	11
\$ 4211-4325	\$ 4301-4400	\$ 4401-4500	\$ 15.00	\$ 75.00	\$ 9.00	\$ 45.00	12
\$ 4326-4650	\$ 4401-4725	\$ 4501-4825	\$ 16.50	\$ 82.50	\$ 9.90	\$ 49.50	13
\$ 4651-4950	\$ 4726-5025	\$ 4826-5125	\$ 17.50	\$ 87.50	\$ 10.50	\$ 52.50	14
\$ 4951-5200	\$ 5026-5275	\$ 5126-5350	\$ 19.00	\$ 95.00	\$ 11.40	\$ 57.00	15
\$ 5201-5750	\$ 5276-5825	\$ 5351-5900	\$ 20.50	\$ 102.50	\$ 12.30	\$ 61.50	16
\$ 5751-6400	\$ 5826-6475	\$ 5901-6550	\$ 22.00	\$ 110.00	\$ 13.20	\$ 66.00	17
\$ 6401-6550	\$ 6476-6625	\$ 6551-6700	\$ 23.00	\$ 115.00	\$ 13.80	\$ 69.00	18
\$ 6551-7034	\$ 6626-7181	\$ 6701-7327	\$ 24.00	\$ 120.00	\$ 14.40	\$ 72.00	19
\$ 7035-7150	\$ 7182-7300	\$ 7328-7450	\$ 25.00	\$ 125.00	\$ 15.00	\$ 75.00	20
\$ 7151-7500	\$ 7301-7650	\$ 7451-7800	\$ 26.00	\$ 130.00	\$ 15.60	\$ 78.00	21
\$ 7501-7700	\$ 7651-7775	\$ 7801-7925	\$ 27.00	\$ 135.00	\$ 16.20	\$ 81.00	22
\$ 7701-8275	\$ 7776-8448	\$ 7926-8620	\$ 28.00	\$ 140.00	\$ 16.80	\$ 84.00	23
\$ 8276-10344	\$ 8448-10560	\$ 8621-10775	\$ 29.00	\$ 145.00	\$ 17.40	\$ 87.00	24
\$ 10345-10856	\$ 10561-11080	\$ 10776-11300	\$ 32.00	\$ 160.00	\$ 19.20	\$ 96.00	25
\$ 10857-11365	\$ 11081-11600	\$ 11301-11840	\$ 35.00	\$ 175.00	\$ 21.00	\$ 105.00	26
\$ 11366-11875	\$ 11601-12125	\$ 11841-12370	\$ 38.00	\$ 190.00	\$ 22.80	\$ 114.00	27
\$ 11876-12387	\$ 12126-12645	\$ 12371-12903	\$ 41.00	\$ 205.00	\$ 24.60	\$ 123.00	28

UAW/UMass Health & Welfare Trust Fund
Flat Fee Expected Parent CoPayment Chart

Color columns show expected parent copayment for a semester or summer period at income levels above 11 derived from the MA EEC Financial Assistance Parent Co-Payment Table

MA EEC Weekly Rates for Parents											
Income Level	Infant/Toddler/PreS	School Age		Infant/Toddler/PreS	School Age		Infant/Toddler/PreS	School Age		Infant/Toddler/PreS	School Age
12	\$75.00	\$45.00		\$562.50	\$337.50		\$375.00	\$225.00		\$187.50	\$112.50
13	\$82.50	\$49.50		\$618.75	\$371.25		\$412.50	\$247.50		\$206.25	\$123.75
14	\$87.50	\$52.50		\$656.25	\$393.75		\$437.50	\$262.50		\$218.75	\$131.25
15	\$95.00	\$57.00		\$712.50	\$427.50		\$475.00	\$285.00		\$237.50	\$142.50
16	\$102.50	\$61.50		\$768.75	\$461.25		\$512.50	\$307.50		\$256.25	\$153.75
17	\$110.00	\$66.00		\$825.00	\$495.00		\$550.00	\$330.00		\$275.00	\$165.00
18	\$115.00	\$69.00		\$862.50	\$517.50		\$575.00	\$345.00		\$287.50	\$172.50
19	\$120.00	\$72.00		\$900.00	\$540.00		\$600.00	\$360.00		\$300.00	\$180.00
20	\$125.00	\$75.00		\$937.50	\$562.50		\$625.00	\$375.00		\$312.50	\$187.50
21	\$130.00	\$78.00		\$975.00	\$585.00		\$650.00	\$390.00		\$325.00	\$195.00
22	\$135.00	\$81.00		\$1,012.50	\$607.50		\$675.00	\$405.00		\$337.50	\$202.50
23	\$140.00	\$84.00		\$1,050.00	\$630.00		\$700.00	\$420.00		\$350.00	\$210.00
24	\$145.00	\$87.00		\$1,087.50	\$652.50		\$725.00	\$435.00		\$362.50	\$217.50
25	\$160.00	\$96.00		\$1,200.00	\$720.00		\$800.00	\$480.00		\$400.00	\$240.00
26	\$175.00	\$105.00		\$1,312.50	\$787.50		\$875.00	\$525.00		\$437.50	\$262.50
27	\$190.00	\$114.00		\$1,425.00	\$855.00		\$950.00	\$570.00		\$475.00	\$285.00
28	\$205.00	\$123.00		\$1,537.50	\$922.50		\$1,025.00	\$615.00		\$512.50	\$307.50

How to use this chart

- 1) Find your income level on the MA EEC Financial Assistance Parent Co-Payment Table
- 2) Determine if your level of care is .75 time, .5 time or .25 time
- 3) Find your semester expected copayment by looking across the correct row for your income level, and down the correct column for your level of care for the age group of your child
- 4) School Age Rates are for children 5 and above

METLAW PREPAID LEGAL BENEFIT

Effective plan year 2022-23, eligible Postdocs who have submitted a benefits application receive the MetLife group legal plan at no cost.

MetLaw 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

How to apply

Postdocs use the same online application to apply for all benefits, available at hwtrust.geouaw.org

Using the 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 <https://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.



Cover the costs on a wide range of common legal issues with a Legal Plan.

Access experienced attorneys to help with estate planning, home sales, tax audits and more.

Powerful legal protection on your side

Quality legal assistance can be pricey. And it can be hard to know where to turn to find an attorney you trust. For a monthly fee, you can have a team of top attorneys ready to help you take care of life's planned and unplanned legal events.

MetLife Legal Plans gives you access to the expert guidance and tools you need to handle the broad range of personal legal needs you might face throughout your life. This could be when you're buying or selling a home, starting a family, dealing with identity theft or caring for aging parents.

Reduce the out-of-pocket cost of legal services with MetLife Legal Plans.

How it works

Our service is tailored to your needs. With network attorneys available in person, by phone or by email and online tools to do-it-yourself — we make it easy to get legal help. And, you will always have a choice in which attorney to use. You can choose one from our network of prequalified attorneys, or use an attorney outside of our network and be reimbursed some of the cost.¹

Best of all, you have unlimited access to our attorneys for all legal matters covered under the plan. For a monthly fee conveniently paid through payroll deduction, an expert is on your side as long as you need them.

When you need help with a personal legal matter, MetLife Legal Plans is there for you to help make it a little easier.

Estate planning at your fingertips

Our website provides you with the ability to create wills, living wills and powers of attorney online in as little as 15 minutes. Answer a few questions about yourself, your family and your assets to create these documents instantly. In states where available, you also have access to sign and notarize your documents online through our video notary feature.²

How to use the plan

1. Find an attorney

Create an account at **members.legalplans.com** to see your coverages and select an attorney for your legal matter. Or, give us a call at **800.821.6400** for assistance.

2. Make an appointment

Call the attorney you select and schedule a time to talk or meet.

3. That's it!

There are no copays, deductibles or claim forms when you use a network attorney for a covered matter.

Helping you navigate life's planned and unplanned events.

For a monthly fee, you, your spouse and dependents get legal assistance for some of the most frequently needed personal legal matters — with no waiting periods, no deductibles and no claim forms when using a network attorney for a covered matter.

Money Matters	<ul style="list-style-type: none"> Debt Collection Defense Identity Theft Defense LifeStages Identity Restoration Services³ 	<ul style="list-style-type: none"> Negotiations with Creditors Personal Bankruptcy Promissory Notes 	<ul style="list-style-type: none"> Tax Audit Representation Tax Collection Defense
Home & Real Estate	<ul style="list-style-type: none"> Boundary or Title Disputes Deeds Eviction Defense Foreclosure 	<ul style="list-style-type: none"> Home Equity Loans Mortgages Property Tax Assessments Refinancing of Home 	<ul style="list-style-type: none"> Sale or Purchase of Home Security Deposit Assistance Tenant Negotiations Zoning Applications
Estate Planning	<ul style="list-style-type: none"> Codicils Complex Wills Healthcare Proxies Living Wills 	<ul style="list-style-type: none"> Powers of Attorney (Healthcare, Financial, Childcare, Immigration) 	<ul style="list-style-type: none"> Revocable & Irrevocable Trusts Simple Wills
Family & Personal	<ul style="list-style-type: none"> Adoption Affidavits Conservatorship Demand Letters Garnishment Defense Guardianship Immigration Assistance 	<ul style="list-style-type: none"> Juvenile Court Defense, Including Criminal Matters Name Change Parental Responsibility Matters Personal Property Protection 	<ul style="list-style-type: none"> Prenuptial Agreement Protection from Domestic Violence Review of ANY Personal Legal Document School Hearings
Civil Lawsuits	<ul style="list-style-type: none"> Administrative Hearings Civil Litigation Defense 	<ul style="list-style-type: none"> Disputes Over Consumer Goods & Services Incompetency Defense 	<ul style="list-style-type: none"> Pet Liabilities Small Claims Assistance
Elder-Care Issues	Consultation & Document Review for your parents: <ul style="list-style-type: none"> Deeds Leases 	<ul style="list-style-type: none"> Medicaid Medicare Notes Nursing Home Agreements 	<ul style="list-style-type: none"> Powers of Attorney Prescription Plans Wills
Vehicle & Driving	<ul style="list-style-type: none"> Defense of Traffic Tickets⁴ Driving Privileges Restoration 	<ul style="list-style-type: none"> License Suspension Due to DUI 	<ul style="list-style-type: none"> Repossession



To learn more about your coverages, view our attorney network or grant your dependents access, create an account at **members.legalplans.com** or call **800.821.6400** Monday – Friday 8:00 am to 8:00 pm (ET).

Your account will also give you access to our self-help document library to complete simple legal forms. The forms are available to you, regardless of enrollment.

1. You will be responsible to pay the difference, if any, between the plan's payment and the out-of-network attorney's charge for services.

2. Digital notary and signing is not available in all states.

3. This benefit provides the Participant with access to LifeStages Identity Restoration Services provided by IdentityForce, A TransUnion® Brand. IdentityForce is not a corporate affiliate of MetLife Legal Plans.

4. Does not cover DUI.

Group 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, group 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. Some services not available in all states. No service, including 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. Coverage for defense of criminal matters is excluded from insurance coverage for individuals located in New York. For all other personal legal matters, an advice and consultation benefit is provided. Additional representation is also included for certain matters. Please see your plan description for details. [MLP3]



UAW UMASS HEALTH&WELFARE TRUST FUND LEGAL SERVICES PLAN

FACT SHEET

HOW TO GET LEGAL SERVICES

To use your Legal Plan, visit our website 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 who answers your call will:

- verify your eligibility for services;
- 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 a Case Number that is similar to a claim number (you will need a new Case Number for each new case you have);
- give you the telephone number of the Plan Attorney most convenient to you; and
- answer any questions you have about your Legal Plan.

Then 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 give them your Case Number, the name of the legal plan you belong to and the type of legal matter you are calling about. Evening and Saturday appointments are available. If you wish, you may choose 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.

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.

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.

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.

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.

Identity Management Services

This service provides the Participant with access to LifeStages Identity Management Services provided by CyberScout. These services include 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 service. For more information on identity theft protection, please visit <http://www.legalplans-idtheft.com/>.

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.

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.

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.

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.

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.

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 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.

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.

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.

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.

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.

TRAFFIC AND CRIMINAL MATTERS

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 Participant 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

Living Wills

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.

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.

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.

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.

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.	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.

NO COST BASIC LIFE INSURANCE

Eligible Postdoc employees who work at least 20 hours per week and have a benefits application on file will receive a \$10,000 individual basic life insurance and accidental death & dismemberment (AD&D) policy at no cost. This policy is portable when you end your Postdoc employment according to the terms established by MetLife. You can opt out of this benefit if you so choose using the enrollment portal at <https://portal.hwtf.org/>

For policy amounts above \$10,000 or for policies for dependents, eligible Postdoc employees can purchase additional MetLife supplemental life insurance at affordable group rates.

OPTIONAL GROUP LIFE INSURANCE

Postdocs working at least 20 hours per week are eligible to purchase supplementary life insurance at affordable rates through MetLife. This benefit is *100% employee paid*. Highlights of the policy include:

- You can purchase up to 5 times your salary to a max benefit of \$500,000
- Spouses & domestic partners can purchase up to \$100,000
- Your first \$100,000 of coverage is without medical evidence (\$25,000 for spouse)
- Coverage is portable at group rates when you leave
- Includes free face-to-face will preparation service
- Rates are based on age (see the chart in the following pages)

How to apply

Log in to our enrollment portal at <https://portal.hwtf.org/> and complete the life insurance portion of the application. Complete Form 1 (Full Life Insurance Benefit Application) and request a secure email from uawdental@external.umass.edu to submit your form within 30 days of your start of employment. Any applicant applying for coverage of \$100,000 or more must also complete and submit Form 2 (Statement of Health Form), which should be mailed directly to MetLife according to the instructions on the form. Forms 1 & 2 are available at <http://www.uawumasstrustfund.org>

Payment of Premiums

Premium payments must be paid via credit card or debit card using PayPal'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 than a non-group policy. Email uawdental@external.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.

Basic Term Life / AD&D

Metropolitan Life Insurance Company

Plan Design for: UAW/UMass Health & Welfare Trust Fund

Date Prepared: July 21, 2022

For All Active Full-Time Employees working at least 20 hours per week

Basic Life	\$10,000
Accidental Death & Dismemberment	An amount equal to Your Basic Life Insurance.
Plan Maximum	\$10,000
Non-Medical Maximum	\$10,000
Age Reduction Formula (reduces by)	Reduces by 35% at age 65, and to 50% of the original amount at age 70
Employee Contribution	
• Basic Life	0%
• AD&D	0%

Term Life Features (1):

- Continuation of Life insurance while totally disabled as defined by the Group Policy (2)
- Life Settlement Account (3)
- Portability (4)
- Grief Counseling (5)
- Funeral Discounts and Planning Services (6)

Additional Features:

- WillsCenter.com (7)

AD&D Features (1):

- Seat Belt Benefit (8)
- Child Care Benefit
- Life Settlement Account (3)
- Air Bag Benefit
- Common Carrier Benefit

What Is Not Covered?

Like most insurance plans, this plan has exclusions. In addition, a reduction schedule may apply. Please see your benefits administrator or certificate for specific details.

Accidental Death & Dismemberment insurance does not include payment for any loss which is caused by or contributed to by: physical or mental illness, diagnosis of or treatment of the illness; an infection, unless caused by an external wound accidentally sustained; suicide or attempted suicide; injuring oneself on purpose; the voluntary intake or use by any means of any drug, medication or sedative, unless taken as prescribed by a doctor or an over-the-counter drug taken as directed; voluntary intake of alcohol in combination with any drug, medication or sedative; war, whether declared or undeclared, or act of war, insurrection, rebellion or riot; committing or trying to commit a felony; any poison, fumes or gas, voluntarily taken, administered or absorbed; service in the armed forces of any country or international authority, except the United States National Guard; operating, learning to operate, or serving as a member of a crew of an aircraft; while in any aircraft for the purpose of descent from such aircraft while in flight (except for self preservation); or operating a vehicle or device while intoxicated as defined by the laws of the jurisdiction in which the accident occurs.

Life and AD&D coverages are provided under a group insurance policy (Policy Form GPNP99 or G2130-S) issued to your employer by MetLife. Life and AD&D coverages under your employer's plan terminates when your employment ceases when your Life and AD&D contributions cease, or upon termination of the group insurance policy. Should your life insurance coverage terminate for reasons other than non-payment of premium, you may convert it to a MetLife individual permanent policy without providing medical evidence of insurability.

This summary provides an overview of your plan's benefits. These benefits are subject to the terms and conditions of the contract between MetLife and your employer. Specific details regarding these provisions can be found in the certificate. If you have additional questions regarding the Life Insurance program underwritten by MetLife, please contact your benefits administrator or MetLife. Like most group life insurance policies, MetLife group policies contain exclusions, limitations, terms and conditions for keeping them in force. Please see your certificate for complete details.

- (1) Features may vary depending on jurisdiction.
- (2) Total disability or totally disabled means your inability to do your job and any other job for which you may be fit by education, training or experience, due to injury or sickness. Please note that this benefit is only available after you have participated in the Basic/Supplemental Term Life Plan for 1 year and it is only available to the employee.
- (3) Subject to state law, and/or group policyholder direction, the Total Control Account is provided for all Life and AD&D benefits of \$5,000 or more. The TCA is not insured by the Federal Deposit Insurance Corporation or any government agency. The assets backing TCA are maintained in MetLife's general account and are subject to MetLife's creditors. MetLife bears the investment risk of the assets backing the TCA, and expects to earn income sufficient to pay interest to TCA Accountholders and to provide a profit on the operation of the TCAs. Guarantees are subject to the financial strength and claims paying ability of MetLife.
- (4) Subject to state availability. To take advantage of this benefit, coverage of at least \$20,000 must be elected.
- (5) Grief Counseling services are provided through an agreement with LifeWorks US Inc. LifeWorks is not an affiliate of MetLife, and the services LifeWorks provides are separate and apart from the insurance provided by MetLife. LifeWorks has a nationwide network of over 30,000 counselors. Counselors have masters or doctoral degrees and are licensed professionals. The Grief Counseling program does not provide support for issues such as: domestic issues, parenting issues, or marital/relationship issues (other than a finalized divorce). For such issues, members should inquire with their human resources department about available company resources. This program is available to insureds, their dependents and beneficiaries who have received a serious medical diagnosis or suffered a loss. Events that may result in a loss are not covered under this program unless and until such loss has occurred. Services are not available in all jurisdictions and are subject to regulatory approval. Not available on all policy forms.
- (6) Services and discounts are provided through a member of the Dignity Memorial® Network, a brand name used to identify a network of licensed funeral, cremation and cemetery providers that are affiliates of Service Corporation International (together with its affiliates, "SCI"), 1929 Allen Parkway, Houston, Texas. The online planning site is provided by SCI Shared Resources, LLC. SCI is not affiliated with MetLife, and the services provided by Dignity Memorial members are separate and apart from the insurance provided by MetLife. Not available in some states. Planning services, expert assistance, and bereavement travel services are available to anyone regardless of affiliation with MetLife. Discounts through Dignity Memorial's network of funeral providers are pre-negotiated. Not available where prohibited by law. If the group policy is issued in an approved state, the discount is available for services held in any state except KY and NY, or where there is no Dignity Memorial presence (AK, MT, ND, SD, and WY). For MI and TN, the discount is available for "At Need" services only. Not approved in AK, FL, KY, MT, ND, NY and WA.
- (7) WillsCenter.com is a document service provided by SmartLegalForms, Inc., an affiliate of Epoq Group, Ltd. SmartLegalForms, Inc. is not affiliated with MetLife and the WillsCenter.com service is separate and apart from any insurance or service provided by MetLife. The WillsCenter.com service does not provide access to an attorney, does not provide legal advice, and may not be suitable for your specific needs. Please consult with your financial, legal, and tax advisors for advice with respect to such matters.
- (8) The Seat Belt Benefit is payable if an insured person dies as a result of injuries sustained in an accident while driving or riding in a private passenger car and wearing a properly fastened seat belt _or a child restraint if the insured is a child_. In such case, his or her benefit can be increased by 10 percent of the Full Amount — but not less than \$1,000 or more than \$25,000.

Supplemental Term Life

Metropolitan Life Insurance Company

Plan Design for: UAW/UMass Health & Welfare Trust Fund

Date Prepared: July 21, 2022

For All Active Full-Time Employees working at least 20 hours per week

Build Your Benefit With MetLife's Supplemental Term Life insurance, your employer gives you the opportunity to buy valuable life insurance coverage for yourself, your spouse and your dependent children -- all at affordable group rates.

	Employee	Spouse & Child	
		Spouse ¹	Child
Life Coverage: provides a benefit in the event of death Schedules:	Increments of \$10,000	Increments of \$5,000	Flat Amount: \$1,000, \$2,000, \$4,000, \$5,000, or \$10,000
Non Medical Maximum	\$100,000	\$25,000	\$10,000
Overall Benefit Maximum	The lesser of 5 times Your Basic Annual Earnings, or \$500,000	\$100,000	\$10,000
AD&D Coverage: provides a benefit in the event of death or dismemberment resulting from a covered accident Schedules:	Yes (benefit amount is same as Supplemental Term Life coverage)	Yes (benefit amount is same as Supplemental Term Life coverage)	Yes (benefit amount is same as Supplemental Term Life coverage)
AD&D Maximum	Maximum amount is same as Supplemental Term Life coverage	Maximum amount is same as Supplemental Term Life coverage	Maximum amount is same as Supplemental Term Life coverage
Employee Contribution	100%	100%	100%

Any purchase or increase in benefits, which does not take place within 31 days of employee's or dependent's eligibility effective date is subject to evidence of insurability. Coverage is subject to the approval of MetLife.

To request coverage:

1. Choose the amount of employee coverage that you want to buy.
2. Look up the premium costs for your age group for the coverage amount you are selecting on the chart below.
3. Choose the amount of coverage you want to buy for your spouse. Again, find the premium costs on the chart below.
Note: Premiums are based on your age, not your spouse's.
4. Choose the amount of coverage you want to buy for your dependent children. The premium costs for each coverage option are shown below.
5. Fill in the enrollment form with the amounts of coverage you are selecting. (To request coverage over the non-medical maximum, please see your Human Resources representative for a medical questionnaire that you will need to complete.) Remember, you must purchase coverage for yourself in order to purchase coverage for your spouse or children.

Employee Age	Employee & Spouse Coverage -- Monthly Premium For:						
	\$1,000	\$10,000	\$20,000	\$40,000	\$50,000	\$100,000	
Under 30	\$0.09	\$0.89	\$1.78	\$3.56	\$4.45	\$8.90	
30-34	\$0.09	\$0.93	\$1.86	\$3.72	\$4.65	\$9.30	
35-39	\$0.11	\$1.10	\$2.20	\$4.40	\$5.50	\$11.00	
40-44	\$0.16	\$1.58	\$3.16	\$6.32	\$7.90	\$15.80	
45-49	\$0.24	\$2.39	\$4.78	\$9.56	\$11.95	\$23.90	
50-54	\$0.37	\$3.70	\$7.40	\$14.80	\$18.50	\$37.00	
55-59	\$0.57	\$5.71	\$11.42	\$22.84	\$28.55	\$57.10	
60-64	\$0.85	\$8.48	\$16.96	\$33.92	\$42.40	\$84.80	
65-69	\$1.47	\$14.74	\$29.48	\$58.96	\$73.70	\$147.40	
70+	\$2.36	\$23.59	\$47.18	\$94.36	\$117.95	\$235.90	

Due to rounding, your actual payroll deduction amount may vary slightly.

Dependent Child Coverage ² Monthly Premium For:	
\$1,000	\$0.29
\$2,000	\$0.58
\$4,000	\$1.16
\$5,000	\$1.46
\$10,000	\$2.91

Features available with Supplemental Life

Grief Counseling³: You, your dependents, and your beneficiaries access to grief counseling sessions and funeral related concierge services to help cope with a loss – at no extra cost. Grief counseling services provide confidential and professional support during a difficult time to help address personal and funeral planning needs. At your time of need, you and your dependents have 24/7 access to a work/life counselor. You simply call a dedicated 24/7 toll-free number to speak with a licensed professional experienced in helping individuals who have suffered a loss. Sessions can either take place in-person or by phone. You can have up to five face-to-face grief counseling sessions per event to discuss any situation you perceive as a major loss, including but not limited to death, bankruptcy, divorce, terminal illness, or losing a pet.³ In addition, you have access to funeral assistance for locating funeral homes and cemetery options, obtaining funeral cost estimates and comparisons, and more. You can access these services by calling 1-1-888-319-7819 or log on to www.metlifegc.lifeworks.com (Username: metlifeassist; Password: support).

Funeral Discounts and Planning Services⁴: As a MetLife group life policyholder, you and your family may have access to funeral discounts, planning and support to help honor a loved one's life - at no additional cost to you. Dignity Memorial provides you and your loved ones access to discounts of up to 10% off of funeral, cremation and cemetery services through the largest network of funeral homes and cemeteries in the United States.

When using the Dignity Memorial Network you have access to convenient planning services - either online at www.finalwishesplanning.com, by phone (1-866-853-0954), or by paper - to help make final wishes easier to manage. You also have access to assistance from compassionate funeral planning experts to help guide you and your family in making confident decisions when planning ahead as well as bereavement travel services - available 24 hours, 7 days a week, 365 days a year - to assist with time-sensitive travel arrangements to be with loved ones.

Digital Estate Planning⁷: Helping to ensure final wishes are clear. Employees can choose to complete wills and other important estate planning documents quickly and easily online with access to online notary services.

Will Preparation⁵: Like life insurance, a carefully prepared Will is important. With a Will, you can define your most important decisions such as who will care for your children or inherit your property. By enrolling for Supplemental Term Life coverage, you will have in person access to MetLife Legal Plans' network of 18,000+ participating attorneys for preparing or updating a will, living will and power of attorney. When you enroll in this plan, you may take advantage of this benefit at no additional cost to you if you use a participating plan attorney. To obtain the legal plan's toll-free number and your company's group access number, contact your employer or your plan administrator for this information.

MetLife Estate Resolution Services (ERS)⁴: is a valuable service offered under the group policy. A MetLife Legal Plan attorney will consult with your beneficiaries by telephone or in person regarding the probate process for your estate. The attorney will also handle the probate of your estate for your executor or administrator.. This can help alleviate the financial and administrative burden upon your loved ones in their time of need.

Portability⁶: If your present employment ends, you can choose to continue your current life benefits.

What Is Not Covered?

Like most insurance plans, this plan has exclusions. Supplemental and Dependent Life Insurance do not provide payment of benefits for death caused by suicide within the first two years (one year in North Dakota) of the effective date of the certificate, or payment of increased benefits for death caused by suicide within two years (one year in North Dakota or Colorado) of an increase in coverage. In addition, a reduction schedule may apply. Please see your benefits administrator or certificate for specific details.

Accidental Death & Dismemberment insurance does not include payment for any loss which is caused by or contributed to by: physical or mental illness, diagnosis of or treatment of the illness; an infection, unless caused by an external wound accidentally sustained; suicide or attempted suicide; injuring oneself on purpose; the voluntary intake or use by any means of any drug, medication or sedative, unless taken as prescribed by a doctor or an over-the-counter drug taken as directed; voluntary intake of alcohol in combination with any drug, medication or sedative; war, whether declared or undeclared, or act of war, insurrection, rebellion or riot; committing or trying to commit a felony; any poison, fumes or gas, voluntarily taken, administered or absorbed; service in the armed forces of any country or international authority, except the United States National Guard; operating, learning to operate, or serving as a member of a crew of an aircraft; while in any aircraft for the purpose of descent from such aircraft while in flight (except for self preservation); or operating a vehicle or device while intoxicated as defined by the laws of the jurisdiction in which the accident occurs.

Life and AD&D coverages are provided under a group insurance policy (Policy Form GPNP99 or G2130-S) issued to your employer by MetLife. Life and AD&D coverages under your employer's plan terminates when your employment ceases, when your Life and AD&D contributions cease, or upon termination of the group insurance policy. Dependent Life coverage will terminate when a dependent no longer qualifies as a dependent. Should your life insurance coverage terminate for reasons other than non-payment of premium, you may convert it to a MetLife individual permanent policy without providing medical evidence of insurability.

This summary provides an overview of your plan's benefits. These benefits are subject to the terms and conditions of the contract between MetLife and your employer and are subject to each state's laws and availability. Specific details regarding these provisions can be found in the certificate.

If you have additional questions regarding the Life Insurance program underwritten by MetLife, please contact your benefits administrator or MetLife. Like most group life insurance policies, MetLife group policies contain exclusions, limitations, terms and conditions for keeping them in force. Please see your certificate for complete details.

1. Spouse amount cannot exceed 50% of the employee's Supplemental Life benefit.
2. Child benefits for children under 6 months old are limited.
3. Grief Counseling services are provided through an agreement with LifeWorks US Inc. LifeWorks is not an affiliate of MetLife, and the services LifeWorks provides are separate and apart from the insurance provided by MetLife. LifeWorks has a nationwide network of over 30,000 counselors. Counselors have master's or doctoral degrees and are licensed professionals. The Grief Counseling program does not provide support for issues such as: domestic issues, parenting issues, or marital/relationship issues (other than a finalized divorce). For such issues, members should inquire with their human resources department about available company resources. This program is available to insureds, their dependents and beneficiaries who have received a serious medical diagnosis or suffered a loss. Events that may result in a loss are not covered under this program unless and until such loss has occurred. Services are not available in all jurisdictions and are subject to regulatory approval. Not available on all policy forms.
4. Services and discounts are provided through a member of the Dignity Memorial® Network, a brand name used to identify a network of licensed funeral, cremation and cemetery providers that are affiliates of Service Corporation International (together with its affiliates, "SCI"), 1929 Allen Parkway, Houston, Texas. The online planning site is provided by SCI Shared Resources, LLC. SCI is not affiliated with MetLife, and the services provided by Dignity Memorial members are separate and apart from the insurance provided by MetLife. Not available in some states. Planning services, expert assistance, and bereavement travel services are available to anyone regardless of affiliation with MetLife. Discounts through Dignity Memorial's network of funeral providers are pre-negotiated. Not available where prohibited by law. If the group policy is issued in an approved state, the discount is available for services held in any state except KY and NY, or where there is no Dignity Memorial presence (AK, MT, ND, SD, and WY). For MI and TN, the discount is available for "At Need" services only. Not approved in AK, FL, KY, MT, ND, NY and WA.
5. Will Preparation and MetLife Estate Resolution Services are offered by MetLife Legal Plans, Inc., Cleveland, Ohio. In certain states, legal services benefits are provided through insurance coverage underwritten by Metropolitan General Insurance Company and Affiliates, Warwick, Rhode Island. Will Preparation and Estate Resolution Services are subject to regulatory approval and currently available in all states. For New York situated cases, the Will Preparation service is an expanded offering that includes office consultations and telephone advice for certain other legal matters beyond Will Preparation. Please note that certain services are not covered by Estate Resolution Services, including matters in which there is a conflict of interest between the executor and any beneficiary or heir and the estate; any disputes with the group policyholder, MetLife and/or any of its affiliates; any disputes involving statutory benefits; will contests or litigation outside probate court; appeals; court costs, filing fees, recording fees, transcripts, witness fees, expenses to a third party, judgments or fines; and frivolous or unethical matters.
6. Subject to state availability and the maturity age specified in the certificate.
7. Digital Estate Planning is not available for customers situated in FL or located in GU, PR and VI. It is not included with dependent life coverages. Domestic Partnerships are not currently supported however members in a domestic partnership may use a MetLife Legal Plans attorney for their planning needs. Online Notary is not available in all states. Group legal plans are provided by MetLife Legal Plans, Inc., Cleveland, OH. In certain states, group legal plans are provided through insurance coverage underwritten by Metropolitan General Insurance Company and Affiliates, Warwick, RI.

You know that life insurance is a **critical part of your overall benefits plan** – that's why you chose to enroll in the Group Life insurance program offered by your employer. As you leave your employment, you have **options** to continue your current Group Life coverage and **maintain this important protection** for you and your family.

Now you have **important decisions to make** about continuing your Group Life insurance benefits. There are **two options** under which you can continue your coverage – **Portability** and **Conversion**. This brochure is designed to answer the most common questions about each option and give you a side-by-side comparison, so you can choose the option that best meets your needs.

Is there anything else I need to know?

To continue your life coverage benefits, you will receive a notice after your group life benefits end which includes coverage amounts and eligibility dates.

If you wish to increase your coverage amount or add spouse or child coverage, the non-underwritten policy available through the Conversion process may not meet your needs. An individually underwritten policy may be more cost-effective and provide additional benefits, such as the ability to elect waiver of premium, accidental death benefit and/or a children's term rider, that are not available with a Conversion policy. You may apply for a medically underwritten life insurance policy simultaneously with your application for the Conversion policy. Underwritten policies are subject to underwriting requirements, so you may have to provide medical information. If you apply for both the Conversion policy and an underwritten policy and are approved for the underwritten policy, then you can choose the underwritten policy. If you are not approved for the underwritten policy, then the Conversion policy will be issued and become effective on the 32nd day after your group coverage ends.

Portability or porting is an optional feature chosen by your former employer. It allows you and your dependents to continue their Group Term Life and Accidental Death and Dismemberment (AD&D) insurance under a separate policy. Once enrolled, MetLife will mail you a portable certificate and your initial bill. Instructions on how to set up the monthly Electronic Funds Transfer (EFT) can be found on the back of your bill. If you apply for Portability, preferred portable rates are available for you and your spouse or domestic partner with Evidence of Insurability (EOI). Portable coverage is effective on the 32nd day after group coverage ends.

What if I still have questions?

Helping you make the best decision for you and your family's needs is important to us. If you have additional questions or need assistance, please contact the following MetLife customer service areas:

To speak with a MetLife representative who can answer questions about Portability, call **1-888-252-3607**.

To be connected with a MetLife representative who can answer questions about Conversion, call **1-877-275-6387**.

The information contained in this document is not intended to (and cannot) be used by anyone to avoid IRS penalties. This document supports the promotion and marketing of insurance products. Employees should seek advice based on their particular circumstances from an independent tax advisor since any discussion of taxes is for general informational purposes only and does not purport to be complete or cover every situation.

MetLife

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Understanding your Options

Portability and Conversion

MetLife



It's Important to understand the differences between these options. use the chart below to help you make an informed decision.

	portability ¹	conversion
what are the basics of each option?	<p>You can continue your group life and AD&D* insurance coverage with MetLife if your coverage terminates in whole or in part due to:</p> <p>employee qualifying events:</p> <ul style="list-style-type: none"> Termination of employment or retirement A change in your employee class Your Group Policy is amended to end coverage, unless coverage is replaced by a similar insurance under another group insurance policy Your Group policy ends with or without a successor plan Reduced coverage due to age or change in plan for your employee class <p>dependent qualifying events:</p> <ul style="list-style-type: none"> Employee is eligible to exercise portability option Spouse can port upon the Death of the Employee, Divorce, Annulment, Civil Union or Reciprocal Beneficiary relationship ends Dependent no longer eligible as a Dependent <p>You are not eligible for Portability if you received approval for Premium Waiver Death Benefits.</p> <p>*Your plan may not include the Portability feature on every product presented on the Election of Portable Coverage Form. The Recordkeeper for your plan will identify which coverage(s) and coverage amount(s) you are eligible to port.²</p>	<p>You can generally convert your group life insurance benefits to an Individual whole life insurance policy⁵ if your coverage terminates in whole or in part due to:</p> <ul style="list-style-type: none"> Retirement or termination of employment A change in your employee class <p>Conversion is available on all Group Life insurance coverages. Conversion is not available on AD&D coverage.</p>
does coverage reduce or terminate?	<ul style="list-style-type: none"> employee: Reduces 50% at age 70, and terminates at age 100. spouse: Terminates at age 70. child(ren): Terminates at age 25. At age 25, each child may apply to continue their portable coverage by completing a NewPort election form. They will also have the option to apply for Preferred Life Rates (lower preferred rates). 	Coverage reductions and termination are subject to the terms of the policy chosen.
will I have to answer medical questions?	No. However, medical questions must be answered to apply for Preferred Life Rates (lower preferred rates). If approved by MetLife, you will be billed using the Preferred Life Rates (lower preferred rates).	No.
what are the minimum and maximum amounts of coverage?	<p>The standard coverage minimum amounts are:</p> <ul style="list-style-type: none"> \$10,000 for employees \$ 2,500 for spouses \$10,000 for Spouse Only (no portable employee coverage) \$1,000 for children <p>Your coverage maximum amount is generally limited to the amount you had at the time group benefits terminated and may vary, depending on the type of coverage you had. The standard maximum coverage amount is \$2 million. Details about your specific coverage can be found on the Election of Portable Coverage form.</p>	<p>The coverage minimum under Conversion is subject to the Individual Life plan features. The maximum coverage amount under Conversion varies based on the following:</p> <ul style="list-style-type: none"> The reason group benefits ended. The amount of group insurance you have. Your eligibility for any other group benefits within 31 days after current benefits terminate. Specific state regulations.
can I increase or decrease coverage amounts after the initial application period?	Coverage can be increased in \$25,000 increments up to \$250,000 with Evidence of Insurability (EOI) at the initial application and annually at the insured's portability anniversary date. Portable coverage may also be decreased, as needed.	Coverage cannot be increased at any time and cannot be decreased on Whole Life policies.
what additional features/services are available?	<ul style="list-style-type: none"> Accelerated Benefits Option (ABO) for Life coverage(s) only.³ Total Control Account* (TCA) for beneficiaries.⁴ 	Total Control Account* (TCA) for beneficiaries. ⁴
how do I enroll/apply for coverage?	<ul style="list-style-type: none"> You will receive an Election of Portable Coverage form from your Group Life Benefits Recordkeeper. You have 31 days from the date on the Election form to complete and return this form to MetLife. Coverage will take effect 32 days after your group coverage ends. 	<ul style="list-style-type: none"> You will receive a Notice of Conversion form from your Group Life Benefits Recordkeeper. You have 31 days from the date your coverage ends to contact MetLife to convert your coverage. You must contact MetLife within this 31-day period to begin the conversion process. A MetLife agent will consult with you on your specific needs and assist you with the application process.
will the rates be different from the rates I paid while I was working?	<ul style="list-style-type: none"> Rates are based on your current age and differ from the rates you paid while employed. As with any group of insureds, rates may change based on the financial experience of the group. MetLife will bill you monthly for your coverage. The option to make monthly payments via Electronic Funds Transfer is available by contacting MetLife at 1-888-252-3607. There is a \$1 administrative fee added to each monthly premium if Employee Life coverage is \$20,000 or more. If Employee Life coverage is less than \$20,000, the monthly administrative fee is \$3. The monthly administrative fee is waived for insureds who use Electronic Funds Transfer. Employee or Spouse can apply for Preferred Life (lower preferred rates) premium rates by answering medical questions. If not approved, Employee and Spouse can still participate in portable coverage at the Non-Preferred (higher) premium rates. 	<ul style="list-style-type: none"> Rates for Conversion are based on your age at the time you convert your coverage and remain level throughout the life of the policy. The MetLife agent will discuss your payment options with you.

¹ Subject to state availability. To take advantage of this benefit, coverage of at least \$10,000 must be elected. Increases, decreases, minimum and maximum coverage amounts are subject to state availability.

² You may later convert ported coverage when ported benefits end, or if the portable plan is terminated by MetLife. Conversion is not available on AD&D coverage. Conversion rates are based on your age at the time you convert.

³ When life expectancy is certified by a physician to be 12 months (24 months in IL, TX or WA) or less. The Accelerated Benefits Option (ABO) is subject to state availability and regulation. The ABO benefits are intended to qualify for favorable federal tax treatment, in which case the benefits will not be subject to federal taxation. This information was written as a supplement to the marketing of life insurance products. Tax laws relating to accelerated benefits are complex and limitations may apply. You are advised to consult with and rely on an independent tax advisor about your own particular circumstances. Receipt of ABO benefits may affect your eligibility, or that of your spouse or your family, for public assistance programs such as medical assistance (Medicaid), Temporary Assistance to Needy Families (TANF), Supplementary Social Security Income (SSI) and drug assistance programs. You are advised to consult with social service agencies concerning the effect that receipt of ABO benefits will have on public assistance eligibility for you, your spouse or your family.

⁴ Subject to state law, and/or group policyholder direction, the Total Control Account is provided for all Life and AD&D benefits of \$5,000 or more. The TCA is not insured by the Federal Deposit Insurance Corporation or any government agency. The assets backing TCA are maintained in MetLife's general account and are subject to MetLife's creditors. MetLife bears the investment risk of the assets backing the TCA, and expects to earn income sufficient to pay interest to TCA Accountholders and to provide a profit on the operation of the TCAs. Guarantees are subject to the financial strength and claims-paying ability of MetLife.

⁵ A non-renewable term life policy may precede a whole life conversion policy if your group coverage is issued in New York or West Virginia.



How You Can Continue Your Group Term Life Insurance – (Portability)

What is Portability?

Portability or porting is an optional feature chosen by your former employer. It allows employees and dependents to continue their Group Term Life and Accidental Death and Dismemberment (AD&D) insurance under a separate group policy. The attached medical questions (Statement of Health Form) do not need to be answered to enroll, however you or your spouse/domestic partner must complete them in order to apply for Preferred Life Rates (lower). If approved by MetLife, you will be billed using the Preferred Life Rates (lower).

- If you do not complete the medical questions or do not satisfy MetLife's underwriting requirements, portable coverage will still be issued based on the Non-Preferred Rates (higher).

Once enrolled MetLife will mail you a portable certificate and your initial bill including instructions on how to set up the monthly Electronic Funds Transfer (EFT). The instructions to set up EFT can be found on the back of your bill.

