September 1, 2023

Dear Plan Participant:

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

→ Benefits for the GEO Unit Health & Welfare Plan (GHWP):

- a dental plan with Altus Dental
- a vision plan with EyeMed Vision Care
- family dental benefits for just $100/year; free family vision coverage
- a wellness reimbursement of up to $225 per year against your gym/fitness receipts
- a childcare reimbursement for on or off-campus childcare receipts
- subsidized childcare slots in the University's Center for Early Education & Care (administered by CEEC)

This booklet is designed to make it easier for you to find the information you need and to understand your rights and responsibilities under the Plans. It is important that you read the entire booklet so that you know what benefits you are eligible to receive, what policies and procedures need to be followed to get your benefits and how to use your benefits wisely.

If you have any questions or concerns about any of your benefits or coverage, contact the Director of Benefit Programs at (413) 345-2156 or uawdental@external.umass.edu The Trust Fund's website also has detailed information about all aspects of the Plans: https://www.uawumasstrustfund.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 GEO 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 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 Benefit Programs: (413) 345-2156

Altus Dental: (877) 223-0588

EyeMed Vision Care: (866) 299-1358

Graduate Employee Organization: (413) 545-0705

UAW Local 2322: (413) 534-7600

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

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

OVERVIEW of GHWP

The benefit plan year for the GHWP 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/login 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.

Your dental, vision, wellness and childcare benefits, administered by the Trust Fund, are completely separate from your student health plan, administered by University Health Services and Wellflee. Your plan elections for Trust Fund benefits are completely separate from your student health plan elections. Though not administered by the Trust Fund, you can find more information regarding your student health plan at wellfleetstudent.com

ELIGIBILITY (GHWP)

Individual Eligibility

You are eligible to participate in the GHWP if:

● You are an actively enrolled graduate student employee at the University of Massachusetts Amherst (no minimum credit requirement, program fee is acceptable) AND

● You meet the minimum earning requirements in a GEO-eligible position during the plan year. The minimum earnings required for benefits are established by multiplying the GEO minimum pay rate by 10 hours per week and the number of weeks in one semester. The GEO minimum pay rate changes with each collectively bargained stipend increase and therefore the minimum earnings required for the GHWP benefits changes periodically.

All qualified earnings between May 28, 2023 and May 25, 2024 will be used to calculate eligibility for GHWP benefits for plan year 2023-24. For plan year 2023-24, the minimum earnings required in a GEO-eligible position is $6205.40.* This amount must be earned between May 28, 2023 and May 25, 2024 to make you eligible for 12 months of Trust Fund benefits between September 1, 2023 and August 31, 2024. *This amount is subject to change whenever stipend increases are applied.

University Without Walls (UWW) Earning Equivalent

If you are teaching in the UWW, teaching a 3-credit course for one semester/session is considered equivalent to earning $6205.40 and makes you eligible for benefits between September 1, 2023 and August 31, 2024.

Prestigious Fellows

Graduate students who are awarded prestigious external fellowships of at least $6205 [or equivalent to a 10-hour semester appointment] between May 28, 2023 and May 25, 2024 will be eligible for 12 months of Trust Fund benefits between September 1, 2023 and August 31, 2024.

Spring-Entering Graduate Employees

If you are a spring semester entering graduate student, and you earn at least $6205.40 between May 28, 2023 and May 25, 2024, you will be eligible as of the first official day of the spring 2024 semester, as established by UMass, through the end of the plan year, August 31, 2024.

How Summer Earnings are Calculated

Summer earnings in a GEO-eligible position count "forward" toward your eligibility for the next plan year that starts in September. If your only earnings during an academic year occur in the summer, this will not make you eligible for coverage during the concurrent summer months. For example, if your only GEO-eligible earnings commence June 1, 2023, these will count toward your eligibility for benefits starting September 1, 2023.

You may also be eligible for benefits if:

You are eligible to receive COBRA continuation coverage and you comply with the Notice Requirements and make the monthly payments required to keep this coverage (see section on COBRA continuation coverage).

Eligibility for your spouse, same-sex or opposite-sex domestic partner

Your spouse, same-sex or opposite sex domestic partner is eligible for dental and vision coverage under the GHWP as long as they are legally married to you, in the case of a spouse; or are in a

committed, long-term relationship, which is similar to marriage and live together at the same address and intend to do so indefinitely, in the case of a partner.