- Your first bill will also include any retroactive premium due from the effective date of your portable coverage and an administrative fee. The current administrative fee is \$1.00 per statement if your total portable life insurance coverage is \$20,000 or more and \$3.00 per statement if your total portable life insurance coverage is less than \$20,000. If you only port dependent term life or AD&D, regardless of the amount of coverage, your administrative fee will be \$3.00 per statement. If you enroll for EFT the monthly administrative fee is no longer charged

Why is Portable Coverage Important?

Portable coverage provides security and helps eliminate gaps in coverage that you may experience during a time of transition, even if your employment ends.

How Much Time Do I Have To Elect Portability?

- If the **Date of This Notice** (see Part A on page 1 of the attached Election of Portable Coverage Form) is within 15 days after your coverage ends or is reduced, you will have 31 days after your coverage ended to enroll.

Example:

if coverage ended	Date of This Notice	to enroll for portable coverage, you will have until	your portable coverage will be effective
July 31	August 8	August 31	September 1
July 31	August 15	August 31	September 1

- If the **Date of This Notice** (see Part A on page 1 of the attached Election of Portable Coverage Form) is given more than 15 days after your coverage ended or is reduced, you will have 45 from the Date of This Notice to enroll.

Example:

if coverage ended	Date of This Notice	to enroll for portable coverage, you will have until	your portable coverage will be effective
July 31	August 16	September 30	September 1
July 31	August 23	October 7	September 1

- Under **no** circumstances will the option to port be extended past 91 days after the date coverage ended under your former employer's plan.

How Do I Enroll For Portable Life And AD&D Insurance Coverage For Myself And My Dependents?

1. Complete Part B beginning on page 1 of the attached Election of Portable Coverage Form and be sure to answer all sections.
2. Complete the enclosed medical questions (Statement of Health Form) only if:
 - a) You are applying for Preferred Life Rates (lower) for you or your Spouse/Domestic Partner; or
 - b) You wish to increase the amount of life insurance that you previously had under your former employer's plan, either for yourself, your Spouse/Domestic Partner, or both.
3. Complete, sign and date the Designation of Beneficiary for Your Life Benefits (Part C of the attached Election of Portable Coverage Form).

What Needs To Be Mailed To Complete My Enrollment?

You must return:

- a) Your Election of Portable Coverage Form, including information for yourself and if applicable your spouse/domestic partner and child(ren) (Part A and Part B); and
- b) Designation of Beneficiary for Your Life Benefits (Part C)

If you are also **applying** for Preferred Life Rates (lower) for you or your Spouse/Domestic Partner or wish to **increase** your or your Spouse/Domestic Partner's amount of life insurance you must also return the medical questions (Statement of Health) for each person.

- This mailing only contains one set of medical questions (Statement of Health Form). If the medical questions need to be completed for more than one individual, you may make a copy prior to completing or you may call the MetLife Customer Service Center for an additional set of medical questions.

Mail all correspondence to:

MetLife Recordkeeping and Enrollment Services
P.O. Box 14401
Lexington, KY 40512-4401

Or Fax to: 1-866-545-7517

Please Note: Certain benefits and provisions that were available under the employer's group policy will no longer be applicable or may be different under your portable coverage.

For questions or assistance, contact the MetLife Customer Service Center toll-free at 1-888-252-3607, Monday – Friday between the hours of 8:00 a.m. and 11:00 p.m. (EST).



ELECTION OF PORTABLE COVERAGE FORM

Instructions to the Recordkeeper: (The Recordkeeper is the party designated to maintain records of coverage in effect prior to the Employee becoming eligible to Port. The Recordkeeper may be the Employer, a Third Party Administrator (TPA) or MetLife.)

1. Immediately upon the Employee's eligibility for Portability, complete Part A below and Column 1 of the table on page 2 and then make a copy of this form.
2. If the Reason for the Portability Eligibility is Death of the Employee or Divorce, complete all of the fields in Part A below with the Spouse/Domestic Partner's information, not the Employee's information. In the column for Amount of Insurance Terminated or Reduced, leave the Employee amounts blank and enter the Dependent Spouse/Domestic Partner/Domestic Partner and Dependent Child(ren) amounts as applicable.
3. Provide the Employee (or Spouse/Domestic Partner in the event of Death of the Employee or Divorce) with the original or mail it to their last known address.
4. Maintain a copy for your records.

Part A – TO BE COMPLETED BY THE RECORDKEEPER		Date of This Notice (ex. MM/DD/YYYY):
Employer's Name:		Group Customer No.:
Employee Name: (First, Middle, Last)		Date Coverage Ended or was Reduced:
Employee's Mailing Address: (Street, City, State Zip)		
Has coverage been assigned? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify coverage assigned _____ and attach a copy of assignment form. If coverage has been assigned this form must be mailed to the owner.		
Employee's Basic Annual Earnings: \$	Reason for Insured's Portability Eligibility:	
Recordkeeper's Name: _____		
Print name of person at Recordkeeper completing Part A:		Telephone Number:

Part B – TO BE COMPLETED BY THE EMPLOYEE		
Employee's Home Email Address:		Employee's Home Telephone No.:
Social Security Number:	Date of Birth: (ex. MM/DD/YYYY)	Sex (M/F):
Note: If you answer Yes to any of the questions below medical questions (Statement of Health Form) must be completed for each person. This mailing only includes one set of medical questions. They may be copied or you may call the MetLife Customer Service Center number for an additional set of medical questions.		
Are you applying for Preferred Life Rates (lower) for yourself?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you applying for Preferred Life Rates (lower) for your Spouse/Domestic Partner?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you requesting an increase in Life Insurance coverage for yourself?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you requesting an increase in Life Insurance coverage for your Spouse/Domestic Partner?		<input type="checkbox"/> Yes <input type="checkbox"/> No

Part B (continued) – ELECTION OF PORTABLE COVERAGE FORM

To be Completed by the Recordkeeper (Shaded areas to be completed by the Recordkeeper).		To be Completed by the Employee (For each Type of Coverage, please indicate whether you want to continue, discontinue, increase, or decrease the amount of insurance in the shaded column. Select just one option for each Type of Coverage).			
		Continue coverage	Discontinue coverage	Increase coverage	Decrease coverage
		I want to <u>continue</u> the same amount of insurance in the shaded column.	I want to <u>discontinue</u> the insurance in the shaded column.	I want to <u>increase</u> my insurance in the shaded column by the following amount. ¹ (Ex. \$25,000 means you want to increase your insurance amount in column 1 by \$25,000).	I want to <u>decrease</u> my insurance in the shaded column by the following amount. (Ex. \$30,000 means you want to decrease your insurance amount in column 1 by \$30,000).
Type of Coverage	Amount of Insurance Terminated or Reduced Insert the actual \$\$ amount of coverage (i.e. \$50,000)				

Employee ^{2,3}

Basic Life	\$	<input type="checkbox"/>	<input type="checkbox"/>	+ \$	– \$
Basic AD&D ⁴	\$	<input type="checkbox"/>	<input type="checkbox"/>	+ \$	– \$
Supplemental/Optional Life	\$	<input type="checkbox"/>	<input type="checkbox"/>	+ \$	– \$
Supplemental/Optional AD&D ⁴	\$	<input type="checkbox"/>	<input type="checkbox"/>	+ \$	– \$
Voluntary AD&D ⁴	\$	<input type="checkbox"/>	<input type="checkbox"/>	+ \$	– \$
<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + Dependents					

Dependent Spouse/Domestic Partner ^{2,3,5}

Dependent Life	\$	<input type="checkbox"/>	<input type="checkbox"/>	+ \$	– \$
Dependent AD&D ⁴	\$	<input type="checkbox"/>	<input type="checkbox"/>	+ \$	– \$
Voluntary AD&D ^{4,6}	\$	<input type="checkbox"/>	<input type="checkbox"/>	+ \$	– \$

Dependent Child(ren) ^{3,5}

Dependent Life	\$	<input type="checkbox"/>	<input type="checkbox"/>	+ \$	– \$
Dependent AD&D ⁴	\$	<input type="checkbox"/>	<input type="checkbox"/>	+ \$	– \$
Voluntary AD&D ^{4,6}	\$	<input type="checkbox"/>	<input type="checkbox"/>	+ \$	– \$

¹ Increases in coverage are available annually and must be in \$25,000 increments up to \$250,000. For a life insurance increase the employee must complete the medical questions and be approved by MetLife. An increase in AD&D coverage only does not require the insured to complete medical questions.

² The maximum amount the employee can continue on a portable basis is \$2,000,000. The maximum amount the spouse/domestic partner can continue on a portable basis is \$250,000.

³ In order to port coverage for yourself or your dependents, you must have had that coverage under your former plan at the time of your coverage termination.

⁴ AD&D coverage is available without Life Insurance coverage.

⁵ Subject to state limits, the Dependent Spouse/Domestic Partner amount can be greater than the Employee Amount. For Employee and Spouse/Domestic Partner coverage: Spouse/Domestic Partner minimum is \$2,500. For Spouse/Domestic Partner only coverage: Spouse/Domestic Partner minimum is \$10,000. The Child minimum is \$1,000.

⁶ Use these fields only when Voluntary AD&D is being requested for the Spouse/Domestic Partner and/or Child because of the death of the Employee or divorce.

NOTE: All coverage amounts are subject to applicable state laws.

Part B (continued) – ELECTION OF PORTABLE COVERAGE FORM – TO BE COMPLETED BY EMPLOYEE

Name(s) of eligible dependent(s) for whom coverage is requested (If additional space is needed, attached a separate sheet of paper, sign and date)

Dependent	Name (First, Middle, Last)	SSN	Sex (M/F)	Date of Birth (MM/DD/YYYY)
Spouse/Domestic Partner				
Child				
Child				
Child				

Part C – TO BE COMPLETED BY THE EMPLOYEE**DESIGNATION OF BENEFICIARY FOR YOUR LIFE INSURANCE (Dependent Life Insurance is payable as specified in the Certificate)****Only check one of the following boxes.**☐ I designate the following person(s) as my primary beneficiary(ies) for my portable term coverage(s). With such designation any previous designation of a beneficiary for such coverage is hereby revoked.☐ My designation of beneficiary is on a separate form which is signed, dated and attached.

The amount of insurance that is paid to you or your beneficiary will be decreased by any amount of contribution owed to MetLife.

☐ Check if you need more space for additional beneficiaries and attach a separate page. Include all beneficiary information, and sign/date the page.

Full Name (First, Middle, Last)	Social Security #	Date of Birth (MM/DD/YYYY)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #:	
Full Name (First, Middle, Last)	Social Security #	Date of Birth (MM/DD/YYYY)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #:	
Full Name (First, Middle, Last)	Social Security #	Date of Birth (MM/DD/YYYY)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #:	
Payment will be made in equal shares or all to the survivor unless otherwise indicated.				TOTAL: 100%

If all the primary beneficiary(ies) die before me, I designate as contingent beneficiary(ies):

Full Name (First, Middle, Last)	Social Security #	Date of Birth (MM/DD/YYYY)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #:	
Full Name (First, Middle, Last)	Social Security #	Date of Birth (MM/DD/YYYY)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #:	
Payment will be made in equal shares or all to the survivor unless otherwise indicated.				TOTAL: 100%

FRAUD WARNING

Before signing this election form, please read the warning below:

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

DECLARATION AND SIGNATURE

1. The person signing below acknowledges that they have read and understand the statements and declarations made in this election form.
2. The person signing below acknowledges that they have read the Fraud Warning provided in this election form.



Signature of Insured/Owner



Date Signed (MM/DD/YYYY)

Please Note: MetLife needs to receive the original. The signature and date above may not be altered.

Please retain a copy of the fully-completed form for your records and return the original to MetLife Customer Service Center.
If you have any questions, please call 1-888-252-3607 Monday – Friday between the hours of 8:00 a.m. and 11:00 p. m. (EST).

(Continued on Following Page)

TABLE A
LIFE INSURANCE ONLY PREFERRED MONTHLY TERM RATES

RATE SHEET
Schedule of Monthly Portable Preferred Group Life Insurance Term Rates
For Insured and Dependent Spouse/Domestic Partner

Rates (cost per \$1,000 of coverage per month) are based on the Insured's age and Dependent Spouse/Domestic Partner's age as of December 31st, of the current calendar year. Rates are subject to change. An administrative fee may also apply.

Sample monthly premium calculation for an insured age 45, electing \$50,000 of portable coverage

$$\frac{\$50,000}{\$1,000} = 50 \times \frac{\$0.150}{\text{age 45}} = \$7.50 + \$1.00 = \$8.50$$

Amount of coverage selected ÷ \$1,000 = # of units x Rate based on age 45 = Monthly insurance premium + Admin fee* = Monthly total due

* Varies by amount of insurance and payment method

AGE	INSURED RATE	DEPENDENT SPOUSE/ DOMESTIC PARTNER RATE
15	\$0.050	\$0.050
16	\$0.050	\$0.050
17	\$0.050	\$0.050
18	\$0.050	\$0.050
19	\$0.050	\$0.050
20	\$0.050	\$0.050
21	\$0.050	\$0.050
22	\$0.050	\$0.050
23	\$0.050	\$0.050
24	\$0.050	\$0.050
25	\$0.060	\$0.060
26	\$0.060	\$0.060
27	\$0.060	\$0.060
28	\$0.060	\$0.060
29	\$0.060	\$0.060
30	\$0.080	\$0.080
31	\$0.080	\$0.080
32	\$0.080	\$0.080
33	\$0.080	\$0.080
34	\$0.080	\$0.080
35	\$0.090	\$0.090
36	\$0.090	\$0.090
37	\$0.090	\$0.090
38	\$0.090	\$0.090
39	\$0.090	\$0.090
40	\$0.100	\$0.100
41	\$0.108	\$0.108
42	\$0.118	\$0.118
43	\$0.128	\$0.128

AGE	INSURED RATE	DEPENDENT SPOUSE/ DOMESTIC PARTNER RATE
44	\$0.138	\$0.138
45	\$0.150	\$0.150
46	\$0.163	\$0.163
47	\$0.178	\$0.178
48	\$0.194	\$0.194
49	\$0.211	\$0.211
50	\$0.230	\$0.230
51	\$0.261	\$0.261
52	\$0.295	\$0.295
53	\$0.335	\$0.335
54	\$0.379	\$0.379
55	\$0.430	\$0.430
56	\$0.468	\$0.468
57	\$0.510	\$0.510
58	\$0.556	\$0.556
59	\$0.606	\$0.606
60	\$0.660	\$0.660
61	\$0.752	\$0.752
62	\$0.858	\$0.858
63	\$0.977	\$0.977
64	\$1.114	\$1.114
65	\$1.270	\$1.270
66	\$1.399	\$1.399
67	\$1.541	\$1.541
68	\$1.698	\$1.698
69	\$1.870	\$1.870
70	\$2.060	N/A
71	\$2.228	N/A
72	\$2.409	N/A

AGE	INSURED RATE	DEPENDENT SPOUSE/ DOMESTIC PARTNER RATE
73	\$2.605	N/A
74	\$2.818	N/A
75	\$3.047	N/A
76	\$3.295	N/A
77	\$3.564	N/A
78	\$3.854	N/A
79	\$4.168	N/A
80	\$4.460	N/A
81	\$4.910	N/A
82	\$5.410	N/A
83	\$5.960	N/A
84	\$6.560	N/A
85	\$7.220	N/A
86	\$7.950	N/A
87	\$8.760	N/A
88	\$9.650	N/A
89	\$10.630	N/A
90	\$11.710	N/A
91	\$12.900	N/A
92	\$14.190	N/A
93	\$15.630	N/A
94	\$17.210	N/A
95	\$18.950	N/A
96	\$20.870	N/A
97	\$22.990	N/A
98	\$25.320	N/A
99	\$27.880	N/A

TABLE B
LIFE INSURANCE ONLY NON-PREFERRED MONTHLY TERM RATES

RATE SHEET

**Schedule of Monthly Portable Non-Preferred Group Life Insurance Term Rates
For Insured and Dependent Spouse/Domestic Partner**

Rates (cost per \$1,000 of coverage per month) are based on the Insured's age and Dependent Spouse/Domestic Partner's age as of December 31st, of the current calendar year. Rates are subject to change. An administrative fee may also apply.

Sample monthly premium calculation for an insured age 45, electing \$50,000 of portable coverage

$$\frac{\$50,000}{\$1,000} = 50 \times \frac{\$0.538}{\text{age 45}} = \$26.90 + \$1.00 = \$27.90$$

Amount of coverage selected ÷ \$1,000 = # of units x Rate based on age 45 = Monthly insurance premium + Admin fee* = Monthly total due *Varies by amount of insurance and payment method

AGE	INSURED RATE	DEPENDENT SPOUSE/ DOMESTIC PARTNER RATE
15	\$0.162	\$0.162
16	\$0.190	\$0.190
17	\$0.208	\$0.208
18	\$0.224	\$0.224
19	\$0.232	\$0.232
20	\$0.234	\$0.234
21	\$0.256	\$0.256
22	\$0.242	\$0.242
23	\$0.202	\$0.202
24	\$0.184	\$0.184
25	\$0.170	\$0.170
26	\$0.170	\$0.170
27	\$0.154	\$0.154
28	\$0.150	\$0.150
29	\$0.146	\$0.146
30	\$0.142	\$0.142
31	\$0.138	\$0.138
32	\$0.150	\$0.150
33	\$0.148	\$0.148
34	\$0.160	\$0.160
35	\$0.176	\$0.176
36	\$0.188	\$0.188
37	\$0.216	\$0.216
38	\$0.244	\$0.244
39	\$0.274	\$0.274
40	\$0.308	\$0.308
41	\$0.350	\$0.350
42	\$0.396	\$0.396
43	\$0.440	\$0.440

AGE	INSURED RATE	DEPENDENT SPOUSE/ DOMESTIC PARTNER RATE
44	\$0.484	\$0.484
45	\$0.538	\$0.538
46	\$0.600	\$0.600
47	\$0.670	\$0.670
48	\$0.742	\$0.742
49	\$0.818	\$0.818
50	\$0.906	\$0.906
51	\$1.006	\$1.006
52	\$1.116	\$1.116
53	\$1.216	\$1.216
54	\$1.312	\$1.312
55	\$1.442	\$1.442
56	\$1.584	\$1.584
57	\$1.752	\$1.752
58	\$1.932	\$1.932
59	\$2.134	\$2.134
60	\$2.372	\$2.372
61	\$2.634	\$2.634
62	\$2.932	\$2.932
63	\$3.192	\$3.192
64	\$3.500	\$3.500
65	\$3.846	\$3.846
66	\$4.216	\$4.216
67	\$4.538	\$4.538
68	\$4.850	\$4.850
69	\$5.212	\$5.212
70	\$5.638	N/A
71	\$6.142	N/A
72	\$6.740	N/A

AGE	INSURED RATE	DEPENDENT SPOUSE/ DOMESTIC PARTNER RATE
73	\$7.340	N/A
74	\$8.012	N/A
75	\$8.742	N/A
76	\$9.634	N/A
77	\$10.576	N/A
78	\$11.416	N/A
79	\$12.356	N/A
80	\$13.564	N/A
81	\$14.806	N/A
82	\$16.234	N/A
83	\$17.844	N/A
84	\$19.202	N/A
85	\$20.573	N/A
86	\$22.137	N/A
87	\$23.932	N/A
88	\$25.745	N/A
89	\$27.876	N/A
90	\$30.427	N/A
91	\$31.876	N/A
92	\$34.257	N/A
93	\$37.304	N/A
94	\$39.972	N/A
95	\$42.821	N/A
96	\$45.858	N/A
97	\$49.095	N/A
98	\$52.551	N/A
99	\$55.858	N/A

TABLE C
COMBINED LIFE & AD&D INSURANCE PREFERRED MONTHLY TERM RATES

RATE SHEET

**Schedule of Combined Monthly Portable Preferred Group Life and AD&D Insurance
Term Rates For Insured and Dependent Spouse/Domestic Partner**

Rates (cost per \$1,000 of coverage per month) are based on the Insured's age and Dependent Spouse/Domestic Partner's age as of December 31st, of the current calendar year. Rates are subject to change. An administrative fee may also apply.

Sample monthly premium calculation for an insured age 45, electing \$50,000 of portable coverage

$$\frac{\$50,000}{\$1,000} = 50 \times \frac{\$0.185}{\text{age 45}} = \$9.25 + \$1.00 = \$10.25$$

Amount of coverage selected ÷ \$1,000 = # of units x Rate based on age 45 = Monthly insurance premium + Admin fee* = Monthly total due

* Varies by amount of insurance and payment method

AGE	INSURED RATE	DEPENDENT SPOUSE/ DOMESTIC PARTNER RATE
15	\$0.085	\$0.075
16	\$0.085	\$0.075
17	\$0.085	\$0.075
18	\$0.085	\$0.075
19	\$0.085	\$0.075
20	\$0.085	\$0.075
21	\$0.085	\$0.075
22	\$0.085	\$0.075
23	\$0.085	\$0.075
24	\$0.085	\$0.075
25	\$0.095	\$0.085
26	\$0.095	\$0.085
27	\$0.095	\$0.085
28	\$0.095	\$0.085
29	\$0.095	\$0.085
30	\$0.115	\$0.105
31	\$0.115	\$0.105
32	\$0.115	\$0.105
33	\$0.115	\$0.105
34	\$0.115	\$0.105
35	\$0.125	\$0.115
36	\$0.125	\$0.115
37	\$0.125	\$0.115
38	\$0.125	\$0.115
39	\$0.125	\$0.115
40	\$0.135	\$0.125
41	\$0.143	\$0.133
42	\$0.153	\$0.143
43	\$0.163	\$0.153

AGE	INSURED RATE	DEPENDENT SPOUSE/ DOMESTIC PARTNER RATE
44	\$0.173	\$0.163
45	\$0.185	\$0.175
46	\$0.198	\$0.188
47	\$0.213	\$0.203
48	\$0.229	\$0.219
49	\$0.246	\$0.236
50	\$0.265	\$0.255
51	\$0.296	\$0.286
52	\$0.330	\$0.320
53	\$0.370	\$0.360
54	\$0.414	\$0.404
55	\$0.465	\$0.455
56	\$0.503	\$0.493
57	\$0.545	\$0.535
58	\$0.591	\$0.581
59	\$0.641	\$0.631
60	\$0.695	\$0.685
61	\$0.787	\$0.777
62	\$0.893	\$0.883
63	\$1.012	\$1.002
64	\$1.149	\$1.139
65	\$1.305	\$1.295
66	\$1.434	\$1.424
67	\$1.576	\$1.566
68	\$1.733	\$1.723
69	\$1.905	\$1.895
70	\$2.095	N/A
71	\$2.263	N/A
72	\$2.444	N/A

AGE	INSURED RATE	DEPENDENT SPOUSE/ DOMESTIC PARTNER RATE
73	\$2.640	N/A
74	\$2.853	N/A
75	\$3.082	N/A
76	\$3.330	N/A
77	\$3.599	N/A
78	\$3.889	N/A
79	\$4.203	N/A
80	\$4.495	N/A
81	\$4.945	N/A
82	\$5.445	N/A
83	\$5.995	N/A
84	\$6.595	N/A
85	\$7.255	N/A
86	\$7.985	N/A
87	\$8.795	N/A
88	\$9.685	N/A
89	\$10.665	N/A
90	\$11.745	N/A
91	\$12.935	N/A
92	\$14.225	N/A
93	\$15.665	N/A
94	\$17.245	N/A
95	\$18.985	N/A
96	\$20.905	N/A
97	\$23.025	N/A
98	\$25.355	N/A
99	\$27.915	N/A

**TABLE D
COMBINED LIFE & AD&D INSURANCE NON-PREFERRED MONTHLY TERM RATES**

**RATE SHEET
Schedule of Combined Monthly Portable Non-Preferred Group Life and AD&D Insurance Term
Rates For Insured and Dependent Spouse/Domestic Partner**

Rates (cost per \$1,000 of coverage per month) are based on the Insured's age and Dependent Spouse/Domestic Partner's age as of December 31st, of the current calendar year. Rates are subject to change. An administrative fee may also apply.

Sample monthly premium calculation for an insured age 45, electing \$50,000 of portable coverage

$$\frac{\$50,000}{\$1,000} = 50 \times \frac{\$0.573}{\text{age 45}} = \$28.65 + \$1.00 = \$29.65$$

Amount of coverage selected ÷ \$1,000 = # of units x Rate based on age 45 = Monthly insurance premium + Admin fee* = Monthly total due

* Varies by amount of insurance and payment method

AGE	INSURED RATE	DEPENDENT SPOUSE/ DOMESTIC PARTNER RATE
15	\$0.197	\$0.187
16	\$0.225	\$0.215
17	\$0.243	\$0.233
18	\$0.259	\$0.249
19	\$0.267	\$0.257
20	\$0.269	\$0.259
21	\$0.291	\$0.281
22	\$0.277	\$0.267
23	\$0.237	\$0.227
24	\$0.219	\$0.209
25	\$0.205	\$0.195
26	\$0.205	\$0.195
27	\$0.189	\$0.179
28	\$0.185	\$0.175
29	\$0.181	\$0.171
30	\$0.177	\$0.167
31	\$0.173	\$0.163
32	\$0.185	\$0.175
33	\$0.183	\$0.173
34	\$0.195	\$0.185
35	\$0.211	\$0.201
36	\$0.223	\$0.213
37	\$0.251	\$0.241
38	\$0.279	\$0.269
39	\$0.309	\$0.299
40	\$0.343	\$0.333
41	\$0.385	\$0.375
42	\$0.431	\$0.421
43	\$0.475	\$0.465

AGE	INSURED RATE	DEPENDENT SPOUSE/ DOMESTIC PARTNER RATE
44	\$0.519	\$0.509
45	\$0.573	\$0.563
46	\$0.635	\$0.625
47	\$0.705	\$0.695
48	\$0.777	\$0.767
49	\$0.853	\$0.843
50	\$0.941	\$0.931
51	\$1.041	\$1.031
52	\$1.151	\$1.141
53	\$1.251	\$1.241
54	\$1.347	\$1.337
55	\$1.477	\$1.467
56	\$1.619	\$1.609
57	\$1.787	\$1.777
58	\$1.967	\$1.957
59	\$2.169	\$2.159
60	\$2.407	\$2.397
61	\$2.669	\$2.659
62	\$2.967	\$2.957
63	\$3.227	\$3.217
64	\$3.535	\$3.525
65	\$3.881	\$3.871
66	\$4.251	\$4.241
67	\$4.573	\$4.563
68	\$4.885	\$4.875
69	\$5.247	\$5.237
70	\$5.673	N/A
71	\$6.177	N/A
72	\$6.775	N/A

AGE	INSURED RATE	DEPENDENT SPOUSE/ DOMESTIC PARTNER RATE
73	\$7.375	N/A
74	\$8.047	N/A
75	\$8.777	N/A
76	\$9.669	N/A
77	\$10.611	N/A
78	\$11.451	N/A
79	\$12.391	N/A
80	\$13.599	N/A
81	\$14.841	N/A
82	\$16.269	N/A
83	\$17.879	N/A
84	\$19.237	N/A
85	\$20.608	N/A
86	\$22.172	N/A
87	\$23.967	N/A
88	\$25.780	N/A
89	\$27.911	N/A
90	\$30.462	N/A
91	\$31.911	N/A
92	\$34.292	N/A
93	\$37.339	N/A
94	\$40.007	N/A
95	\$42.856	N/A
96	\$45.893	N/A
97	\$49.130	N/A
98	\$52.586	N/A
99	\$55.893	N/A

RATE SHEET
Schedule of Monthly Portable Group Life and AD&D Insurance Term Rates
For Insured and Dependents

TABLE E
CHILD MONTHLY TERM RATES

Table E – Sample monthly premium calculation for child(ren) only. An administrative fee will be not charged for the child coverage if you also port your term life insurance. However if only the child(ren) coverage is ported a \$3.00 per statement administrative fee will be charged.

$$\frac{\$10,000}{\$1,000} = 10 \times \$0.162 = \$1.62$$

Amount of coverage selected per child ÷ \$1,000 = # of units per child x Rate = Monthly premium

AGE	LIFE DEPENDENT CHILD(REN) RATE	COMBINED LIFE & AD&D DEPENDENT CHILD(REN) RATE
N/A	\$0.162	\$0.209

Please Note: Each child is covered for the same premium regardless of the number of children covered under the certificate. For instance, using the example above, if you have one child covered for \$10,000, the amount of premium per month is \$1.62. If you have 5 children, each child is covered for \$10,000, but the amount of premium per month is still \$1.62. A billing fee may also apply.

TABLE F
AD&D INSURANCE ONLY MONTHLY TERM RATES

Table F – Sample monthly premium calculation of AD&D Premium For Insured Only. An administrative fee will be not charged for AD&D coverage if you also port your term life insurance. However if only AD&D coverage is ported a \$3.00 per statement administrative fee will be charged.

$$\frac{\$50,000}{\$1,000} = 50 \times \$0.035 = \$1.75$$

Amount of coverage selected ÷ \$1,000 = # of units x Rate = Monthly premium

AD&D TERM RATES			VAD&D TERM RATES	
AD&D INSURED RATE	AD&D DEPENDENT SPOUSE/ DOMESTIC PARTNER RATE	AD&D CHILD(REN) RATE	VAD&D INSURED ONLY RATE	VAD&D INSURED + DEPENDENTS RATE
\$0.035	\$0.025	\$0.047	\$0.035	\$0.050

INSTRUCTIONS

FOR THE **STATEMENT OF HEALTH** FORM AND THE **AUTHORIZATION** FORM THAT FOLLOW THIS SECTION

INSTRUCTIONS TO THE EMPLOYEE

A Statement of Health Form is required if you are:

- Requesting Preferred Life Rates for you or your Dependent Spouse/Domestic Partner; or
- Applying for additional amounts of Life Insurance for you or your Dependent Spouse/Domestic Partner.

Give the forms to the Proposed Insured to complete and send to MetLife.

INSTRUCTIONS TO THE PROPOSED INSURED (The Proposed Insured is the person for whom insurance is being requested. The Proposed Insured may be the Employee or the Employee's Spouse/Domestic Partner.) A separate Statement of Health form must be completed by each Proposed Insured.

Based on the election form submitted by the Employee, a Statement of Health form is required to complete the employee's request for group insurance coverage for you, the Proposed Insured.

1. Complete the Statement of Health form and sign where indicated by an arrow.
2. Sign the Authorization form where indicated by an arrow.
3. After completion, make a copy of both completed forms for your records and MAIL the original forms to: ►

MetLife Recordkeeping and
Enrollment Services
P.O. Box 14401
Lexington, KY 40512-4401

For questions, call MetLife at 1-800-638-6420, prompt 1 (Statement of Health Unit) or email us at eoim@metlife.com.

Note: Additional medical information may be required after MetLife's initial review of a completed Statement of Health form. The additional information requested may be a physical examination, paramedical exam, or an Attending Physician Report. Correspondence will be sent within ten days by MetLife or our approved vendor. Incomplete forms will be returned to you for completion.

Some services in connection with your Statement of Health form may be performed by our affiliate, MetLife Global Operations Support Center Private Limited. This service arrangement in no way alters Metropolitan Life Insurance Company's obligations to you. Services will not be performed by our affiliate if prohibited by state or local law or by mutual agreement with the Group Customer.

STATEMENT OF HEALTH FORM

MetLife

Metropolitan Life Insurance Company, New York, NY

GROUP CUSTOMER INFORMATION (To be Completed by MetLife)

Name of Group Customer/Employer/Association MetLife Group Life and Health Insurance Program Trust		Group Customer # 123470	Reporting Location #
Street Address 1314 King Street	City Wilmington	State Delaware	Zip Code 19801

YOUR INFORMATION (To be Completed by the Proposed Insured)

Name (First, Middle, Last)		Relationship to Employee <input type="checkbox"/> Self <input type="checkbox"/> Spouse/Domestic Partner		<input type="checkbox"/> Male <input type="checkbox"/> Female
Street Address		City	State	Zip Code
Date of Birth (MM/DD/YYYY)	Daytime Phone #	Home Phone #	Email Address	

HEALTH INFORMATION

Please complete all questions below. Omitted information will cause delays. In this section, "you" and "your" refers to the person for whom insurance is being requested.

Your name _____ Employee's Social Security/Identification# _____

- | | | |
|--|------------------------------|-----------------------------|
| 1. Your height _____ feet _____ inches Your weight _____ pounds | | |
| 2. Are you now on a diet prescribed by a physician or other health care provider? If "yes" indicate type _____ | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 3. Are you now pregnant? If "yes," what is your due date (month/day/year)? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are you now, or have you in the past 5 years, used tobacco in any form? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. In the past 5 years, have you received medical treatment or counseling by a physician or other health care provider for, or been advised by a physician or other health care provider to discontinue, the use of alcohol or prescribed or non-prescribed drugs? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. In the past 5 years, have you been convicted of driving while intoxicated or under the influence of alcohol and/or any drug? If "yes", specify "date(s) of conviction(s) (month/day/year) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you had any application for life, accidental death and dismemberment or disability insurance declined, postponed, withdrawn, rated, modified, or issued other than as applied for? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Are you now receiving or applying for any disability benefits, including workers' compensation? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you been Hospitalized as defined below (not including well-baby delivery) in the past 90 days? | <input type="checkbox"/> | <input type="checkbox"/> |
- Hospitalized** means admission for inpatient care in a hospital; receipt of care in a hospice facility, intermediate care facility, or long term care facility; or receipt of the following treatment wherever performed: chemotherapy, radiation therapy, or dialysis.
- | | | |
|---|------------------------------|-----------------------------|
| 10. Have you ever been diagnosed or treated by a physician or other health care provider for Acquired Immunodeficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you ever been diagnosed, treated or given medical advice by a physician or other health care provider for: | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| a. cardiac or cardiovascular disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. stroke or circulatory disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. high blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. cancer, Hodgkins disease, lymphoma or tumors? Indicate type _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| e. anemia, leukemia or other blood disorder? Indicate type _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| f. diabetes? Your age at diagnosis? _____ <input type="checkbox"/> Check if insulin treated | <input type="checkbox"/> | <input type="checkbox"/> |
| g. asthma, COPD, emphysema or other lung disease? Indicate type _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| h. ulcers, stomach, hepatitis or other liver disorder? Indicate type _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| i. colitis, Crohn's, diverticulitis or other intestinal disorder? Indicate type _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| j. memory loss? | <input type="checkbox"/> | <input type="checkbox"/> |
| k. epilepsy, paralysis, seizures, dizziness or other neurological disorder? Specify date of last seizure (month/year) _____ Indicate type _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| l. Epstein-Barr, chronic fatigue syndrome or fibromyalgia? | <input type="checkbox"/> | <input type="checkbox"/> |
| m. multiple sclerosis, ALS or muscular dystrophy? | <input type="checkbox"/> | <input type="checkbox"/> |
| n. lupus, scleroderma, auto immune disease or connective tissue disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| o. arthritis? <input type="checkbox"/> osteoarthritis <input type="checkbox"/> rheumatoid <input type="checkbox"/> other/type _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| p. back, neck, knee, spinal, joint or other musculoskeletal disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| q. carpal tunnel syndrome? | <input type="checkbox"/> | <input type="checkbox"/> |
| r. kidney, urinary tract or prostate disorder? Indicate type _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| s. thyroid or other gland disorder? Indicate type _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| t. mental, anxiety, depression, attempted suicide or nervous disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| u. sleep apnea | <input type="checkbox"/> | <input type="checkbox"/> |

For "yes" answers, please provide full details on the next page in Section 2, then complete Section 3. If all questions are answered "no," you may proceed directly to Section 3 on the next page.

SECTION 2 – Please provide full details below for each “Yes” answer to the preceding questions 1- 11. If you need more space to provide full details, attach a separate sheet with the information and sign and date it. Delays in processing your application may occur if complete details are not provided. MetLife may contact you for additional or missing information.

Question Number	Condition/Diagnosis	Medication Prescribed
		<input type="checkbox"/> Yes _____ <input type="checkbox"/> No _____
Date of Diagnosis (Month/Year)	Date of Last Treatment (Month/Year)	Type of Treatment
Treating Health Professional		
Personal Physician's Name: _____		
Date of last visit: _____ Reason for visit: _____		
Address _____		
Street	City	State Zip Code
Telephone: () -		

Question Number	Condition/Diagnosis	Medication Prescribed
		<input type="checkbox"/> Yes _____ <input type="checkbox"/> No _____
Date of Diagnosis (Month/Year)	Date of Last Treatment (Month/Year)	Type of Treatment
Treating Health Professional		
Personal Physician's Name: _____		
Date of last visit: _____ Reason for visit: _____		
Address _____		
Street	City	State Zip Code
Telephone: () -		

Question Number	Condition/Diagnosis	Medication Prescribed
		<input type="checkbox"/> Yes _____ <input type="checkbox"/> No _____
Date of Diagnosis (Month/Year)	Date of Last Treatment (Month/Year)	Type of Treatment
Treating Health Professional		
Personal Physician's Name: _____		
Date of last visit: _____ Reason for visit: _____		
Address _____		
Street	City	State Zip Code
Telephone: () -		

SECTION 3

1. Personal Physician's Name: _____	Telephone: () -
Address (Street, City, State, Zip Code): _____	
Date of last visit (MM/DD/YYYY): _____ Reason for visit: _____	
2. Are you currently taking any other prescribed medications? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Medication: _____ Condition/Diagnosis: _____	
Prescribing Physician's Name: _____	Telephone: () -
Address (Street, City, State, Zip Code): _____	

FRAUD WARNINGS

Before signing this Statement of Health form, please read the warning for the state where you reside and for the state where the contract under which you are applying for coverage was issued.

Alabama, Arkansas, District of Columbia, Louisiana, Massachusetts, New Mexico, Ohio, Rhode Island and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Colorado: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

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

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

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

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

New Jersey: Any person who files an application containing any false or misleading information is subject to criminal and civil penalties.

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

Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon and Vermont: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Puerto Rico: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars (\$5,000), not to exceed ten thousand dollars (\$10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Pennsylvania and all other states: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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DECLARATIONS AND SIGNATURES

By signing below, I acknowledge:

1. I have read this Statement of Health form and declare that all information I have given, including any health information, is true and complete to the best of my knowledge and belief. I understand that this information will be used by MetLife to determine my insurability.
2. I have read the applicable Fraud Warning(s) provided in this Statement of Health form.



Signature of Proposed Insured

Print Name

Date Signed (MM/DD/YYYY)

If a child proposed for insurance is age 18 or over, the child must sign this Statement of Health. If the child is under age 18, a Personal Representative for the child must sign, **and indicate the legal relationship between the Personal Representative and the proposed insured.** A Personal Representative for the child is a person who has the right to control the child's health care, usually a parent, legal guardian, or a person appointed by a court.



Signature of Personal Representative

Print Name

Date Signed (MM/DD/YYYY)

Relationship of Personal Representative

AUTHORIZATION

This Authorization is in connection with an enrollment in group insurance and information required for underwriting and claim purposes for the proposed insured(s) ("employee", spouse, and /or any other person(s) named below). Underwriting means classification of individuals for determination of insurability and / or rates, based upon physician health reports, prescription drug history, laboratory test results, and other factors. Notwithstanding any prior restriction placed on information, records or data by a proposed insured, each proposed insured hereby authorizes:

- Any medical practitioner, facility or related entity; any insurer; MIB Group, Inc ("MIB"); any employer; any group policyholder, contract holder or benefit plan administrator; any pharmacy or pharmacy related service organization; any consumer reporting agency; or any government agency to give Metropolitan Life Insurance Company ("MetLife") or any third party acting on MetLife's behalf in this regard:
 - personal information and data about the proposed insured including employment and occupational information;
 - medical information, records and data about the proposed insured including information, records and data about drugs prescribed, medical test results and sexually transmitted diseases;
 - information, records and data about the proposed insured related to alcohol and drug abuse and treatment, including information and data records and data related to alcohol and drug abuse protected by Federal Regulations 42 CFR part 2;
 - information, records and data about the proposed insured relating to Acquired Immunodeficiency Syndrome (AIDS) or AIDS related conditions including, where permitted by applicable law, Human Immunodeficiency Virus (HIV) test results;
 - information, records and data about the proposed insured relating to mental illness, except psychotherapy notes; and
 - motor vehicle reports.

Note to All Health Care Providers: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Expiration, Revocation and Refusal to Sign: This authorization will expire 24 months from the date on this form or sooner if prescribed by law. The proposed insured may revoke this authorization at any time. To revoke the authorization, the proposed insured must write to MetLife at [P.O. Box 14069, Lexington, KY 40512-4069.] and inform MetLife that this Authorization is revoked. Any action taken before MetLife receives the proposed insured's revocation will be valid. Revocation may be the basis for denying coverage or benefits. If the proposed insured does not sign this Authorization, that person's enrollment for group insurance cannot be processed.

By signing below, each proposed insured acknowledges his or her understanding that:

- All or part of the information, records and data that MetLife receives pursuant to this authorization may be disclosed to MIB. Such information may also be disclosed to and used by any reinsurer, employee, affiliate or independent contractor who performs a business service for MetLife on the insurance applied for or on existing insurance with MetLife, or disclosed as otherwise required or permitted by applicable laws.
- Medical information, records and data that may have been subject to federal and state laws or regulations, including federal rules issued by Health and Human Services, setting forth standards for the use, maintenance and disclosure of such information by health care providers and health plans and records and data related to alcohol and drug abuse protected by Federal Regulations 42 CFR part 2, once disclosed to MetLife or upon redisclosure by MetLife, may no longer be covered by those laws or regulations.
- Information relating to HIV test results will only be disclosed as permitted by applicable law.
- Information obtained pursuant to this authorization about a proposed insured may be used, to the extent permitted by applicable law, to determine the insurability of other family members.
- A photocopy of this form is as valid as the original form. Each proposed insured has a right to receive a copy of this form.
- I authorize MetLife, or its reinsurers, to make a brief report of my personal health information to MIB.



Signature of Employee

Date Signed (Mo./Day/Yr.)

Print Name

State of Birth

Country of Birth



Signature of Spouse

Date Signed (Mo./Day/Yr.)

Print Name

State of Birth

Country of Birth



Our Privacy Notice

We know that you buy our products and services because you trust us. This notice explains how we protect your privacy and treat your personal information. It applies to current and former customers. "Personal information" as used here means anything we know about you personally.

Plan Sponsors and Group Insurance Contract Holders

This privacy notice is for individuals who apply for or obtain our products and services under an employee benefit plan, or group insurance or annuity contract. In this notice, "you" refers to these individuals.

Protecting Your Information

We take important steps to protect your personal information. We treat it as confidential. We tell our employees to take care in handling it. We limit access to those who need it to perform their jobs. Our outside service providers must also protect it, and use it only to meet our business needs. We also take steps to protect our systems from unauthorized access. We comply with all laws that apply to us.

Collecting Your Information

We typically collect your name, address, age, and other relevant information. We may also collect information about any business you have with us, our affiliates, or other companies. Our affiliates include life, car, and home insurers. They also include a bank, a legal plans company, and securities broker-dealers. In the future, we may also have affiliates in other businesses.

How We Get Your Information

We get your personal information mostly from you. We may also use outside sources to help ensure our records are correct and complete. These sources may include consumer reporting agencies, employers, other financial institutions, adult relatives, and others. These sources may give us reports or share what they know with others. We don't control the accuracy of information outside sources give us. If you want to make any changes to information we receive from others about you, you must contact those sources.

We may ask for medical information. The Authorization that you sign when you request insurance permits these sources to tell us about you. We may also, at our expense:

- Ask for a medical exam
- Ask for blood and urine tests
- Ask health care providers to give us health data, including information about alcohol or drug abuse

We may also ask a consumer reporting agency for a "consumer report" about you (or anyone else to be insured). Consumer reports may tell us about a lot of things, including information about:

- Reputation
- Driving record
- Finances
- Work and work history
- Hobbies and dangerous activities

The information may be kept by the consumer reporting agency and later given to others as permitted by law. The agency will give you a copy of the report it provides to us, if you ask the agency and can provide adequate identification. If you write to us and we have asked for a consumer report about you, we will tell you so and give you the name, address and phone number of the consumer reporting agency.

Another source of information is MIB Group, Inc. ("MIB"). It is a non-profit association of life insurance companies. We and our reinsurers may give MIB health or other information about you. If you apply for life or health coverage from another member of MIB, or claim benefits from another member company, MIB will give that company any information that it has about you. If you contact MIB, it will tell you what it knows about you. You have the right to ask MIB to correct its information about you. You may do so by writing to MIB, Inc., 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734, by calling MIB at (866) 692-6901 (TTY (866) 346-3642 for the hearing impaired), or by contacting MIB at www.mib.com.

Using Your Information

We collect your personal information to help us decide if you're eligible for our products or services. We may also need it to verify identities to help deter fraud, money laundering, or other crimes. How we use this information depends on

what products and services you have or want from us. It also depends on what laws apply to those products and services. For example, we may also use your information to:

- administer your products and services
- perform business research
- market new products to you
- comply with applicable laws
- process claims and other transactions
- confirm or correct your information
- help us run our business

Sharing Your Information With Others

We may share your personal information with others with your consent, by agreement, or as permitted or required by law. For example, we may share your information with businesses hired to carry out services for us. We may also share it with our affiliated or unaffiliated business partners through joint marketing agreements. In those situations, we share your information to jointly offer you products and services or have others offer you products and services we endorse or sponsor. Before sharing your information with any affiliate or joint marketing partner for their own marketing purposes, however, we will first notify you and give you an opportunity to opt out.

Other reasons we may share your information include:

- doing what a court, law enforcement, or government agency requires us to do (for example, complying with search warrants or subpoenas)
- telling another company what we know about you if we are selling or merging any part of our business
- giving information to a governmental agency so it can decide if you are eligible for public benefits
- giving your information to someone with a legal interest in your assets (for example, a creditor with a lien on your account)
- giving your information to your health care provider
- having a peer review organization evaluate your information, if you have health coverage with us
- those listed in our “Using Your Information” section above

HIPAA

We will not share your health information with any other company – even one of our affiliates – for their own marketing purposes. If you have dental, long-term care, or medical insurance from us, the Health Insurance Portability and Accountability Act (“HIPAA”) may further limit how we may use and share your information.

Accessing and Correcting Your Information

You may ask us for a copy of the personal information we have about you. Generally, we will provide it as long as it is reasonably retrievable and within our control. You must make your request in writing listing the account or policy numbers with the information you want to access. For legal reasons, we may not show you anything we learned as part of a claim or lawsuit, unless required by law.

If you tell us that what we know about you is incorrect, we will review it. If we agree, we will update our records. Otherwise, you may dispute our findings in writing, and we will include your statement whenever we give your disputed information to anyone outside MetLife.

Questions

We want you to understand how we protect your privacy. If you have any questions about this notice, please contact us. When you write, include your name, address, and policy or account number.

Send privacy questions to:

MetLife Privacy Office, P. O. Box 489, Warwick, RI 02887-9954
privacy@metlife.com

We may revise this privacy notice. If we make any material changes, we will notify you as required by law. We provide this privacy notice to you on behalf of these MetLife companies:

**Metropolitan Life Insurance Company
General American Life Insurance Company
SafeHealth Life Insurance Company**

**MetLife Insurance Company of Connecticut
SafeGuard Health Plans, Inc.**

HOW TO APPLY FOR BENEFITS

You must complete the online application and electronically sign the benefits authorization form before you will be eligible for benefits. Apply using the online enrollment portal at <https://portal.hwtf.org/>. If you have any difficulty with the online application, please contact the Director of Benefits at uawdental@external.umass.edu or (413) 345-2156.

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

Your name; Your address; Your UMass Employee ID Number; 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.

Notify the Trust Fund About Any Changes

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 Benefits at uawdental@external.umass.edu or (413) 345-2156 so that your records can be updated.

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 signing the form, you agree to and understand the following: 1) 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; 2) 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; 3) 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, 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 begins, 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 Periods

When you enroll, you enroll for your 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 period which occurs each August 15-September 15 (check website for any changes).

You must fully complete your application, including providing your employee ID and electronically signing your authorization form, in order to meet the enrollment deadlines above.

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 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 EyeMed Vision Care if you have opted into vision benefits. Altus does not issue hard-copy ID cards but you can download a digital ID by registering at www.altusdental.com. You will need your unique Altus ID number which can be requested by emailing uawdental@external.umass.edu or by checking your dashboard at <https://portal.hwtf.org/>. Additionally, 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 #: 3001-0002

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

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

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 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.

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 (18 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 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 <https://www.hwtf.org/pd-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.

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 listed above. 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.

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 <https://www.hwtf.org/pd-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.

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.

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 Benefits at uawdental@external.umass.edu or (413) 345-2156 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

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.

-Second Qualifying Event

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.

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 Benefits at uawdental@external.umass.edu or (413) 345-2156 to confirm the correct amount of your first payment or to discuss payment issues related to the ARRA premium reduction.

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 will 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 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 Benefits 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.

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 <https://www.hwtf.org/pd-cobra> or <http://www.dol.gov/dol/topic/health-plans-cobra.htm>

POLICIES FOR PAYMENT ISSUED FROM THE TRUST FUND

Payments are processed by 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 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. The Trust Fund will only reissue payments after 1) 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 2) 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 3) the original payment has been refunded to our PayPal account due to not being claimed within 30 days. If you've elected to be reimbursed via PayPal and the Trust Fund incurs an additional fee because your PayPal 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.

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.

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.
- 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.

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.

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.

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.

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 below).

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.

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: uawdental@external.umass.edu

By phone: (413) 345-2156



**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 September 1

Effective Date: September 1, 2022
Date of Issue: September 1, 2022

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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.

ខ្មែរ (Cambodian): ប្រសិនបើ លោក/ស្រី អ្នកនិយាយ ខ្មែរ, សេវាជំនួយភាសា ឥតគិតថ្លៃ មាន រៀបចំ ឲ្យបាន។
សេវាជំនួយភាសា ឥតគិតថ្លៃ
អ្នក ចង់ ទទួលបាន សេវា ជំនួយភាសា ឥតគិតថ្លៃ ទូរស័ព្ទ 1-877-223-0588
ឬ ប្រើប្រាស់

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: ຖ້າ ທ່ານ ກວ້າ ພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອ ອາໄດ້ ທ່ານ. ໂທ 1-877-223-0588.

ອດ ກວ້າ ພາສາ, ໂດຍບໍ່ເສຍ ງົດ ກ, ແມ່ນ ນາມ

ية (Arabic):

مقرب لصتا. ناجملا بلكل رفاوتت تيوجللا ةدعاسملا تامدخ نإف، ةغللا ركذا ثدحتت تنك اذا: 0588-223-877-1 (مكبلاو مصلا فتاه مقر: 0588-223-877-1).

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.

Bàsò ò -wùdù-po-nyò (Bassa): Dè dɛ nìà kɛ dyédé gbo: ɔ jũ ké m[ʔBàsò ò -wùdù-po-nyò] jũ ní, níí, à wuɖu kà kò dò po-poò bɛ̀n m̀gbo kpáa. Ɖá 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.

हंद (Hindi): ध्यान दें: यदि आप हंद बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-877-223-0588 पर कॉल करें।

જરાતી (Gujarati): ધ્યાન: જો તમે જરાતી બોલતા હો, તો બિન-મુક્ત 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.

<u>Benefit Class</u>	<u>Class Description</u>
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		\$2,250*+

*Type 1 Procedures do not count toward the Maximum Benefit.

+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	\$1,000

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		\$2,250*+

*Type 1 Procedures do not count toward the Maximum Benefit.

+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	\$1,000

PREMIUMS

TABLE OF MONTHLY PREMIUM WORKING RATES

Classes 01 & 02

Dental	\$29.28 Subscriber
	\$58.65 Subscriber + 1
	\$100.66 Family

COBRA 3001-0003 (Classes 01 & 02)

Dental	\$29.87 Subscriber
	\$59.82 Subscriber + 1
	\$102.67 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. Each 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.

VirtualSpecEx

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.

Your *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*.

Your 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 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.

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 *plan*.

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 jointcustody, 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*, *you* 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 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*.

Services Covered by the Plan

Dental Expense Benefits

- Your benefits are based on a Benefit Year. A Benefit Year runs from September 1 through August 31.
- Benefit Period means the period from September 1 of any year through August 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 August 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
Class 2

Post Doctoral Researcher
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		\$2,250*+

*Type 1 Procedures do not count toward the Maximum Benefit.

+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

\$1,000

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		\$2,250*+

*Type 1 Procedures do not count toward the Maximum Benefit.

+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

\$1,000

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
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

TYPE 2 PROCEDURES

Re-cement or re-bond indirectly fabricated or prefabricated post and core. D2920 Re-cement or re-bond crown.

- 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/calcalcific repair of perforations, root resorption, etc.).
- D3352 Apexification/recalcification - interim medication replacement (apical closure/calcalcific repair of perforations, root resorption, pulp space disinfection, etc.).
- D3353 Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcalcific 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.

TYPE 2 PROCEDURES

D3421	Apicoectomy - premolar (first root).
D3425	Apicoectomy - molar (first root).
D3426	Apicoectomy (each additional root).
D3471	Surgical repair of root resorption - anterior.
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.

TYPE 2 PROCEDURES

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.
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	Alveoplasty 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	Alveoplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.

TYPE 2 PROCEDURES

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.
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 osteotomy/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.

TYPE 2 PROCEDURES

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 materials, 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.

TYPE 3 PROCEDURES

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 Point of Service Option

The UAW/UMASS HEALTH & WELFARE TRUST FUND-GEO

Policy Number	3001-0002
State of Delivery	Massachusetts
Plan Effective Date	September 1, 2022
Renewal Date	September 1

Effective Date: September 1, 2022
Date of Issue: September 1, 2022

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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.

ខ្មែរ (Cambodian): ប្រសិនបើ លោកស្រី ឬ កុមារ មានបញ្ហា ក្នុងការយល់ដឹង ឬ ប្រើប្រាស់ ព័ត៌មាន យើង ផ្តល់ជូន ការបកប្រែ និង ការបំប្លែង ឯកសារ ឱ្យបាន ងាយស្រួល បំផុត ឱ្យបាន ឥតគិតថ្លៃ ។ សូម ទូរស័ព្ទ មក ទៅ ទាក់ទង បន្ថែម ទៀត ទៅ លេខ 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: ຖ້າ ທ່ານ ກວ້າ ພາສາ ລາວ, ອົງ ກວ້າ ພາສາ, ໂດຍ ບໍ່ ຕ້ອງ ຈ່າ ຄ່າ ນັ້ນ ການ ບໍ່ ປະ ການ ຊ່ວຍ ອອກ ຈາກ ທ່ານ. ໂທ 1-877-223-0588.

ية (Arabic):

مقرب لصتا. ناجملا بلكل رفاوتت تيوجللا ةدعاسملا تامدخ نإف، ةغللا ركذا تئحتت تنك اذا: 0588-223-877-1 (مكبلاو مصلا فتاهمقر: 0588-223-877-1).

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.

Bàsò ò -wùdù-po-nyò (Bassa): Dè dɛ nìà kɛ dyédé gbo: ɔ jũ ké m[ʔBàsò ò -wùdù-po-nyò] jũ ní, níí, à wuɖu kà kò dò po-poò bɛin m̀gbo kpáa. Ɖá 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.

हंद (Hindi): ध्यान दें: यदि आप हंद बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-877-223-0588 पर कॉल करें।

જરાતી (Gujarati): ધ્યાન: જો તમે જરાતી બોલતા હો, તો બિન-મુક્ત 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 2

Class Description
Graduate Employee

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		\$2,250*+

*Type 1 Procedures do not count toward the Maximum Benefit.

+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	\$1,000

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. Each 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.

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 02 Geo—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

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 *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.

Your *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*.

Your 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 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.

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 *plan*.

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 jointcustody, 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*, *you* 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. 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 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*.

Services Covered by the Plan

Dental Expense Benefits

- Your benefits are based on a Benefit Year. A Benefit Year runs from September 1 through August 31.
- Benefit Period means the period from September 1 of any year through August 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 August 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 2

Class Description
Graduate Employee

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		\$2,250*+

*Type 1 Procedures do not count toward the Maximum Benefit.

+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	\$1,000

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.

TYPE 1 PROCEDURES

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.

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.

TYPE 1 PROCEDURES

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.
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
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

TYPE 2 PROCEDURES

Re-cement or re-bond indirectly fabricated or prefabricated post and core. D2920 Re-cement or re-bond crown.

- 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.

TYPE 2 PROCEDURES

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.
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.

TYPE 2 PROCEDURES

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.

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 TISSUE CONDITIONING

Coverage is limited to service dates more than 6 months after placement date.

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).

TYPE 2 PROCEDURES

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 Alveoplasty 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 Alveoplasty 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.
- 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.

TYPE 2 PROCEDURES

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.

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.

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.
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,

TYPE 3 PROCEDURES

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)

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.

TYPE 3 PROCEDURES

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 materials, 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.

TYPE 3 PROCEDURES

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.



FEE FOR SERVICE AGREEMENT

A wholly owned subsidiary of EyeMed Vision Care

UAW/UMass Health & Welfare Trust Fund

This Agreement is entered into by and between EyeMed Vision Care, L.L.C. ("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 329 Middlesex House, 111 County Circle, Amherst, MA 01003-9255, as Plan Sponsor and Plan Administrator, on behalf of itself and its ERISA plan ("Plan Sponsor").

RECITALS

Plan Sponsor is an employer that provides benefits for its employees and their qualified dependents and now intends to offer vision benefits to such Participants (as defined herein);

Plan Sponsor has elected to pay for these vision benefits by self-funding vision benefits under its ERISA plan (the "ERISA Plan") and contracting out claims administration and Vision Network administration services;

Plan Sponsor wishes to engage the services of EyeMed to provide a vision benefit, claims administration, and Vision Network administration to assist employer in their responsibilities as Plan Sponsor and Plan Administrators for self-funded vision benefits;

EyeMed makes its Vision Network of Participating Providers available to Plan Sponsor's Members who have vision care coverage;

First American Administrators, Inc. ("FAA"), is a wholly owned subsidiary of EyeMed and a duly licensed third-party administrator in required states to provide certain administrative services available to Plan Sponsor's Members who have vision care coverage contained in their Plans.

NOW, THEREFORE, in accordance with the terms and conditions contained herein, the parties agree as follows:

I. EFFECTIVE DATE, TERM AND RENEWAL

A. Effective Date

This Agreement is effective November 1, 2010 ("Effective Date") and shall continue until terminated pursuant to this Agreement. For purposes of this Agreement: (i) all references to "Business Days" shall mean a day when both EyeMed and/or FAA and Plan Sponsor are open for business, excluding Saturday and Sunday; and (ii) any references to a particular time of the day shall be considered Eastern Time.

B. Term

The Agreement shall commence on the Effective Date have an initial 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 XIII.

C. Renewal

At least one hundred twenty (120) calendar days prior to the end of the current term, EyeMed shall provide Plan Sponsor with written notice of the Vision Benefits revised rates for the renewal period. If Plan Sponsor does not agree to the revised rates, this Agreement shall terminate at the end of the current term.

D. Definitions

Capitalized terms and otherwise defined terms within the section are defined on Exhibit A.

II. RESPONSIBILITIES OF EYEMED

A. Services

EyeMed shall provide the following:

1. Vision Benefit

EyeMed shall make available to Members the Vision Benefit as set forth on Exhibit B at Participating Provider locations. EyeMed shall also provide additional services, including but not limited to, responding to questions from Members, Providers and Plan Sponsor regarding Vision Benefits.

2. Enrollment Information for Participants

EyeMed shall maintain Participant enrollment records based on and in reliance upon data furnished to it by Plan Sponsor or its agent.

3. Identification Cards/Member Materials/SPD Review

EyeMed shall design, produce and distribute identification cards. In addition, upon request, EyeMed shall make available open enrollment materials and other communication materials. EyeMed agrees to review and advise concerning the description of Vision Benefits within Plan documents, including the Summary Plan Description and other materials intended for distribution to Participants.

4. Customer Service

EyeMed shall train and maintain adequate levels of staff as determined by EyeMed and provide a toll-free telephone number to respond to inquiries from Plan Sponsor's administrative staff, Members and Participating Providers concerning the Vision Benefit.

5. Web Access

EyeMed will maintain web access to the Vision Benefit and Member's eligibility information.

6. Usage Reporting

EyeMed shall provide standard usage reports quarterly, as defined by EyeMed, at no charge. All other requested reports shall be produced upon the mutual agreement of the parties, including but not limited to any associated cost(s) for such report(s).

7. Reporting Assistance for Plan Sponsor

EyeMed shall provide to Plan Sponsor reports regarding the financial and claims experience of the Plan, and other information the Plan Sponsor reasonably requires that assists Plan Sponsor in its compliance with income tax, ERISA reporting and disclosure requirements.

B. Provider Network Services and Provider Locator Service

1. Participating Provider Network

EyeMed shall provide a Vision Network of ophthalmologists, optometrists, opticians, and retail optical locations that are contracted with EyeMed to deliver services consisting of vision exams, materials, and contact lenses, at negotiated prices ("Participating Providers"). Any additions or deletions to the Vision Network shall be in EyeMed's sole discretion; provided, however, that EyeMed will make reasonable efforts to provide Plan Sponsor with reasonable advance notice of significant changes in the Vision Network, which would materially affect the nature or extent of services provided to Participants. EyeMed shall reimburse the Participating Provider at the rate contracted between EyeMed and the Participating Provider, which may be an amount different than what is set forth on Exhibit B.

2. Participating Provider Independent Contractor

EyeMed does not employ Participating Providers and such providers are not EyeMed's agents or partners. Participating Providers participate in the Vision Network only as independent contractors. Participating Providers are solely responsible for exercising professional judgment related to a Participant's care.

3. Participating Provider Locator

EyeMed shall maintain a provider locator service of Participating Providers that the Member may access through a toll-free telephone number or via the EyeMed website.

4. Credentialing

EyeMed shall credential, contract with, and re-credential each ophthalmologist and optometrist in accordance with EyeMed's credentialing procedures, which meet NCQA standards. EyeMed may contract with a NCQA accredited credentials verification organization of their choice to perform verifications of the credentials.

5. Nondiscrimination

EyeMed's Participating Providers Agreement requires Participating Providers make its services available to Members on the same basis as those services are provided to all other patients, and that Participating Provider shall not discriminate on the basis of age, sex, race, religion, or color.

6. Balance Billing

EyeMed's Participating Provider Agreement requires providers to not balance bill Members for Vision Benefits; provided, however, a Participating Provider shall collect from Members any copayment or coinsurance amounts for which Members are financially obligated under the ERISA Plan and any non-covered service(s).

C. Claims Processing Services

1. Claims Submission

FAA shall process in-network and out-of-network claims for Vision Benefits. In-network claims will be submitted directly to FAA by the Participating Provider. Out-of-network claims must initially be paid by the Member in full; the Member may then submit the out-of-network claim directly to FAA on the appropriate claim form. EyeMed shall make the out-of-network claim form available to Members through a toll-free telephone number or on the EyeMed website.

2. Claims Delegation

Plan Sponsor delegates to FAA the discretionary authority to determine the validity of claims and appeals under the ERISA Plan.

3. Claims Processing Services

FAA shall: (a) determine the amount of Vision Benefits payable, if any, for each claim; (b) notify the Member its decision concerning the claim; (c) disburse payments to the Participating Provider (per the Participating Provider Agreement) or the Member (per the out-of-network information on Exhibit B), as applicable. FAA's services under this paragraph shall comply with the provisions of ERISA Section 503 and its implementing regulations, to the extent that they address initial claims for benefits.

4. Claims Review Services

FAA shall provide for a review of denied claims upon request by the Member. FAA shall notify the Member of its decision on review. FAA's services under this paragraph shall comply with the provisions of ERISA Section 503 and its implementing regulations, to the extent that they address decisions on review.

5. Run-Out Claims Services

After the termination of this Agreement, FAA shall continue to provide claims processing services and claims review services, but only for those claims incurred prior to the date of termination of the Agreement. FAA shall provide such services for a period of 12 calendar months (the "Run-Out Period") following termination. During the Run-Out Period, FAA will continue to invoice the Plan Sponsor for the claims cost, and will additionally invoice the Plan Sponsor for an administrative fee equal to 6% of the claims cost. Plan Sponsor will be responsible for payment of such invoices. Invoicing and payment procedures applicable during the term of this Agreement shall continue to be applicable during the Run-Out Period. This clause shall survive the termination of this Agreement.

III. RESPONSIBILITIES OF PLAN SPONSOR

A. Responsibility for the ERISA Plan

1. Plan Administrator

Plan Sponsor is the Plan Administrator (as that term is defined in Section 3 (16) of the Employee Retirement Income Security Act of 1974 ("ERISA")) of the Plan. Plan Sponsor may name another entity or individual as Plan Administrator, provided that such Plan Administrator is not EyeMed or FAA and is not an EyeMed or FAA employee. EyeMed or FAA expressly decline to accept responsibility for being Plan Administrator.

2. Final Authority for the Plan

Plan Sponsor retains all final authority and responsibility for the Plan and its operations. Both parties shall be responsible for compliance with any and all applicable laws and regulations.

3. Plan Amendment and Certification from Plan Sponsor

Plan Sponsor represents and warrants that: (a) its ERISA Plan documents have been amended, in accordance with 45 CFR §164.504(f), so as to allow Plan Sponsor to receive Protected Health Information; (b) the Plan Sponsor has received a certification from the ERISA Plan in accordance with 45 CFR §164.504(f)(2)(ii), and will provide a copy of such certification to EyeMed prior to the Effective Date; (c) the ERISA Plan document amendments permit Plan Sponsor to receive detailed invoices from FAA; and (d) Plan Sponsor has determined, through its own policies and procedures, that the detailed invoice from FAA contains the minimum information necessary for Plan Sponsor to carry out its payment and health care operations.

B. Enrollment Services

1. Participant Enrollment Information

Plan Sponsor will determine Participants eligibility in the Plan and provide EyeMed with data sufficient to enable EyeMed to maintain accurate Participant enrollment records. In the event benefits under the Plan are made available to an individual who is no longer eligible to receive such benefits resulting from Plan Sponsor's failure to timely notify FAA of the ineligibility of such individual, Plan Sponsor shall be liable to FAA for the payment of all benefits provided to such individual.

2. Membership File.

Plan Sponsor shall be responsible for determining and identifying those individuals that the Plan Sponsor determines is eligible to receive vision benefits under the ERISA Plan.

(a) Data Format. Plan Sponsor will provide EyeMed with electronic Member enrollment in either (i) the EyeMed standard data layout format; or (ii) the format required by the HIPAA rule governing the enrollment and disenrollment in a health plan transaction, as outlined in 42 CFR 162.1502, as it may be amended from time to time.

(b) Data Transmission Method. The electronic Member enrollment information shall be sent to EyeMed utilizing either (i) a secure FTP transmission or (ii) secure email.

(c) Data Updates. Plan Sponsor agrees to provide full electronic file updates no more frequently than two (2) times per calendar month in the agreed to format. Plan Sponsor may also utilize the EyeMed Group Portal for interim additions, changes or deletions related to Members and Plan Sponsor agrees to include all such interim modifications on the next full electronic file update.

(d) Changes to Data Format. Plan Sponsor and EyeMed must mutually agree in advance to changes to the electronic data format. Plan Sponsor must contact the EyeMed Account Service Manager to submit a request to change the current data format.

(e) Data Accuracy and Reliance. Plan Sponsor represents and warrants that, to the best of its ability, the electronic Member enrollment will be accurate and that EyeMed may rely on such information to authorize services for such enrolled Members.

IV. INVOICING ARRANGEMENTS

A. Invoice for Vision Benefits

FAA shall invoice Plan Sponsor on a monthly basis for eligible claims processed and paid during the previous month ("Claims Invoice"). In addition, FAA shall invoice Plan Sponsor a monthly administration fee as set forth on Exhibit B ("Administrative Invoice"). The monthly Administrative Invoice shall be determined by multiplying the number of Members identified by Plan Sponsor's electronic Member enrollment by the applicable rate set forth on Exhibit B. For purposes of the Administrative Invoice, FAA will count the Members who are active and eligible for the applicable billing month as of the 15th day of each month prior to the billing month in which the invoice is issued to Plan Sponsor. For example, FAA will determine the active and eligible Members for the July invoice as of June 15th.

B. Payment of Invoice

Plan Sponsor shall pay the entire amount of both the Claims Invoice and Administrative Invoice (excluding only "Disputed Amounts", as defined below) within thirty (30) calendar days from the date of each invoice. If any non-Disputed Amount owed by Plan Sponsor to EyeMed and/or FAA is not paid within sixty (60) calendar days of the date of such invoice, EyeMed may apply interest equal to one and one-half percent (1.5%) per month. In addition, if any Disputed Amount agreed or

determined to be owed by Plan Sponsor to EyeMed is not paid within fifteen (15) business days from the date of such agreement or determination, EyeMed may apply interest equal to one and one-half percent (1.5%) per month. Payment shall be considered credited to the account of Plan Sponsor when received by EyeMed. As used herein, "Disputed Amounts" shall mean invoice amounts that are subject to a bona fide dispute raised by Plan Sponsor in a writing received by EyeMed within fifteen (15) calendar days of the date of an invoice therefore and with respect to which the parties are making reasonable, diligent and good faith efforts to resolve.

V. RECORDS MAINTENANCE AND AUDIT

A. Records Maintenance

EyeMed owns and shall keep all books and records necessary to reflect accurately the business it transacts with respect to Plan Sponsor and to determine the respective rights of the parties under this Agreement. Such books and records shall be kept at the principal place of business of EyeMed or at such other location as EyeMed determines in its sole discretion. All records will be maintained for a period of at least seven (7) years after the date they are first prepared or for such longer period as may be required by law.

B. Audit

During the term of the Agreement, and at any time within twelve (12) months following its termination, Plan Sponsor or a mutually agreeable entity or a regulatory authority with jurisdiction over Plan Sponsor may audit or inspect the records of EyeMed and/or FAA to determine whether EyeMed and/or FAA is fulfilling the terms of this Agreement. Plan Sponsor must advise EyeMed and/or FAA at least thirty (30) calendar days in advance of Plan Sponsor's intent to audit. The place, time, type, duration, and frequency of all audits must be agreed to in writing by EyeMed and/or FAA in advance of the audit, which approval shall not be unreasonably withheld, excluding any information, including but not limited to, reports that EyeMed considers to be proprietary.

1. All audits shall be on a regular business day, during normal business hours and conducted in such manner as to avoid, to the extent reasonably possible, interference with the normal business functions of EyeMed and/or FAA. Plan Sponsor shall be solely responsible for all costs of the audit, except for any EyeMed and/or FAA employee time and office space. In addition, Plan Sponsor shall have the right to make copies, at Plan Sponsor's expense, of applicable files, records or other information maintained by EyeMed and/or FAA related to Plan Sponsor.

2. All audits shall be limited to information relating to the calendar year in which the audit is conducted and/or the immediately preceding calendar year. With respect to EyeMed's and/or FAA's transaction processing services, the audit scope and methodology shall be consistent with generally acceptable auditing standards, including a statistically valid random sample or other acceptable audit technique as approved in writing.

3. Plan Sponsor will provide EyeMed and/or FAA with a copy of any audit reports.

VI. INDEMNIFICATION

A. EyeMed and/or FAA Indemnification to Plan Sponsor

EyeMed and/or FAA will indemnify, defend and hold Plan Sponsor harmless from and against any loss, cost, damage, expense or other liability, including, without limitation, reasonable costs and reasonable attorney fees ("Costs") incurred in connection with any third party claims, suits, investigations or enforcement actions, including claims of infringement of any intellectual property rights ("Claims") which may be asserted against, imposed upon or incurred by Plan Sponsor and arising as a result of (i) EyeMed's and/or FAA's negligent acts or omissions or willful misconduct, or (ii) EyeMed's and/or FAA's breach of its obligations under this Agreement. EyeMed and/or FAA shall not be liable to Plan Sponsor for any third party claims, suits, investigations or enforcement actions, arising directly or indirectly from the acts or omissions of a Participating Provider.

B. Plan Sponsor Indemnification to EyeMed and/or FAA

Plan Sponsor will indemnify, defend and hold EyeMed and/or FAA harmless from and against any loss, cost, damage, expense or other liability, including, without limitation, reasonable costs and reasonable attorney fees ("Costs") incurred in connection with any third party claims, suits, investigations or enforcement actions, including claims of infringement of any intellectual property rights ("Claims") which may be asserted against, imposed upon or incurred by EyeMed and/or FAA and arising as a result of (i) Plan Sponsor's negligent acts or omissions or willful misconduct, or (ii) Plan Sponsor's breach of its obligations under this Agreement.

C. Notification of Claim

The party seeking indemnification shall notify the indemnifying party in writing within thirty (30) calendar days of receipt of any Claim for which indemnification may be sought hereunder, and shall tender the defense of such claim to the indemnifying party thereafter.

D. Survival

This clause shall survive the termination of this Agreement.

VII. INSURANCE

A. Commercial General Liability Insurance

EyeMed shall maintain Commercial General Liability Insurance, including coverage for contractual liability, public liability, property damage, products-completed operations, cross liability and severability of interest claims, personal injury and advertising injury, with limits of at least:

\$3,000,000 per occurrence
\$6,000,000 general aggregate

B. Workers' Compensation Insurance

EyeMed shall maintain Workers' Compensation Insurance with benefits afforded under the laws of any state in which the services are to be performed and Employer's Liability insurance with limits of at least:

\$1,000,000 for Bodily Injury – each accident
\$1,000,000 for Bodily Injury by disease – policy limits
\$1,000,000 for Bodily Injury by disease – each employee

In states where Workers' Compensation Insurance is a monopolistic state-run system, EyeMed shall maintain Stop Gap Employer's Liability insurance with limits not less than One Million Dollars (\$1,000,000) each accident or disease.

C. Business Automobile Insurance

EyeMed shall maintain Business Automobile Insurance with limits of at least One Million Dollars (\$1,000,000) each accident for bodily injury and property damage, extending to all owned, hired and non-owned vehicles.

D. Commercial Crime Insurance

EyeMed shall maintain Commercial Crime Insurance with a limit of not less than Three Million Dollars (\$3,000,000). The policy shall provide Employee Theft, Premises, Transit, Depositor's Forgery and Computer Theft and Funds Transfer coverages. The Commercial Crime policy shall include a third party customer property coverage endorsement with limits of at least One Million Dollars (\$1,000,000).

E. Managed Care Error and Omissions Insurance

EyeMed shall maintain Managed Care Organization Errors and Omissions Insurance with a policy limit of not less than Three Million Dollars (\$3,000,000) each claim and in the aggregate.

F. Policies of Insurance--Financial Rating

All policies of insurance required of EyeMed herein shall be issued by insurance companies having and maintaining a Financial Strength Rating of "A minus" or better and a Financial Size Category of "VII" or better in the A.M. Best Key Rating Guide for Property and Casualty Insurance Companies, except that, in the case of Workers' Compensation insurance, EyeMed may procure insurance from the stated fund of the state where services are to be provided.

G. Proof of Insurance

Upon Plan Sponsor's written request, certificates of insurance shall be delivered to Plan Sponsor upon execution of the Agreement. All policies of insurance will provide for at least thirty (30) days prior written notice to Plan Sponsor of the cancellation or substantial modification thereof. All policies required of EyeMed herein shall be endorsed to read that such policies are primary policies and any insurance carried by Plan Sponsor shall be noncontributing with such policies

VIII. LICENSE TO USE NAME AND TRADEMARKS

A. Plan Sponsor's Use of EyeMed's Name

Plan Sponsor may use the EyeMed name, as provided by EyeMed (the "Licensed Marks") solely in connection with communicating the Vision Benefit to its Members, and shall not use the Licensed Marks or any other trademarks, services marks or trade names of EyeMed (the "Trademarks") for any other purpose. Plan Sponsor shall not use EyeMed's logo without prior written consent or inconsistent with the attached Link and Logo Terms and Conditions related to website linking. Plan Sponsor shall not question, contest or challenge EyeMed's rights in and to the Trademarks, nor seek to register the same. Plan Sponsor expressly recognizes and acknowledges that the use of the Licensed Marks shall not

confer upon Plan Sponsor any proprietary rights to such marks. Upon termination of this Agreement, Plan Sponsor shall immediately stop using the Licensed Marks.

B. EyeMed's Use of Plan Sponsor's Name

EyeMed may use Plan Sponsor's name and logo(s) as provided by Plan Sponsor (the "Licensed Marks") solely in connection with communicating the Vision Benefit, and shall not use the Licensed Marks or any other trademarks, service marks or trade names of Plan Sponsor ("Trademarks") for any other purpose. EyeMed shall not question, contest or challenge Plan Sponsor's rights in and to the Trademarks, nor seek to register the same. EyeMed expressly recognizes and acknowledges that the Licensed Marks shall not confer upon EyeMed any proprietary rights to such marks. Upon termination of this Agreement, EyeMed shall immediately stop using the Licensed Marks.

C. Remedies

The parties expressly agree and understand that the remedy at law for any breach by it of the terms of this section would be inadequate and the damages flowing from such breach are not readily susceptible to being measured in monetary terms. Accordingly, it is acknowledged by each party that upon its breach of any provision of this section, the non-breaching party shall be entitled to seek immediate injunctive relief and may seek to obtain a temporary order restraining any threatened or further breach without the necessity of proof of actual damage. Nothing contained herein shall be deemed to limit the non-breaching party's remedy at law or in equity for any breach by the breaching party of the provisions of this section which may be pursued or availed of by the non-breaching party.

X. WEBSITE LINKING BY PLAN SPONSOR

EyeMed is the owner or operator of a web site located at www.eyemedvisioncare.com (the "EyeMed Site"). Plan Sponsor is the owner or operator of a web site (the "Plan Sponsor Site"). EyeMed and Plan Sponsor desire to allow users of the Plan Sponsor Site to link to the EyeMed Site landing on EyeMed's home page.

In the event Plan Sponsor establishes a hyperlink from Plan Sponsor's Site to EyeMed's site the parties hereby agree to the terms and conditions as set forth in the attached Link and Logo Terms and Conditions, Exhibit C.

X. PROTECTION OF CONFIDENTIAL INFORMATION

Plan Sponsor and EyeMed shall not disclose to any other person, firm or corporation, or use for its own benefit except as provided herein, the terms of this Agreement, or any information that it receives from the other party that is marked either "Confidential" or "Proprietary" or "Strictly Private" or "Internal Data," or that is any unmarked information in the form of financial information or trade secrets (collectively referred to as "Confidential Information"), without the express written authorization of the other party. Both parties shall take all necessary steps to protect the other party's trade secrets and confidential business information and records. Upon the termination of this Agreement, both parties agree to return any and all materials containing such Confidential Information, plus any and all copies, written or machine made, in whatever medium, that it may have, within ten (10) days of a request from the other party.

Confidential Information shall not include information that:

- A. Was, at the time of receipt, otherwise known to the recipient without restrictions as to use or disclosure;
- B. Was in the public domain at the time of disclosure or thereafter enters into the public domain through no breach of this Agreement by the recipient;
- C. Becomes known to the recipient from a source other than the disclosing party, which source has no duty of confidentiality with respect to the information;
- D. Is independently developed by the recipient without reliance on or access to any of the disclosing party's Confidential Information; or
- E. Is required to be disclosed by a government agency or bureau, by a court of law or equity with competent jurisdiction over the recipient or by a recognized body engaged in professional self-regulation (such as national accounting or auditing associations), provided that the recipient will first have provided the disclosing party with prompt written notice of such required disclosure and will take reasonable steps to allow the disclosing party to seek a protective order with respect to the Confidential Information required to be disclosed. The recipient will promptly cooperate with and assist the disclosing party, at the disclosing party's expense, in connection with obtaining such protective order.

XI. BUSINESS ASSOCIATE AGREEMENT/HIPAA PRIVACY

In order to comply with the Administrative Simplification Provisions of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et. seq., and regulations promulgated thereunder, as amended from time to time (statute and regulations hereafter collectively referred to as "HIPAA"), the parties hereby agree to the terms and conditions described in the attached Business Associate Agreement-HIPAA Privacy, Exhibit D. Terms used, but not otherwise defined, shall have the same meaning as those terms in HIPAA.

XII. TERMINATION

A. Voluntary Termination

This Agreement may be terminated, without cause: (i) by mutual written agreement of the parties; or (ii) by either party providing sixty (60) days prior written notice without cause to the other party at any time during the term of the Agreement or any renewal term.

B. Termination for Cause or Default

Either party may terminate this Agreement if the other party is in material breach of this Agreement and fails to cure such breach within thirty (30) calendar days after receiving written notice reasonably detailing such breach. In the event that the breach is not cured within the thirty (30) day cure period, this Agreement shall terminate in accordance with the initial notice of breach. Additionally, either party shall be deemed to have materially breached this Agreement upon the occurrence of any of the following events, which list is not intended to be inclusive of what constitutes a material breach:

1. Either party shall become insolvent or otherwise admit in writing its inability to pay its debts when they become due, becomes bankrupt, seeks protection under any law for the protection of insolvents, or have a receiver or conservator appointed under any law pertaining to such party's insolvency.
2. Either party fails to remit any amounts due (excluding Disputed Amounts") under this Agreement within thirty (30) calendar days of the date such amount is due and payable.
3. Either party shall knowingly commit a material violation of the laws or regulations of any state where this Agreement is performed.
4. Any misrepresentation or falsification of any information supplied by Plan Sponsor or EyeMed for consideration by the other, except that EyeMed will not be responsible for any misrepresentation or falsification of information provided to it by a Participating Provider.
5. EyeMed or Plan Sponsor ceases to engage in all business activities.
6. EyeMed substantially fails to perform its obligations under this Agreement, including but not limited to maintaining an adequate Vision Network of Participating Providers, maintaining a Participating Provider locator service for Members to be able to locate Participating Providers, and maintaining sufficient customer service representatives to answer Member and Participating Provider calls.
7. FAA is in default of its payment obligations to any Participating Provider or Members with respect to the services rendered under this Agreement to the Member and fails to cure such default within ten (10) business days of written notice from Plan Sponsor, so long as FAA does not dispute in good faith the amount that is owed to the Participating Provider or Member. If FAA disputes in good faith that any money is owed or the amount which is owed, FAA is not in default under this Agreement.

XIII. GENERAL PROVISIONS

A. Requirements Imposed by Law

Each party agrees to adhere to legal requirements imposed by federal, state or other law as of the date such law becomes effective and applicable to this Agreement.

B. Independent Contractor

In the performance of the work, duties and obligations of the parties pursuant to this Agreement, each of the parties shall at all times be acting and performing as an independent contractor, and nothing in this Agreement shall be construed or deemed to create a relationship of employer and employee or partner or principal and agent.