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

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

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 yearly premium for single+1 or family dental coverage is $100 per year, due upon application. There is no premium due for single+1 or family vision coverage. Trustees reserve the right to terminate the family portion of any participant's coverage due to lack of payment of the applicable family premiums, retroactive to the start of coverage date or retroactive to the last month that was paid in full.

Eligibility 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 GHWP.

After your Child Ages Out of Eligibility

Your child’s Altus Dental coverage may be continued up to his or her 26th

birthday if: Your child is unmarried; and

They're not eligible to enroll in another employer-sponsored dental/vision plan (excluding parent coverage).

Your child's EyeMed Vision 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 GHWP

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. Each 9/1, the dental plan year maximum amount renews. Our vision plan is the EyeMed Select Plan. The 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.uawumasstrustfund.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.uawumasstrustfund.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/login This decision cannot be changed until the next open enrollment period. If you wish to enroll later during an open enrollment period, return to the website and complete the enrollment application.

altus dental

UAW/UMass HEALTH & WELFARE TRUST FUND

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-Netork 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 maximim

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.

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

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 EST. 1961 TARGET OPTICAL

PDF-2004-M-377

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

INDEPENDENT PROVIDER NETWORK + LENSCRAFTERS PEARLE VISION TARGET OPTICAL

WELLNESS REIMBURSEMENT BENEFITS

Eligible graduate employees can be reimbursed for up to $225 per plan year towards expenses for wellness/fitness receipts. The eligible grad employee's receipts are eligible as are the expenses of family members who are enrolled on the employee's dental and/or vision plans. Family members don't receive their own $225 reimbursement benefit, but instead share the total $225 benefit with the eligible employee.

The wellness reimbursement application is accessed through the same online enrollment process as the dental & vision plans, except that you must include a copy of a valid receipt demonstrating your payment of membership fees/fees/tuition to a gym, physical fitness institution or organization. This benefit follows the same plan year of September 1-August 31 of each year. If you are eligible for dental & vision benefits, you are eligible for a maximum reimbursement of $225 per plan year.

Reimbursements are made for receipts dated during our plan year, 9/1 to 8/31 of each year. If you pay on a monthly basis, charges dated after 9/1 are eligible. If you purchase semester or yearly plans, the period of the receipt must include a majority of the plan year to be eligible (i.e. though dated in Sept, UMass Fall 2023 gym receipts are eligible; receipts for the previous summer are not).

Eligible Wellness Activities

Eligible activities promote fitness and stress reduction through physical exercise. Examples include gym memberships, yoga, dance, aerobics and martial arts classes, golf and ski fees, marathon, road race and endurance course fees, swim fees, intramural sport fees, court fees and ice rental fees for related sport. Weight loss programs with fitness components, workout program DVDs, personal coaching/fitness tracking devices (all brands are eligible, excludes accessories and only 1 per person per plan year), fitness and personal training apps, mental health apps and out-of-pocket mental health costs not covered by insurance, state & national park passes and camping fees. Equipment purchases supporting fitness and well-being are also eligible for reimbursement, including weights and dumbbells, resistance bands, yoga mats and blocks, treadmills, ellipticals and rowing machines, sport equipment like balls and rackets, camping and backpacking equipment, skis and snowshoes, ergonomic desks and chairs, face masks, and headphones/earbuds. Final approval of equipment purchases is per the decision of the Trustees.

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

Activities that aren't eligible include: massage, health costs, spa treatments, facials, and clothing and shoes.

Special Circumstances

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

Pre-Paid Memberships as an Alternative to Reimbursement

For the 2023-24 plan year, the Trust Fund will offer 100 pre-paid, 4-month gym memberships at Central Rock Gym (CRG) in Hadley, MA, 75 5-packs of 30 minutes massages at The Healing ZONE (THZ) in Hadley, MA, and 9 20-class yoga cards for Cadence Yoga in Sunderland, MA which can be accepted by eligible grad employees in lieu of receiving a reimbursement of eligible receipts. Prepaid memberships are awarded on a first-come, first-served basis to an eligible grad employee who has completed the online benefits application and completed the separate Prepaid User Agreement. Receiving a pre-paid membership constitutes a full and complete wellness reimbursement for the plan year and recipients are not eligible for any additional wellness reimbursement for that plan year. If you accept a pre-paid membership and then fail to claim the membership by appearing at the facility and completing their registration, you will not be eligible for any other reimbursement for that plan year and will forfeit eligibility for reimbursement for the next plan year.

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 are separate from the wellness reimbursement and do not count against the reimbursement you are otherwise eligible for. Daily Burn subscriptions may be claimed on the dashboard of your Trust Fund benefits account at https://portal.hwtf.org/login

Calm Subscriptions

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

How & When You'll Receive a Wellness Reimbursement

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

How to Submit Your Receipt

Even if you are declining dental & vision benefits, you still need to submit an application using our enrollment portal at https://hwtrust.geouaw.org/ in order to access the wellness reimbursement. Once you complete the application, submit your receipt by uploading it with your application into our system or providing it by email. UMass Recreation Center members are not always required to upload their membership receipts if we are able to verify memberships directly with the Recreation Center and reimburse based on their reporting.

The Trust Fund is unable to issue a wellness reimbursement without an electronically signed application on file for you. You may submit receipts up to two times per year. If you have multiple receipts, you will need to group them together across two submissions. In no case will the Trust Fund issue your reimbursement in more than two payments per year.

CHILDCARE REIMBURSEMENT BENEFIT

The Trust Fund will distribute at least $215,000 during the 2023-24 plan year in reimbursements across eligible graduate employees for their costs for on or off-campus licensed childcare.

Eligibility

To be eligible you must be 1) a UMass graduate student employee 2) working in a GEO-eligible position earning at least $6205.40 during the plan year and 3) use an eligible source of childcare. Trust Fund Trustees reserve the right to ultimately determine eligibility. Eligible childcare includes:

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

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.