C. Governing Law

This Agreement shall be governed by and construed in accordance with ERISA, federal law, and to the extent not preempted, by the laws of the State of Ohio.

D. Entire Contract

This Agreement together with all attachments contains all the terms and conditions agreed upon by the parties, and supersedes all other agreements, express or implied regarding the subject matter.

E. Waiver

The waiver of any party of any breach of this Agreement shall not be construed as a continuing waiver or a waiver of any other breach of this Agreement.

F. Attorney Fees

If EyeMed or Plan Sponsor find it necessary to enforce any part of this Agreement through legal proceedings, resulting in final judgment by a court of competent jurisdiction, Plan Sponsor and EyeMed agree that each party shall pay all of their own costs and attorneys' fees incurred for such purpose.

G. Severability

In the event that any clause, term, or condition of this Agreement shall be held invalid or contrary to law, this Agreement shall remain in full force and effect as to all other clauses, terms, and conditions.

H. Force Majeure

No party to this Agreement shall be liable for failure to perform any duty or obligation that such party may have under this Agreement where such failure has been caused by an act of God, fire, flood, strike, unavoidable accident, war or any cause outside the reasonable control of the party who had the duty to perform.

I. Heading

The section headings used herein are for reference and convenience only, and shall not enter into the interpretation hereof.

J. Counterparts

This Agreement may be executed in several counterparts, each of which shall be deemed an original, but all of which shall constitute one Agreement.

K. Assignment

This Agreement may not be assigned by a party, in whole or in part, without the prior written consent of the other, except that a party may, without the consent of the other, assign this Agreement to an affiliate.

L. Successor/Survival

All terms of this Agreement shall be binding upon, inure to the benefit of, and be enforceable by the parties hereto and their respective successors and assigns. All rights and obligations of the parties arising out of this Agreement prior to termination which by their nature are designed or intended to continue shall survive the termination of this Agreement.

M. Amendments

This Agreement may be amended from time to time by mutual agreement between Plan Sponsor and EyeMed, which amendment shall be in writing signed by the parties. Notwithstanding any provision contained herein to the contrary, each party shall have the right, for the purpose of complying with the provisions of any law or lawful order of a court or regulatory authority, to amend this Agreement including any Exhibits hereto, to increase, reduce or eliminate any of the Vision Benefits provided under this Agreement. If the parties cannot agree to an amendment, notwithstanding any provision of this Agreement to the contrary, Plan Sponsor or EyeMed may terminate this Agreement as of the end of any month by the giving of ninety (90) days prior written notice.

N. No Third Party Beneficiaries. Nothing express or implied in this Agreement is intended or shall be construed to confer upon or give any person, other than Plan Sponsor and EyeMed, any right or remedies under or by reason of this Agreement.

O. Notice

All notices, requests and demands under this Agreement shall be in writing. They shall be deemed to have been given upon delivery if (i) delivered in person, (ii) mailed by certified mail, postage pre-paid and return receipt requested, and (iii) deposited with an overnight delivery service by a nationally recognized overnight courier service. Notice shall be effective upon receipt and shall be directed to the individuals below and at the address in the first paragraph.

If to Plan Sponsor:

Ms. Leslie Edwards
Benefits Administrator

If to EyeMed or FAA

Ms. Liz DiGiandomenico
President
CC: EyeMed Legal

IN WITNESS WHEREOF, the undersigned have executed this Agreement.

EyeMed Vision Care, LLC

By: [Signature]
nevin thist

Title: VP-client services

Date: 11-5-10

First American Administrators, Inc.

By: [Signature]
nevin thist

Title: VP client services

Date: 11-5-10

UAW/UMass Health & Welfare Trust Fund

x By: Susan Chinman
Name: Susan Chinman
Title: University Trustee
Date: 10/22/10

x [Signature]
Ronald R. Potnowicz
President UAW 2322
10/22/10

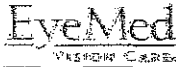
EXHIBIT A- DEFINITIONS

I. DEFINITIONS

The following terms used in this Agreement shall have the meaning as set forth hereafter:

- A. "Agreement" shall mean the Fee for Service Agreement between EyeMed and/or FAA and Plan Sponsor
- B. "Business Days" shall mean a day when both EyeMed and/or FAA and Plan Sponsor are open for business, excluding Saturday and Sunday.
- C. "ERISA" shall mean the Employee Retirement Income Security Act of 1974.
- D. "HIPAA" shall mean Health Insurance Portability and Accountability Act of 1996.
- E. "Members" shall mean the Participant and eligible dependents who have health benefits under the ERISA Plan.
- F. "PHI" shall mean Protected Health Information.
- G. "Participants" shall mean the individual who has an employment arrangement, contractual arrangement, or affiliation with Plan Sponsor.
- H. "Participating Provider" shall mean the ophthalmologists, optometrists, opticians, and retail optical locations who are contracted with EyeMed to deliver services consisting of vision exams, materials, and contact lenses, at negotiated prices.
- I. "Plan" or "ERISA Plan" shall mean the plan established by the employer or other entity for self-funding vision benefits.
- J. "Plan Administrator" shall mean the employer name in the plan document as responsible for day-to-day operations. Also known as the Plan Sponsor.
- K. "Plan Sponsor" shall mean the entity that sponsor the vision plan.
- L. "Vision Benefit" shall mean the vision benefit as set forth on Exhibit B available to Members from Participating Providers.
- M. "Vision Network" shall mean the collection of Participating Providers; the specific network as identified on Exhibit B.

EXHIBIT B - BENEFIT SCHEDULE



UMASSIAW - GEO Vision
EyeMed Select Plan H, Fee For Service
100% Employer Paid - On-Benefit With Group Medical or Dental
Option 1

Version 4

Vision Care Services	Member Cost	Group Cost per Service	Out-of-Network
Exam with Dilatation as Necessary	\$10 Copay	Up to \$35	\$50
Exam Options:			
Standard Contact Lens Fit and Follow-Up:	Up to \$40	N/A	N/A
Premium Contact Lens Fit and Follow-Up:	10% off Retail	N/A	N/A
Frames:			
Any available frame at provider location	\$0 Copay, \$120 Allowance, 20% off balance over \$120	\$65	\$66
Standard Plastic Lenses			
Single Vision	\$10 Copay	\$25	\$42
Bifocal	\$10 Copay	\$45	\$78
Trifocal	\$10 Copay	\$50	\$130
Standard Progressive Lens**	\$25	\$55	\$75
Premium Progressive Lens**	\$25, 60% of Charge less \$120 Allowance	\$55	\$75
Lens Options:			
UV Treatment	\$15	\$0	N/A
Tint (Solid and Gradient)	\$15	\$0	N/A
Standard Plastic Scratch Coating	\$15	\$0	N/A
Standard Polycarbonate - Adults	\$40	\$0	N/A
Standard Polycarbonate - Kids under 19	\$40	\$0	N/A
Standard Anti-Reflective Coating	\$45	\$0	N/A
Polarized	20% off Retail Price	\$0	N/A
Other Add-Ons	20% off Retail Price	\$0	N/A
Contact Lenses			
Contact Lens allowance includes materials only			
Conventional	\$0 Copay, \$135 allowance, 15% off balance over \$135	\$114.75	\$108
Disposable	\$0 Copay, \$135 allowance, plus balance over \$135	\$135	\$108
Medically Necessary	\$0 Copay, Paid-in-Full	Retail less 5%	\$200
Laser Vision Correction			
Laser or PRK from U.S. Laser Network	15% off retail price or 5% off promotional price	N/A	N/A
Additional Pairs Benefit:	Members also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the needed benefit has been used.	N/A	N/A
Frequency:			
Examination	Once every 12 months		
Lenses	Once every 12 months		
Contact Lenses	Once every 12 months		
Frame	Once every 12 months		
Monthly Administrative Fee			
Per Subscriber Per Month (Composite)	\$0.99		

All plans are based on a 48-month contract term and 48-month rate guarantee.

** Standard/Premium Progressive lenses not covered - fund as a Bifocal Lens

Additional Discounts:
Member receives a 25% discount on items not covered by the plan at network Providers, which cannot be combined with any other discounts or promotional offers. Discount does not apply to EyeMed Provider's professional services, or contact lenses.
Members also receive 10% off retail price or 5% off promotional price for Laser or PRK from the U.S. Laser Network, owned and operated by LCA Vision.
After initial purchase, replacement contact lenses may be obtained via the Internet at substantial savings and mailed directly to the member. Details are available at www.eyemedvisioncare.com.
The contact lens benefit allowance is not applicable to this service.
Benefit Allowances provide no replenishing balance for future use within the same Benefit Frequency.
Certain brand name Vision Materials in which the manufacturer imposes a no-discount practice.

Rules are valid for groups domiciled in the State of MA.
Fees quoted will be valid until the 1/1/2010 plan implementation date. Data quoted: 8/24/2010.
Rates assume 100% employer contribution for employees and dependents or that the Vision program is bundled with medical/dental benefit.

Plan Exclusions:
1) Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; 2) Medical (and/or surgical) treatment of the eye, eye or supporting structures;
3) Any eye or Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; 4) Safety eyewear;
5) 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;
6) Plano (non-prescription) lenses and/or contact lenses; 7) Non-prescription sunglasses; 8) Two pair of glasses in lieu of bifocals;
9) Services or materials provided by any other group benefit plan providing vision care;
10) 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;
11) Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available.

If UMMAIAW - GEO Vision has chosen this benefit design, attach this document to the group application and sign here:

Signature

Date

8/17/10

TCC

EXHIBIT C - LINK AND LOGO TERMS AND CONDITIONS

I. LINKING RIGHTS

A. Use of EyeMed Marks. EyeMed hereby grants Plan Sponsor the limited right to use the EyeMed Marks on the Plan Sponsor Site as a hyperlink to the EyeMed Site (the "Hyperlink"). "EyeMed Marks" means the trademarks, service marks, domain names, logos, and identifiers of EyeMed listed in Attachment A to this Agreement, which is incorporated herein.

B. Hyperlink. The Hyperlink will only be accessible to those Plan Sponsor Members users who are valid and existing Plan Sponsor Members. Plan Sponsor agrees to provide EyeMed upon request all information and data necessary to authenticate such users access to the EyeMed Site.

C. Ownership of Materials. Each Party retains all rights, title and interest in and to their respective web sites, including all intellectual property rights therein. All rights, title and interest in and to the EyeMed Marks, including all intellectual property rights therein, are owned and retained exclusively by EyeMed and its affiliates.

II. REPRESENTATIONS AND WARRANTIES.

A. EyeMed Marks. Plan Sponsor represents and warrants that: Plan Sponsor will not (i) use, register or attempt to register any EyeMed Mark as its own, (ii) use, register, or attempt to register any name, logo, mark, domain name, or other identifier which is likely to lead to confusion with the EyeMed Marks, (iii) use the EyeMed Marks in a manner likely to disparage or misrepresent EyeMed, or (iv) use the EyeMed Marks in a manner not expressly permitted by this Agreement or approved in writing by EyeMed. EyeMed represents and warrants that it owns the EyeMed Marks or otherwise has the right to grant the licenses granted herein.

B. The Sites. Each Party represents and warrants to the other with regard to its respective Site that (i) it is the owner or otherwise has the right to use and provide the Site; (ii) the Site is not and will not be obscene, defamatory, libelous, or otherwise offensive to a reasonable person; (iii) they employ customary security measures standard in the industry to protect access to the Sites and (iv) the Site will not be fraudulent, misleading, or in violation of any applicable law.

C. DISCLAIMER OF WARRANTY. EYMED EXPRESSLY DISCLAIMS, AND PLAN SPONSOR HEREBY EXPRESSLY WAIVES, ALL WARRANTIES, EXPRESS OR IMPLIED, INCLUDING, WITHOUT LIMITATION, WARRANTIES OF MERCHANTABILITY, NONINFRINGEMENT, AND FITNESS FOR A PARTICULAR PURPOSE WITH REGARD TO THE EYMED MARKS.

III. INDEMNIFICATION

Plan Sponsor shall indemnify, defend, and hold harmless EyeMed with respect to any third party claim, including reasonable attorneys' fees (collectively, "Claims"), to the extent that any such Claim is based upon improper access to the EyeMed Site via the Plan Sponsor Site, Breach of any of Plan Sponsor's representations or warranties under this Agreement or obligations under applicable law; or arises out of Plan Sponsor's negligence or willful misconduct.

**Attachment A
EYEMED MARKS**

Logo. The EyeMed logo most recently provided by EyeMed and described in this Attachment A (or in any such revised logo display standards) is the only logo that may be used by Plan Sponsor.



Attachment B
EYEMED INTERNET USE GUIDELINES

Upon execution of the Fee for Services Agreement with EyeMed you will be granted the limited right to use the EyeMed name, trademarks and logos ("marks") in accordance with these Guidelines.

Requirements for Internet/Web Site Use and Hot Linking

Use of the EyeMed name and logo on your web site is permitted for the purpose of providing a link to the EyeMed web site (www.eyemedvisioncare.com), so long as the link satisfies all six (6) of the following requirements:

- a. Delivers users to the EyeMed homepage at www.eyemedvisioncare.com.
- b. Provides users with a "point and click" feature clearly indicating the link will lead to the EyeMed homepage at www.eyemedvisioncare.com.
- c. Does not represent or suggest any relationship between the linking site and EyeMed Vision Care (in suggestions of affiliation, endorsement, or sponsorship).
- d. Maintains the integrity of the EyeMed layout, content, and look and feel.
- e. Delivers users to the EyeMed web site, unaltered, unmodified, unadulterated in any way.
- f. Delivers the EyeMed content in its own browser and does not frame the EyeMed content in any way or through any action, including, but not limited to referencing EyeMed or EyeMed Vision Care as a metatag, which may create a misimpression or confusion among users with respect to sponsorship or affiliation.

Eligibility

Any deviation from these Guidelines require prior written approval from EyeMed. Questions regarding use of the EyeMed marks should be addressed to eyemedmarketing@eyemedvisioncare.com.

EXHIBIT D - BUSINESS ASSOCIATE ADDENDUM

I. DEFINITIONS

A. **In General.** Terms used, but not otherwise defined, in this Addendum shall have the same meaning as those terms in the Applicable Law.

B. **Specific Definitions**

1. "Applicable Law" shall mean any of the following items, including any amendments to any such item as such may become effective:
 - a. the Health Insurance Portability and Accountability Act of 1996 ("HIPAA");
 - b. the federal regulations regarding privacy and promulgated with respect to HIPAA, found at Title 45 CFR Parts 160 and 164 (the "Privacy Rule");
 - c. the federal regulations regarding electronic data interchange and promulgated with respect to HIPAA, found at Title 45 CFR Parts 160 and 162 (the "Transaction Rule");
 - d. the federal regulations regarding security and promulgated with respect to HIPAA, found at Title 45 CFR Parts 160 and 164 (the "Security Rule"); and
 - e. the American Recovery and Reinvestment Act of 2009 ("ARRA"), §§ 13400-24.
2. "Business Associate" shall mean EyeMed Vision Care, LLC and First American Administrators, Inc.
3. "Covered Entity" shall mean the Plan Administrator and Plan Sponsor, on behalf of itself and the ERISA Plan.
4. "ePHI" shall mean electronic protected health information within the meaning of 45 CFR § 160.103, limited to the information created, received, maintained, or transmitted by Business Associate from or on behalf of Covered Entity.
5. "HIPAA Breach" shall have the same meaning as the term "breach" in 45 CFR § 164.402.
6. "Protected Health Information" or "PHI" shall have the same meaning as the term "protected health information" in 45 CFR § 160.103, limited to the information created, received, maintained, or transmitted by Business Associate from or on behalf of Covered Entity.
7. "Service Agreement" shall mean the Fee For Service Agreement.
8. "Unsecured PHI" shall have the same meaning as the term "unsecured protected health information" in 45 CFR § 164.402, limited to the information created, received, maintained, or transmitted by Business Associate from or on behalf of Covered Entity.

II. RIGHTS AND OBLIGATIONS OF BUSINESS ASSOCIATE

A. **General Obligations**

1. **Compliance with Privacy Rule**

- a. Business Associate shall not use or further disclose PHI other than as permitted or required by HIPAA, the Privacy Rule, and this Addendum.
- b. Business Associate shall use appropriate safeguards to prevent use or disclosure of the PHI other than as provided for by this Addendum.
- c. Business Associate shall report to Covered Entity any use or disclosure of PHI, known to Business Associate, that is not permitted by this Addendum.

2. **Compliance with Security Rule.**

- a. Business Associate shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of ePHI.

- b. Business Associate shall report to Covered Entity any Security Incident of which Business Associate becomes aware.

3. **Compliance with ARRA.**

- a. Business Associate shall comply with the security breach notice requirements provided in Section II.A.4 of the Addendum below.
- b. Business Associate shall not receive remuneration, either directly or indirectly, in exchange for PHI, except as may be permitted by ARRA § 13405(d). This paragraph shall be effective 180 days after issuance of final regulations implementing ARRA § 13405.
- c. Pursuant to the Privacy Rule, made applicable to Business Associate by ARRA, Business Associate shall adopt, implement, and follow privacy policies and procedures in the same manner and to the same extent as if it were a Covered Entity. This paragraph shall be effective on and after February 17, 2010.
- d. Pursuant to the Security Rule, made applicable to Business Associate by ARRA, Business Associate shall adopt, implement, and follow security policies and procedures in the same manner and to the same extent as if it were a Covered Entity. This paragraph shall be effective on and after February 17, 2010.

4. **Notice of Security Breach.**

- a. **Notice to the Covered Entity.** Business Associate shall notify the Covered Entity without unreasonable delay and within thirty (30) calendar days of Business Associate's discovery of a HIPAA Breach of Unsecured PHI. The notice to the Covered Entity shall include the identity of each Individual whose Unsecured PHI was involved in the HIPAA Breach, a brief description of the HIPAA Breach and any mitigation efforts. To the extent that the Business Associate does not know the identities of all affected Individuals when it is required to notify the Covered Entity, the Business Associate shall provide such additional information as soon as administratively practicable after such information becomes available. For purposes of this paragraph, a HIPAA Breach shall be treated as discovered as of the first day on which the HIPAA Breach is known or should reasonably have been known to Business Associate (including any person, other than the one committing the HIPAA Breach, which is an employee, officer, or other agent of the Business Associate).
- b. **Notice to Individuals.** Business Associate will provide written notice of the HIPAA Breach of Unsecured PHI, on behalf of the Covered Entity, without unreasonable delay but no later than sixty (60) calendar days following the date the HIPAA Breach of Unsecured PHI is discovered or such later date as is authorized under 45 CFR § 164.412 to each Individual whose Unsecured PHI has been, or is reasonably believed by Business Associate to have been, accessed, used, or disclosed as a result of the HIPAA Breach. For purposes of this paragraph, a HIPAA Breach shall be treated as discovered as of the first day on which the HIPAA Breach is known or should reasonably have been known to Business Associate (including any person, other than the one committing the HIPAA Breach, which is an employee, officer, or other agent of the Business Associate).

The content, form, and delivery of such written notice shall comply in all respects with 45 CFR § 164.404(c)-(d).

Business Associate and Covered Entity shall cooperate in all respects regarding the drafting and the content of the notice. To that end, before sending any notice to any Individual, the Business Associate shall first provide a draft of the notice to the Covered Entity. Covered Entity shall have five (5) business days (plus any reasonable extensions) to provide comments on the Business Associate's draft of the notice.

- c. **Notice to Media.** Business Associate will provide written notice of the HIPAA Breach of Unsecured PHI, on behalf of the Covered Entity, to the media to the extent required under 45 CFR § 164.406. Business Associate and the Covered Entity shall cooperate in all respects regarding the drafting and the content of the notice. To that end, before sending any notice to the media, Business Associate shall first provide a draft of the notice to the Covered Entity. Covered Entity shall have five (5) business days (plus any reasonable extensions) to provide comments on the Business Associate's draft of the notice.

- d. **Notice to Secretary.** Business Associate will provide written notice of the HIPAA Breach of Unsecured PHI, on behalf of the Covered Entity, to the Secretary to the extent required under 45 CFR § 164.408. Business Associate and Covered Entity shall cooperate in all respects regarding the drafting and the content of the notice. To that end, before sending any notice to the Secretary, Business Associate shall first provide a draft of the notice to the Covered Entity. Covered Entity shall have five business days (plus any reasonable extensions) to provide comments on Business Associate's draft of the notice.

If the HIPAA Breach of Unsecured PHI involves less than five hundred (500) individuals, Business Associate will maintain a log or other documentation of the HIPAA Breach of Unsecured PHI which contains such information as would be required to be included if the log were maintained by the Covered Entity pursuant to 45 CFR § 164.408, and provide such log to the Covered Entity within five (5) business days of the Covered Entity's written request.

5. **Subcontractors and Agents.** Business Associate shall ensure that any agent, including a subcontractor, to whom it provides PHI agrees to the same restrictions and conditions that apply through this Addendum to Business Associate with respect to such PHI.
6. **Access to Books and Records by Secretary.** Business Associate shall make its internal practices, books, and records relating to the use, disclosure, and security of PHI available to the Secretary for purposes of the Secretary determining Covered Entity's compliance with HIPAA. Effective February 17, 2010, Business Associate shall make its internal practices, books, and records relating to the use, disclosure, and security of PHI available to the Secretary for purposes of the Secretary determining Business Associate's compliance with HIPAA.
7. **Mitigation.** Business Associate shall mitigate, to the extent practicable, any harmful effect that is known to Business Associate of (a) a use or disclosure of PHI by Business Associate in violation of the requirements of this Addendum, or (b) a Security Incident.

B. Obligations Relating to Individual Rights

1. **Restrictions on Disclosures.** Upon request by an Individual, Covered Entity shall determine whether an Individual shall be granted a restriction on disclosure of the PHI pursuant to 45 CFR § 164.522. Covered Entity will not agree to any such restriction, if such restriction would affect Business Associate's use or disclosure of PHI, without the prior consent of Business Associate, provided, however, that effective February 17, 2010, Business Associate's consent is not required for requests that must be granted under ARRA § 13405(a). Covered Entity will communicate any grant of a request, made consistent with the foregoing, to Business Associate. Business Associate will restrict its disclosures of the Individual's PHI in the same manner as would be required for Covered Entity. If Business Associate receives an Individual's request for restrictions, Business Associate shall forward such request to Covered Entity within five (5) business days.
2. **Access to PHI.** Upon request by an Individual, Covered Entity shall determine whether an Individual is entitled to access his or her PHI pursuant to 45 CFR § 164.524. If Covered Entity determines that an Individual is entitled to such access, and that such PHI is under the control of Business Associate, Covered Entity will communicate the decision to Business Associate. Business Associate shall provide access to the PHI in the same manner as would be required for Covered Entity. If Business Associate receives an Individual's request to access his or her PHI, Business Associate shall forward such request to Covered Entity within five (5) business days.
3. **Amendment of PHI.** Upon request by an Individual, Covered Entity shall determine whether any Individual is entitled to amend his or her PHI pursuant to 45 CFR § 164.526. If Covered Entity determines that an Individual is entitled to such an amendment, and that such PHI is both in a designated record set and under the control of Business Associate, Covered Entity will communicate the decision to Business Associate. Business Associate shall provide an opportunity to amend the PHI in the same manner as would be required for Covered Entity. If Business Associate receives an Individual's request to amend his or her PHI, Business Associate shall forward such request to Covered Entity within five (5) business days.
4. **Accounting of Disclosures.** Upon request by an Individual, Covered Entity shall determine whether any Individual is entitled to an accounting pursuant to 45 CFR § 164.528. If Covered Entity determines that an Individual is entitled to an accounting, Covered Entity will communicate the decision to Business Associate. Business Associate will provide information to Covered Entity that will enable Covered Entity to meet its accounting obligations. If Business

Associate receives an Individual's request for an accounting, Business Associate shall forward such request to Covered Entity within five (5) business days.

C. Permitted Uses and Disclosures by Business Associate

Except as otherwise limited in this Addendum or by Applicable Law, Business Associate may:

1. Use or disclose PHI to perform functions, activities, or services for or on behalf of Covered Entity, as specified in the Service Agreement between the Parties and in this Addendum, provided that such use or disclosure (i) is consistent with Covered Entity's Notice of Privacy Practices and (ii) would not violate HIPAA or the Privacy Rule if done by Covered Entity;
2. Use PHI for the proper management and administration of Business Associate or to carry out the legal responsibilities of Business Associate;
3. Disclose PHI for the proper management and administration of Business Associate, provided that (i) Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached or (ii) the disclosures are Required By Law; and
4. Use PHI to provide Data Aggregation services to Covered Entity as permitted by 42 CFR § 164.504(e)(2)(i)(B).

III. RIGHTS AND OBLIGATIONS OF COVERED ENTITY

A. Privacy Practices and Restrictions

1. Upon request, Covered Entity shall provide Business Associate with the notice of privacy practices that Covered Entity produces in accordance with 45 CFR § 164.520. If Covered Entity subsequently revises the notice, Covered Entity shall provide a copy of the revised notice to Business Associate.
2. Covered Entity shall notify Business Associate of any restriction to the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 CFR § 164.522. Covered Entity shall provide Business Associate with any changes in, or revocation of, permission by an Individual to use or disclose PHI, if such changes affect Business Associate's permitted or required uses and disclosures.

B. Permissible Requests by Covered Entity

Covered Entity shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under the Privacy Rule if done by Covered Entity.

IV. TERM AND TERMINATION

- A. Term.** The term of this Addendum shall begin on the Effective Date, and shall end upon the termination of the Services Agreement or upon termination for cause as set forth in the following Section IV.B, whichever is earlier.
- B. Termination for Cause.** Upon any Party's knowledge of a material breach of this Addendum by another Party, the nonbreaching Party shall have the following rights:
1. If the breach is curable, the nonbreaching party may provide an opportunity for the other Party to cure the breach or end the violation. Alternatively, or if the other Party fails to cure the breach or end the violation, the nonbreaching Party may terminate this Addendum and the Services Agreement.
 2. If the breach is not curable, the nonbreaching Party may immediately terminate this Addendum and the Services Agreement.
 3. If termination is not feasible, the nonbreaching Party may report the problem to the Secretary.
- C. Effect of Termination.**

1. Except as provided in the following paragraph, upon termination of this Addendum, for any reason, Business Associate shall return or destroy all PHI within its possession or control, and

all PHI that is in the possession or control of Business Associate's subcontractors or agents. Business Associate shall retain no copies of the PHI.

2. If Business Associate determines that returning or destroying the PHI is infeasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction infeasible. Business Associate shall extend the protections of this Addendum to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such PHI.

V. Miscellaneous

- A. **Electronic Health Records.** The Parties agree that Business Associate shall not maintain any "electronic health record" or "personal health record," as those terms are defined in ARRA, for or on behalf of Covered Entity. As such, Business Associate has no obligation to document disclosures that are exempt from the accounting requirement under 45 CFR § 164.528(1)(i)-(ix), and Covered Entity agrees not to include Business Associate on any list Covered Entity produces pursuant to ARRA § 13405(c)(3).
- B. **Regulatory References.** A reference in this Addendum to a section in any Applicable Law means the section in effect or as amended, and for which compliance is required.
- C. **Amendment.** The Parties agree to take such action as is necessary to amend this Addendum from time to time as is necessary for Covered Entity to comply with the requirements of Applicable Law. All amendments to this Addendum, except those occurring by operation of law, shall be in writing and signed by both Parties.
- D. **Survival.** The respective rights and obligations of Business Associate under Section IV.C. of this Addendum shall survive the term and termination of this Addendum.
- E. **Interpretation.** Any ambiguity in this Addendum shall be resolved in favor of a meaning that permits Covered Entity to comply with Applicable Law.
- F. **No Third Party Beneficiaries.** Nothing express or implied in this Addendum is intended to confer, nor shall anything herein confer upon any person, other than Covered Entity, Business Associate and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.
- G. **Assignment.** No assignment of rights or obligations under this Addendum shall be made by either Party without the prior written consent of the other Party; provided however, that Business Associate may assign this Addendum to an affiliate.
- H. **Effect on Addendum.** Except as specifically required to implement the purposes of this Addendum, or to the extent inconsistent with this Addendum, all other terms of the underlying Services Agreement shall remain in force and effect.

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

This First Amendment to the Fee for Service Agreement ("Agreement") is effective July 1, 2016, (the "Effective Date") and is entered into by and between EyeMed Vision Care, L.L.C. ("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 Dr. 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; and

WHEREAS, pursuant to III.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 July 1, 2016 for a term of thirty (30) 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 July 1, 2016.

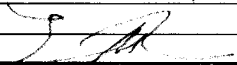

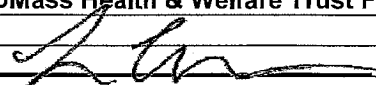
EyeMed Vision Care, L.L.C.	First American Administrators, Inc.
By: 	By: 
Name: <u>Jason M. Roma</u>	Name: <u>Jason M. Roma</u>
Title: <u>SVP</u>	Title: <u>SVP</u>
Date: <u>8/24/16</u>	Date: <u>8/24/16</u>
UAW/UMass Health & Welfare Trust Fund	
By: 	
Name: <u>Leslie Edwards Davis</u>	
Title: <u>Senior Benefits Specialist</u>	
Date: <u>8/11/2016</u>	

Exhibit B-Benefit Schedule

UMass Post Doctoral Unit
EyeMed Select Plan H: Fee For Service
 Employer pays 100% or more - OR - Bundled With Group Medical or Dental
 Option 1

Version 7

	Member Cost In-Network	
Exam with Dilatation Necessary	\$10 Copay	\$50
Retinal Imaging Benefit	Up to \$39	N/A
Exam Options:		
Standard Contact Lens Fit and Follow-Up:	Up to \$40	N/A
Premium Contact Lens Fit and Follow-Up:	10% off Retail Price	N/A
Frames:		
Any available frame at provider location	\$0 Copay; \$150 Allowance, 20% off balance over \$150	\$90
Standard Plastic Lenses		
Single Vision	\$10 Copay	\$42
Bifocal	\$10 Copay	\$78
Trifocal	\$10 Copay	\$130
Standard Progressive Lens	\$10 Copay	\$78
Premium Progressive Lens	\$10 Copay, 10% off Balance over \$150 Allowance	\$196
Lens Options:		
UV Treatment	\$15	N/A
Tint (Solid and Gradient)	\$15	N/A
Standard Plastic Scratch Coating	\$15	N/A
Standard Polycarbonate - Adults	\$40	N/A
Standard Polycarbonate - Kids under 25	\$40	N/A
Standard Anti-Reflective Coating	\$10	N/A
Polarized	20% off Retail Price	N/A
Other Add Ons	20% off Retail Price	N/A
Contact Lenses		
(Protect lens allowance includes materials only)		
Conventional	\$0 Copay; \$135 allowance, 15% off balance over \$135	\$106
Disposable	\$0 Copay; \$135 allowance, plus balance over \$135	\$108
Medically Necessary	\$0 Copay, Paid in Full	\$210
Laser Vision Correction		
Lasek or PRK from U.S. Laser Network	15% off Retail Price or 5% off promotional price	N/A
Additional Pairs Benefit:	Members also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used.	N/A
Frequency:		
Examination	Once every 12 months	
Lenses	Once every 12 months	
Contact	Once every 12 months	
Frame	Once every 12 months	
Monthly Administrative Fee		
Per Subscriber Per Month (Composite)	\$0.92	

All plans are based on a 30-month contract term and 30-month rate guarantee.

Premium is subject to adjustment over 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 laws, local or amendments by Federal or State regulatory agencies.

* Member Reimbursement Out-of-Network will be the lesser of the listed amount or the member's actual cost from the out-of-network provider. 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.

** Group Contract Rate per Service will be the lesser of the listed amount or the Provider Contract Rate.

Additional Discounts:

Member receives a 20% discount on items not covered by the plan at network providers. Discount does not apply to EyeMed Provider's professional services, or contact lenses. Plan discounts cannot be combined with any other discounts or promotional offers. Services or materials provided by any other group benefit plan providing vision care may not be covered.

Members also receive 15% off retail price or 5% off promotional price for Lasek or PRK from the U.S. Laser Network, owned and operated by LCA Vision.

After initial purchase, replacement contact lenses may be obtained via the Internet at substantial savings, and mailed directly to the member. Details are available at www.eyemedvisioncare.com.

The contact lens benefit allowance is not applicable to this service.

Benefit Allowances provide no remaining balance for future use within the same benefit frequency.

Certain brand name Vision Materials which the manufacturer imposes a no-discount practice.

Rates are valid only when the quoted plan is the sole stand-alone vision plan offered by the group.

Rates are valid for groups domiciled in the State of MA.

Fees quoted will be valid until the 7/1/2016 plan implementation date. Date quoted: 5/10/2016.

Rates assume greater than 20% employer contribution for employees and dependents or that the vision program is funded with medical/dental benefit.

Plan Exclusions:

- 1) Orthoptic or vision training; subnormal vision aids and any associated supplemental testing; Amblyopia therapy; 2) Medical and/or surgical treatment of the eye, eyes or supporting structures; 3) Any eye or vision condition, or any corrective eyewear required by a policyholder as a condition of employment; 4) Safety eyewear; 5) 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 subdivision thereof; 6) Plans (non-prescription) lenses and/or contact lenses; 7) Non-prescription sunglasses; 8) Two pair of glasses in lieu of bifocals; 9) 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 30 days from the date of such order; 10) Services or materials provided by any other group benefit plan providing vision care; 11) Loss or broken lenses, frames, repairs, or contact lenses will not be replaced except in the next benefit frequency when Vision Materials would next become available.

If UMass Post Doctoral Unit has chosen this benefit design, sign here:

Signature

5/13/2016

Date

T00

For PD Unit, 9878760 effective 7/1/2016

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

This Second Amendment to the Fee for Service Agreement ("Agreement") is effective July 1, 2019, (the "Effective Date") and is entered into by and between EyeMed Vision Care, L.L.C. ("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, pursuant to III.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:

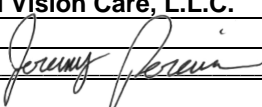
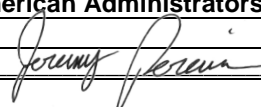

B. TERM

The Agreement shall commence on the July 1, 2019 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 July 1, 2019.

EyeMed Vision Care, L.L.C.	First American Administrators, Inc.
By: 	By: 
Name: <u>Jeremy Pereira</u>	Name: <u>Jeremy Pereira</u>
Title: <u>VP, Sales & Account Mgmt</u>	Title: <u>VP, Sales & Account Mgmt</u>
Date: <u>November 6, 2019</u>	Date: <u>November 6, 2019</u>
UAW/UMass Health & Welfare Trust Fund	UAW/UMass Health & Welfare Trust Fund
By: 	By: _____
Name: <u>Leslie Edwards Davis</u>	Name: _____
Title: <u>Director of Benefit Programs</u>	Title: _____
Date: <u>10/24/2019</u>	Date: _____

Reviewed As to Form by EyeMed Legal:



Exhibit B-Benefit Schedule – Page 1



UAW UMass Post Doctoral Unit
 Fee for Service Plan H, Fee For Service
 Employer pays 80% or more -OR- Bundled With Group Medical or Dental
 Option 1

1000007

Vision Care Services	Member Cost In-Network	Member Out-of-Network Reimbursement* & Group Charge Diff. of Network
Exam with Dilation as Necessary	\$10 Copay	\$50
Retinal Imaging Benefit	Up to \$35	N/A
Exam Options: Standard Contact Lens Fit and Follow-Up: Premium Contact Lens Fit and Follow-Up:	Up to \$40 10% off Retail Price	N/A N/A
Frames: Any available frame at provider location	\$0 Copay; \$150 Allowance, 20% off balance over \$150	\$90
Standard Plastic Lenses Single Vision Bifocal Trifocal Standard Progressive Lenses Premium Progressive Lenses	\$10 Copay \$10 Copay \$10 Copay \$10 Copay See attached Fixed Premium Progressive price list.	\$40 \$78 \$130 \$78 \$78
Lens Options: UV Treatment Tint (Solid and Gradient) Standard Plastic Scratch Coating Standard Polycarbonate - Adults Standard Polycarbonate - Kids under 26 Standard Anti-Reflective Coating Polarized Premium Anti-Reflective Other Add-Ons	\$15 \$15 \$15 \$40 \$40 \$45 20% off Retail Price See attached Fixed Premium Anti-Reflective Coating Int. 20% off Retail Price	N/A N/A N/A N/A N/A N/A N/A N/A
Contact Lenses (Contact lens allowance includes materials only) Conventional Disposable Medically Necessary	\$0 Copay; \$150 allowance, 15% off balance over \$150 \$0 Copay; \$150 allowance, plus balance over \$150 \$0 Copay; Retail Price	\$120 \$120 \$210
Laser Vision Correction Lasek or PRK from U.S. Laser Network	15% off Retail Price or 5% off promotional price	N/A
Amplifon Hearing Health Care	Hearing Health Care from Amplifon Hearing Health Care Network Members receive a 40% discount off hearing exams and a low price guarantee on discounted hearing aids.	N/A
Additional Pairs Benefit:	Members also receive a 40% discount off complete pair eyeglass purchase and a 15% discount off conventional contact lenses once the funded benefit has been used.	N/A
Frequencies: Examination Lenses Contact Lenses Frame	Once every 12 months Once every 12 months Once every 12 months Once every 12 months	
Monthly Administrative Fee Per Subscriber Per Month (Composite)	\$0.43	

UAW (UAW Trust Fund) and UMare Post Doctoral Unit agrees to be financially responsible for (i) the actual Provider Contracted Reimbursement rate per service above less applicable copay and (ii) the Monthly Administrative Fee.

All plans are based on a 48 month contract term and 48 month rate guarantee.

Premium 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

* Member Reimbursement Out-of-Network will be the lesser of the listed amount or the member's actual cost from the out-of-network provider. In certain states members may be required to pay the full retail rate and net 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.

Additional Discounts:

Member receives a 20% discount on items not covered by the plan at network providers. Discount does not apply to EyeMed Provider's professional services, or contact lenses. Plan discounts cannot be combined with any other discounts or promotional offers. Services or materials provided by any other group benefit plan providing vision care may not be covered.

Members also receive 15% off retail price or 5% off promotional price for Lasek or PRK from the U.S. Laser Network, owned and operated by LCA Vision.

After initial purchase, replacement contact lenses may be obtained via the Internet at substantial savings and mailed directly to the member. Details are available at www.eyemedvisioncare.com.

The contact lens benefit allowance is not applicable to this service.

Benefit Allowances provide no remaining balance for future use within the same Benefit Frequency.

Certain Brand name Vision Materials in which the manufacturer imposes a no-discount practice.

Rates are valid only when the quoted plan is the sole stand-alone vision plan offered by the group.

Rates are valid for groups domiciled in the State of MA.

Rates quoted will be valid until the 7/1/2016 plan implementation date. Date quoted: 6/27/2016.

Rates assume greater than 80% Employer contribution for employees and dependents or that the vision program is bundled with medical/dental benefit.

Plan Exclusions:

- Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Antireflective lenses; 2) Medical and/or surgical treatment of the eye, eyes or supporting structures;
- Any eye or vision examination, or any corrective eyewear required by a policyholder as a condition of employment; Safety eyewear;
- 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;
- Plans (non-prescription) lenses and/or contact lenses; 6) Non-prescription sunglasses; 7) Two pair of glasses in lieu of bifocals;
- Services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended and delivered;
- and the services rendered to the insured Person are within 31 days from the date of such order; 9) Services or materials provided by any other group benefit plan providing vision care;
- Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available.

If UAW/UMass Post Doctoral Unit has chosen this benefit design, sign here:

Signature

8/21/2018

Date

Leslie Edwards Davis, Director of Benefit Programs

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Exhibit B-Benefit Schedule – Page 2

UAW UMass Post Doctoral Unit
Supplement
Option 1

Progressive Price List*	Member Cost In-Network (Includes Lens Copay)
Standard Progressive	\$10 copay
Premium Progressives as Follows:	
Tier 1	\$30 Copay
Tier 2	\$40 Copay
Tier 3	\$55 Copay
Tier 4	\$10 copay, 80% of charge less \$120 Allowance
Anti-Reflective Coating Price List*	Member Cost In-Network
Standard Anti-Reflective Coating	\$45
Premium Anti-Reflective Coatings as Follows:	
Tier 1	\$57
Tier 2	\$68
Tier 3	80% of charge
Other Add-ons Price List	Member Cost In-Network
Photochromic (Plastic)	80% of Retail
Polarized	80% of charge
EyeMed Vision Care 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.	

For a current listing of brands by tier, go to:

<http://www.eyemedvisioncare.com/theme/pdf/microsite-template/eyemedlenslist.pdf>



UAW/UMass Health & Welfare Trust Fund
6 University Dr.
Suite 206-229
Amherst, MA 01002

August 19, 2021

Group Number: TM 05993054-G

Dear Leslie Edwards Davis:

Thank you again for selecting MetLife as your Group Benefit Carrier.

We are pleased to advise you that the installation of your new coverage(s) with us is now complete!

Enclosed is your MetLife policy, which includes your Application for Group Insurance, and the applicable certificate(s). Coverage certificates must be distributed to all of your insured employees. If you did not choose to receive certificates electronically, they will be shipped separately within the next few days. Please be advised that the certificates include the MetLife Gramm-Leach-Bliley (GLB) Privacy Notice.

We are pleased to provide you access to our online administrative manual at www.metlifeadminmanual.com/am1. This site provides you the most current and important administration information such as: required state Life and Health Guaranty Association Notices (to inform you about state protections in case of insurer insolvency), forms, and other helpful tools.