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								PARENT CO-PAYMENT				FEE LEVEL
Family of Two	Family of Three	Family of Four	Family of Five	Family of Six	Family of Seven	Family of Eight	Family of Nine	Daily Fee	Weekly Fee	Daily Fee SACC Blended	Weekly Fee SACC Blended	
$ 0-971	$ 0-1180	$ 0-1421	$ 0-1663	$ 0-1905	$ 0-2146	$ 0-2387	$ 0-2630	→ $ -	$ -	$ -	$ -	1
$ 972-1095	$ 1181-1260	$ 1422-1499	$ 1664-1739	$ 1906-1980	$ 2147-2205	$ 2388-2450	$ 2631-2675	→ $ 2.00	$ 10.00	$ 1.20	$ 6.00	2
$ 1096-1219	$ 1261-1340	$ 1500-1575	$ 1740-1825	$ 1981-2080	$ 2206-2315	$ 2451-2575	$ 2676-2775	→ $ 3.00	$ 15.00	$ 1.80	$ 9.00	3
$ 1220-1380	$ 1341-1420	$ 1576-1675	$ 1826-1900	$ 2081-2180	$ 2316-2550	$ 2576-2700	$ 2776-2825	→ $ 4.50	$ 22.50	$ 2.70	$ 13.50	4
$ 1381-1457	$ 1421-1529	$ 1676-1799	$ 1901-2087	$ 2181-2380	$ 2551-2675	$ 2701-2800	$ 2826-2940	→ $ 5.50	$ 27.50	$ 3.30	$ 16.50	5
$ 1458-1540	$ 1530-1675	$ 1800-1900	$ 2088-2150	$ 2381-2500	$ 2676-2800	$ 2801-2900	$ 2941-3050	→ $ 6.50	$ 32.50	$ 3.90	$ 19.50	6
$ 1541-1634	$ 1676-1760	$ 1901-2000	$ 2151-2260	$ 2501-2650	$ 2801-2900	$ 2901-3000	$ 3051-3125	→ $ 7.50	$ 37.50	$ 4.50	$ 22.50	7
$ 1635-1725	$ 1761-1850	$ 2001-2175	$ 2261-2435	$ 2651-2800	$ 2901-3000	$ 3001-3100	$ 3126-3242	→ $ 8.00	$ 40.00	$ 4.80	$ 24.00	8
$ 1726-1843	$ 1851-1931	$ 2176-2250	$ 2436-2550	$ 2801-3000	$ 3001-3100	$ 3101-3200	$ 3243-3340	→ $ 8.50	$ 42.50	$ 5.10	$ 25.50	9
$ 1844-1986	$ 1932-2414	$ 2251-2874	$ 2551-3333	$ 3001-3793	$ 3101-3879	$ 3201-3966	$ 3341-4052	→ $ 9.00	$ 45.00	$ 5.40	$ 27.00	10
$ 1987-2186	$ 2415-2476	$ 2875-3130	$ 3334-3550	$ 3794-3900	$ 3880-4030	$ 3967-4100	$ 4053-4125	→ $ 12.50	$ 62.50	$ 7.50	$ 37.50	11
$ 2187-2286	$ 2477-2676	$ 3131-3340	$ 3551-3800	$ 3901-4000	$ 4031-4132	$ 4101-4199	$ 4126-4249	→ $ 15.00	$ 75.00	$ 9.00	$ 45.00	12
$ 2287-2429	$ 2677-2876	$ 3341-3550	$ 3801-4100	$ 4001-4199	$ 4133-4350	$ 4200-4499	$ 4250-4599	→ $ 16.50	$ 82.50	$ 9.90	$ 49.50	13
$ 2430-2573	$ 2877-3076	$ 3551-3760	$ 4101-4363	$ 4200-4500	$ 4351-4700	$ 4500-4799	$ 4600-4899	→ $ 17.50	$ 87.50	$ 10.50	$ 52.50	14
$ 2574-2717	$ 3077-3277	$ 3761-3970	$ 4364-4607	$ 4501-4966	$ 4701-4998	$ 4800-5099	$ 4900-5149	→ $ 19.00	$ 95.00	$ 11.40	$ 57.00	15
$ 2718-2860	$ 3278-3477	$ 3971-4180	$ 4608-4851	$ 4967-5444	$ 4999-5549	$ 5100-5650	$ 5150-5699	→ $ 20.50	$ 102.50	$ 12.30	$ 61.50	16
$ 2861-3004	$ 3478-3677	$ 4181-4490	$ 4852-5095	$ 5445-5939	$ 5550-6074	$ 5651-6209	$ 5700-6344	→ $ 22.00	$ 110.00	$ 13.20	$ 66.00	17
$ 3005-3132	$ 3678-3869	$ 4491-4606	$ 5096-5342	$ 5940-6079	$ 6075-6217	$ 6210-6355	$ 6345-6494	→ $ 23.00	$ 115.00	$ 13.80	$ 69.00	18
$ 3133-3322	$ 3870-4104	$ 4607-4885	$ 5343-5667	$ 6080-6433	$ 6218-6595	$ 6356-6743	$ 6495-6887	→ $ 24.00	$ 120.00	$ 14.40	$ 72.00	19
$ 3323-3410	$ 4105-4210	$ 4886-5012	$ 5668-5812	$ 6434-6615	$ 6596-6765	$ 6744-6915	$ 6888-7066	→ $ 25.00	$ 125.00	$ 15.00	$ 75.00	20
$ 3411-3549	$ 4211-4380	$ 5013-5214	$ 5813-6047	$ 6616-6883	$ 6766-7039	$ 6916-7195	$ 7067-7350	→ $ 26.00	$ 130.00	$ 15.60	$ 78.00	21
$ 3550-3685	$ 4381-4551	$ 5215-5418	$ 6048-6285	$ 6884-7153	$ 7040-7314	$ 7196-7477	$ 7351-7639	→ $ 27.00	$ 135.00	$ 16.20	$ 81.00	22
$ 3686-3908	$ 4552-4828	$ 5419-5747	$ 6286-6666	$ 7154-7586	$ 7315-7758	$ 7478-7932	$ 7640-8103	→ $ 28.00	$ 140.00	$ 16.80	$ 84.00	23
$ 3909-4885	$ 4829-6035	$ 5748-7184	$ 6667-8333	$ 7587-9483	$ 7759-9698	$ 7933-9915	$ 8104-10129	→ $ 29.00	$ 145.00	$ 17.40	$ 87.00	24
$ 4886-5150	$ 6036-6325	$ 7185-7550	$ 8334-8750	$ 9484-9950	$ 9699-10300	$ 9916-10400	$ 10130-10650	→ $ 32.00	$ 160.00	$ 19.20	$ 96.00	25
$ 5151-5400	$ 6326-6625	$ 7551-7900	$ 8751-9200	$ 9951-10400	$ 10301-10750	$ 10401-10900	$ 10651-11150	→ $ 35.00	$ 175.00	$ 21.00	$ 105.00	26
$ 5401-5650	$ 6626-6925	$ 7901-8250	$ 9201-9550	$ 10401-10950	$ 10751-11150	$ 10901-11400	$ 11151-11650	→ $ 38.00	$ 190.00	$ 22.80	$ 114.00	27
$ 5651-5849	$ 6925-7225	$ 8251-8601	$ 9551-9978	$ 10951-11353	$ 11151-11611	$ 11401-11869	$ 11651-12126	→ $ 41.00	$ 205.00	$ 24.60	$ 123.00	28