I'd like to remind you that our toll-free Customer Service number, 1-800-275-4638, is available to you and your employees. Option 2 will allow you, as Administrator, to accomplish a number of self-service functions. For example, among other actions, you can terminate an employee's coverage or check your premium balance or the last payment posted. (You will need your Customer number and Division when using the toll-free number. These numbers are referenced on your monthly billing statement).

If you are a customer with employees working in the State of Connecticut, please review the "CT Employee Terminations" topic found in MetLife's online Administration Manual under the appropriate coverage section www.metlifeadminmanual.com/am1.

We are committed to ensuring that our customers know how intermediaries are paid. To keep you informed, we have enclosed a document titled, "Intermediary and Producer Compensation Notice."

Our goal is to provide you with an exceptional level of consistent and responsive service. Reinforcing our brand positioning in the marketplace, *MetLife is easier*, we aim to make you and your employees' experience with MetLife both productive and pleasant.

Sincerely,
Small Market Customer Service Team

Enclosures: Policy/Certificate
Cc: (Broker)

U.S. Business Intermediary and Producer Compensation Notice

Metropolitan Life Insurance Company, Metropolitan Tower Life Insurance Company, and Metropolitan General Insurance Company (collectively herein called “MetLife”), enters into arrangements concerning the sale, servicing and/or renewal of MetLife group insurance and certain other group-related products (“Products”) with brokers, agents, consultants, third party administrators, general agents, associations, and other parties that may participate in the sale, servicing and/or renewal of such products (*each an “Intermediary”*). MetLife may pay your Intermediary compensation, which may include, among other things, base compensation, supplemental compensation and/or a service fee. MetLife may pay compensation for the sale, servicing and/or renewal of products, or remit compensation to an Intermediary on your behalf. Your Intermediary may also be owned by, controlled by or affiliated with another person or party, which may also be an Intermediary and who may also perform marketing and/or administration services in connection with your products and be paid compensation by MetLife.

Base compensation, which may vary from case to case and may change if you renew your products with MetLife, may be payable to your Intermediary as a percentage of premium or a fixed dollar amount. MetLife may also pay your Intermediary compensation that is based upon your Intermediary placing and/or retaining a certain volume of business (*number of products sold or dollar value of premium*) with MetLife. In addition, supplemental compensation may be payable to your Intermediary for eligible Products. Under MetLife’s current supplemental compensation plan (SCP), the amount payable as supplemental compensation may range from 0% to 8% of premium. The supplemental compensation percentage may be based on one or more of: (1) the number of products sold through your Intermediary during a one-year period, or other defined period; (2) the amount of premium or fees with respect to products sold through your Intermediary during a one-year period; (3) the persistency percentage of products inforce through your Intermediary during a one-year period; (4) the block growth of the products inforce through your Intermediary during a one-year period; (5) premium growth during a one-year period; or (6) a flat amount, fixed percentage or sliding scale of the premium for products as set by MetLife. The supplemental compensation percentage will be set by MetLife based on the achievement of the outlined qualification criteria and it may not be changed until the following SCP plan year. As such, the supplemental compensation percentage may vary from year to year, but will not exceed 8% under the current supplemental compensation plan.

The cost of supplemental compensation is not directly charged to the price of our products except as an allocation of overhead expense, which is applied to all eligible group insurance products, whether or not supplemental compensation is paid in relation to a particular sale or renewal. As a result, your rates will not differ by whether or not your Intermediary receives supplemental compensation. If your Intermediary collects the premium from you in relation to your products, your Intermediary may earn a return on such amounts. Additionally, MetLife may have a variety of other relationships with your Intermediary or its affiliates, or with other parties, that involve the payment of compensation and benefits that may or may not be related to your relationship with MetLife (*e.g., insurance and employee benefits exchanges, enrollment firms and platforms, sales contests, consulting agreements, participation in an insurer panel, or reinsurance arrangements*).

More information about the eligibility criteria, limitations, payment calculations and other terms and conditions under MetLife’s base compensation and supplemental compensation plans can be found on MetLife’s Website at www.metlife.com/business-and-brokers/broker-resources/broker-compensation. Questions regarding Intermediary compensation can be directed to ask4met@metlifeservice.com, or if you would like to speak to someone about Intermediary compensation, please call (800) ASK 4MET. In addition to the compensation paid to an Intermediary, MetLife may also pay compensation to your representative. Compensation paid to your representative is for participating in the sale, servicing, and/or renewal of products, and the compensation paid may vary based on a number of factors including the type of product(s) and volume of business sold. If you are the person or entity to be charged under an insurance policy or annuity contract, you may request additional information about the compensation your representative expects to receive as a result of the sale or concerning compensation for any alternative quotes presented, by contacting your representative or calling (866) 796-1800.

Non-U.S. Coverage

When providing you with information concerning an eligible group insurance policy issued or proposed to your affiliate or subsidiary outside the United States by a MetLife affiliate or by other locally licensed insurers that are members of the MAXIS Global Benefits Network (MAXIS GBN), New York insurance law requires the person providing the information to be licensed as an insurance broker. In this capacity, the information provided to you will only be on behalf of such insurers and not on behalf of MetLife or any other insurer that is not a member of MAXIS GBN. Please note that while MetLife is a member of MAXIS GBN and is licensed to transact insurance business in New York, the other MAXIS GBN member insurers are not licensed or authorized to do business in New York. The group insurance policies they issue are for coverage outside the United States and are governed by the laws of the country they were issued in. These policies have not been approved by the New York Superintendent of Financial Services, are not subject to all of the laws of New York, and are not protected by the New York State Guaranty Fund.



Metropolitan Life Insurance Company
200 Park Avenue, New York, New York 10166

POLICY ENDORSEMENT

Group Policy No.: TM 05993054-G
Policyholder: UAW/UMass Health & Welfare Trust Fund
Effective date: September 1, 2021

Metropolitan Life Insurance Company ("MetLife"), a stock company, issues this endorsement to change the following:

In the "END OF INSURANCE PROVIDED BY THIS POLICY" section of the Group Policy (which addresses the conditions under which MetLife may end the Group Policy) item 4 is changed as follows:

"4. on any Policy Anniversary, by giving the Policyholder 31 days advance Written notice."

This endorsement is to be attached to and made a part of the policy. This endorsement is subject to the terms and provisions of the policy.

A handwritten signature in blue ink, appearing to read 'M. Khalaf', with a stylized flourish at the end.

Michel Khalaf
President



Metropolitan Life Insurance Company
200 Park Avenue, New York, New York 10166-0188

Metropolitan Life Insurance Company ("MetLife"), a stock company, will pay the benefits specified in the Exhibits of this policy subject to the terms and provisions of this policy. The Schedule of Exhibits lists each Exhibit to this policy, to whom it applies and its effective date.

Policyholder: UAW/UMass Health & Welfare Trust Fund

Group Policy No.: TM 05993054-G

EFFECTIVE DATE:

This policy will take effect on September 1, 2021.

POLICY ANNIVERSARIES

Policy anniversaries will be September 1, 2022 and each subsequent September 1.

PREMIUM PAYMENTS

This policy is issued in return for the payment by the Policyholder of required Premiums. Premiums are payable at the home office of MetLife or to its authorized agent. The first Premium is due on and must be paid by this policy's effective date. Any later Premiums are due monthly in advance on the first day of each Policy Month. These dates are the Premium Due Dates.

POLICY SITUS

This policy is issued for delivery in and governed by the laws of Massachusetts.

Signed as of this policy's effective date at MetLife's home office in New York, New York.

Timothy J. Ring
Secretary

Michel Khalaf
President

Signed by
(A licensed MetLife agent or resident agent as required by law.)

Date: 10/4/2021

**GROUP BASIC TERM LIFE AND ACCIDENT
AND HEALTH INSURANCE POLICY**

NON-DIVIDEND PAYING

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DEFINITIONS

As used in this policy, the terms listed below will have the meanings defined below. When defined terms are used in this policy, they will appear with initial capitalization. The plural use of a term defined in the singular will share the same meaning.

Contribution means the amount the Policyholder may require the Employee to pay towards the total Premium that MetLife charges for the insurance provided by this policy.

Contributory Insurance means insurance for which the Policyholder may require the Employee to pay at least part of the Premium.

Covered Person means an Employee and/or a Dependent as set forth in the Exhibit which applies to the Employee.

Employee is described in the Exhibit which applies to the Employee.

Employer means the Policyholder shown on page 1.

Noncontributory Insurance means insurance for which the Policyholder may not require the Employee to pay any part of the Premium.

Policy Anniversary is defined on page 1.

Policy Month The first Policy Month will begin on the effective date shown on page 1. Subsequent Policy Months will begin on the same day of each subsequent calendar month.

Premium means the amount the Policyholder must pay to MetLife for all the insurance provided under this policy.

Premium Due Date is defined on page 1.

Signed means any symbol or method executed or adopted by a person with the present intention to authenticate a record, and which is on or transmitted by paper or electronic media, and which is consistent with applicable law.

Written or **Writing** means a record which is on or transmitted by paper or electronic media, and which is consistent with applicable law.

SCHEDULE OF INSURANCE

The Schedules of Insurance which apply under this policy are set forth in the Exhibits.

ELIGIBILITY AND EFFECTIVE DATES OF INSURANCE

The Eligibility and Effective Dates of Insurance provisions that apply under this policy are set forth in the Exhibits.

CONTRIBUTIONS

The Policyholder will not require an Employee to contribute to the cost of Noncontributory Insurance.

The maximum amount that an Employee may be required to contribute to the cost of Contributory Insurance will not exceed the Premium charged for the amounts of such insurance.

PREMIUM RATE(S)

Initial Rate(s)

The initial Premium rate(s) are shown in Exhibit 1.

Frequency of Premium Payment

Premiums for this policy will be paid as shown on page 1. MetLife and the Policyholder may agree that payment be made in advance every 3, 6, or 12 months.

Computation of Premium

The Premium due on any Premium Due Date is determined by the total amount of insurance provided by this policy on such Premium Due Date, multiplied by the appropriate Premium rate(s) which are then in effect subject to any Premium adjustments, if applicable.

MetLife may use any reasonable method to compute Premiums due under this policy.

Premiums for Changes in Insurance

For insurance that takes effect after the first day of a Policy Month, Premium will be charged from the first day of the next Policy Month. However, if a policy amendment or evidence of good health is required for such insurance, Premium will be charged as of the date such insurance takes effect.

If this policy ends, or if insurance ends for a class of persons, Premium will be charged to the date insurance ends. If insurance ends for other reasons, Premium will be charged to the end of the Policy Month in which insurance ends.

PREMIUM RATES (continued)

Right to Change Premium Rates

MetLife may change Premium rates for changes which materially affect the risk assumed for the insurance provided by this policy, as follows:

1. when this policy is amended or endorsed;
2. when a class of eligible persons is added to or deleted from this policy for any reason including corporate restructuring, acquisition, spin-off or similar situations;
3. when a Policyholder's subsidiary, affiliate, division, branch or other similar entity is added to or deleted from this policy for any reason including corporate restructuring, acquisition, spin-off or similar situations;
4. when there is a significant change in the geographic distribution of insured Employees;
5. when applicable law requires a change in:
 - a. the insurance provided by this policy; and/or
 - b. the class of persons eligible for insurance under this policy; or
6. when a Premium Due Date coincides with or next follows:
 - a. a change greater than 25% in the number of Covered Persons since the later of the policy Effective Date and the last date Premium rates were changed; or
 - b. a change greater than 25% in the amount of insurance provided by this policy since the later of the policy Effective Date and the last date Premium rates were changed.

In addition, MetLife may change Premium rates:

1. except as may be stated in Exhibit 1, on any date on or after the first Policy Anniversary; this will be done no more frequently than every 12 months and only if MetLife notifies the Policyholder, in Writing, at least 31 days before such change; and
2. on any other date agreed to by MetLife and the Policyholder.

The new Premium rates will apply only to Premiums due on or after the date the rate change takes effect.

GRACE PERIOD

Each Premium due after the effective date of this policy may be paid up to 31 days after its Premium Due Date. This period is the grace period. The insurance provided by this policy will stay in effect during this period. MetLife will notify the Policyholder in Writing that, if the Premium is not paid by the end of the grace period, this policy will end at the end of the last day of the grace period. If MetLife fails to give Written notice to the Policyholder, this policy will continue in effect until the date such notice is given.

Policyholder's intent to end this policy during the grace period. The Policyholder may notify MetLife in Writing prior to the end of the grace period of its intent to end this policy before the end of the grace period. In this case, this policy will end on the later of:

1. the date stated in the notice; or
2. the date MetLife receives the notice.

GRACE PERIOD (continued)

If the Policyholder replaces this policy with another group insurance policy but does not give MetLife notice of intent to end this policy, the grace period provisions will apply.

Grace period extensions. MetLife may extend the grace period by giving Written notice to the Policyholder. Such notice will state the date this policy will end if the Premium remains unpaid.

Premiums must be paid for a grace period, any extension of such period and any period insurance under this policy was in effect for which Premium was not paid.

END OF INSURANCE PROVIDED BY THIS POLICY

The Policyholder can end this policy by giving 60 days advance Written notice to MetLife. The policy will end on the later of:

1. the date stated in the notice; or
2. the date MetLife receives the notice.

MetLife can end this policy as follows:

1. on the date Premium is not paid when due, subject to the Grace Period provisions; or
2. on any Premium Due Date, by giving the Policyholder 31 days advance Written notice, if less than:
 - a. for Life Insurance and Accidental Death or Dismemberment Insurance for Employees, 75% of persons eligible under this policy are insured for Contributory Insurance;
 - b. 100% of persons eligible under this policy are insured for Noncontributory Insurance; or
 - c. 5 Employees are insured by this policy;
3. on any Premium Due Date, by giving the Policyholder 60 days advance Written notice, if the Policyholder fails to provide information on a timely basis or perform any obligations required by this policy or any applicable law; or
4. on any Policy Anniversary, except during a Rate Guarantee Period as may be provided in Exhibit 1, by giving the Policyholder 31 days advance Written notice.

This policy will end on the date on which the last certificate in effect under this policy ends.

If this policy ends, all Premiums due must be paid. If MetLife accepts Premium after the date this policy ends, such acceptance will not act to reinstate the policy. MetLife will refund any unearned Premium.

REINSTATEMENT

The Policyholder may request to reinstate this policy within one year from the date it ended. The request must be in Writing and it must provide MetLife with information that MetLife requires to consider such request. If MetLife approves the request, the policy will be reinstated on the date stated in Writing by MetLife.

GENERAL PROVISIONS

Entire Contract. The entire contract is made up of the following:

1. this policy, including its Exhibits;
2. the Policyholder's application; and
3. the amendments and endorsements to this policy, if any.

Policy Changes or Waivers. The terms and provisions of this policy may be changed, at any time, without the consent of the Covered Persons or anyone else with a beneficial interest in it. MetLife will issue amendments or endorsements to effect such changes. MetLife will only make changes that are consistent with applicable law. An amendment or endorsement will not affect the insurance provided under certificates issued before the effective date of the change, unless retroactivity is consistent with applicable law.

An officer of MetLife must approve in Writing any change or waiver of the terms and provisions of this policy. A sales representative, or other MetLife employee, who is not an officer of MetLife; does not have MetLife's authority to approve such changes or waivers. A change or waiver will be evidenced by an amendment Signed by an officer of MetLife and the Policyholder or an endorsement Signed by an officer of MetLife. A copy of the amendment or endorsement will be provided to the Policyholder for attachment to this policy.

Incontestability: Statements Made by the Policyholder. Any statement made by the Policyholder will be considered a representation and not a warranty. MetLife will not use such statement to avoid insurance, reduce benefits or defend a claim unless it is contained in a Written application. MetLife will not use such statement to contest life insurance after it has been in force for 2 years from its effective date, or date of last reinstatement, unless the statement is fraudulent.

Incontestability: Statements Made by Covered Persons. Any statement made by a Covered Person will be considered a representation and not a warranty. MetLife will not use such statement to avoid insurance, reduce benefits or defend a claim unless the following requirements are met:

1. the statement is in a Written application or enrollment form;
2. the Covered Person has Signed the application or enrollment form; and
3. a copy of the application or enrollment form has been given to the Covered Person or his beneficiary.

MetLife will not use a Covered Person's statements which relate to insurability to contest life insurance after it has been in force for 2 years during his life, unless the statement is fraudulent. In addition, MetLife will not use such statements to contest an increase or benefit addition to such insurance after the increase or benefit has been in force for 2 years during his life, unless the statement is fraudulent.

Certificates. MetLife will issue certificates to the Policyholder for delivery to each Covered Person, as appropriate. Such certificate will describe the Covered Person's benefits and rights under this policy. "Certificate" includes any of MetLife's insurance riders, notices or other attachments to the certificate.

GENERAL PROVISIONS (continued)

Assignment. The life and accidental death or dismemberment insurance rights and benefits under this policy are assignable by gift. An Employee may have made an irrevocable assignment under a group policy that this policy replaces. In this case, MetLife will recognize the assignee(s) under such assignment as owner(s) of the Employee's right, title and interest under this policy if:

1. a Written form satisfactory to MetLife, affirming this assignment, has been completed;
2. the Written form has been Signed by the Employer, assignee(s) and Policyholder; and
3. the Written form is delivered to MetLife for recording.

MetLife is not responsible for the validity of an assignment. All other insurance under this policy may not be assigned prior to a claim for benefits, except as required by law or as permitted by MetLife.

Information Needed and Policy Administration. All information necessary to compute Premiums and carry out the terms of this policy will be provided by the Policyholder to MetLife. Such information:

- Will be provided in a timely manner and in a format as agreed to by MetLife and the Policyholder;
- Will be provided, maintained and administered as agreed to in Writing by MetLife and the Policyholder; and
- If maintained by the Policyholder, may be examined by MetLife at any reasonable time.

If MetLife or the Policyholder makes a clerical error in keeping or providing the information, the Premium and/or benefits will be adjusted as warranted, according to the correct information. An error will not end insurance validly in effect, nor will it continue insurance validly ended or create insurance coverage where no coverage existed.

Any act undertaken by the Policyholder that relates to the insurance provided under this policy must be consistent with the terms of such insurance and with MetLife's requirements; including but not limited to the eligibility requirements of the Policyholder's plan as set forth in the certificates to this policy.

Misstatement of Age. If a Covered Person's age is misstated, the correct age will be used to determine if insurance is in effect and, as appropriate, adjust the Premium and/or benefits.

Non-Dividend Paying. This policy does not pay dividends.

Conformity with Law. If the terms and provisions of this policy do not conform to any applicable law, this policy shall be interpreted to so conform.

SCHEDULE OF EXHIBITS

Exhibit Number	Exhibit Type	Applies To	Effective Date
1	Schedule of Premium Rates	All Covered Persons	September 1, 2021
2	Certificate Forms	All Covered Persons	September 1, 2021

EXHIBIT 1

SCHEDULE OF PREMIUM RATES

The initial monthly Premium rates for the insurance provided by this policy are as follows:

Rate Guarantee Period

Subject to the Right to Change Premium Rates provision on page 7, the Premium rates for Life Benefits will be in effect from September 01, 2021 through June 30, 2023.

Subject to the Right to Change Premium Rates provision on page 7, the Premium rates for Accidental Death and Dismemberment Benefits will be in effect from September 01, 2021 through June 30, 2023.

Life Benefits for Employees: - \$0.068 per \$1,000 of Life Benefits in force hereunder.

Certain non-insured grief counseling services are included with contributory Basic Life Insurance coverage and provided at no additional premium. MetLife has arranged for these services to be provided to Employees through a third party service provider. MetLife is not responsible for providing or failing to provide these services nor is it liable for any negligence in the provision of such services by the third party service provider.

Employees who become insured for MetLife non-contributory Basic Life Insurance under the Group Policy are eligible to receive discounts of up to 10% off the service provider's standard price for certain funeral services including funeral, cremation and cemetery products and services provided by a third party national network of funeral and funeral planning providers while such insurance remains in effect. Employees who become insured for MetLife non-contributory Basic Life Insurance will also have access to funeral planning resources including funeral planning tools and concierge services provided by the same national network of providers. MetLife has arranged for these services and discounts to be provided to Employees and their spouses and children and the parents, grandparents and great-grandparents of the Employees and their spouses for no additional premium.

MetLife is not responsible for providing or failing to provide these services nor is it liable for any negligence in the provision of such services by the third party service provider.

Accidental Death or Dismemberment Benefits for Employees: - \$0.016 per \$1,000 of the Full Amount of Accidental Death or Dismemberment Benefits for Employees.

EXHIBIT 2

CERTIFICATE FORMS

Certificate Number	Certificate Form	Applies To	Effective Date
1	GCERT2000	All Active Full-Time Employees	September 1, 2021



Metropolitan Life Insurance Company
200 Park Avenue, New York, New York 10166

CERTIFICATE RIDER

Group Policy No.: TM 05993054-G

Employer: UAW/UMass Health & Welfare Trust Fund

Effective Date: September 1, 2021

The Certificate is changed as shown below:

The Certificate is revised to add the following:

"How We Will Pay Benefits

Unless the Beneficiary requests payment by check, when the Certificate states that We will pay benefits in "one sum", "lump sum", or a "single sum", We may pay the full benefit amount:

1. by check;
2. by establishing an account that earns interest and provides the Beneficiary with immediate access to the full benefit amount; or
3. by any other method that provides the Beneficiary with immediate access to the full benefit amount.

Other modes of payment may be available upon request. For details, call Our toll free number shown on the Certificate Face Page."

This rider is to be attached to and made a part of the Certificate.



Metropolitan Life Insurance Company
200 Park Avenue, New York, New York 10166-0188

CERTIFICATE OF INSURANCE

Metropolitan Life Insurance Company ("MetLife"), a stock company, certifies that You are insured for the benefits described in this certificate, subject to the provisions of this certificate. This certificate is issued to You under the Group Policy and it includes the terms and provisions of the Group Policy that describe Your insurance. **PLEASE READ THIS CERTIFICATE CAREFULLY.**

This certificate is part of the Group Policy. The Group Policy is a contract between MetLife and the Employer and may be changed or ended without Your consent or notice to You.

Employer: UAW/UMass Health & Welfare Trust Fund

Group Policy Number: TM 05993054-G

Type of Insurance: Basic Term Life & Accidental Death and
Dismemberment Insurance

MetLife Toll Free Number(s):
For General Information 1-800-275-4638

THIS CERTIFICATE ONLY DESCRIBES LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE.

**THE BENEFITS OF THE POLICY PROVIDING YOUR COVERAGE ARE GOVERNED PRIMARILY BY THE
LAW OF A STATE OTHER THAN FLORIDA.**

**THE GROUP INSURANCE POLICY PROVIDING COVERAGE UNDER THIS CERTIFICATE WAS ISSUED
IN A JURISDICTION OTHER THAN MARYLAND AND MAY NOT PROVIDE ALL THE BENEFITS
REQUIRED BY MARYLAND LAW.**

**WE ARE REQUIRED BY STATE LAW TO INCLUDE THE NOTICE(S) WHICH APPEAR ON THIS PAGE
AND IN THE NOTICE(S) SECTION WHICH FOLLOWS THIS PAGE. PLEASE READ THE(SE) NOTICE(S)
CAREFULLY.**

NOTICE FOR RESIDENTS OF TEXAS

Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company or HMO first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company or HMO. If you don't, you may lose your right to appeal.

Metropolitan Life Insurance Company

To get information or file a complaint with your insurance company or HMO:

Call: Corporate Consumer Relations Department at 1-800-438-6388

Toll-free: 1-800-438-6388

Email: Johnstown_Complaint_Referrals@metlife.com

Mail: Metropolitan Life Insurance Company
700 Quaker Lane
2nd Floor
Warwick, RI 02886

The Texas Department of Insurance

To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439

File a complaint: www.tdi.texas.gov

Email: ConsumerProtection@tdi.texas.gov

Mail: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

Metropolitan Life Insurance Company

Para obtener información o para presentar una queja ante su compañía de seguros o HMO:

Llame a: Departamento de Relaciones Corporativas del Consumidor al 1-800-438-6388

Teléfono gratuito: 1-800-438-6388

Correo electrónico: Johnstown_Complaint_Referrals@metlife.com

Dirección postal: Metropolitan Life Insurance Company
700 Quaker Lane
2nd Floor
Warwick, RI 02886

El Departamento de Seguros de Texas

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439

Presente una queja en: www.tdi.texas.gov

Correo electrónico: ConsumerProtection@tdi.texas.gov

Dirección postal: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

NOTICE FOR RESIDENTS OF ARKANSAS

If You have a question concerning Your coverage or a claim, first contact the Policyholder or group account administrator. If, after doing so, You still have a concern, You may call the toll free telephone number shown on the Certificate Face Page.

Policyholders have the right to file a complaint with the Arkansas Insurance Department (AID). You may call AID to request a complaint form at (800) 852-5494 or (501) 371-2640 or write the Department at:

Arkansas Insurance Department
Consumer Services Division
1 Commerce Way, Suite 102
Little Rock, Arkansas 72202

NOTICE FOR RESIDENTS OF CALIFORNIA

IMPORTANT NOTICE

TO OBTAIN ADDITIONAL INFORMATION, OR TO MAKE A COMPLAINT, CONTACT THE POLICYHOLDER OR METLIFE AT:

**METROPOLITAN LIFE INSURANCE COMPANY
ATTN: CONSUMER RELATIONS DEPARTMENT
500 SCHOOLHOUSE ROAD
JOHNSTOWN, PA 15904**

1-800-438-6388

IF, AFTER CONTACTING THE POLICYHOLDER AND/OR METLIFE, YOU FEEL THAT A SATISFACTORY SOLUTION HAS NOT BEEN REACHED, YOU MAY FILE A COMPLAINT WITH THE CALIFORNIA DEPARTMENT OF INSURANCE DEPARTMENT AT:

**DEPARTMENT OF INSURANCE
CONSUMER SERVICES
300 SOUTH SPRING STREET
LOS ANGELES, CA 90013**

WEBSITE: <http://www.insurance.ca.gov/>

**1-800-927-4357 (within California)
1-213-897-8921 (outside California)**

NOTICE FOR RESIDENTS OF CALIFORNIA

If Your certificate includes an exclusion for the voluntary intake or use by any means of any drug, medication or sedative, unless it is taken or used as prescribed by a Physician (or a similar exclusion), We will adjudicate your claim as follows:

We will exclude any Covered Loss as a consequence of being under the influence of any intoxicant or controlled substance unless administered on the advice of a Physician.

NOTICE FOR RESIDENTS OF GEORGIA

IMPORTANT NOTICE

The laws of the state of Georgia prohibit insurers from unfairly discriminating against any person based upon his or her status as a victim of family violence.

NOTICE FOR RESIDENTS OF IDAHO

If You have a question concerning Your coverage or a claim, first contact the Employer. If, after doing so, You still have a concern, You may call the toll free telephone number shown on the Certificate Face Page.

If You are still concerned after contacting both the Employer and MetLife, You should feel free to contact:

Idaho Department of Insurance
Consumer Affairs
700 West State Street, 3rd Floor
PO Box 83720
Boise, Idaho 83720-0043
1-800-721-3272 or www.DOI.Idaho.gov

NOTICE FOR RESIDENTS OF ILLINOIS

IMPORTANT NOTICE

To make a complaint to MetLife, You may write to:

MetLife
200 Park Avenue
New York, New York 10166

The address of the Illinois Department of Insurance is:

Illinois Department of Insurance
Public Services Division
Springfield, Illinois 62767

NOTICE FOR RESIDENTS OF INDIANA

Questions regarding your policy or coverage should be directed to:

**Metropolitan Life Insurance Company
1-800-275-4638**

If you (a) need the assistance of the government agency that regulates insurance; or (b) have a complaint you have been unable to resolve with your insurer you may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204

Consumer Hotline: (800) 622-4461; (317) 232-2395

Complaint can be filed electronically at *www.in.gov/doi*

NOTICE FOR RESIDENTS OF MISSOURI

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

EXCLUSIONS

If You reside in Missouri the exclusion for "suicide or attempted suicide" is as follows:

"suicide or attempted suicide while sane"

LIFE INSURANCE

GENERAL PROVISIONS

If You reside in Missouri the suicide provision is as follows:

Suicide

If You commit suicide within 1 year from the date Life Insurance for You takes effect, We will not pay such insurance and Our liability will be limited as follows:

- any premium paid by You will be returned to the Beneficiary.
- any premium paid by the Policyholder will be returned to the Policyholder.

If You commit suicide within 1 year from the date an increase in Your Life Insurance takes effect, We will pay to the Beneficiary the amount of Insurance in effect on the day before the increase. Any premium You paid for the increase will be returned to the Beneficiary. Any premium paid by the Policyholder for the increase will be returned to the Policyholder.

NOTICE FOR RESIDENTS OF NORTH DAKOTA

GENERAL PROVISIONS

If You reside in North Dakota the suicide provision is as follows:

Suicide

If You commit suicide within 1 year from the date Life Insurance for You takes effect, We will not pay such insurance and Our liability will be limited as follows:

- any premium paid by You will be returned to the Beneficiary.
- any premium paid by the Policyholder will be returned to the Policyholder.

If You commit suicide within 1 year from the date an increase in Your Life Insurance takes effect, We will pay to the Beneficiary the amount of Insurance in effect on the day before the increase. Any premium You paid for the increase will be returned to the Beneficiary. Any premium paid by the Policyholder for the increase will be returned to the Policyholder.

NOTICE FOR RESIDENTS OF NEW MEXICO

Consumer Complaint Notice

If You are a resident of New Mexico, Your coverage will be administered in accordance with the minimum applicable standards of New Mexico law. If You have concerns regarding a claim, premium, or other matters relating to this coverage, You may file a complaint with the New Mexico Office of Superintendent of Insurance (OSI) using the complaint form available on the OSI website and found at: <https://www.osi.state.nm.us/ConsumerAssistance/index.aspx>.

NOTICE FOR RESIDENTS OF TEXAS

THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.

NOTICE FOR RESIDENTS OF UTAH

Notice of Protection Provided by Utah Life and Health Insurance Guaranty Association

This notice provides a brief summary of the Utah Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Utah law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, health, or annuity insurance company becomes financially unable to meet its obligations and is taken over by its insurance regulatory agency. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Utah law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are:

- Life Insurance
 - o \$500,000 in death benefits
 - o \$200,000 in cash surrender or withdrawal values
- Health Insurance
 - o \$500,000 in hospital, medical and surgical insurance benefits
 - o \$500,000 in long-term care insurance benefits
 - o \$500,000 in disability income insurance benefits
 - o \$500,000 in other types of health insurance benefits
- Annuities
 - o \$250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is \$500,000. Special rules may apply with regard to hospital, medical and surgical insurance benefits.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. Coverage is conditioned on residency in this state and there are substantial limitations and exclusions. For a complete description of coverage, consult Utah Code, Title 31A, Chapter 28.

Insurance companies and agents are prohibited by Utah law to use the existence of the Association or its coverage to encourage you to purchase insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between Utah law and this notice, Utah law will control.

To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website at www.utlifega.org or contact:

Utah Life and Health Insurance Guaranty Assoc.
60 East South Temple, Suite 500
Salt Lake City UT 84111
(801) 320-9955

Utah Insurance Department
3110 State Office Building
Salt Lake City UT 84114-6901
(801) 538-3800

A written complaint about misuse of this Notice or the improper use of the existence of the Association may be filed with the Utah Insurance Department at the above address.

NOTICE FOR RESIDENTS OF VIRGINIA

IMPORTANT INFORMATION REGARDING YOUR INSURANCE

In the event You need to contact someone about this insurance for any reason please contact Your agent. If no agent was involved in the sale of this insurance, or if You have additional questions You may contact the insurance company issuing this insurance at the following address and telephone number:

MetLife
200 Park Avenue
New York, New York 10166
Attn: Corporate Consumer Relations Department

To phone in a claim related question, You may call Claims Customer Service at:
1-800-275-4638

If You have been unable to contact or obtain satisfaction from the company or the agent, You may contact the Virginia State Corporation Commission's Bureau of Insurance at:

Bureau of Insurance
Life and Health Division
P.O. Box 1157
Richmond, VA 23218-1157
1-804-371-9691 - phone
1-877-310-6560 - toll-free
1-804-371-9944 – fax
www.scc.virginia.gov - web address
BureauOfInsurance@scc.virginia.gov - email

Written correspondence is preferable so that a record of Your inquiry is maintained. When contacting Your agent, company or the Bureau of Insurance, have Your policy number available.

NOTICE FOR RESIDENTS OF THE STATE OF WASHINGTON

Washington law provides that the following apply to Your certificate:

Wherever the term "**Spouse**" appears in this certificate it shall, unless otherwise specified, be read to include Your Domestic Partner.

Domestic Partner means each of two people, one of whom is an Employee of the Employer, who have registered as each other's domestic partner, civil union partner or reciprocal beneficiary with a government agency where such registration is available.

Wherever the term "step-child" appears in this certificate it shall be read to include the children of Your Domestic Partner.

NOTICE FOR RESIDENTS OF WASHINGTON

LIFE INSURANCE

GENERAL PROVISIONS

The suicide provision is not applicable to residents of Washington.

NOTICE FOR RESIDENTS OF WASHINGTON

This non-insurance benefit does not constitute an insurance funded prearrangement contract, pursuant to RCW 18.39.255.

Employees who become insured for MetLife non-contributory Basic Life Insurance under the Group Policy are eligible to receive discounts of up to 10% off the service provider's standard price for certain funeral services including funeral, cremation and cemetery products and services provided by a third party national network of funeral and funeral planning providers while such insurance remains in effect. Employees who become insured for MetLife non-contributory Basic Life Insurance will also have access to funeral planning resources including funeral planning tools and concierge services provided by the same national network of providers. MetLife has arranged for these services and discounts to be provided to Employees and their spouses for no additional premium. MetLife is not responsible for providing or failing to provide these services nor is it liable for any negligence in the provision of such services by the third party service provider.

The discounts and planning services are not available in all jurisdictions and are subject to regulatory approval.

NOTICE FOR RESIDENTS OF WISCONSIN

KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

PROBLEMS WITH YOUR INSURANCE? - If you are having problems with your insurance company or agent, do not hesitate to contact the insurance company or agent to resolve your problem.

MetLife
Attn: Corporate Consumer Relations Department
200 Park Avenue
New York, NY 10166-0188
1-800-638-5433

You can also contact the **OFFICE OF THE COMMISSIONER OF INSURANCE**, a state agency which enforces Wisconsin's insurance laws, and file a complaint. You can contact the **OFFICE OF THE COMMISSIONER OF INSURANCE** by contacting:

Office of the Commissioner of Insurance
Complaints Department
P.O. Box 7873
Madison, WI 53707-7873
1-800-236-8517 outside of Madison or 608-266-0103 in Madison.

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SCHEDULE OF BENEFITS

This schedule shows the benefits that are available under the Group Policy. You will only be insured for the benefits:

- for which You become and remain eligible, and
- which You elect, if subject to election; and
- which are in effect.

BENEFIT

BENEFIT AMOUNT AND HIGHLIGHTS

Life Insurance For You

Basic Life Insurance

Basic Life Insurance for You is Portability Eligible Insurance

For All Active Full-Time Employees.....	\$10,000
Non-Medical Issue Amount.....	\$10,000
Accelerated Benefit Option.....	None

If You Are Age 65 Or Older

If You are over age 65 but under age 70 on Your effective date of insurance, the amount of Your Basic Life Insurance will be limited to 65% of such amount. On and after Your 70th birthday, the amount of such insurance will be 50% of the amount of such insurance in effect on the effective date of Your insurance. If You are age 70 or older on the effective date of Your insurance, the amounts of Your Basic Life Insurance on Your effective date of insurance will be limited to 50% of such amount.

If You are under age 65 on the effective date of Your insurance, the amounts of Your Basic Life Insurance on and after age 65 will be 65% of such insurance in effect on the day before Your 65th birthday. On and after Your 70th birthday, the amount of such insurance will be 50% of the amount of such insurance in effect on the day before Your 65th birthday.

Accidental Death and Dismemberment Insurance (AD&D) for You

Basic Accidental Death and Dismemberment Insurance for You is Portability Eligible Insurance

Full Amount for AD&D

For All Active Full-Time Employees.....	An amount equal to Your Life Insurance
---	--

If You Are Age 65 Or Older

If You are over age 65 but under age 70 on Your effective date of insurance, the amount of Your Accidental Death and Dismemberment Insurance will be limited to 65% of such amount. On and after Your 70th birthday, the amount of such insurance will be 50% of the amount of such insurance in effect on the effective date of Your insurance. If You are age 70 or older on the effective date of Your insurance, the amounts of Your Accidental Death and Dismemberment Insurance on Your effective date of insurance will be limited to 50% of such amount.

SCHEDULE OF BENEFITS (continued)

If You are under age 65 on the effective date of Your insurance, the amounts of Your Accidental Death and Dismemberment Insurance on and after age 65 will be 65% of such insurance in effect on the day before Your 65th birthday. On and after Your 70th birthday, the amount of such insurance will be 50% of the amount of such insurance in effect on the day before Your 65th birthday.

For All Active Full-Time Employees

Additional Benefits:

Air Bag Benefit.....	Yes
Seat Belt Benefit.....	Yes
Child Care Benefit.....	Yes
Common Carrier Benefit.....	Yes, an amount equal to the Basic AD&D Full Amount

Schedule of Covered Losses for Accidental Death and Dismemberment Insurance

All amounts listed are stated as percentages of the Full Amount.

Covered Losses

Loss of life.....	100%
Loss of an arm permanently severed at or above the elbow...	75%
Loss of a leg permanently severed at or above the knee.....	75%
Loss of a hand permanently severed at or above the wrist but below the elbow.....	50%
Loss of a foot permanently severed at or above the ankle but below the knee.....	50%
Loss of sight in one eye.....	50%

Loss of sight means permanent and uncorrectable loss of sight in the eye. Visual acuity must be 20/200 or worse in the eye or the field of vision must be less than 20 degrees.

Loss of any combination of hand, foot, or sight of one eye, as defined above.....	100%
Loss of the thumb and index finger of same hand.....	25%

Loss of thumb and index finger of same hand means that the thumb and index finger are permanently severed through or above the third joint from the tip of the index finger and the second joint from the tip of the thumb.

Loss of speech and loss of hearing.....	100%
Loss of speech or loss of hearing.....	50%

Loss of speech means the entire and irrecoverable loss of speech that continues for 6 consecutive months following the accidental injury.

Loss of hearing means the entire and irrecoverable loss of hearing in both ears that continues for 6 consecutive months following the accidental injury.

Paralysis of both arms and both legs.....	100%
Paralysis of both legs.....	50%
Paralysis of the arm and leg on either side of the body.....	50%
Paralysis of one arm or leg.....	25%

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SCHEDULE OF BENEFITS (continued)

Paralysis means loss of use of a limb, without severance. A Physician must determine the paralysis to be permanent, complete and irreversible.

Brain Damage..... **100%**

Brain Damage means permanent and irreversible physical damage to the brain causing the complete inability to perform all the substantial and material functions and activities normal to everyday life. Such damage must manifest itself within 30 days of the accidental injury, require a hospitalization of at least 5 days and persists for 12 consecutive months after the date of the accidental injury.

Coma..... 1% monthly, beginning on the 7th day of the Coma and for the duration of the Coma to a maximum of 60 months

Coma means a state of deep and total unconsciousness from which the comatose person cannot be aroused. Such state must begin within 30 days of the accidental injury and continue for 7 consecutive days.

Portability Eligible Life and AD&D Insurance

Life and AD&D Insurance For You:

Portability Eligible Life Insurance For You:

Basic Life Insurance:

Minimum Portability Eligible Life Insurance Amount..... \$10,000

Maximum Portability Eligible Life Insurance Amount..... The lesser of Your total Life Insurance in effect on the date You elect to Port or \$2,000,000.

Portability Eligible Accidental Death and Dismemberment Insurance For You:

Basic Accidental Death and Dismemberment Insurance:

Minimum Portability Eligible AD&D Insurance Amount..... \$10,000

Maximum Portability Eligible AD&D Insurance Amount..... The lesser of Your total AD&D Insurance in effect on the date You elect to Port or \$2,000,000.

If Your Portability Eligible Insurance ends due to the end of the Group Policy or the amendment of the Group Policy to end the Portability Eligible Insurance for an eligible class of which You are a member, the maximum amount of insurance that You may Port is the lesser of:

- the amount of Your Portability Eligible Insurance that ends under the Group Policy less the amount of Life and AD&D insurance for which You become eligible under any group policy issued to replace this Group Policy; or
- \$10,000.

DEFINITIONS

As used in this certificate, the terms listed below will have the meanings set forth below. When defined terms are used in this certificate, they will appear with initial capitalization. The plural use of a term defined in the singular will share the same meaning.

Actively at Work or Active Work means that You are performing all of the usual and customary duties of Your job on a Full-Time basis. This must be done at:

- the Employer's place of business;
- an alternate place approved by the Employer; or
- a location to which the Employer's business requires You to travel.

You will be deemed to be Actively at Work during weekends or Employer-approved vacations, holidays or business closures if You were Actively at Work on the last scheduled work day preceding such time off.

Beneficiary means the person(s) to whom We will pay insurance as determined in accordance with the General Provisions section.

Common Carrier means a government regulated entity that is in the business of transporting fare paying passengers. **The term does not include:**

- chartered or other privately arranged transportation;
- taxis; or
- limousines.

Contributory Insurance means insurance for which the Employer requires You to pay any part of the premium.

Full-Time means Active Work on the Employer's regular work schedule for the class of employees to which You belong. The work schedule must be at least 20 hours a week. Full-Time does not include temporary or seasonal employees.