Commonwealth of Massachusetts

Department of Early Education and Care (EEC)

SHERRI KILLINS
COMMISSIONER

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				
Family of Ten	Family of Eleven	Family of Twelve	Daily Fee	Weekly Fee	Daily Fee SACC Blended	Weekly Fee SACC Blended	FEE LEVEL
$ 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

			.75 time or more 30-40 hrs/wk care		.5 time 20-30 hrs/wk care		.25 time or less less than 20 hrs/wk	
	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

The Trust Fund crosschecks receipts provided for care at the Center for Early Education and Care (CEEC) with CEEC records from the same period. In addition, the Trust Fund receives information from the Graduate Student Senate (GSS) and the CCAMPIS grant administrator for childcare awards families receive from GSS, Student Affairs or CCAMPIS for the same period and reduces reported costs accordingly. If an applicant family has received a Postdoc childcare subsidy for the same period, this will likewise 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. The 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 2023receipts
- 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 regular online benefits application, available at

https://portal.hwtf.org/login if you've enrolled for dental & vision, log in to your existing application, following prompts for the childcare section only. If you are new to our system, you can start a new application.

Outschool Benefit

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

OPTIONAL METLAW PREPAID LEGAL BENEFIT

Eligible graduate employees can elect to enroll in the *optional, 100% employee paid* group legal plan, MetLaw. The employee premium to participate in MetLaw is $216/year paid in 6 monthly installments of $36 and the minimum enrollment period is 12 months. The premium for this benefit is not prorated if your opt into the benefit mid-year.

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
Use the regular online enrollment portal at https://portal.hwtf.org/login

Payments
MetLaw premium payments 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.

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.

MetLife | Legal Plans

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	• Debt Collection Defense • Identity Theft Defense • LifeStages Identity Restoration Services[3]	• Negotiations with Creditors • Personal Bankruptcy • Promissory Notes	• Tax Audit Representation • Tax Collection Defense
Home & Real Estate	• Boundary or Title Disputes • Deeds • Eviction Defense • Foreclosure	• Home Equity Loans • Mortgages • Property Tax Assessments • Refinancing of Home	• Sale or Purchase of Home • Security Deposit Assistance • Tenant Negotiations • Zoning Applications
Estate Planning	• Codicils • Complex Wills • Healthcare Proxies • Living Wills	• Powers of Attorney (Healthcare, Financial, Childcare, Immigration)	• Revocable & Irrevocable Trusts • Simple Wills
Family & Personal	• Adoption • Affidavits • Conservatorship • Demand Letters • Garnishment Defense • Guardianship • Immigration Assistance	• Juvenile Court Defense, Including Criminal Matters • Name Change • Parental Responsibility Matters • Personal Property Protection	• Prenuptial Agreement • Protection from Domestic Violence • Review of ANY Personal Legal Document • School Hearings
Civil Lawsuits	• Administrative Hearings • Civil Litigation Defense	• Disputes Over Consumer Goods & Services • Incompetency Defense	• Pet Liabilities • Small Claims Assistance
Elder-Care Issues	Consultation & Document Review for your parents: • Deeds • Leases	• Medicaid • Medicare • Notes • Nursing Home Agreements	• Powers of Attorney • Prescription Plans • Wills
Vehicle & Driving	• Defense of Traffic Tickets[4] • Driving Privileges Restoration	• License Suspension Due to DUI	• 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.

MetLife

MetLife Legal Plans | 1111 Superior Avenue, Suite 800 | Cleveland, OH 44114

MetLife | Legal Plans

Benefit Definitions & Reimbursements

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

Benefit Definitions & Reimbursements (Continued)

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

Benefit Definitions & Reimbursements (Continued)

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

Benefit Definitions & Reimbursements (Continued)

Debt Collection Defense (Foreclosures)		
• Negotiation	Fully Covered	$500
• Complaint and Answer Filed, Settlement Negotiations	Fully Covered	$850
• Trial	Fully Covered	$1,500
• Plus Trial Supplement for Out-of-Network Service*		$100,000
Identity Theft Defense: This service provides the participant with consultations with an attorney regarding potential creditor actions resulting from identity theft and attorney services as needed to contact creditors, credit bureaus and financial institutions. It also provides defense services for specific creditor actions over disputed accounts. The defense services include limiting creditor harassment and representation in defense of any action that arises out of the identity theft such as foreclosure, repossession or garnishment, up to and including trial if necessary. The service also provides the participant with online help and information about identity theft and prevention. It does not include counter, cross or third party claims, bankruptcy, any action arising out of family law matters, including support and post-decree matters or any matter where the creditor is affiliated with the sponsor or employer.	Fully Covered	$250
LifeStages Identity Management Services: This benefit provides the Participant with access to LifeStages Identity Management Services provided by Cyberscout, LLC. It includes both Proactive Services when the Participant believes their personal data has been compromised as well as Resolution Services to assist the Participant in recovering from account takeover or identity theft with unlimited assistance to fix issues, handle notifications, and provide victims with credit and fraud monitoring. Theft Support, Fraud Support, Recovery, and Replacement services are covered by this benefit.	Fully Covered	
Personal Bankruptcy or Wage Earner Plan: This service covers the participant and spouse in pre-bankruptcy planning, the preparation and filing of a personal bankruptcy or Wage Earner petition, and representation at all court hearings and trials. This service is not available if a creditor is affiliated with the sponsor or employer, even if the participant or spouse chooses to reaffirm that specific debt.		
• Chapter 7 Individual or Member/Spouse	Fully Covered	$850
• Chapter 13 Individual or Member/Spouse	Fully Covered	$1,400
Tax Audit Representation: This service covers reviewing tax returns and answering questions the IRS or a state or local taxing authority has concerning the participant's tax return, negotiating with the agency advising the participant on necessary documentation, and attending an IRS or a state or local taxing authority audit. The service does not include prosecuting a claim for the return of overpaid taxes or the preparation of any tax returns.		
• Negotiation and Settlement	Fully Covered	$500
• Audit Hearing	Fully Covered	$1,200
Immigration	**In-Network**	**Out-of-Network**
Immigration Assistance: This service covers advice and consultation, preparation of affidavits and powers of attorney, review of any immigration documents and helping the participant prepare for hearings.	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.

HOW TO APPLY FOR TRUST FUND BENEFITS

You must complete the online application form and electronically sign the benefits authorization form before you will be enrolled. The online application is available at https://portal.hwtf.org/login 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 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 Benefit Programs 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 GEO/UAW Local 2322, and to any and all vendors employed by the Trust Fund for the purpose of providing benefits, information necessary to provide you with, and to verify your eligibility for, any and all benefits offered by the Trust Fund (including but not limited to dental, vision, wellness, and childcare assistance).

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

WHEN YOUR COVERAGE BEGINS

The timing of when you can start receiving benefits from the GHWP is dependent on several factors: when your status as an enrolled graduate student starts, when you are employed as a GEO-eligible employee, when you complete your application and the dates of our open enrollment periods.

If you are a new employee

If you are an incoming graduate student employee for academic year 2023-24 the earliest start date for your benefits is September 1, 2023.

If you are an existing employee

Existing employees must re-enroll once during each plan year in order to maintain their coverage.

Open Enrollment Periods

Each year, there are several open enrollment periods during which you can submit a benefits application online at https://www.hwtf.org/geo-eligibility For plan year 2023-24, open enrollment occurs according to the following schedule:

Aug 15-Sept 15, 2023, for a coverage start date of 9/1/23

Oct 15-Oct 31, 2023, for a coverage start date of 10/1/23

Nov 15-Nov 30, 2023 for a coverage start date of 11/1/23

Jan 15-Jan 30, 2024, for a coverage start date of 1/1/24

March 15-March 31, 2024, for a coverage start date of 3/1/24

May 15-May 30, 2024; for a coverage start date of 5/1/24

You must fully complete your application and electronically sign 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 GHWP 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/login

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 #: 9794348

For both the dental and the vision plans, your member ID is made up of your UMass student 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 at the end of the plan year on 8/31 if you do not have GEO-qualified earnings meeting the minimum required for the next academic year. If you fail to enroll as a student, withdraw from student status, or fail to meet the minimum earnings requirement due to early termination of employment, your coverage ends 30 days after the date of the aforementioned event. If you graduate, you will lose your eligibility for Trust Fund benefits at the end of the plan year in which you graduate on August 31.