Noncontributory Insurance means insurance for which the Employer does not require You to pay any part of the premium.

Physician means:

- a person licensed to practice medicine in the jurisdiction where such services are performed; or
- any other person whose services, according to applicable law, must be treated as Physician's services for purposes of the Group Policy. Each such person must be licensed in the jurisdiction where the service is performed and must act within the scope of that license. Such person must also be certified and/or registered if required by such jurisdiction.

The term does not include:

- You;
- Your Spouse; or
- any member of Your immediate family including Your and/or Your spouse's parents; children (natural, step or adopted); siblings; grandparents; or grandchildren.

Proof means Written evidence satisfactory to Us that a person has satisfied the conditions and requirements for any benefit described in this certificate. When a claim is made for any benefit described in this certificate, Proof must establish:

- the nature and extent of the loss or condition;
- Our obligation to pay the claim; and
- the claimant's right to receive payment.

Proof must be provided at the claimant's expense.

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Sickness means illness, disease or pregnancy, including complications of pregnancy.

DEFINITIONS (continued)

Signed means any symbol or method executed or adopted by a person with the present intention to authenticate a record, which is on or transmitted by paper or electronic media which is acceptable to Us and consistent with applicable law.

Spouse means Your lawful Spouse.

The term does not include any person who:

- is on active duty in the military of any country or international authority; however, active duty for this purpose does not include weekend or summer training for the reserve forces of the United States, including the National Guard; or
- is insured under the Group Policy as an employee.

We, Us and **Our** mean MetLife.

Written or **Writing** means a record which is on or transmitted by paper or electronic media which is acceptable to Us and consistent with applicable law.

You and **Your** mean an employee who is insured under the Group Policy for the insurance described in this certificate.

ELIGIBILITY PROVISIONS: INSURANCE FOR YOU

ELIGIBLE CLASS(ES)

All Active Full-Time Employees

DATE YOU ARE ELIGIBLE FOR INSURANCE

You may only become eligible for the insurance available for Your class as shown in the SCHEDULE OF BENEFITS.

All Active Full-Time Employees

Basic Life Insurance

If You are in an eligible class on September 01, 2021, You will be eligible for insurance on that date.

If You enter an eligible class after September 01, 2021, You will be eligible for insurance on the date You enter that class.

Basic Accidental Death and Dismemberment Insurance

If You are in an eligible class on September 01, 2021, You will be eligible for insurance on that date.

If You enter an eligible class after September 01, 2021, You will be eligible for insurance on the date You enter that class.

Waiting Period means the period of continuous membership in an eligible class that You must wait before You become eligible for insurance. This period begins on the date You enter an eligible class and ends on the date You complete the period(s) specified.

ENROLLMENT PROCESS

If You are eligible for insurance, You may enroll for such insurance by completing the required form. In addition, You must give evidence of Your insurability satisfactory to Us at Your expense if You are required to do so under the section entitled EVIDENCE OF INSURABILITY. If you enroll for Contributory Insurance, You must also give the Employer written permission to deduct premiums from Your pay for such insurance. You will be notified by the Employer how much You will be required to contribute.

If Your Employer establishes an annual enrollment period for Life Insurance, You may enroll for Life Insurance **only** when You are first eligible or during an annual enrollment period or If You have a Qualifying Event. You should contact the Employer for more information regarding the annual enrollment period.

DATE YOUR INSURANCE TAKES EFFECT

Rules for Noncontributory Insurance

When You complete the enrollment process for Noncontributory Insurance, such insurance will take effect as follows:

- if You are **not required** to give evidence of Your insurability, such insurance will take effect on the date You become eligible, provided You are Actively at Work on that date; or
- if You are **required** to give evidence of Your insurability and We determine that You are insurable, such insurance will take effect on the date We state in Writing, provided You are Actively at Work on that date. Basic Accidental Death and Dismemberment Insurance does not require evidence of Your insurability but such insurance will not take effect until the day Your Basic Life Insurance takes effect.

ELIGIBILITY PROVISIONS: INSURANCE FOR YOU (continued)

If You are not Actively at Work on the date the Noncontributory Insurance benefit would otherwise take effect, the insurance will take effect on the day You resume Active Work.

Rules for Contributory Insurance

If You request Contributory Insurance **before** the date You become eligible for such insurance, such insurance will take effect as follows:

- if You are **not required** to give evidence of Your insurability, such insurance will take effect on the date You become eligible, provided You are Actively at Work on that date. Basic Accidental Death and Dismemberment Insurance does not require evidence of Your insurability but such insurance will not take effect until the day Your Basic Life Insurance takes effect.
- if You are **required** to give evidence of Your insurability and We determine that You are insurable, such insurance will take effect on the date We state in Writing, provided You are Actively at Work on that date. Basic Accidental Death and Dismemberment Insurance does not require evidence of Your insurability but such insurance will not take effect until the day Your Basic Life Insurance takes effect.

If You request Contributory Insurance within 12 months of the date You become eligible for such insurance, or during the Employer's next annual enrollment period, whichever occurs first, such insurance will take effect as follows:

- if You are **not required** to give evidence of Your insurability, such insurance will take effect on the later of:
 - the date You become eligible for such insurance; and
 - the date You enroll provided You are Actively at Work on that date. Basic Accidental Death and Dismemberment Insurance does not require evidence of Your insurability but such insurance will not take effect until the day Your Basic Life Insurance takes effect.
- if You are **required** to give evidence of Your insurability and We determine that You are insurable, such insurance will take effect on the date We state in Writing, provided You are Actively at Work on that date. Basic Accidental Death and Dismemberment Insurance does not require evidence of Your insurability but such insurance will not take effect until the day Your Basic Life Insurance takes effect.
- If You request Contributory Insurance more than 12 months after the date You become eligible for such insurance or after the first annual enrollment period for which You may enroll, whichever occurs first, You must give such evidence at Your expense. If We determine that You are insurable, such insurance will take effect on the date We state in Writing, if You are Actively at Work on that date. Basic Accidental Death and Dismemberment Insurance does not require evidence of Your insurability but such insurance will not take effect until the day Your Basic Life Insurance takes effect.

If You are not Actively at Work on the date insurance would otherwise take effect, insurance will take effect on the day You resume Active Work.

See the DEFINITIONS section of this certificate for a complete list of Contributory Insurance benefits.

Enrollment Due to a Qualifying Event

You may enroll for insurance for which You are eligible or change the amount of Your insurance between annual enrollment periods only if You have a Qualifying Event.

If You have a Qualifying Event, You will have 12 months from the date of that change or the Employer's next annual enrollment period following the date of that change to make a request, whichever occurs first.

This request must be consistent with the nature of the Qualifying Event. The insurance enrolled for or changes to Your insurance made as a result of a Qualifying Event will take effect on the day after the date of Your request, if You are Actively at Work on that date.

If You are not Actively at Work on the date insurance would otherwise take effect, insurance will take effect on the day You resume Active Work.

ELIGIBILITY PROVISIONS: INSURANCE FOR YOU (continued)

Qualifying Event includes:

- marriage; or
- the birth, adoption or placement for adoption of a dependent child; or
- divorce, legal separation or annulment; or
- the death of a dependent; or
- You previously did not enroll for life coverage for You or Your dependent because You had other group coverage, but that coverage has ceased due to loss of eligibility for the other group coverage; or
- Your dependent's ceasing to qualify as a dependent under this insurance or under other group coverage.

DATE YOUR INSURANCE ENDS

Your insurance will end on the earliest of:

1. the date the Group Policy ends;
2. the date insurance ends for Your class;
3. the end of the period for which the last premium has been paid for You; or
4. for Basic Life Insurance, the last day of the calendar month in which Your employment ends; Your employment will end if You cease to be Actively at Work in any eligible class, except as stated in the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT; or
5. for Basic Life Insurance, the last day of the calendar month in which You retire in accordance with the Employer's retirement plan.
6. for Basic Accidental Death and Dismemberment Insurance, the last day of the calendar month in which Your employment ends; Your employment will end if You cease to be Actively at Work in any eligible class, except as stated in the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT; or
7. for Basic Accidental Death and Dismemberment Insurance, the last day of the calendar month in which You retire in accordance with the Employer's retirement plan.

Please refer to the section entitled ELIGIBILITY FOR CONTINUATION OF CERTAIN INSURANCE WHILE YOU ARE TOTALLY DISABLED for information concerning continuation of Your Life and Accidental Death and Dismemberment Insurance if insurance ends while You are Totally Disabled. Please refer to the section entitled LIFE INSURANCE: CONVERSION OPTION FOR YOU for information concerning the option to convert to an individual policy of life insurance if Your Life Insurance ends.

CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT

FOR FAMILY AND MEDICAL LEAVE

Certain leaves of absence may qualify for continuation of insurance under the Family and Medical Leave Act of 1993 (FMLA), or other legally mandated leave of absence or similar laws. Please contact the Employer for information regarding such legally mandated leave of absence laws.

AT YOUR OPTION: PORTABILITY

For Basic Life and Basic Accidental Death and Dismemberment Insurance

If Your Portability Eligible Insurance ends for any of the reasons stated below, You have the option to continue that insurance under another group policy in accordance with the conditions and requirements of this section. This is referred to as Porting. Evidence of Your insurability will not be required.

For purposes of this subsection the term "Portability Eligible Insurance" refers to Your Basic Life and Basic Accidental Death and Dismemberment benefits for which the Portability Eligible Insurance is shown as available in the SCHEDULE OF BENEFITS.

When Porting is an Option

Porting may only be exercised by a request in Writing during the Request Period specified below.

If You choose not to Port, Life Insurance benefits may be converted in accordance with the section entitled LIFE INSURANCE: CONVERSION OPTION FOR YOU.

1. You may choose to Port if Portability Eligible Insurance ends while You are Actively at Work or on an approved leave of absence because:
 - You retired from active service with the Employer; or
 - Your employment ends, due to a reason other than retirement; or
 - You cease to be in a class that is eligible for such insurance; or
 - The Policy is amended to end the Portability Eligible Insurance, unless such insurance is replaced by similar insurance under another group insurance policy issued to the Policyholder or its successor; or
 - This Policy has ended, unless such insurance is replaced by similar insurance under another group insurance policy issued to the Policyholder or its successor.
 2. You may choose to Port the reduced amount of insurance if Your Portability Eligible Insurance is reduced due to:
 - Your age; or
 - An amendment to the Plan which affects the amount of insurance for Your class.
- the person making the request resides in a jurisdiction that permits this Portability feature.

Request Period

For You to Port, We must receive a completed request form within the Request Period as described below.

If written notice of the option to Port is given within 15 days before or after the date such insurance ends, the Request Period:

- begins on the date the insurance ends, and
- expires 31 days after the date.

If written notice of the option to Port is given more than 15 days after but within 90 days of the date such insurance ends, the Request Period:

- begins on the date the insurance ends, and
- expires 45 days after the date of the notice.

CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT (continued)

If written notice of the option to Port is not given within 91 days of the date such insurance ends, the Request Period:

- begins on the date the insurance ends, and
- expires at the end of such 91 day period.

Amount of the New Certificate

The amount of Ported Insurance for You that may be continued is shown in the SCHEDULE OF BENEFITS. However, at the time of Porting You may change the amount of Portability Eligible Insurance in the following circumstances:

Your Increase in Amount

For Portability Eligible Life Insurance

At the time of Porting, You may increase the amount of Your Portability Eligible Life Insurance. This may be done in increments of \$25,000, up to a maximum ported amount of \$2,000,000. To be eligible for this increased amount, You must provide evidence of Your insurability satisfactory to us, at Your expense. If We approve the increase, it will take effect on the date We state in Writing.

For Portability Eligible Accidental Death and Dismemberment Insurance

At the time of Porting, You may increase the amount of Your Portability Eligible Accidental Death and Dismemberment Insurance. This may be done in increments of \$25,000, up to a maximum ported amount of \$2,000,000. This increase will take effect on the date We state in Writing.

Your Decrease in Amount

If We receive a request to decrease an amount of insurance, any such decrease will take place on the date We state in Writing.

Premiums for the New Certificate

All premium payments must be made directly to Us. When We issue the new certificate, We will also provide a schedule of premiums and payment instructions.

You are not required to provide evidence of insurability to Port Your existing amount of Portability Eligible Basic Life and Basic Accidental Death and Dismemberment. However, to qualify for a lower premium rate, You may give us, at Your expense, evidence of Your insurability satisfactory to Us. If We determine that the evidence satisfies Us, We will notify You that the lower premium rates will apply to You.

Right to Convert Life Insurance Amounts Not Ported

Any amount of Life Insurance not Ported under this subsection may be converted under the section entitled LIFE INSURANCE: CONVERSION OPTION FOR YOU.

If You Die Within 31 Days of the Date Portability Eligible Life Insurance Ends

If You die within 31 days of the date Portability Eligible Life Insurance ends and an application to Port is not received by Us during such period, We will determine whether Your life insurance qualifies for payment. This determination will be made in accordance with the section entitled LIFE INSURANCE: CONVERSION OPTION FOR YOU.

CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT (continued)

If You are Totally Disabled on the Date Your Employment Ends.

If You are Totally Disabled on the date Your employment ends and You elect to continue Portability Eligible Insurance as provided in this subsection, You may at a later date become approved for continuation of insurance under the section entitled ELIGIBILITY FOR CONTINUATION OF CERTAIN INSURANCE WHILE YOU ARE TOTALLY DISABLED. If You are so approved, all insurance continued under this subsection or any new certificate provided under this subsection will end and We will return any premium paid by You for such insurance.

AT THE EMPLOYER'S OPTION

The Employer has elected to continue insurance by paying premiums for employees who cease Active Work in an eligible class for any of the reasons specified below. You will be notified by the Employer how much You will be required to contribute.

Insurance will continue for the following periods:

1. for the period You cease Active Work in an eligible class due to injury or Sickness, up to 9 months;
2. for the period You cease Active Work in an eligible class due to part-time work, layoff or strike, up to 2 months;
3. for the period You cease Active Work in an eligible class due to any other Employer approved leave of absence, up to 2 months.
4. for the period You cease Active Work in an eligible class due to any Employer approved leave of absence because of a call-up to active military service, up to 24 months.

At the end of any of the continuation periods listed above, Your insurance will be affected as follows:

- if You resume Active Work in an eligible class at this time, You will continue to be insured under the Group Policy;
- if You do not resume Active Work in an eligible class at this time, Your employment will be considered to end and Your insurance will end in accordance with the DATE YOUR INSURANCE ENDS subsection of the section entitled ELIGIBILITY PROVISIONS: INSURANCE FOR YOU.

Option to Convert

In addition to the Continuation of Insurance options described above, You may have the right to convert to a policy of individual life insurance. We urge You to read the section entitled LIFE INSURANCE: CONVERSION OPTION FOR YOU.

CONTINUATION OF ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D)

Special Rules For Massachusetts Residents

1. If Your AD&D Insurance ends due to a Plant Closing or Covered Partial Closing, such insurance will be continued for 90 days after the date it ends.
2. If Your AD&D Insurance ends because:
 - You cease to be in an Eligible Class; or
 - Your employment terminates

for any reason other than a Plant Closing or Covered Partial Closing, such insurance will continue for 31 days after the date it ends.

Continuation of Your AD&D Insurance under this subsection will end before the end of continuation periods shown above if You become covered for similar benefits under another plan.

CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT (continued)

Plant Closing and **Covered Partial Closing** have the meaning set forth in Massachusetts Annotated Laws, Chapter 151A, Section 71A.

EVIDENCE OF INSURABILITY

We require evidence of insurability satisfactory to Us as follows:

1. In the case of transferred business, if You did not elect coverage under the prior plan for which You were eligible.

If You do not give Us evidence of insurability or the evidence of insurability is not accepted by Us as satisfactory, You will not be covered for Life Insurance.

The evidence of insurability is to be given at Your expense.

LIFE INSURANCE: FOR YOU

If You die, Proof of Your death must be sent to Us. When We receive such Proof with the claim, We will review the claim and if We approve it, will pay the Beneficiary the Life Insurance in effect on the date of Your death.

PAYMENT OPTIONS

We will pay the Life Insurance in one sum. Other modes of payment may be available upon request. For details, call Our toll free number shown on the Certificate Face Page.

LIFE INSURANCE: CONVERSION OPTION FOR YOU

If Your Life Insurance ends or is reduced for any of the reasons stated below, You have the option to buy an individual policy of life insurance ("new policy") from Us during the Application Period in accordance with the conditions and requirements of this section. This is referred to as the "option to convert". Evidence of Your insurability will not be required.

When You Will Have the Option to Convert

You will have the option to convert when:

- Your Life Insurance ends because:
 - You cease to be in an eligible class; or
 - Your employment ends; or
 - the Group Policy ends provided You have been insured for Life Insurance for at least 5 years; or
 - the Group Policy is amended to end Life Insurance for an eligible class of which You are a member, provided You have been insured for Life Insurance for at least 5 years; or
- Your Life Insurance is reduced:
 - on or after the date You attain age 60 in any increment or series of increments aggregating 20% or more of the amount of Your Life Insurance in effect before the first reduction due to Your age;
 - because You change from one eligible class to another; or
 - due to an amendment of the Group Policy.

If You opt not to convert a reduction in the amount of Your Life Insurance as described above, You will not have the option to convert that amount at a later date.

Application Period

If You opt to convert Your Life Insurance for any of the reasons stated above, We must receive a completed conversion application form from You within the Application Period described below.

If You are given Written notice of the option to convert within 15 days before or after the date Your Life Insurance ends or is reduced, the Application Period begins on the date that such Life Insurance ends or is reduced and expires 31 days after such date.

If You are given Written notice of the option to convert more than 15 days after but within 90 days of the date Your Life Insurance ends or is reduced, the Application Period begins on the date such Life Insurance ends or is reduced and expires 15 days from the date of such notice. In no event will the Application Period exceed 91 days from the date Your Life Insurance ends or is reduced.

Option Conditions

The option to convert is subject to these conditions:

1. Our receipt within the Application Period of:
 - Your Written application for the new policy; and
 - the premium due for such new policy;
2. The premium rates for the new policy will be based on:
 - Our rates then in use;
 - the form and amount of insurance;
 - Your class of risk; and
 - Your attained age when Your Life Insurance ends or is reduced;
3. the new policy may be on any form then customarily offered by Us excluding term insurance;

LIFE INSURANCE: CONVERSION OPTION FOR YOU (continued)

4. the new policy will be issued without an accidental death and dismemberment benefit, a continuation benefit, an accelerated benefit option, a waiver of premium benefit or any other rider or additional benefit; and
5. the new policy will take effect on the 32nd day after the date Your Life Insurance ends or is reduced; this will be the case regardless of the duration of the Application Period.

Maximum Amount of the New Policy

If Your Life Insurance ends due to the end of the Group Policy or the amendment of the Group Policy to end Life Insurance for an eligible class of which You are a member, the maximum amount of insurance that You may elect for the new policy is the lesser of:

- the amount of Your Life Insurance that ends under the Group Policy less the amount of life insurance for which You become eligible under any group policy within 31 days after the date insurance ends under the Group Policy; or
- \$2,000

If Your Life Insurance ends for any other reason, the maximum amount of insurance that You may elect for the new policy is the amount of Your Life Insurance that ends under the Group Policy.

If You Die Within 31 Days After Your Life Insurance Ends or is reduced

If You die within 31 days after Your Life Insurance ends or is reduced by an amount You are entitled to convert, Proof of Your death must be sent to Us. When We receive such Proof with the claim, We will review the claim and if We approve it will pay the Beneficiary the amount of Life Insurance You were entitled to convert.

Effect of Previous Conversion

If You obtained a new policy through this conversion option and Your Life Insurance is later continued under the section entitled ELIGIBILITY FOR CONTINUATION OF CERTAIN INSURANCE WHILE YOU ARE TOTALLY DISABLED. We will only pay Your Life Insurance under such section if the new policy is returned to Us. If the new policy is returned to us, We will refund to Your estate the premium paid for such policy without interest, less any debt incurred under such policy. If the new policy is not returned to Us, We will only pay the life insurance in effect under such new policy.

We will not pay insurance under both the Group Policy and the new policy.

ELIGIBILITY FOR CONTINUATION OF CERTAIN INSURANCE WHILE YOU ARE TOTALLY DISABLED

If You become Totally Disabled while You are insured for Continuation Eligible Insurance under this policy, You may qualify to continue certain insurance under this section. If continued, premium payment will not be required. We will determine if You qualify for this continuation after We receive Proof that You have satisfied the conditions of this section.

Total Disability must start before You attain age 60 and while You are insured for Continuation Eligible Insurance.

Your Total Disability must continue without interruption from the date You became Totally Disabled through the end of the Continuation Waiting Period.

DEFINITIONS

For the purpose of this section, "Continuation Eligible Insurance" means Your

- Basic Life Insurance;
- Basic Accidental Death and Dismemberment Insurance if You continue Basic Life Insurance;

to the extent that such insurance was in effect for You on the date Your Total Disability began.

Continuation Waiting Period means the period which starts on the date You become Totally Disabled and ends 9 consecutive months later.

Total Disability or **Totally Disabled** means, for purposes of this section, that due to an injury or sickness:

- You are unable to perform the material and substantial duties of Your regular job; and
- You are unable to perform any other job for which You are fit by education, training or experience.

TOTAL DISABILITY AND PROOF REQUIREMENTS

If You become disabled You should contact Us as soon as reasonably possible. After the Continuation Waiting Period ends, You must send Us Proof that You were Totally Disabled with no interruption throughout the Continuation Waiting Period. You must do this within the time frame specified in the section entitled FILING A CLAIM.

As part of such Proof, We may choose a Physician to examine You to verify that You are Totally Disabled. We will pay for the exam.

After We receive and review Your Proof, We will determine if You qualify. We will notify You in writing of Our decision.

To verify that You continue to be Totally Disabled without interruption, We may require from time to time that You send Us Proof that You continue to be Totally Disabled. We will not ask for Proof more than once each year.

IF YOU DIE OR SUSTAIN A LOSS COVERED BY THE CONTINUED INSURANCE DURING CONTINUATION

If You die or sustain a loss for which you believe benefits may be payable during the continuation, Proof of the death must be sent to Us. In addition to the Proof which is otherwise required for the insurance, the Proof must show that Your Total Disability continued with no interruption from the date We informed You that the continuation was approved until the date of the death or the date of loss.

When We receive such Proof with the claim, We will review the claim and if We approve it, will pay any benefit payable under the insurance continued under this section.

ELIGIBILITY FOR CONTINUATION OF CERTAIN INSURANCE WHILE YOU ARE TOTALLY DISABLED

EFFECT OF PREVIOUS CONVERSION

If You converted any portion of Your Continuation Eligible Life Insurance to an individual policy, We will only pay the life insurance under this section if the individual policy is returned to Us. If it is returned to Us, We will refund to Your estate the premiums paid for such policy without interest, less any debt incurred under such policy.

If such individual policy is not returned to Us, We will pay the life insurance in effect under the individual policy.

We will not pay insurance under both the Group Policy and the individual policy.

EFFECT OF PREVIOUS ELECTION TO PORT COVERAGE

If You ported any portion of Your Continuation Eligible Insurance to a certificate under another policy, We will only pay insurance under this section if the other policy's certificate is surrendered to Us. If it is returned to Us, We will refund to Your estate the premiums paid under such policy without interest.

If that certificate is not returned to Us, We will pay any insurance which applies under the other policy's certificate.

We will not pay insurance under both this Group Policy and the other policy.

DATE CONTINUATION ENDS

The Continuation Eligible Insurance continued under this section may be continued in a reduced amount on account of Your age and will end at the earliest of:

1. the date You die;
2. the date Your Total Disability ends;
3. the date You do not give Us Proof of Total Disability, as required;
4. the date You refuse to be examined by Our Physician, as required;
5. if You become Totally Disabled before age 60, the date You reach age 65.

Option To Convert Your Continuation Eligible Life Insurance

When a continuation under this section ends, You may buy an individual policy of life insurance from Us. The details of this option are described in the section entitled LIFE INSURANCE: CONVERSION OPTION FOR YOU. For the purpose of that section, the end of this continuation will be considered the end of Your employment. You may not use the conversion option described in those sections if before the end of the Application Period for conversion You return to Active Work in an eligible class and become insured under the Group Policy. You will not be able to convert any of Your Continuation Eligible Life Insurance which You have already converted to an individual policy.

Option To Port Your Continuation Eligible Insurance

When a continuation under this section ends, You may elect to port to a different policy the insurance which has been continued under this section. The details of this option are described in the At Your Option: Portability subsection of the CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT section. For the purpose of that section, the end of this continuation will be considered the end of Your employment. You may not use the portability option described in that section if before the end of the Portability Request Period, You return to Active Work in an eligible class and become insured under the Group Policy. You will not be able to port any of Your Continuation Eligible Insurance which You have already converted to an individual policy.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

Applicable to Basic Accidental Death and Dismemberment Insurance

If You sustain an accidental injury that is the Direct and Sole Cause of a Covered Loss described in the SCHEDULE OF BENEFITS, Proof of the accidental injury and Covered Loss must be sent to Us. When We receive such Proof We will review the claim and, if We approve it, We will pay the insurance in effect on the date of the injury.

Direct and Sole Cause means that the Covered Loss occurs within 12 months of the date of the accidental injury and was a direct result of the accidental injury, independent of other causes.

We will deem a loss to be the direct result of an accidental injury if it results from unavoidable exposure to the elements and such exposure was a direct result of an accident.

PRESUMPTION OF DEATH

You will be presumed to have died as a result of an accidental injury if:

- the aircraft or other vehicle in which You were traveling disappears, sinks, or is wrecked; and
- the body of the person who has disappeared is not found within 1 year of:
 - the date the aircraft or other vehicle was scheduled to have arrived at its destination, if traveling in an aircraft or other vehicle operated by a Common Carrier; or
 - the date the person is reported missing to the authorities, if traveling in any other aircraft or vehicle.

EXCLUSIONS (See notice page for residents of Missouri)

We will not pay benefits under this section for any loss caused or contributed to by:

1. physical or mental illness or infirmity, or the diagnosis or treatment of such illness or infirmity;
2. infection, other than infection occurring in an external accidental wound;
3. suicide or attempted suicide;
4. intentionally self-inflicted injury;
5. service in the armed forces of any country or international authority, except the United States National Guard;
6. any incident related to:
 - travel in an aircraft as a pilot, crew member, flight student or while acting in any capacity other than as a passenger; or
 - travel in an aircraft for the purpose of parachuting or otherwise exiting from such aircraft while it is in flight;
 - parachuting or otherwise exiting from an aircraft while such aircraft is in flight except for self-preservation;
 - travel in an aircraft or device used:
 - for testing or experimental purposes; or
 - by or for any military authority; or
 - for travel or designed for travel beyond the earth's atmosphere;
7. committing or attempting to commit a felony;

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE (continued)

8. the voluntary intake or use by any means of:

- any drug, medication or sedative, unless it is:
 - taken or used as prescribed by a Physician, or
 - an “over the counter” drug, medication or sedative taken as directed; or
- alcohol in combination with any drug, medication, or sedative; or
- poison, gas, or fumes; or

9. war, whether declared or undeclared; or act of war, insurrection, rebellion, or riot.

Exclusion for Intoxication

We will not pay benefits under this section for any loss if the injured party is intoxicated at the time of the incident and is the operator of a vehicle or other device involved in the incident.

Intoxicated means that the injured person's blood alcohol level met or exceeded the level that creates a legal presumption of intoxication under the laws of the jurisdiction in which the incident occurred.

BENEFIT PAYMENT

For loss of Your life, We will pay benefits to Your Beneficiary.

For any other loss sustained by You We will pay benefits to You.

If You sustain more than one Covered Loss due to an accidental injury, the amount We will pay, on behalf of any such injured person, will not exceed the Full Amount.

We will pay benefits in one sum. Other modes of payment may be available upon request. For details call Our toll free number shown on the Certificate Face Page.

APPLICABILITY OF PROVISIONS

The provisions set forth in this ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE section apply to all Accidental Death and Dismemberment Insurance – Additional Benefit sections included in this certificate except as may otherwise be provided in such Additional Benefit sections.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE -

ADDITIONAL BENEFIT: AIR BAG USE

If You die as a result of an accidental injury, We will pay this additional benefit if:

1. We pay a benefit for loss of life under the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE section;
2. this benefit is in effect on the date of the injury; and
3. We receive Proof that the deceased person:
 - was in an accident while driving or riding as a passenger in a Passenger Car equipped with an Air Bag(s);
 - was riding in a seat protected by an Air Bag;
 - was wearing a Seat Belt which was properly fastened at the time of the accident; and
 - died as a result of injuries sustained in the accident.

A police officer investigating the accident must certify that the Seat Belt was properly fastened and that the Passenger Car in which the deceased was traveling was equipped with Air Bags. A copy of such certification must be submitted to Us with the claim for benefits.

Passenger Car means any validly registered four-wheel private passenger car. It does not include any commercially licensed car or any private car being used for commercial purposes.

Seat Belt means any restraint device that:

- meets published United States government safety standards;
- is properly installed by the car manufacturer; and
- is not altered after the installation.

Air Bag means an inflatable restraint device that:

- meets published United States government safety standards;
- is properly installed by the car manufacturer; and
- is not altered after the installation.

BENEFIT AMOUNT

The Air Bag Use Benefit is an additional benefit equal to 5% of the Full Amount shown in the SCHEDULE OF BENEFITS. However, the amount We will pay for this benefit will not be less than \$100 or more than \$10,000.

BENEFIT PAYMENT

For loss of Your life We will pay benefits to Your Beneficiary.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE -

ADDITIONAL BENEFIT: SEAT BELT USE

If You die as a result of an accidental injury, We will pay this additional Seat Belt Use benefit if:

1. We pay a benefit for loss of life under the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE section;
2. this benefit is in effect on the date of the injury; and
3. We receive Proof that the deceased person:
 - was in an accident while driving or riding as a passenger in a Passenger Car;
 - was wearing a Seat Belt which was properly fastened at the time of the accident; and
 - died as a result of injuries sustained in the accident.

A police officer investigating the accident must certify that the Seat Belt was properly fastened. A copy of such certification must be submitted to Us with the claim for benefits.

Passenger Car means any validly registered four-wheel private passenger car. It does not include any commercially licensed car or any private car being used for commercial purposes.

Seat Belt means any restraint device that:

- meets published United States Government safety standards;
- is properly installed by the car manufacturer; and
- is not altered after the installation.

BENEFIT AMOUNT

The Seat Belt Use benefit is an additional benefit equal to **10%** of the Full Amount shown in the SCHEDULE OF BENEFITS. However, the amount We will pay for this benefit will not be less than **\$1,000** or more than **\$25,000**.

BENEFIT PAYMENT

For loss of Your life, We will pay benefits to Your Beneficiary.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE -

ADDITIONAL BENEFIT: CHILD CARE

If You die as a result of an accidental injury, We will pay this additional Child Care benefit if:

1. We pay a benefit for loss of life under the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE section;
2. This benefit is in effect on the date of the injury; and
3. We receive Proof that:
 - on the date of Your death a Child was enrolled in a Child Care Center; or
 - within 12 months after the date of Your death a Child was enrolled in a Child Care Center.

Child Care Center means a facility that:

- is operated and licensed according to the law of the jurisdiction where it is located; and
- provides care and supervision for children in a group setting on a regularly scheduled and daily basis.

BENEFIT AMOUNT

For each Child who qualifies for this benefit, We will pay an amount equal to the Child Care Center charges incurred for a period of up to 4 consecutive years, not to exceed:

- an annual maximum of \$5,000; and
- an overall maximum of 12% of the Full Amount shown in the SCHEDULE OF BENEFITS.

We will not pay for Child Care Center charges incurred after the date a Child attains age 12.

We may require Proof of the Child's continued enrollment in a Child Care Center during the period for which a benefit is claimed.

BENEFIT PAYMENT

We will pay this benefit quarterly when We receive Proof that Child Care Center charges have been paid. Payment will be made to the person who pays such charges on behalf of the Child.

If this benefit is in effect on the date You die and there is no Child who could qualify for it, We will pay \$1,000 to Your Beneficiary in one sum.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE -

ADDITIONAL BENEFIT: COMMON CARRIER

If You die as a result of an accidental injury, We will pay this additional benefit if:

1. We pay a benefit for loss of life under the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE section;
2. this benefit is in effect on the date of the injury; and
3. We receive Proof that the injury resulting in the deceased's death occurred while traveling in a Common Carrier.

BENEFIT AMOUNT

The Common Carrier Benefit is shown in the SCHEDULE OF BENEFITS.

BENEFIT PAYMENT

For loss of Your life We will pay benefits to Your Beneficiary.

FILING A CLAIM

The Employer should have a supply of claim forms. Obtain a claim form from the Employer and fill it out carefully. Return the completed claim form with the required Proof to the Employer. The Employer will certify Your insurance under the Group Policy and send the certified claim form and Proof to Us.

When we receive the claim form and Proof We will review the claim and, if We approve it, We will pay benefits subject to the terms and provisions of this certificate and the Group Policy.

CLAIMS FOR LIFE INSURANCE BENEFITS

When a claimant files a claim for Life Insurance benefits, Proof should be sent to Us as soon as is reasonably possible after the death of an insured.

CLAIMS FOR INSURANCE BENEFITS

When a claimant files a claim for insurance benefits described in this certificate, both the notice of claim and the required Proof should be sent to us within 90 days of the date of a loss.

Notice of claim and Proof may also be given to Us by following the steps set forth below:

Step 1

A claimant may give Us notice by calling Us at the toll free number shown in the Certificate Face Page within 20 days of the date of a loss.

Step 2

We will send a claim form to the claimant and explain how to complete it. The claimant should receive the claim form within 15 days of giving Us notice of claim.

Step 3

When the claimant receives the claim form, the claimant should fill it out as instructed and return it with the required Proof described in the claim form. If the claimant does not receive a claim form within 15 days after giving Us notice of claim, Proof may be sent using any form sufficient to provide Us with the required Proof.

Step 4

The claimant must give Us Proof not later than 90 days after the date of the loss.

If notice of claim or Proof is not given within the time limits described in this section, the delay will not cause a claim to be denied or reduced if such notice and Proof are given as soon as is reasonably possible.

Time Limit on Legal Actions. A legal action on a claim may only be brought against Us during a certain period. This period begins 60 days after the date Proof is filed and ends 3 years after the date such Proof is required.

GENERAL PROVISIONS

Assignment

You may assign Your Life Insurance rights and benefits under the Group Policy as a gift or as a viatical assignment. You may also assign Your Accidental Death and Dismemberment Insurance rights and benefits under the Group Policy as a gift.

We will recognize the assignee(s) under such assignment as owner(s) of Your right, title and interest in the Group Policy if:

1. a Written form satisfactory to Us, affirming this assignment, has been completed;
2. the Written form has been Signed by You and the assignee(s);
3. the Employer acknowledges that the Life Insurance and Accidental Death and Dismemberment Insurance being assigned is in force on the life of the assignor; and
4. the Written form is delivered to Us for recording.

Viatical assignments may only be made after Your Life Insurance has been in effect under this certificate for 2 years. However, you may make a viatical assignment before the end of the 2 year period if you are Terminally Ill.

Terminally Ill means that You are expected to die within 6 months. As Proof of Your Terminal Illness You or Your legal representative must send Us a signed Physician's certification that You are Terminally Ill. We may also request an exam by a Physician of Our choice, at Our expense.

Beneficiary

You may designate a Beneficiary in Your application or enrollment form. You may change Your Beneficiary at any time. To do so, You must send a Signed and dated, Written request to the Employer using a form satisfactory to Us. Your Written request to change the Beneficiary must be sent to the Employer within 30 days of the date You Sign such request.

You do not need the Beneficiary's consent to make a change. When We receive the change, it will take effect as of the date You Signed it. The change will not apply to any payment made in good faith by Us before the change request was recorded.

If two or more Beneficiaries are designated and their shares are not specified, they will share the insurance equally.

If there is no Beneficiary designated or no surviving designated Beneficiary at Your death, We may determine the Beneficiary to be one or more of the following who survive You:

1. Your Spouse;
 2. Your child(ren);
 3. Your parent(s); or
 4. Your siblings(s)
- Instead of making payment to any of the above, we may pay Your estate. Any payment made in good faith will discharge our liability to the extent of such payment.

If a Beneficiary or payee is a minor or incompetent to receive payment, We will pay that person's guardian.

Entire Contract

Your insurance is provided under a contract of group insurance with the Employer. The entire contract with the Employer is made up of the following:

1. the Group Policy and its Exhibits, which include the certificate(s);
2. the Employer's application; and
3. any amendments and/or endorsements to the Group Policy.

GENERAL PROVISIONS (continued)

Incontestability: Statements Made by You

Any statement made by You will be considered a representation and not a warranty. We will not use such statement to avoid insurance, reduce benefits or defend a claim unless the following requirements are met:

1. the statement is in a Written application or enrollment form;
2. You have Signed the application or enrollment form; and
3. a copy of the application or enrollment form has been given to You or Your Beneficiary.

We will not use Your statements which relate to insurability to contest life insurance after it has been in force for 2 years during Your life. In addition, We will not use such statements to contest an increase or benefit addition to such insurance after the increase or benefit has been in force for 2 years during Your life.

Misstatement of Age

If Your age is misstated, the correct age will be used to determine if insurance is in effect and, as appropriate, We will adjust the benefits and/or premiums.

Conformity with Law

If the terms and provisions of this certificate do not conform to any applicable law, this certificate shall be interpreted to so conform.

Physical Exams

If a claim is submitted for insurance benefits, We have the right to ask the insured to be examined by a Physician(s) of Our choice as often as is reasonably necessary to process the claim. We will pay the cost of such exam.

Autopsy

Subject to Your religious practices or beliefs, We have the right to make a reasonable request for an autopsy where permitted by law. Any such request will set forth the reasons We are requesting the autopsy.

THIS IS THE END OF THE CERTIFICATE. THE FOLLOWING IS ADDITIONAL INFORMATION

Delaware American Life Insurance Company
MetLife Health Plans, Inc.
MetLife Legal Plans, Inc.
MetLife Legal Plans of Florida, Inc.

Metropolitan Life Insurance Company
Metropolitan Tower Life Insurance Company
SafeGuard Health Plans, Inc.
SafeHealth Life Insurance

Our Privacy Notice

We know that you buy our products and services because you trust us. This notice explains how we protect your privacy and treat your personal information. It applies to current and former customers. "Personal information" as used here means anything we know about you personally.

SECTION 1: Plan Sponsors and Group Insurance Contract Holders

This privacy notice is for individuals who apply for or obtain our products and services under an employee benefit plan, group insurance or annuity contract, or as an executive benefit. In this notice, "you" refers to these individuals.

SECTION 2: Protecting Your Information

We take important steps to protect your personal information. We treat it as confidential. We tell our employees to take care in handling it. We limit access to those who need it to perform their jobs. Our outside service providers must also protect it, and use it only to meet our business needs. We also take steps to protect our systems from unauthorized access. We comply with all laws that apply to us.

SECTION 3: Collecting Your Information

We typically collect your name, address, age, and other relevant information. We may also collect information about any business you have with us, our affiliates, or other companies. Our affiliates include life, car, and home insurers. They also include a legal plans company, and a securities broker-dealer. In the future, we may also have affiliates in other businesses.

SECTION 4: How We Get Your Information

We get your personal information mostly from you. We may also use outside sources to help ensure our records are correct and complete. These sources may include consumer reporting agencies, employers, other financial institutions, adult relatives, and others. These sources may give us reports or share what they know with others. We don't control the accuracy of information outside sources give us. If you want to make any changes to information we receive from others about you, you must contact those sources.

We may ask for medical information. The Authorization that you sign when you request insurance permits these sources to tell us about you. We may also, at our expense:

- Ask for a medical exam
- Ask for blood and urine tests
- Ask health care providers to give us health data, including information about alcohol or drug abuse

We may also ask a consumer reporting agency for a "consumer report" about you (or anyone else to be insured). Consumer reports may tell us about a lot of things, including information about:

- Reputation
- Driving record
- Finances
- Work and work history
- Hobbies and dangerous activities

The information may be kept by the consumer reporting agency and later given to others as permitted by law. The agency will give you a copy of the report it provides to us, if you ask the agency and can provide adequate identification. If you write to us and we have asked for a consumer report about you, we will tell you so and give you the name, address and phone number of the consumer reporting agency.

Another source of information is MIB, Inc. ("MIB"). It is a not-for-profit membership organization of insurance companies which operates an information exchange on behalf of its Members. We, or our reinsurers, may make a brief report to MIB. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted, MIB, upon request, will supply such company with the information in its file. Upon receipt of a request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. You may do so by writing to MIB, Inc., 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734 or go to MIB website at www.mib.com.

SECTION 5: Using Your Information

We collect your personal information to help us decide if you're eligible for our products or services. We may also need it to verify identities to help deter fraud, money laundering, or other crimes. How we use this information depends on what

products and services you have or want from us. It also depends on what laws apply to those products and services. For example, we may also use your information to:

- administer your products and services
- perform business research
- market new products to you
- comply with applicable laws
- process claims and other transactions
- confirm or correct your information
- help us run our business

SECTION 6: Sharing Your Information With Others

We may share your personal information with others with your consent, by agreement, or as permitted or required by law. We may share your personal information without your consent if permitted or required by law. For example, we may share your information with businesses hired to carry out services for us. We may also share it with our affiliated or unaffiliated business partners through joint marketing agreements. In those situations, we share your information to jointly offer you products and services or have others offer you products and services we endorse or sponsor. Before sharing your information with any affiliate or joint marketing partner for their own marketing purposes, however, we will first notify you and give you an opportunity to opt out.