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 GHWP eligibility is lost, graduate 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 GHWP are subject to COBRA continuation coverage.

Continuation coverage is the same coverage that the GHWP gives to other participants or beneficiaries under the GHWP who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the GHWP as other participants or beneficiaries covered under the GHWP. 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/geo-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/geo-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 Benefit Programs 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 Benefit Programs 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 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 Stripes's automatic, recurring payment feature. Recurring payments may be ended at any time by either the participant or the Trust Fund. Contact the Director of Benefit Programs to set up recurring automatic payments. You may elect, at your discretion, to make payments in advance, through the end of the current plan year through which rates are guaranteed.

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/geo-cobra or
http://www.dol.gov/dol/topic/health- plans/cobra.htm

PAYMENT POLICIES

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/ Stripe payment within 30 days and it is subsequently returned to the Trust Fund's account. If you require a second reissue of the same payment, we will deduct a $25 processing fee from the total

amount of your reissued payment. No fee deduction shall apply if the reissue is processed via PayPal/Stripe. The Trust Fund will only reissue payments after 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.

ែ (Cambodian): ុបយ័ៈ េបើសិន អ កនិ យ ែ េ ែ, េស ជំនួយែ ក
េយមិនគិតឈ ល
គឺ ច នសំ ក។ ចូរ ទូរស័ព 1-877-223-0588
ប់បំេរ

Français (French): ATTENTION : Si vous parlez français, des services d'aidelinguistique vous sont proposés gratuitement. Appelez le 1-877-223-0588.

Italiano (Italian): ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-877-223-0588.

ພາສາລາວ (Lao): ໂປດຊາບ: ຖ້ າຫ ່ ານເອ ້ ົ າພາສາ ລາວ, ອ ດ ົ ານພາສາ, ໂດຍ ່ ບ ເ ສ ີ ຽ ງ ຄ ່ າ, ແ ມ ່ ນ ມ ການ ່ ບ ິ ລ ິ ການ ຊ ່ ວ ຍ ເ ຫ ຼ ື ອ ພ ້ ອ ມ ໃ ຫ ້ ຫ ່ ານ. ໂ ທ ຣ 1-877-223-0588.

ية **(Arabic):**

مقرب لصتا .نإجملابكل رفاوتتةيوغللا ةدعاسملا تامدخن إف ،ةغللا ركذا ثدحتت تنك اذإ :ةظوحلم 1-877-223-0588 (مكبلاو مصلا فتاه مقر: 1-877-223-0588).

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-223-0588.

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-223-0588.

Bàsɔ̀ ɔ̀ -wùqù-po-nyɔ̀ (Bassa): Dè qɛ nià kɛ dyéqé gbo: Ɔ jǔ ké m̀[Bàsɔ́ ɔ̀ -wùqù-po-nyɔ̀] jǔ ní, nìí, à wuqu kà kò qò po-poɔ̀ bɛ́ìn m̀gbo kpáa. Đá 1-877-223-0588.

Igbo asusu (Ibo): Ige nti: O buru na asu Ibo asusu, enyemaka diri gi site na call 1-877-223-0588.

èdè Yorùbá (Yoruba): AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi 1-877-223-0588.

Polski (Polish): UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-223-0588.

한국어 (Korean): 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-223-0588 번으로 전화해 주십시오.

Tagalog (Tagalog – Filipino): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-223-0588.

ह ं द (Hindi): ध ् य ा न द : य द आप ह ं द ब ो लत े ह त ो आपक े ल ए म ु फ ् त म भ ा ष ा सह ा यत ा स े व ा ए ं उपलब ् ध ह । 1-877-223-0588 पर कॉल क ।

ગ જ ર ા ત ી (Gujarati): ધ ્ ય ા ન આ પ : જ ો ત મ ે ગ જ ર ા ત ી બ ો લ ત ા હ ો , ત ો વ િ ન ા શ ુ લ ્ ક ભ ા ષ ા સ હ ા ય સ ે વ ા ઓ ઉ પ લ બ ્ ધ છ ે . ફ ો ન ક ર ો 1-877-223-0588.

Ελληνικά (Greek): ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-877-223-0588.