Other reasons we may share your information include:

- doing what a court, law enforcement, or government agency requires us to do (for example, complying with search warrants or subpoenas)
- telling another company what we know about you if we are selling or merging any part of our business
- giving information to a governmental agency so it can decide if you are eligible for public benefits
- giving your information to someone with a legal interest in your assets (for example, a creditor with a lien on your account)
- giving your information to your health care provider
- having a peer review organization evaluate your information, if you have health coverage with us
- those listed in our “Using Your Information” section above

SECTION 7: HIPAA

We will not share your health information with any other company – even one of our affiliates – for their own marketing purposes. The Health Insurance Portability and Accountability Act (“HIPAA”) protects your information if you request or purchase dental, vision, long-term care and/or medical insurance from us. HIPAA limits our ability to use and disclose the information that we obtain as a result of your request or purchase of insurance. Information about your rights under HIPAA will be provided to you with any dental, vision, long-term care or medical coverage issued to you.

You may obtain a copy of our HIPAA Privacy Notice by visiting our website at www.MetLife.com. For additional information about your rights under HIPAA; or to have a HIPAA Privacy Notice mailed to you, contact us at HIPAAprivacyAmericasUS@metlife.com, or call us at telephone number (212) 578-0299.

SECTION 8: Accessing and Correcting Your Information

You may ask us for a copy of the personal information we have about you. We will provide it as long as it is reasonably locatable and retrievable. You must make your request in writing listing the account or policy numbers with the information you want to access. For legal reasons, we may not show you privileged information relating to a claim or lawsuit, unless required by law.

If you tell us that what we know about you is incorrect, we will review it. If we agree, we will update our records. Otherwise, you may dispute our findings in writing, and we will include your statement whenever we give your disputed information to anyone outside MetLife.

SECTION 9: Questions

We want you to understand how we protect your privacy. If you have any questions or want more information about this notice, please contact us. A detailed notice shall be furnished to you upon request. When you write, include your name, address, and policy or account number.

Send privacy questions to:

MetLife Privacy Office
P. O. Box 489
Warwick, RI 02887-9954
privacy@metlife.com

We may revise this privacy notice. If we make any material changes, we will notify you as required by law. We provide this privacy notice to you on behalf of the MetLife companies listed at the top of the first page.

THIS SUMMARY PLAN DESCRIPTION IS EXPRESSLY MADE PART OF THE PLAN AND IS LEGALLY ENFORCEABLE AS PART OF THE PLAN WITH RESPECT TO ITS TERMS AND CONDITIONS. IN THE EVENT THERE IS NO OTHER PLAN DOCUMENT, THIS DOCUMENT SHALL SERVE AS A SUMMARY PLAN DESCRIPTION AND SHALL ALSO CONSTITUTE THE PLAN.

ERISA INFORMATION

NAME OF THE PLAN

UAW/UMass Health & Welfare Trust Fund Welfare Benefit Plan ("Plan")

NAME AND ADDRESS OF EMPLOYER

UAW/UMass Health & Welfare Trust Fund
6 University Dr.
Suite 206-229
Amherst, MA 01002
(413) 345-2156

EMPLOYER IDENTIFICATION NUMBER: 043538613

COVERAGE

PLAN NAME

Basic Life & Accidental Death
and Dismemberment Insurance

UAW/UMass Health & Welfare
Trust Fund Welfare Benefit Plan

TYPE OF ADMINISTRATION

The above listed benefits are insured by Metropolitan Life Insurance Company ("MetLife").

PLAN ADMINISTRATOR NAME, BUSINESS ADDRESS AND PHONE NUMBER

UAW/UMass Health & Welfare Trust Fund
6 University Dr.
Suite 206-229
Amherst, MA 01002
(413) 345-2156

AGENT FOR SERVICE OF LEGAL PROCESS

For disputes arising under the Plan, service of legal process may be made upon the Plan Administrator at the above address. For disputes arising under those portions of the Plan insured by MetLife, service of legal process may be made upon MetLife at one of its local offices, or upon the supervisory official of the Insurance Department in the state in which you reside.

ELIGIBILITY FOR PARTICIPATION; DESCRIPTION OR SUMMARY OF BENEFITS

Your MetLife certificate describes the eligibility requirements for insurance provided by MetLife under the Plan. It also includes a detailed description of the insurance provided by MetLife under the Plan.

PLAN TERMINATION OR CHANGES

Written notice of termination must be given to the Employer at least 31 days prior to the date such insurance will be terminated.

Premiums are due and payable on the first day of each month for which insurance coverage is to be provided. If a payment is not received within 31 days after the due date, coverage will terminate as follows:

- a. with respect to coverages other than Life Insurance and Accidental Death or Dismemberment Insurance - on the earlier of the 31st day following the due date and the date requested in writing by the Employer, provided such request is made before such 31st day; and
- b. with respect to Life Insurance and Accidental Death or Dismemberment Insurance -- on the later of the 31st day following the due date and the date MetLife's written notice of termination is received by the Employer.

The Employer is liable to MetLife for payment of the pro-rata premium which accrues while any coverage remains in force.

The group policy sets forth those situations in which the Employer and/or MetLife have the right to end the policy.

The Employer reserves the right to change or terminate the Plan at any time. Therefore, there is no guarantee that you will be eligible for the benefits described herein for the duration of your employment. Any such action will be taken only after careful consideration.

Your consent or the consent of your beneficiary is not required to terminate, modify, amend, or change the Plan.

In the event Your coverage ends in accord with the Date Your Insurance Ends provision of Your certificate, you may still be eligible to receive benefits. The circumstances under which benefits are available are described in Your MetLife certificate.

CONTRIBUTIONS TO PREMIUM

There are benefits insured under the group insurance coverages or the group insurance policy or policies which are combined for experience. This means that the costs of these coverages are determined on a combined basis, and the costs are accumulated from year to year. As a result, favorable experience under one or more coverages in a particular year may offset unfavorable experience on other coverages in the same year, or offset unfavorable experience of coverage in prior years.

No contribution is required for Basic Life Insurance and Accidental Death and Dismemberment Insurance.

PLAN YEAR

The Plan's fiscal records are kept on a Plan year basis beginning each January 1 and ending on the following December 31.

CLAIMS INFORMATION

Procedures for Presenting Claims for Benefits

All claim forms needed to file for benefits under the group insurance program can be obtained from the Employer who will also be ready to answer questions about the insurance benefits and to assist you or, if applicable, the claimant in filing claims. The instructions on the claim form should be followed carefully. This will expedite the processing of the claim. Be sure all questions are answered fully.

Life and Accidental Death and Dismemberment Benefits Claims

Claim Submission

In submitting claims for life and accidental death and dismemberment benefits ("Benefits"), the claimant must complete the appropriate claim form and submit the required proof as described in the certificate.

Claim forms must be submitted in accordance with the instructions on the claim form.

Initial Determination

After MetLife receives your claim for Benefits, MetLife will review your claim and notify you of its decision to approve or deny your claim.

Such notification will be provided to you within a reasonable period, not to exceed 90 days from the date we received your claim, unless MetLife notifies you within that period that there are special circumstances requiring an extension of time of up to 90 additional days.

If MetLife denies your claim in whole or in part, the notification of the claims decision will state the reason why your claim was denied and reference the specific Plan provision(s) on which the denial is based. If the claim is denied because MetLife did not receive sufficient information, the claims decision will describe the additional information needed and explain why such information is needed. The notification will also include a description of the Plan review procedures and time limits, including a statement of your right to bring a civil action if your claim is denied after an appeal.

Appealing the Initial Determination

In the event a claim has been denied in whole or in part, you or, if applicable, your beneficiary can request a review of your claim by MetLife. This request for review should be sent in writing to Group Insurance Claims Review at the address of MetLife's office which processed the claim within 60 days after you or, if applicable, your beneficiary received notice of denial of the claim. When requesting a review, please state the reason you or, if applicable, your beneficiary believe the claim was improperly denied and submit in writing any written comments, documents, records or other information you or, if applicable, your beneficiary deem appropriate. Upon your written request, MetLife will provide you free of charge with copies of relevant documents, records and other information.

MetLife will re-evaluate all the information, will conduct a full and fair review of the claim, and you or, if applicable, your beneficiary will be notified of the decision. Such notification will be provided within a reasonable period not to exceed 60 days from the date we received your request for review, unless MetLife notifies you within that period that there are special circumstances requiring an extension of time of up to 60 additional days.

If MetLife denies the claim on appeal, MetLife will send you a final written decision that states the reason(s) why the claim you appealed is being denied, references any specific Plan provision(s) on which

the denial is based, any voluntary appeal procedures offered by the Plan, and a statement of your right to bring a civil action if your claim is denied after an appeal. Upon written request, MetLife will provide you free of charge with copies of documents, records and other information relevant to your claim.

Claims Involving Disability Determinations in connection with Life and Accidental Death and Dismemberment Insurance

Claim Submission

For any claim which requires a determination of disability in connection with life insurance or accidental death and dismemberment insurance, the claimant must complete the appropriate claim form and submit the required proof as described in the certificate. For example, if your Plan provides that you are not required to continue paying for your life insurance coverage after you are found to be disabled, or if your plan provides that a portion of your life insurance benefits are payable to you after you are found to be disabled, your request for such determination is treated as a claim involving a disability determination.

Claim forms must be submitted in accordance with the instructions on the claim form.

Please note that for some plans such claims involving disability determination are decided by employers. If that is the case for your plan, your employer rather than MetLife may administer the procedure below.

Initial Determination

After MetLife receives your claim involving a disability determination, MetLife will review your claim and notify you of its decision to approve or deny your claim.

Such notification will be provided to you within a reasonable period, not to exceed 45 days from the date we received your claim; except for situations requiring an extension of time because of matters beyond the control of the Plan, in which case MetLife may have up to two (2) additional extensions of 30 days each to provide you such notification. If MetLife needs an extension, it will notify you prior to the expiration of the initial 45 day period (or prior to the expiration of the first 30 day extension period if a second 30 day extension period is needed), state the reason why the extension is needed, and state when it will make its determination. If an extension is needed because you did not provide sufficient information or filed an incomplete claim, the time from the date of MetLife's notice requesting further information and an extension until MetLife receives the requested information does not count toward the time period MetLife is allowed to notify you as to its claim decision. You will have 45 days to provide the requested information from the date you receive the extension notice requesting further information from MetLife.

If MetLife denies your claim in whole or in part, the notification of the claims decision will state the reason why your claim was denied and reference the specific Plan provision(s) on which the denial is based. If the claim is denied because MetLife did not receive sufficient information, the claims decision will describe the additional information needed and explain why such information is needed. The notification will also include a description of the Plan review procedures and time limits, including a statement of your right to bring a civil action if your claim is denied after an appeal.

Appealing the Initial Determination

If MetLife denies your claim, you may appeal the decision. Upon your written request, MetLife will provide you free of charge with copies of documents, records and other information relevant to your claim. You must submit your appeal to MetLife at the address indicated on the claim form within 180 days of receiving MetLife's decision. Appeals must be in writing and must include at least the following information:

- Name of Employee
- Name of the Plan
- Reference to the initial decision
- An explanation why you are appealing the initial determination

As part of your appeal, you may submit any written comments, documents, records, or other information relating to your claim.

After MetLife receives your written request appealing the initial determination, MetLife will conduct a full and fair review of your claim. Deference will not be given to the initial denial, and MetLife's review will look at the claim anew. The review on appeal will take into account all comments, documents, records, and other information that you submit relating to your claim without regard to whether such information was submitted or considered in the initial determination. The person who will review your appeal will not be the same person as the person who made the initial decision to deny your claim. In addition, the person who is reviewing the appeal will not be a subordinate of the person who made the initial decision to deny your claim. If the initial denial is based in whole or in part on a medical judgment, MetLife will consult with a health care professional with appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional will not have consulted on the initial determination, and will not be a subordinate of any person who was consulted on the initial determination.

MetLife will notify you in writing of its final decision within a reasonable period of time, but no later than 45 days after MetLife's receipt of your written request for review, except that under special circumstances MetLife may have up to an additional 45 days to provide written notification of the final decision. If such an extension is required, MetLife will notify you prior to the expiration of the initial 45-day period, state the reason(s) why such an extension is needed, and state when it will make its determination. If an extension is needed because you did not provide sufficient information, the time period from MetLife's notice to you of the need for an extension to when MetLife receives the requested information does not count toward the time MetLife is allowed to notify you of its final decision. You will have 45 days to provide the requested information from the date you receive the notice from MetLife.

If MetLife denies the claim on appeal, MetLife will send you a final written decision that states the reason(s) why the claim you appealed is being denied, references any specific Plan provision(s) on which the denial is based, any voluntary appeal procedures offered by the Plan, and a statement of your right to bring a civil action if your claim is denied after an appeal. Upon written request, MetLife will provide you free of charge with copies of documents, records and other information relevant to your claim.

Routine Questions

If there is any question about a claim payment, an explanation may be requested from the Employer who is usually able to provide the necessary information.

Discretionary Authority of Plan Administrator and Other Plan Fiduciaries

In carrying out their respective responsibilities under the Plan, the Plan Administrator and other Plan fiduciaries shall have discretionary authority to interpret the terms of the Plan and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

STATEMENT OF ERISA RIGHTS

The following statement is required by federal law and regulation.

As a participant in The Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, all Plan documents governing the Plan, including insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor, and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the policyholder's benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including the Employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees.

If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest Office of the Employee Benefits Security Administration, U.S. Department of Labor listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

FUTURE OF THE PLAN

It is hoped that This Plan will be continued indefinitely, but UAW/UMass Health & Welfare Trust Fund reserves the right to change or terminate the Plan in the future. Any such action would be taken only after careful consideration.

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

This Fourth Amendment to the Fee for Service Agreement ("Agreement") is effective September 1, 2023, (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, 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. Exhibit B shall be revised in its entirety as attached hereto.

II. 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, 2023.

EyeMed Vision Care, LLC

First American Administrators, Inc.

By: 

By: 

Name: Jason Rome

Name: Jason Rome

Title: Senior Vice President

Title: Senior Vice President

Date: October 25, 2023

Date: October 25, 2023

UAW/UMass Health & Welfare Trust Fund

By: 

Reviewed As to Form by EyeMed Legal:



Name: Leslie Edwards Davis

Director of Benefits

Title: 10/24/23

Date: _____

Exhibit B – Benefit Schedule - Page 1

BENEFITS

UAW/UMass Health & Welfare Trust



Benefits

+ \$10 FA
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	\$10 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, II, or III	\$30, \$40, or \$55 copay	Up to \$100
Progressive – Premium Tier IV	\$10 copay; 20% off retail price less \$120 allowance	Up to \$95
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 36 month contract and 36 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.

Plan Details

Quote for group situated in the State of MA and will be valid until the 09/01/2023 implementation date. Date Quoted 08/01/2023. 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

9/21/23

Signature

P201603 TCO Q-C0042631 QL-0000095870

Date

MEMBER SAVINGS

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

Tint – Solid or Gradient \$15

UV Treatment \$15

All Other Lens Options 20% off retail price

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 64%OFF

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



Members can get exclusive additional discounts and deals that are often stackable with their vision benefits at member.eyemedvisioncare.com

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.

P201603 TCO Q-C0042631 QL-0000095870

Exhibit B – Benefit Schedule - Page 3



UAW/UMass Health & Welfare Trust Fund

Proposed benefits	DIABETIC CARE SERVICES	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER REIMBURSEMENT
	<i>For Type 1 or Type 2 Diabetes with Diabetic Retinopathy</i>		
Option Diabetic	Medical Follow-Up Eye Examination	\$0 copay	Up to \$77
Exam & Materials	Fundus Photography Examination	\$0 copay	Up to \$50
Select Network	Extended Ophthalmoscopy (initial and subsequent)	\$0 copay	Up to \$15
ASO	Gonioscopy	\$0 copay	Up to \$15
Employer Paid	Scanning Laser	\$0 copay	Up to \$33
Funded Benefits			

*Benefit frequency: All Diabetic Care Services are covered once every 6 months**

QL-0000070171

Definitions:

Medical Follow-Up Eye 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 and report.

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.

	<p style="text-align: center;">FEE FOR SERVICE AGREEMENT</p>	 <p style="text-align: center; font-size: small;">A wholly owned subsidiary of EyeMed Vision Care</p>
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UAW/UMass Health & Welfare Trust Fund

This Agreement is entered into by and between EyeMed Vision Care, L.L.C. ("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 329 Middlesex House, 111 County Circle, Amherst, MA 01003-9255, as Plan Sponsor and Plan Administrator, on behalf of itself and its ERISA plan ("Plan Sponsor").

RECITALS

Plan Sponsor is an employer that provides benefits for its employees and their qualified dependents and now intends to offer vision benefits to such Participants (as defined herein);

Plan Sponsor has elected to pay for these vision benefits by self-funding vision benefits under its ERISA plan (the "ERISA Plan") and contracting out claims administration and Vision Network administration services;

Plan Sponsor wishes to engage the services of EyeMed to provide a vision benefit, claims administration, and Vision Network administration to assist employer in their responsibilities as Plan Sponsor and Plan Administrators for self-funded vision benefits;

EyeMed makes its Vision Network of Participating Providers available to Plan Sponsor's Members who have vision care coverage;

First American Administrators, Inc. ("FAA"), is a wholly owned subsidiary of EyeMed and a duly licensed third-party administrator in required states to provide certain administrative services available to Plan Sponsor's Members who have vision care coverage contained in their Plans.

NOW, THEREFORE, in accordance with the terms and conditions contained herein, the parties agree as follows:

I. EFFECTIVE DATE, TERM AND RENEWAL

A. Effective Date

This Agreement is effective November 1, 2010 ("Effective Date") and shall continue until terminated pursuant to this Agreement. For purposes of this Agreement: (i) all references to "Business Days" shall mean a day when both EyeMed and/or FAA and Plan Sponsor are open for business, excluding Saturday and Sunday; and (ii) any references to a particular time of the day shall be considered Eastern Time.

B. Term

The Agreement shall commence on the Effective Date have an initial 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 XIII.

C. Renewal

At least one hundred twenty (120) calendar days prior to the end of the current term, EyeMed shall provide Plan Sponsor with written notice of the Vision Benefits revised rates for the renewal period. If Plan Sponsor does not agree to the revised rates, this Agreement shall terminate at the end of the current term.

D. Definitions

Capitalized terms and otherwise defined terms within the section are defined on Exhibit A.

II. RESPONSIBILITIES OF EYEMED

A. Services

EyeMed shall provide the following:

1. Vision Benefit

EyeMed shall make available to Members the Vision Benefit as set forth on Exhibit B at Participating Provider locations. EyeMed shall also provide additional services, including but not limited to, responding to questions from Members, Providers and Plan Sponsor regarding Vision Benefits.

2. Enrollment Information for Participants

EyeMed shall maintain Participant enrollment records based on and in reliance upon data furnished to it by Plan Sponsor or its agent.

3. Identification Cards/Member Materials/SPD Review

EyeMed shall design, produce and distribute identification cards. In addition, upon request, EyeMed shall make available open enrollment materials and other communication materials. EyeMed agrees to review and advise concerning the description of Vision Benefits within Plan documents, including the Summary Plan Description and other materials intended for distribution to Participants.

4. Customer Service

EyeMed shall train and maintain adequate levels of staff as determined by EyeMed and provide a toll-free telephone number to respond to inquiries from Plan Sponsor's administrative staff, Members and Participating Providers concerning the Vision Benefit.

5. Web Access

EyeMed will maintain web access to the Vision Benefit and Member's eligibility information.

6. Usage Reporting

EyeMed shall provide standard usage reports quarterly, as defined by EyeMed, at no charge. All other requested reports shall be produced upon the mutual agreement of the parties, including but not limited to any associated cost(s) for such report(s).

7. Reporting Assistance for Plan Sponsor

EyeMed shall provide to Plan Sponsor reports regarding the financial and claims experience of the Plan, and other information the Plan Sponsor reasonably requires that assists Plan Sponsor in its compliance with income tax, ERISA reporting and disclosure requirements.

B. Provider Network Services and Provider Locator Service

1. Participating Provider Network

EyeMed shall provide a Vision Network of ophthalmologists, optometrists, opticians, and retail optical locations that are contracted with EyeMed to deliver services consisting of vision exams, materials, and contact lenses, at negotiated prices ("Participating Providers"). Any additions or deletions to the Vision Network shall be in EyeMed's sole discretion; provided, however, that EyeMed will make reasonable efforts to provide Plan Sponsor with reasonable advance notice of significant changes in the Vision Network, which would materially affect the nature or extent of services provided to Participants. EyeMed shall reimburse the Participating Provider at the rate contracted between EyeMed and the Participating Provider, which may be an amount different than what is set forth on Exhibit B.

2. Participating Provider Independent Contractor

EyeMed does not employ Participating Providers and such providers are not EyeMed's agents or partners. Participating Providers participate in the Vision Network only as independent contractors. Participating Providers are solely responsible for exercising professional judgment related to a Participant's care.

3. Participating Provider Locator

EyeMed shall maintain a provider locator service of Participating Providers that the Member may access through a toll-free telephone number or via the EyeMed website.

4. Credentialing

EyeMed shall credential, contract with, and re-credential each ophthalmologist and optometrist in accordance with EyeMed's credentialing procedures, which meet NCQA standards. EyeMed may contract with a NCQA accredited credentials verification organization of their choice to perform verifications of the credentials.

5. Nondiscrimination

EyeMed's Participating Providers Agreement requires Participating Providers make its services available to Members on the same basis as those services are provided to all other patients, and that Participating Provider shall not discriminate on the basis of age, sex, race, religion, or color.

6. Balance Billing

EyeMed's Participating Provider Agreement requires providers to not balance bill Members for Vision Benefits; provided, however, a Participating Provider shall collect from Members any copayment or coinsurance amounts for which Members are financially obligated under the ERISA Plan and any non-covered service(s).

C. Claims Processing Services

1. Claims Submission

FAA shall process in-network and out-of-network claims for Vision Benefits. In-network claims will be submitted directly to FAA by the Participating Provider. Out-of-network claims must initially be paid by the Member in full; the Member may then submit the out-of-network claim directly to FAA on the appropriate claim form. EyeMed shall make the out-of-network claim form available to Members through a toll-free telephone number or on the EyeMed website.

2. Claims Delegation

Plan Sponsor delegates to FAA the discretionary authority to determine the validity of claims and appeals under the ERISA Plan.

3. Claims Processing Services

FAA shall: (a) determine the amount of Vision Benefits payable, if any, for each claim; (b) notify the Member its decision concerning the claim; (c) disburse payments to the Participating Provider (per the Participating Provider Agreement) or the Member (per the out-of-network information on Exhibit B), as applicable. FAA's services under this paragraph shall comply with the provisions of ERISA Section 503 and its implementing regulations, to the extent that they address initial claims for benefits.

4. Claims Review Services

FAA shall provide for a review of denied claims upon request by the Member. FAA shall notify the Member of its decision on review. FAA's services under this paragraph shall comply with the provisions of ERISA Section 503 and its implementing regulations, to the extent that they address decisions on review.

5. Run-Out Claims Services

After the termination of this Agreement, FAA shall continue to provide claims processing services and claims review services, but only for those claims incurred prior to the date of termination of the Agreement. FAA shall provide such services for a period of 12 calendar months (the "Run-Out Period") following termination. During the Run-Out Period, FAA will continue to invoice the Plan Sponsor for the claims cost, and will additionally invoice the Plan Sponsor for an administrative fee equal to 6% of the claims cost. Plan Sponsor will be responsible for payment of such invoices. Invoicing and payment procedures applicable during the term of this Agreement shall continue to be applicable during the Run-Out Period. This clause shall survive the termination of this Agreement.

III. RESPONSIBILITIES OF PLAN SPONSOR

A. Responsibility for the ERISA Plan

1. Plan Administrator

Plan Sponsor is the Plan Administrator (as that term is defined in Section 3 (16) of the Employee Retirement Income Security Act of 1974 ("ERISA")) of the Plan. Plan Sponsor may name another entity or individual as Plan Administrator, provided that such Plan Administrator is not EyeMed or FAA and is not an EyeMed or FAA employee. EyeMed or FAA expressly decline to accept responsibility for being Plan Administrator.

2. Final Authority for the Plan

Plan Sponsor retains all final authority and responsibility for the Plan and its operations. Both parties shall be responsible for compliance with any and all applicable laws and regulations.

3. Plan Amendment and Certification from Plan Sponsor

Plan Sponsor represents and warrants that: (a) its ERISA Plan documents have been amended, in accordance with 45 CFR §164.504(f), so as to allow Plan Sponsor to receive Protected Health Information; (b) the Plan Sponsor has received a certification from the ERISA Plan in accordance with 45 CFR §164.504(f)(2)(ii), and will provide a copy of such certification to EyeMed prior to the Effective Date; (c) the ERISA Plan document amendments permit Plan Sponsor to receive detailed invoices from FAA; and (d) Plan Sponsor has determined, through its own policies and procedures, that the detailed invoice from FAA contains the minimum information necessary for Plan Sponsor to carry out its payment and health care operations.

B. Enrollment Services

1. Participant Enrollment Information

Plan Sponsor will determine Participants eligibility in the Plan and provide EyeMed with data sufficient to enable EyeMed to maintain accurate Participant enrollment records. In the event benefits under the Plan are made available to an individual who is no longer eligible to receive such benefits resulting from Plan Sponsor's failure to timely notify FAA of the ineligibility of such individual, Plan Sponsor shall be liable to FAA for the payment of all benefits provided to such individual.

2. Membership File.

Plan Sponsor shall be responsible for determining and identifying those individuals that the Plan Sponsor determines is eligible to receive vision benefits under the ERISA Plan.

(a) Data Format. Plan Sponsor will provide EyeMed with electronic Member enrollment in either (i) the EyeMed standard data layout format; or (ii) the format required by the HIPAA rule governing the enrollment and disenrollment in a health plan transaction, as outlined in 42 CFR 162.1502, as it may be amended from time to time.

(b) Data Transmission Method. The electronic Member enrollment information shall be sent to EyeMed utilizing either (i) a secure FTP transmission or (ii) secure email.

(c) Data Updates. Plan Sponsor agrees to provide full electronic file updates no more frequently than two (2) times per calendar month in the agreed to format. Plan Sponsor may also utilize the EyeMed Group Portal for interim additions, changes or deletions related to Members and Plan Sponsor agrees to include all such interim modifications on the next full electronic file update.

(d) Changes to Data Format. Plan Sponsor and EyeMed must mutually agree in advance to changes to the electronic data format. Plan Sponsor must contact the EyeMed Account Service Manager to submit a request to change the current data format.

(e) Data Accuracy and Reliance. Plan Sponsor represents and warrants that, to the best of its ability, the electronic Member enrollment will be accurate and that EyeMed may rely on such information to authorize services for such enrolled Members.

IV. INVOICING ARRANGEMENTS

A. Invoice for Vision Benefits

FAA shall invoice Plan Sponsor on a monthly basis for eligible claims processed and paid during the previous month ("Claims Invoice"). In addition, FAA shall invoice Plan Sponsor a monthly administration fee as set forth on Exhibit B ("Administrative Invoice"). The monthly Administrative Invoice shall be determined by multiplying the number of Members identified by Plan Sponsor's electronic Member enrollment by the applicable rate set forth on Exhibit B. For purposes of the Administrative Invoice, FAA will count the Members who are active and eligible for the applicable billing month as of the 15th day of each month prior to the billing month in which the invoice is issued to Plan Sponsor. For example, FAA will determine the active and eligible Members for the July invoice as of June 15th.

B. Payment of Invoice

Plan Sponsor shall pay the entire amount of both the Claims Invoice and Administrative Invoice (excluding only "Disputed Amounts", as defined below) within thirty (30) calendar days from the date of each invoice. If any non-Disputed Amount owed by Plan Sponsor to EyeMed and/or FAA is not paid within sixty (60) calendar days of the date of such invoice, EyeMed may apply interest equal to one and one-half percent (1.5%) per month. In addition, if any Disputed Amount agreed or

determined to be owed by Plan Sponsor to EyeMed is not paid within fifteen (15) business days from the date of such agreement or determination, EyeMed may apply interest equal to one and one-half percent (1.5%) per month. Payment shall be considered credited to the account of Plan Sponsor when received by EyeMed. As used herein, "Disputed Amounts" shall mean invoice amounts that are subject to a bona fide dispute raised by Plan Sponsor in a writing received by EyeMed within fifteen (15) calendar days of the date of an invoice therefore and with respect to which the parties are making reasonable, diligent and good faith efforts to resolve.

V. RECORDS MAINTENANCE AND AUDIT

A. Records Maintenance

EyeMed owns and shall keep all books and records necessary to reflect accurately the business it transacts with respect to Plan Sponsor and to determine the respective rights of the parties under this Agreement. Such books and records shall be kept at the principal place of business of EyeMed or at such other location as EyeMed determines in its sole discretion. All records will be maintained for a period of at least seven (7) years after the date they are first prepared or for such longer period as may be required by law.

B. Audit

During the term of the Agreement, and at any time within twelve (12) months following its termination, Plan Sponsor or a mutually agreeable entity or a regulatory authority with jurisdiction over Plan Sponsor may audit or inspect the records of EyeMed and/or FAA to determine whether EyeMed and/or FAA is fulfilling the terms of this Agreement. Plan Sponsor must advise EyeMed and/or FAA at least thirty (30) calendar days in advance of Plan Sponsor's intent to audit. The place, time, type, duration, and frequency of all audits must be agreed to in writing by EyeMed and/or FAA in advance of the audit, which approval shall not be unreasonably withheld, excluding any information, including but not limited to, reports that EyeMed considers to be proprietary.

1. All audits shall be on a regular business day, during normal business hours and conducted in such manner as to avoid, to the extent reasonably possible, interference with the normal business functions of EyeMed and/or FAA. Plan Sponsor shall be solely responsible for all costs of the audit, except for any EyeMed and/or FAA employee time and office space. In addition, Plan Sponsor shall have the right to make copies, at Plan Sponsor's expense, of applicable files, records or other information maintained by EyeMed and/or FAA related to Plan Sponsor.

2. All audits shall be limited to information relating to the calendar year in which the audit is conducted and/or the immediately preceding calendar year. With respect to EyeMed's and/or FAA's transaction processing services, the audit scope and methodology shall be consistent with generally acceptable auditing standards, including a statistically valid random sample or other acceptable audit technique as approved in writing.

3. Plan Sponsor will provide EyeMed and/or FAA with a copy of any audit reports.

VI. INDEMNIFICATION

A. EyeMed and/or FAA Indemnification to Plan Sponsor

EyeMed and/or FAA will indemnify, defend and hold Plan Sponsor harmless from and against any loss, cost, damage, expense or other liability, including, without limitation, reasonable costs and reasonable attorney fees ("Costs") incurred in connection with any third party claims, suits, investigations or enforcement actions, including claims of infringement of any intellectual property rights ("Claims") which may be asserted against, imposed upon or incurred by Plan Sponsor and arising as a result of (i) EyeMed's and/or FAA's negligent acts or omissions or willful misconduct, or (ii) EyeMed's and/or FAA's breach of its obligations under this Agreement. EyeMed and/or FAA shall not be liable to Plan Sponsor for any third party claims, suits, investigations or enforcement actions, arising directly or indirectly from the acts or omissions of a Participating Provider.

B. Plan Sponsor Indemnification to EyeMed and/or FAA

Plan Sponsor will indemnify, defend and hold EyeMed and/or FAA harmless from and against any loss, cost, damage, expense or other liability, including, without limitation, reasonable costs and reasonable attorney fees ("Costs") incurred in connection with any third party claims, suits, investigations or enforcement actions, including claims of infringement of any intellectual property rights ("Claims") which may be asserted against, imposed upon or incurred by EyeMed and/or FAA and arising as a result of (i) Plan Sponsor's negligent acts or omissions or willful misconduct, or (ii) Plan Sponsor's breach of its obligations under this Agreement.

C. Notification of Claim

The party seeking indemnification shall notify the indemnifying party in writing within thirty (30) calendar days of receipt of any Claim for which indemnification may be sought hereunder, and shall tender the defense of such claim to the indemnifying party thereafter.

D. Survival

This clause shall survive the termination of this Agreement.

VII. INSURANCE**A. Commercial General Liability Insurance**

EyeMed shall maintain Commercial General Liability Insurance, including coverage for contractual liability, public liability, property damage, products-completed operations, cross liability and severability of interest claims, personal injury and advertising injury, with limits of at least:

\$3,000,000 per occurrence
\$6,000,000 general aggregate

B. Workers' Compensation Insurance

EyeMed shall maintain Workers' Compensation Insurance with benefits afforded under the laws of any state in which the services are to be performed and Employer's Liability insurance with limits of at least:

\$1,000,000 for Bodily Injury – each accident
\$1,000,000 for Bodily Injury by disease – policy limits
\$1,000,000 for Bodily Injury by disease – each employee

In states where Workers' Compensation Insurance is a monopolistic state-run system, EyeMed shall maintain Stop Gap Employer's Liability insurance with limits not less than One Million Dollars (\$1,000,000) each accident or disease.

C. Business Automobile Insurance

EyeMed shall maintain Business Automobile Insurance with limits of at least One Million Dollars (\$1,000,000) each accident for bodily injury and property damage, extending to all owned, hired and non-owned vehicles.

D. Commercial Crime Insurance

EyeMed shall maintain Commercial Crime Insurance with a limit of not less than Three Million Dollars (\$3,000,000). The policy shall provide Employee Theft, Premises, Transit, Depositor's Forgery and Computer Theft and Funds Transfer coverages. The Commercial Crime policy shall include a third party customer property coverage endorsement with limits of at least One Million Dollars (\$1,000,000).

E. Managed Care Error and Omissions Insurance

EyeMed shall maintain Managed Care Organization Errors and Omissions Insurance with a policy limit of not less than Three Million Dollars (\$3,000,000) each claim and in the aggregate.

F. Policies of Insurance--Financial Rating

All policies of insurance required of EyeMed herein shall be issued by insurance companies having and maintaining a Financial Strength Rating of "A minus" or better and a Financial Size Category of "VII" or better in the A.M. Best Key Rating Guide for Property and Casualty Insurance Companies, except that, in the case of Workers' Compensation insurance, EyeMed may procure insurance from the stated fund of the state where services are to be provided.

G. Proof of Insurance

Upon Plan Sponsor's written request, certificates of insurance shall be delivered to Plan Sponsor upon execution of the Agreement. All policies of insurance will provide for at least thirty (30) days prior written notice to Plan Sponsor of the cancellation or substantial modification thereof. All policies required of EyeMed herein shall be endorsed to read that such policies are primary policies and any insurance carried by Plan Sponsor shall be noncontributing with such policies.

VIII. LICENSE TO USE NAME AND TRADEMARKS**A. Plan Sponsor's Use of EyeMed's Name**

Plan Sponsor may use the EyeMed name, as provided by EyeMed (the "Licensed Marks") solely in connection with communicating the Vision Benefit to its Members, and shall not use the Licensed Marks or any other trademarks, services marks or trade names of EyeMed (the "Trademarks") for any other purpose. Plan Sponsor shall not use EyeMed's logo without prior written consent or inconsistent with the attached Link and Logo Terms and Conditions related to website linking. Plan Sponsor shall not question, contest or challenge EyeMed's rights in and to the Trademarks, nor seek to register the same. Plan Sponsor expressly recognizes and acknowledges that the use of the Licensed Marks shall not

confer upon Plan Sponsor any proprietary rights to such marks. Upon termination of this Agreement, Plan Sponsor shall immediately stop using the Licensed Marks.

B. EyeMed's Use of Plan Sponsor's Name

EyeMed may use Plan Sponsor's name and logo(s) as provided by Plan Sponsor (the "Licensed Marks") solely in connection with communicating the Vision Benefit, and shall not use the Licensed Marks or any other trademarks, service marks or trade names of Plan Sponsor ("Trademarks") for any other purpose. EyeMed shall not question, contest or challenge Plan Sponsor's rights in and to the Trademarks, nor seek to register the same. EyeMed expressly recognizes and acknowledges that the Licensed Marks shall not confer upon EyeMed any proprietary rights to such marks. Upon termination of this Agreement, EyeMed shall immediately stop using the Licensed Marks.

C. Remedies

The parties expressly agree and understand that the remedy at law for any breach by it of the terms of this section would be inadequate and the damages flowing from such breach are not readily susceptible to being measured in monetary terms. Accordingly, it is acknowledged by each party that upon its breach of any provision of this section, the non-breaching party shall be entitled to seek immediate injunctive relief and may seek to obtain a temporary order restraining any threatened or further breach without the necessity of proof of actual damage. Nothing contained herein shall be deemed to limit the non-breaching party's remedy at law or in equity for any breach by the breaching party of the provisions of this section which may be pursued or availed of by the non-breaching party.

X. WEBSITE LINKING BY PLAN SPONSOR

EyeMed is the owner or operator of a web site located at www.eyemedvisioncare.com (the "EyeMed Site"). Plan Sponsor is the owner or operator of a web site (the "Plan Sponsor Site"). EyeMed and Plan Sponsor desire to allow users of the Plan Sponsor Site to link to the EyeMed Site landing on EyeMed's home page.

In the event Plan Sponsor establishes a hyperlink from Plan Sponsor's Site to EyeMed's site the parties hereby agree to the terms and conditions as set forth in the attached Link and Logo Terms and Conditions, Exhibit C.

X. PROTECTION OF CONFIDENTIAL INFORMATION

Plan Sponsor and EyeMed shall not disclose to any other person, firm or corporation, or use for its own benefit except as provided herein, the terms of this Agreement, or any information that it receives from the other party that is marked either "Confidential" or "Proprietary" or "Strictly Private" or "Internal Data," or that is any unmarked information in the form of financial information or trade secrets (collectively referred to as "Confidential Information"), without the express written authorization of the other party. Both parties shall take all necessary steps to protect the other party's trade secrets and confidential business information and records. Upon the termination of this Agreement, both parties agree to return any and all materials containing such Confidential Information, plus any and all copies, written or machine made, in whatever medium, that it may have, within ten (10) days of a request from the other party.

Confidential Information shall not include information that:

- A. Was, at the time of receipt, otherwise known to the recipient without restrictions as to use or disclosure;
- B. Was in the public domain at the time of disclosure or thereafter enters into the public domain through no breach of this Agreement by the recipient;
- C. Becomes known to the recipient from a source other than the disclosing party, which source has no duty of confidentiality with respect to the information;
- D. Is independently developed by the recipient without reliance on or access to any of the disclosing party's Confidential Information; or
- E. Is required to be disclosed by a government agency or bureau, by a court of law or equity with competent jurisdiction over the recipient or by a recognized body engaged in professional self-regulation (such as national accounting or auditing associations), provided that the recipient will first have provided the disclosing party with prompt written notice of such required disclosure and will take reasonable steps to allow the disclosing party to seek a protective order with respect to the Confidential Information required to be disclosed. The recipient will promptly cooperate with and assist the disclosing party, at the disclosing party's expense, in connection with obtaining such protective order.

XI. BUSINESS ASSOCIATE AGREEMENT/HIPAA PRIVACY

In order to comply with the Administrative Simplification Provisions of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et. seq., and regulations promulgated thereunder, as amended from time to time (statute and regulations hereafter collectively referred to as "HIPAA"), the parties hereby agree to the terms and conditions described in the attached Business Associate Agreement-HIPAA Privacy, Exhibit D. Terms used, but not otherwise defined, shall have the same meaning as those terms in HIPAA.

XII. TERMINATION

A. Voluntary Termination

This Agreement may be terminated, without cause: (i) by mutual written agreement of the parties; or (ii) by either party providing sixty (60) days prior written notice without cause to the other party at any time during the term of the Agreement or any renewal term.

B. Termination for Cause or Default

Either party may terminate this Agreement if the other party is in material breach of this Agreement and fails to cure such breach within thirty (30) calendar days after receiving written notice reasonably detailing such breach. In the event that the breach is not cured within the thirty (30) day cure period, this Agreement shall terminate in accordance with the initial notice of breach. Additionally, either party shall be deemed to have materially breached this Agreement upon the occurrence of any of the following events, which list is not intended to be inclusive of what constitutes a material breach:

1. Either party shall become insolvent or otherwise admit in writing its inability to pay its debts when they become due, becomes bankrupt, seeks protection under any law for the protection of insolvents, or have a receiver or conservator appointed under any law pertaining to such party's insolvency.
2. Either party fails to remit any amounts due (excluding Disputed Amounts") under this Agreement within thirty (30) calendar days of the date such amount is due and payable.
3. Either party shall knowingly commit a material violation of the laws or regulations of any state where this Agreement is performed.
4. Any misrepresentation or falsification of any information supplied by Plan Sponsor or EyeMed for consideration by the other, except that EyeMed will not be responsible for any misrepresentation or falsification of information provided to it by a Participating Provider.
5. EyeMed or Plan Sponsor ceases to engage in all business activities.
6. EyeMed substantially fails to perform its obligations under this Agreement, including but not limited to maintaining an adequate Vision Network of Participating Providers, maintaining a Participating Provider locator service for Members to be able to locate Participating Providers, and maintaining sufficient customer service representatives to answer Member and Participating Provider calls.
7. FAA is in default of its payment obligations to any Participating Provider or Members with respect to the services rendered under this Agreement to the Member and fails to cure such default within ten (10) business days of written notice from Plan Sponsor, so long as FAA does not dispute in good faith the amount that is owed to the Participating Provider or Member. If FAA disputes in good faith that any money is owed or the amount which is owed, FAA is not in default under this Agreement.

XIII. GENERAL PROVISIONS

A. Requirements Imposed by Law

Each party agrees to adhere to legal requirements imposed by federal, state or other law as of the date such law becomes effective and applicable to this Agreement.

B. Independent Contractor

In the performance of the work, duties and obligations of the parties pursuant to this Agreement, each of the parties shall at all times be acting and performing as an independent contractor, and nothing in this Agreement shall be construed or deemed to create a relationship of employer and employee or partner or principal and agent.

C. Governing Law

This Agreement shall be governed by and construed in accordance with ERISA, federal law, and to the extent not preempted, by the laws of the State of Ohio.

D. Entire Contract

This Agreement together with all attachments contains all the terms and conditions agreed upon by the parties, and supersedes all other agreements, express or implied regarding the subject matter.

E. Waiver

The waiver of any party of any breach of this Agreement shall not be construed as a continuing waiver or a waiver of any other breach of this Agreement.

F. Attorney Fees

If EyeMed or Plan Sponsor find it necessary to enforce any part of this Agreement through legal proceedings, resulting in final judgment by a court of competent jurisdiction, Plan Sponsor and EyeMed agree that each party shall pay all of their own costs and attorneys' fees incurred for such purpose.

G. Severability

In the event that any clause, term, or condition of this Agreement shall be held invalid or contrary to law, this Agreement shall remain in full force and effect as to all other clauses, terms, and conditions.

H. Force Majeure

No party to this Agreement shall be liable for failure to perform any duty or obligation that such party may have under this Agreement where such failure has been caused by an act of God, fire, flood, strike, unavoidable accident, war or any cause outside the reasonable control of the party who had the duty to perform.

I. Heading

The section headings used herein are for reference and convenience only, and shall not enter into the interpretation hereof.

J. Counterparts

This Agreement may be executed in several counterparts, each of which shall be deemed an original, but all of which shall constitute one Agreement.

K. Assignment

This Agreement may not be assigned by a party, in whole or in part, without the prior written consent of the other, except that a party may, without the consent of the other, assign this Agreement to an affiliate.

L. Successor/Survival

All terms of this Agreement shall be binding upon, inure to the benefit of, and be enforceable by the parties hereto and their respective successors and assigns. All rights and obligations of the parties arising out of this Agreement prior to termination which by their nature are designed or intended to continue shall survive the termination of this Agreement.

M. Amendments

This Agreement may be amended from time to time by mutual agreement between Plan Sponsor and EyeMed, which amendment shall be in writing signed by the parties. Notwithstanding any provision contained herein to the contrary, each party shall have the right, for the purpose of complying with the provisions of any law or lawful order of a court or regulatory authority, to amend this Agreement including any Exhibits hereto, to increase, reduce or eliminate any of the Vision Benefits provided under this Agreement. If the parties cannot agree to an amendment, notwithstanding any provision of this Agreement to the contrary, Plan Sponsor or EyeMed may terminate this Agreement as of the end of any month by the giving of ninety (90) days prior written notice.

N. No Third Party Beneficiaries. Nothing express or implied in this Agreement is intended or shall be construed to confer upon or give any person, other than Plan Sponsor and EyeMed, any right or remedies under or by reason of this Agreement.

O. Notice

All notices, requests and demands under this Agreement shall be in writing. They shall be deemed to have been given upon delivery if (i) delivered in person, (ii) mailed by certified mail, postage pre-paid and return receipt requested, and (iii) deposited with an overnight delivery service by a nationally recognized overnight courier service. Notice shall be effective upon receipt and shall be directed to the individuals below and at the address in the first paragraph.

If to Plan Sponsor:

Ms. Leslie Edwards
Benefits Administrator

If to EyeMed or FAA

Ms. Liz DiGiandomenico
President
CC: EyeMed Legal

IN WITNESS WHEREOF, the undersigned have executed this Agreement.

EyeMed Vision Care, LLC

By: [Signature]
nevin thist

Title: VP-client services

Date: 11-5-10

First American Administrators, Inc.

By: [Signature]
nevin thist

Title: VP client services

Date: 11-5-10

UAW/UMass Health & Welfare Trust Fund

x By: Susan Chinman
Name: Susan Chinman
Title: University Trustee
Date: 10/22/10

x [Signature]
Ronald R. Potnowicz
President UAW 2322
10/22/10

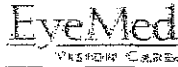
EXHIBIT A- DEFINITIONS

I. DEFINITIONS

The following terms used in this Agreement shall have the meaning as set forth hereafter:

- A. "Agreement" shall mean the Fee for Service Agreement between EyeMed and/or FAA and Plan Sponsor
- B. "Business Days" shall mean a day when both EyeMed and/or FAA and Plan Sponsor are open for business, excluding Saturday and Sunday.
- C. "ERISA" shall mean the Employee Retirement Income Security Act of 1974.
- D. "HIPAA" shall mean Health Insurance Portability and Accountability Act of 1996.
- E. "Members" shall mean the Participant and eligible dependents who have health benefits under the ERISA Plan.
- F. "PHI" shall mean Protected Health Information.
- G. "Participants " shall mean the individual who has an employment arrangement, contractual arrangement, or affiliation with Plan Sponsor.
- H. "Participating Provider" shall mean the ophthalmologists, optometrists, opticians, and retail optical locations who are contracted with EyeMed to deliver services consisting of vision exams, materials, and contact lenses, at negotiated prices.
- I. "Plan" or "ERISA Plan" shall mean the plan established by the employer or other entity for self-funding vision benefits.
- J. "Plan Administrator" shall mean the employer name in the plan document as responsible for day-to-day operations. Also known as the Plan Sponsor.
- K. "Plan Sponsor" shall mean the entity that sponsor the vision plan.
- L. "Vision Benefit" " shall mean the vision benefit as set forth on Exhibit B available to Members from Participating Providers.
- M. "Vision Network" shall mean the collection of Participating Providers; the specific network as identified on Exhibit B.

EXHIBIT B - BENEFIT SCHEDULE



UMASSRAW - GEO Vision
 EyeMed Select Plan H, Fee For Service
 100% Employer Paid - COB, Bundled With Group Medical or Dental
 Option 1

Version 4

Vision Care Services	Member Cost	Group Cost per Service	Out-of-Network
Exam with Dilatation as Necessary	\$10 Copay	Up to \$35	\$50
Exam Options:			
Standard Contact Lens Fit and Follow-Up:	Up to \$40	N/A	N/A
Premium Contact Lens Fit and Follow-Up:	10% off Retail	N/A	N/A
Frames:			
Any available frame at provider location	\$0 Copay, \$120 Allowance, 20% off balance over \$120	\$65	\$66
Standard Plastic Lenses			
Single Vision	\$10 Copay	\$25	\$42
Bifocal	\$10 Copay	\$45	\$78
Trifocal	\$10 Copay	\$50	\$130
Standard Progressive Lens**	\$25	\$55	\$75
Premium Progressive Lens**	\$25, 60% of Charge less \$120 Allowance	\$55	\$75
Lens Options:			
UV Treatment	\$15	\$0	N/A
Tint (Solid and Gradient)	\$15	\$0	N/A
Standard Plastic Scratch Coating	\$15	\$0	N/A
Standard Polycarbonate - Adults	\$40	\$0	N/A
Standard Polycarbonate - Kids under 19	\$40	\$0	N/A
Standard Anti-Reflective Coating	\$45	\$0	N/A
Polarized	20% off Retail Price	\$0	N/A
Other Add-Ons	20% off Retail Price	\$0	N/A
Contact Lenses			
Contact Lens allowance includes materials only			
Conventional	\$0 Copay, \$135 allowance, 15% off balance over \$135	\$114.75	\$108
Disposable	\$0 Copay, \$135 allowance, plus balance over \$135	\$135	\$108
Medically Necessary	\$0 Copay, Paid-in-Full	Retail less 50%	\$200
Laser Vision Correction			
Laser or PRK from U.S. Laser Network	15% off retail price or 5% off promotional price	N/A	N/A
Additional Pairs Benefit:	Members also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used.	N/A	N/A
Frequency:			
Examination	Once every 12 months		
Lenses	Once every 12 months		
Contact Lenses	Once every 12 months		
Frame	Once every 12 months		
Monthly Administrative Fee			
Per Subscriber Per Month (Composite)	\$0.99		

All plans are based on a 48-month contract term and 48-month rate guarantee.

** Standard/Premium Progressive lenses not covered - fund as a Bifocal Lens

Additional Discounts:

Member receives a 25% discount on items not covered by the plan at network Providers, which cannot be combined with any other discounts or promotional offers. Discount does not apply to EyeMed Provider's professional services, or contact lenses.

Members also receive 10% off retail price or 5% off promotional price for Laser or PRK from the U.S. Laser Network, owned and operated by LCA Vision.

After initial purchase, replacement contact lenses may be obtained via the Internet at substantial savings and mailed directly to the member. Details are available at www.eyemedvisioncare.com.

The contact lens benefit allowance is not applicable to this service.

Benefit Allowances provide no replenishing balance for future use within the same Benefit Frequency.

Certain brand name Vision Materials in which the manufacturer imposes a no-discount practice.

Rules are valid for groups domiciled in the State of MA.

Fees quoted will be valid until the 1/1/2010 plan implementation date. Data quoted: 8/24/2010.

Rules assume 100% employer contribution for employees and dependents or that the Vision program is bundled with medical/dental benefit.

Plan Exclusions:

- 1) Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Artificially tinted lenses; 2) Medical (and/or surgical) treatment of the eye, eye or supporting structures;
- 3) Any eye or Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; Safety eyewear;
- 4) 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;
- 5) Plano (non-prescription) lenses and/or contact lenses; 6) Non-prescription sunglasses; 7) Two pair of glasses in lieu of bifocals;
- 8) Services or materials provided by any other group benefit plan providing vision care;
- 9) 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;
- 10) Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available.

If UMMASSRAW - GEO Vision has chosen this benefit design, attach this document to the group application and sign here:

Signature

Date

8/17/10

TCO

EXHIBIT C - LINK AND LOGO TERMS AND CONDITIONS

I. LINKING RIGHTS

A. Use of EyeMed Marks. EyeMed hereby grants Plan Sponsor the limited right to use the EyeMed Marks on the Plan Sponsor Site as a hyperlink to the EyeMed Site (the "Hyperlink"). "EyeMed Marks" means the trademarks, service marks, domain names, logos, and identifiers of EyeMed listed in Attachment A to this Agreement, which is incorporated herein.

B. Hyperlink. The Hyperlink will only be accessible to those Plan Sponsor Members users who are valid and existing Plan Sponsor Members. Plan Sponsor agrees to provide EyeMed upon request all information and data necessary to authenticate such users access to the EyeMed Site.

C. Ownership of Materials. Each Party retains all rights, title and interest in and to their respective web sites, including all intellectual property rights therein. All rights, title and interest in and to the EyeMed Marks, including all intellectual property rights therein, are owned and retained exclusively by EyeMed and its affiliates.

II. REPRESENTATIONS AND WARRANTIES.

A. EyeMed Marks. Plan Sponsor represents and warrants that: Plan Sponsor will not (i) use, register or attempt to register any EyeMed Mark as its own, (ii) use, register, or attempt to register any name, logo, mark, domain name, or other identifier which is likely to lead to confusion with the EyeMed Marks, (iii) use the EyeMed Marks in a manner likely to disparage or misrepresent EyeMed, or (iv) use the EyeMed Marks in a manner not expressly permitted by this Agreement or approved in writing by EyeMed. EyeMed represents and warrants that it owns the EyeMed Marks or otherwise has the right to grant the licenses granted herein.

B. The Sites. Each Party represents and warrants to the other with regard to its respective Site that (i) it is the owner or otherwise has the right to use and provide the Site; (ii) the Site is not and will not be obscene, defamatory, libelous, or otherwise offensive to a reasonable person; (iii) they employ customary security measures standard in the industry to protect access to the Sites and (iv) the Site will not be fraudulent, misleading, or in violation of any applicable law.

C. DISCLAIMER OF WARRANTY. EYMED EXPRESSLY DISCLAIMS, AND PLAN SPONSOR HEREBY EXPRESSLY WAIVES, ALL WARRANTIES, EXPRESS OR IMPLIED, INCLUDING, WITHOUT LIMITATION, WARRANTIES OF MERCHANTABILITY, NONINFRINGEMENT, AND FITNESS FOR A PARTICULAR PURPOSE WITH REGARD TO THE EYMED MARKS.

III. INDEMNIFICATION

Plan Sponsor shall indemnify, defend, and hold harmless EyeMed with respect to any third party claim, including reasonable attorneys' fees (collectively, "Claims"), to the extent that any such Claim is based upon improper access to the EyeMed Site via the Plan Sponsor Site, Breach of any of Plan Sponsor's representations or warranties under this Agreement or obligations under applicable law; or arises out of Plan Sponsor's negligence or willful misconduct.

**Attachment A
EYEMED MARKS**

Logo. The EyeMed logo most recently provided by EyeMed and described in this Attachment A (or in any such revised logo display standards) is the only logo that may be used by Plan Sponsor.

EyeMed
VISION CARE®

EyeMed Vision Care

Attachment B
EYEMED INTERNET USE GUIDELINES

Upon execution of the Fee for Services Agreement with EyeMed you will be granted the limited right to use the EyeMed name, trademarks and logos ("marks") in accordance with these Guidelines.

Requirements for Internet/Web Site Use and Hot Linking

Use of the EyeMed name and logo on your web site is permitted for the purpose of providing a link to the EyeMed web site (www.eyemedvisioncare.com), so long as the link satisfies all six (6) of the following requirements:

- a. Delivers users to the EyeMed homepage at www.eyemedvisioncare.com.
- b. Provides users with a "point and click" feature clearly indicating the link will lead to the EyeMed homepage at www.eyemedvisioncare.com.
- c. Does not represent or suggest any relationship between the linking site and EyeMed Vision Care (in suggestions of affiliation, endorsement, or sponsorship).
- d. Maintains the integrity of the EyeMed layout, content, and look and feel.
- e. Delivers users to the EyeMed web site, unaltered, unmodified, unadulterated in any way.
- f. Delivers the EyeMed content in its own browser and does not frame the EyeMed content in any way or through any action, including, but not limited to referencing EyeMed or EyeMed Vision Care as a metatag, which may create a misimpression or confusion among users with respect to sponsorship or affiliation.

Eligibility

Any deviation from these Guidelines require prior written approval from EyeMed. Questions regarding use of the EyeMed marks should be addressed to eyemedmarketing@eyemedvisioncare.com.

EXHIBIT D - BUSINESS ASSOCIATE ADDENDUM**I. DEFINITIONS**

- A. In General.** Terms used, but not otherwise defined, in this Addendum shall have the same meaning as those terms in the Applicable Law.
- B. Specific Definitions**
1. "Applicable Law" shall mean any of the following items, including any amendments to any such item as such may become effective:
 - a. the Health Insurance Portability and Accountability Act of 1996 ("HIPAA");
 - b. the federal regulations regarding privacy and promulgated with respect to HIPAA, found at Title 45 CFR Parts 160 and 164 (the "Privacy Rule");
 - c. the federal regulations regarding electronic data interchange and promulgated with respect to HIPAA, found at Title 45 CFR Parts 160 and 162 (the "Transaction Rule");
 - d. the federal regulations regarding security and promulgated with respect to HIPAA, found at Title 45 CFR Parts 160 and 164 (the "Security Rule"); and
 - e. the American Recovery and Reinvestment Act of 2009 ("ARRA"), §§ 13400-24.
 2. "Business Associate" shall mean EyeMed Vision Care, LLC and First American Administrators, Inc.
 3. "Covered Entity" shall mean the Plan Administrator and Plan Sponsor, on behalf of itself and the ERISA Plan.
 4. "ePHI" shall mean electronic protected health information within the meaning of 45 CFR § 160.103, limited to the information created, received, maintained, or transmitted by Business Associate from or on behalf of Covered Entity.
 5. "HIPAA Breach" shall have the same meaning as the term "breach" in 45 CFR § 164.402.
 6. "Protected Health Information" or "PHI" shall have the same meaning as the term "protected health information" in 45 CFR § 160.103, limited to the information created, received, maintained, or transmitted by Business Associate from or on behalf of Covered Entity.
 7. "Service Agreement" shall mean the Fee For Service Agreement.
 8. "Unsecured PHI" shall have the same meaning as the term "unsecured protected health information" in 45 CFR § 164.402, limited to the information created, received, maintained, or transmitted by Business Associate from or on behalf of Covered Entity.

II. RIGHTS AND OBLIGATIONS OF BUSINESS ASSOCIATE**A. General Obligations**

1. **Compliance with Privacy Rule**
 - a. Business Associate shall not use or further disclose PHI other than as permitted or required by HIPAA, the Privacy Rule, and this Addendum.
 - b. Business Associate shall use appropriate safeguards to prevent use or disclosure of the PHI other than as provided for by this Addendum.
 - c. Business Associate shall report to Covered Entity any use or disclosure of PHI, known to Business Associate, that is not permitted by this Addendum.
2. **Compliance with Security Rule.**
 - a. Business Associate shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of ePHI.

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- b. Business Associate shall report to Covered Entity any Security Incident of which Business Associate becomes aware.

3. Compliance with ARRA.

- a. Business Associate shall comply with the security breach notice requirements provided in Section II.A.4 of the Addendum below.
- b. Business Associate shall not receive remuneration, either directly or indirectly, in exchange for PHI, except as may be permitted by ARRA § 13405(d). This paragraph shall be effective 180 days after issuance of final regulations implementing ARRA § 13405.
- c. Pursuant to the Privacy Rule, made applicable to Business Associate by ARRA, Business Associate shall adopt, implement, and follow privacy policies and procedures in the same manner and to the same extent as if it were a Covered Entity. This paragraph shall be effective on and after February 17, 2010.
- d. Pursuant to the Security Rule, made applicable to Business Associate by ARRA, Business Associate shall adopt, implement, and follow security policies and procedures in the same manner and to the same extent as if it were a Covered Entity. This paragraph shall be effective on and after February 17, 2010.

4. Notice of Security Breach.

- a. **Notice to the Covered Entity.** Business Associate shall notify the Covered Entity without unreasonable delay and within thirty (30) calendar days of Business Associate's discovery of a HIPAA Breach of Unsecured PHI. The notice to the Covered Entity shall include the identity of each Individual whose Unsecured PHI was involved in the HIPAA Breach, a brief description of the HIPAA Breach and any mitigation efforts. To the extent that the Business Associate does not know the identities of all affected Individuals when it is required to notify the Covered Entity, the Business Associate shall provide such additional information as soon as administratively practicable after such information becomes available. For purposes of this paragraph, a HIPAA Breach shall be treated as discovered as of the first day on which the HIPAA Breach is known or should reasonably have been known to Business Associate (including any person, other than the one committing the HIPAA Breach, which is an employee, officer, or other agent of the Business Associate).
- b. **Notice to Individuals.** Business Associate will provide written notice of the HIPAA Breach of Unsecured PHI, on behalf of the Covered Entity, without unreasonable delay but no later than sixty (60) calendar days following the date the HIPAA Breach of Unsecured PHI is discovered or such later date as is authorized under 45 CFR § 164.412 to each Individual whose Unsecured PHI has been, or is reasonably believed by Business Associate to have been, accessed, used, or disclosed as a result of the HIPAA Breach. For purposes of this paragraph, a HIPAA Breach shall be treated as discovered as of the first day on which the HIPAA Breach is known or should reasonably have been known to Business Associate (including any person, other than the one committing the HIPAA Breach, which is an employee, officer, or other agent of the Business Associate).

The content, form, and delivery of such written notice shall comply in all respects with 45 CFR § 164.404(c)-(d).

Business Associate and Covered Entity shall cooperate in all respects regarding the drafting and the content of the notice. To that end, before sending any notice to any Individual, the Business Associate shall first provide a draft of the notice to the Covered Entity. Covered Entity shall have five (5) business days (plus any reasonable extensions) to provide comments on the Business Associate's draft of the notice.

- c. **Notice to Media.** Business Associate will provide written notice of the HIPAA Breach of Unsecured PHI, on behalf of the Covered Entity, to the media to the extent required under 45 CFR § 164.406. Business Associate and the Covered Entity shall cooperate in all respects regarding the drafting and the content of the notice. To that end, before sending any notice to the media, Business Associate shall first provide a draft of the notice to the Covered Entity. Covered Entity shall have five (5) business days (plus any reasonable extensions) to provide comments on the Business Associate's draft of the notice.

- d. **Notice to Secretary.** Business Associate will provide written notice of the HIPAA Breach of Unsecured PHI, on behalf of the Covered Entity, to the Secretary to the extent required under 45 CFR § 164.408. Business Associate and Covered Entity shall cooperate in all respects regarding the drafting and the content of the notice. To that end, before sending any notice to the Secretary, Business Associate shall first provide a draft of the notice to the Covered Entity. Covered Entity shall have five business days (plus any reasonable extensions) to provide comments on Business Associate's draft of the notice.

If the HIPAA Breach of Unsecured PHI involves less than five hundred (500) individuals, Business Associate will maintain a log or other documentation of the HIPAA Breach of Unsecured PHI which contains such information as would be required to be included if the log were maintained by the Covered Entity pursuant to 45 CFR § 164.408, and provide such log to the Covered Entity within five (5) business days of the Covered Entity's written request.

5. **Subcontractors and Agents.** Business Associate shall ensure that any agent, including a subcontractor, to whom it provides PHI agrees to the same restrictions and conditions that apply through this Addendum to Business Associate with respect to such PHI.
6. **Access to Books and Records by Secretary.** Business Associate shall make its internal practices, books, and records relating to the use, disclosure, and security of PHI available to the Secretary for purposes of the Secretary determining Covered Entity's compliance with HIPAA. Effective February 17, 2010, Business Associate shall make its internal practices, books, and records relating to the use, disclosure, and security of PHI available to the Secretary for purposes of the Secretary determining Business Associate's compliance with HIPAA.
7. **Mitigation.** Business Associate shall mitigate, to the extent practicable, any harmful effect that is known to Business Associate of (a) a use or disclosure of PHI by Business Associate in violation of the requirements of this Addendum, or (b) a Security Incident.

B. Obligations Relating to Individual Rights

1. **Restrictions on Disclosures.** Upon request by an Individual, Covered Entity shall determine whether an Individual shall be granted a restriction on disclosure of the PHI pursuant to 45 CFR § 164.522. Covered Entity will not agree to any such restriction, if such restriction would affect Business Associate's use or disclosure of PHI, without the prior consent of Business Associate, provided, however, that effective February 17, 2010, Business Associate's consent is not required for requests that must be granted under ARRA § 13405(a). Covered Entity will communicate any grant of a request, made consistent with the foregoing, to Business Associate. Business Associate will restrict its disclosures of the Individual's PHI in the same manner as would be required for Covered Entity. If Business Associate receives an Individual's request for restrictions, Business Associate shall forward such request to Covered Entity within five (5) business days.
2. **Access to PHI.** Upon request by an Individual, Covered Entity shall determine whether an Individual is entitled to access his or her PHI pursuant to 45 CFR § 164.524. If Covered Entity determines that an Individual is entitled to such access, and that such PHI is under the control of Business Associate, Covered Entity will communicate the decision to Business Associate. Business Associate shall provide access to the PHI in the same manner as would be required for Covered Entity. If Business Associate receives an Individual's request to access his or her PHI, Business Associate shall forward such request to Covered Entity within five (5) business days.
3. **Amendment of PHI.** Upon request by an Individual, Covered Entity shall determine whether any Individual is entitled to amend his or her PHI pursuant to 45 CFR § 164.526. If Covered Entity determines that an Individual is entitled to such an amendment, and that such PHI is both in a designated record set and under the control of Business Associate, Covered Entity will communicate the decision to Business Associate. Business Associate shall provide an opportunity to amend the PHI in the same manner as would be required for Covered Entity. If Business Associate receives an Individual's request to amend his or her PHI, Business Associate shall forward such request to Covered Entity within five (5) business days.
4. **Accounting of Disclosures.** Upon request by an Individual, Covered Entity shall determine whether any Individual is entitled to an accounting pursuant to 45 CFR § 164.528. If Covered Entity determines that an Individual is entitled to an accounting, Covered Entity will communicate the decision to Business Associate. Business Associate will provide information to Covered Entity that will enable Covered Entity to meet its accounting obligations. If Business

Associate receives an Individual's request for an accounting, Business Associate shall forward such request to Covered Entity within five (5) business days.

C. Permitted Uses and Disclosures by Business Associate

Except as otherwise limited in this Addendum or by Applicable Law, Business Associate may:

1. Use or disclose PHI to perform functions, activities, or services for or on behalf of Covered Entity, as specified in the Service Agreement between the Parties and in this Addendum, provided that such use or disclosure (i) is consistent with Covered Entity's Notice of Privacy Practices and (ii) would not violate HIPAA or the Privacy Rule if done by Covered Entity;
2. Use PHI for the proper management and administration of Business Associate or to carry out the legal responsibilities of Business Associate;
3. Disclose PHI for the proper management and administration of Business Associate, provided that (i) Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached or (ii) the disclosures are Required By Law; and
4. Use PHI to provide Data Aggregation services to Covered Entity as permitted by 42 CFR § 164.504(e)(2)(i)(B).

III. RIGHTS AND OBLIGATIONS OF COVERED ENTITY

A. Privacy Practices and Restrictions

1. Upon request, Covered Entity shall provide Business Associate with the notice of privacy practices that Covered Entity produces in accordance with 45 CFR § 164.520. If Covered Entity subsequently revises the notice, Covered Entity shall provide a copy of the revised notice to Business Associate.
2. Covered Entity shall notify Business Associate of any restriction to the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 CFR § 164.522. Covered Entity shall provide Business Associate with any changes in, or revocation of, permission by an Individual to use or disclose PHI, if such changes affect Business Associate's permitted or required uses and disclosures.

B. Permissible Requests by Covered Entity

Covered Entity shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under the Privacy Rule if done by Covered Entity.

IV. TERM AND TERMINATION

- A. Term.** The term of this Addendum shall begin on the Effective Date, and shall end upon the termination of the Services Agreement or upon termination for cause as set forth in the following Section IV.B, whichever is earlier.

- B. Termination for Cause.** Upon any Party's knowledge of a material breach of this Addendum by another Party, the nonbreaching Party shall have the following rights:

1. If the breach is curable, the nonbreaching party may provide an opportunity for the other Party to cure the breach or end the violation. Alternatively, or if the other Party fails to cure the breach or end the violation, the nonbreaching Party may terminate this Addendum and the Services Agreement.
2. If the breach is not curable, the nonbreaching Party may immediately terminate this Addendum and the Services Agreement.
3. If termination is not feasible, the nonbreaching Party may report the problem to the Secretary.

C. Effect of Termination.

1. Except as provided in the following paragraph, upon termination of this Addendum, for any reason, Business Associate shall return or destroy all PHI within its possession or control, and

all PHI that is in the possession or control of Business Associate's subcontractors or agents. Business Associate shall retain no copies of the PHI.

2. If Business Associate determines that returning or destroying the PHI is infeasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction infeasible. Business Associate shall extend the protections of this Addendum to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such PHI.

V. Miscellaneous

- A. **Electronic Health Records.** The Parties agree that Business Associate shall not maintain any "electronic health record" or "personal health record," as those terms are defined in ARRA, for or on behalf of Covered Entity. As such, Business Associate has no obligation to document disclosures that are exempt from the accounting requirement under 45 CFR § 164.528(1)(i)-(ix), and Covered Entity agrees not to include Business Associate on any list Covered Entity produces pursuant to ARRA § 13405(c)(3).
- B. **Regulatory References.** A reference in this Addendum to a section in any Applicable Law means the section in effect or as amended, and for which compliance is required.
- C. **Amendment.** The Parties agree to take such action as is necessary to amend this Addendum from time to time as is necessary for Covered Entity to comply with the requirements of Applicable Law. All amendments to this Addendum, except those occurring by operation of law, shall be in writing and signed by both Parties.
- D. **Survival.** The respective rights and obligations of Business Associate under Section IV.C. of this Addendum shall survive the term and termination of this Addendum.
- E. **Interpretation.** Any ambiguity in this Addendum shall be resolved in favor of a meaning that permits Covered Entity to comply with Applicable Law.
- F. **No Third Party Beneficiaries.** Nothing express or implied in this Addendum is intended to confer, nor shall anything herein confer upon any person, other than Covered Entity, Business Associate and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.
- G. **Assignment.** No assignment of rights or obligations under this Addendum shall be made by either Party without the prior written consent of the other Party; provided however, that Business Associate may assign this Addendum to an affiliate.
- H. **Effect on Addendum.** Except as specifically required to implement the purposes of this Addendum, or to the extent inconsistent with this Addendum, all other terms of the underlying Services Agreement shall remain in force and effect.

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

This First Amendment to the Fee for Service Agreement ("Agreement") is effective July 1, 2016, (the "Effective Date") and is entered into by and between EyeMed Vision Care, L.L.C. ("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 Dr. 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; and

WHEREAS, pursuant to III.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 July 1, 2016 for a term of thirty (30) 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 July 1, 2016.

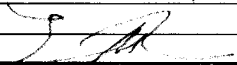

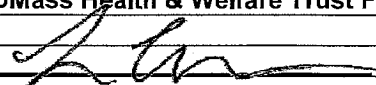
EyeMed Vision Care, L.L.C.	First American Administrators, Inc.
By: 	By: 
Name: <u>Tara M. Roma</u>	Name: <u>Tara M. Roma</u>
Title: <u>SVP</u>	Title: <u>SVP</u>
Date: <u>8/24/16</u>	Date: <u>8/24/16</u>
UAW/UMass Health & Welfare Trust Fund	
By: 	
Name: <u>Leslie Edwards Davis</u>	
Title: <u>Senior Benefits Specialist</u>	
Date: <u>8/11/2016</u>	

Exhibit B-Benefit Schedule

UMass Post Doctoral Unit
LysMed Select Plan H: Fee For Service
 Employer pays 100% or more - OR - Bundled With Group Medical or Dental
 Option 1

Version 7

	Member Cost In-Network	
Exam with Dilation as Necessary	\$10 Copay	\$50
Retinal Imaging Benefit	Up to \$39	N/A
Exam Options:		
Standard Contact Lens Fit and Follow-Up:	Up to \$40	N/A
Premium Contact Lens Fit and Follow-Up:	10% off Retail Price	N/A
Frames: Any available frame at provider location	\$0 Copay; \$150 Allowance, 20% off balance over \$150	\$90
Standard Plastic Lenses		
Single Vision	\$10 Copay	\$42
Bifocal	\$10 Copay	\$78
Trifocal	\$10 Copay	\$130
Standard Progressive Lens	\$10 Copay	\$78
Premium Progressive Lens	\$10 Copay, 10% off Balance over \$150 Allowance	\$196
Lens Options:		
UV Treatment	\$15	N/A
Tint (Solid and Gradient)	\$15	N/A
Standard Plastic Scratch Coating	\$15	N/A
Standard Polycarbonate - Adults	\$40	N/A
Standard Polycarbonate - Kids under 25	\$40	N/A
Standard Anti-Reflective Coating	\$10	N/A
Polarized	20% off Retail Price	N/A
Other Add Ons	20% off Retail Price	N/A
Contact Lenses (Protect lens allowance includes materials only)		
Conventional	\$0 Copay; \$135 allowance, 15% off balance over \$135	\$106
Disposable	\$0 Copay; \$135 allowance, plus balance over \$135	\$108
Medically Necessary	\$0 Copay, Paid in Full	\$210
Laser Vision Correction Lasek or PRK from U.S. Laser Network	15% off Retail Price or 5% off promotional price	N/A
Additional Pairs Benefit:	Members also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used.	N/A
Frequency:		
Examination	Once every 12 months	
Lenses	Once every 12 months	
Contact	Once every 12 months	
Frame	Once every 12 months	
Monthly Administrative Fee Per Subscriber Per Month (Composite)	\$0.92	

All plans are based on a 30-month contract term and 30-month rate guarantee.

Premium is subject to adjustment over 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 laws, local or amendments by Federal or State regulatory agencies.

* Member Reimbursement Out-of-Network will be the lesser of the listed amount or the member's actual cost from the out-of-network provider. 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 LysMed's online provider locator to determine which participating providers have agreed to the discounted rate.

** Group Contact Rate per Service will be the lesser of the listed amount or the Provider Contract Rate.

Additional Discounts:

Member receives a 20% discount on items not covered by the plan at network providers. Discount does not apply to LysMed Provider's professional services, or contact lenses. Plan discounts cannot be combined with any other discounts or promotional offers. Services or materials provided by any other group benefit plan providing vision care may not be covered.

Members also receive 15% off retail price or 5% off promotional price for Lasek or PRK from the U.S. Laser Network, owned and operated by LCA Vision.

After initial purchase, replacement contact lenses may be obtained via the Internet at substantial savings, and mailed directly to the member. Details are available at www.lysmedvisioncare.com.

The contact lens benefit allowance is not applicable to this service.

Benefit Allowances provide no remaining balance for future use within the same benefit frequency.

Certain brand name Vision Materials which the manufacturer imposes a no-discount practice.

Rates are valid only when the quoted plan is the sole stand-alone vision plan offered by the group.

Rates are valid for groups domiciled in the State of MA.

Fees quoted will be valid until the 7/1/2016 plan implementation date. Date quoted: 5/10/2016.

Rates assume greater than 20% employer contribution for employees and dependents or that the vision program is funded with medical/dental benefit.

Plan Exclusions:

- 1) Orthoptic or vision training, subnormal vision aids and any associated supplemental testing, diagnostic testing;
- 2) Medical and/or surgical treatment of the eye, eyes or supporting structures;
- 3) Any eye or vision condition, or any corrective eyewear required by a third party as a condition of employment; Safety eyewear;
- 4) 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 subdivision thereof;
- 5) Plans (non-prescription) lenses and/or contact lenses; 6) Non-prescription sunglasses; 7) Two pairs of glasses in lieu of bifocals;
- 8) 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;
- 9) Services rendered to the insured person are within 30 days from the date of such order;
- 10) Services or materials provided by any other group benefit plan providing vision care;
- 11) Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next benefit frequency when Vision Materials would next become available.

If UMass Post Doctoral Unit has chosen this benefit design, sign here:

Signature

5/13/2016

Date

T00

For PD Unit, 9878760 effective 7/1/2016

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

This Second Amendment to the Fee for Service Agreement ("Agreement") is effective July 1, 2019, (the "Effective Date") and is entered into by and between EyeMed Vision Care, L.L.C. ("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, pursuant to III.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:

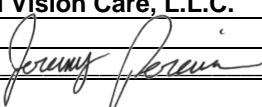
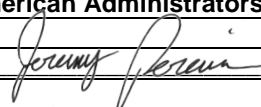

B. TERM

The Agreement shall commence on the July 1, 2019 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 July 1, 2019.

EyeMed Vision Care, L.L.C.	First American Administrators, Inc.
By: 	By: 
Name: <u>Jeremy Pereira</u>	Name: <u>Jeremy Pereira</u>
Title: <u>VP, Sales & Account Mgmt</u>	Title: <u>VP, Sales & Account Mgmt</u>
Date: <u>November 6, 2019</u>	Date: <u>November 6, 2019</u>
UAW/UMass Health & Welfare Trust Fund	UAW/UMass Health & Welfare Trust Fund
By: 	By: _____
Name: <u>Leslie Edwards Davis</u>	Name: _____
Title: <u>Director of Benefit Programs</u>	Title: _____
Date: <u>10/24/2019</u>	Date: _____

Reviewed As to Form by EyeMed Legal:



Exhibit B-Benefit Schedule – Page 1



UAW UMass Post Doctoral Unit
 Fee-for-Service Plan H, Fee For Service
 Employer pays 80% or more -OR- Bundled With Group Medical or Dental
 Option 1

1000007

Vision Care Services	Member Cost In-Network	Member Out-of-Network Reimbursement* & Group Charge Out-of-Network
Exam with Dilation as Necessary	\$10 Copay	\$50
Retinal Imaging Benefit	Up to \$35	N/A
Exam Options:		
Standard Contact Lens Fit and Follow-Up:	Up to \$40	N/A
Premium Contact Lens Fit and Follow-Up:	10% off Retail Price	N/A
Frames:		
Any available frame at provider location	\$0 Copay; \$150 Allowance, 20% off balance over \$150	\$90
Standard Plastic Lenses		
Single Vision	\$10 Copay	\$40
Bifocal	\$10 Copay	\$75
Trifocal	\$10 Copay	\$130
Standard Progressive Lenses	\$10 Copay	\$75
Premium Progressive Lenses	See attached Fixed Premium Progressive price list.	\$75
Lens Options:		
UV Treatment	\$15	N/A
Tint (Solid and Gradient)	\$15	N/A
Standard Plastic Scratch Coating	\$15	N/A
Standard Polycarbonate - Adults	\$40	N/A
Standard Polycarbonate - Kids under 26	\$40	N/A
Standard Anti-Reflective Coating	\$45	N/A
Polarized	20% off Retail Price	N/A
Premium Anti-Reflective	See attached Fixed Premium Anti-Reflective Coating Int.	N/A
Other Add-Ons	20% off Retail Price	N/A
Contact Lenses		
(Contact lens allowance includes materials only)		
Conventional	\$0 Copay; \$150 allowance, 15% off balance over \$150	\$120
Disposable	\$0 Copay; \$150 allowance, plus balance over \$150	\$120
Medically Necessary	\$0 Copay; Retail Price	\$210
Laser Vision Correction		
Lasek or PRK from U.S. Laser Network	15% off Retail Price or 5% off promotional price	N/A
Amplifon Hearing Health Care	Hearing Health Care from Amplifon Hearing Health Care Network Members receive a 40% discount off hearing exams and a low price guarantee on discounted hearing aids.	N/A
Additional Pairs Benefit:	Members also receive a 40% discount off complete pair eyeglass purchase and a 15% discount off conventional contact lenses once the funded benefit has been used.	N/A
Frequencies:		
Examination	Once every 12 months	
Lenses	Once every 12 months	
Contact Lenses	Once every 12 months	
Frame	Once every 12 months	
Monthly Administrative Fee		
Per Subscriber Per Month (Composite)	\$0.43	

UAW (UDW) Trust Fund and UMass Post Doctoral Unit agrees to be financially responsible for (i) the actual Provider Contracted Reimbursement rate per service above less applicable copay and (ii) the Monthly Administrative Fee.

All plans are based on a 48 month contract term and 48 month rate guarantee.

Premium 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

* Member Reimbursement Out-of-Network will be the lesser of the listed amount or the member's actual cost from the out-of-network provider. In certain states members may be required to pay the full retail rate and net 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.

Additional Discounts:

Member receives a 20% discount on items not covered by the plan at network providers. Discount does not apply to EyeMed Provider's professional services, or contact lenses. Plan discounts cannot be combined with any other discounts or promotional offers. Services or materials provided by any other group benefit plan providing vision care may not be covered.

Members also receive 15% off retail price or 5% off promotional price for Lasek or PRK from the U.S. Laser Network, owned and operated by LCA Vision.

After initial purchase, replacement contact lenses may be obtained via the Internet at substantial savings and mailed directly to the member. Details are available at www.eyemedvisioncare.com.

The contact lens benefit allowance is not applicable to this service.

Benefit Allowances provide no remaining balance for future use within the same Benefit Frequency.

Certain Brand name Vision Materials in which the manufacturer imposes a no-discount practice.

Rates are valid only when the quoted plan is the sole stand-alone vision plan offered by the group.

Rates are valid for groups domiciled in the State of MA.

Rates quoted will be valid until the 7/1/2016 plan implementation date. Date quoted: 6/27/2016.

Rates assume greater than 80% Employer contribution for employees and dependents or that the vision program is bundled with medical/dental benefit.

Plan Exclusions:

1) Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Antireflective lenses; 2) Medical and/or surgical treatment of the eye, eyes or supporting structures;

3) Any eye or vision examination, or any corrective eyewear required by a policyholder as a condition of employment; Safety eyewear;

4) 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;

5) Plano (non-prescription) lenses and/or contact lenses; 6) Non-prescription sunglasses; 7) Two pair of glasses in lieu of bifocals;

8) Services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended and delivered;

and the services rendered to the insured Person are within 31 days from the date of such order; 9) Services or materials provided by any other group benefit plan providing vision care;

10) Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available.

If UAW/UMass Post Doctoral Unit has chosen this benefit design, sign here:

Signature

8/21/2018

Date

Leslie Edwards Davis, Director of Benefit Programs

1100

Exhibit B-Benefit Schedule – Page 2

UAW UMass Post Doctoral Unit

Supplement

Option 1

Progressive Price List*	Member Cost In-Network (Includes Lens Copay)
Standard Progressive	\$10 copay
Premium Progressives as Follows:	
Tier 1	\$30 Copay
Tier 2	\$40 Copay
Tier 3	\$55 Copay
Tier 4	\$10 copay, 80% of charge less \$120 Allowance
Anti-Reflective Coating Price List*	Member Cost In-Network
Standard Anti-Reflective Coating	\$45
Premium Anti-Reflective Coatings as Follows:	
Tier 1	\$57
Tier 2	\$68
Tier 3	80% of charge
Other Add-ons Price List	Member Cost In-Network
Photochromic (Plastic)	80% of Retail
Polarized	80% of charge
EyeMed Vision Care 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.	

For a current listing of brands by tier, go to:

<http://www.eyemedvisioncare.com/theme/pdf/microsite-template/eyemedlenslist.pdf>