SCHEDULE OF BENEFITS
OUTLINE OF COVERAGE

The Insurance for each Insured and each Insured Dependent will be based on the Insured's class shown in this Schedule of Benefits.

Benefit Class	Class Description
Class 1	Post Doctoral Researcher
Class 2	Graduate Employee

Class Number 1-Post Doctoral Researcher

DENTAL EXPENSE BENEFITS

When you select a Participating Provider, a discounted fee schedule is used which is intended to provide you, the Insured, reduced out of pocket costs.

Deductible Amount:
In Network Deductible: $0

Out of Network Deductible: $0 Type 1 & Type 4
$75 Individual/$225 Family Type 2 & Type 3

On the date that three members of one family have satisfied their own Deductible Amounts for that Benefit Period, no Covered Expenses incurred after that date by any other family member will be applied toward the satisfaction of any Deductible Amount for the rest of that Benefit Period. No Covered Expense that was incurred prior to such date, which was used to satisfy any part of a Deductible Amount, will be eligible for reimbursement.

Coinsurance Percentage:	Participating Provider	Non-Participating Provider
Type 1 Procedures*	100%	100%
Type 2 Procedures	80%	80%
Type 3 Procedures	65%	65%
Type 4 Procedures	65%	65%
Policy Year Maximum		$2,250*+

*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*.** **Eac**h Member of the eligible class(es) for dependent coverage is eligible for the Dependent Insurance under the policy and will qualify for this

Dependent Insurance on the latest of:

1. the day he or she qualifies for coverage as a Member;
2. the day he or she first becomes a Member; or
3. the day he or she first has a dependent. For dependent children, a newborn child will be considered an eligible dependent upon reaching their 2nd birthday. The child may be added at birth or within 31 days of the 2nd birthday.

A Member must be an Insured to also insure his or her dependents.

If employment is the basis for membership, a member of the Eligible Class for Dependent Insurance is any graduate employee working at least 20 hours per week and has eligible dependents. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

When a member of the Eligible Class for Dependent Insurance dies and, if at the date of death, has dependents insured, the Policyholder has the option of offering the dependents of the deceased employee continued coverage. If elected by the Policyholder and the affected dependents, the name of such deceased member will continue to be listed as a member of the Eligible Class for Dependent Insurance.

***Contribution Requirements*.** Member Insurance: An Insured is not required to contribute to the payment of his or her insurance premiums. An insured may or may not be required to contribute to the payment of insurance premiums if he or she is both covered under this policy and also covered under another plan.

Dependent Insurance: An Insured is required to contribute to the payment of insurance premiums for his or her dependents.

Eligibility Period. For Members on the Plan Effective Date of the policy, qualification will occur after an eligibility period defined by the Policyholder is satisfied. The same eligibility period will be applied to all members.

For persons who become Members after the Plan Effective Date of the policy, qualification will occur after an eligibility period defined by the Policyholder is satisfied. The same eligibility period will be applied to all members.

If employment is the basis for membership in the Eligible Class for Members, an Insured whose eligibility terminates and is established again, may or may not have to complete a new eligibility period before he or she can again qualify for insurance.

Effective Date. Each Member has the option of being insured and insuring his or her Dependents. To elect coverage, he or she must agree in writing to contribute to the payment of the insurance premiums. The Effective Date for each Member and his or her Dependents, will be:

1. the date on which the Member qualifies for insurance, if the Member agrees to contribute on or before that date.

2. the date on which the Member agrees to contribute, if that date is within 31 days after the date he or she qualifies for insurance.

3. the date we accept the Member and/or Dependent for insurance when the Member and/or Dependent is a Late Entrant. The Member and/or Dependent will be subject to any limitation concerning Late Entrants.

How You Join

You join by enrolling online at www.uawumasstrustfund.org through the Enrollment Portal. If your family status changes and you need to add or remove dependents from your plan, contact us or your plan sponsor. We can only accept membership changes from a Subscriber or your plan sponsor.

When Coverage Begins

Coverage generally starts the first of the month after the plan sponsor enrolls you on the portal.

Class 01—You must wait until *your plan sponsor's* next open enrollment period, if *you* or *your dependent(s)* do not enroll when first eligible. *You* may also enroll when there is a qualifying event or subsequent open enrollment period.

Class 02—You must wait until *your plan sponsor's* next open enrollment period, if *you* or *your dependent(s)* do not enroll when first eligible. *You* may also enroll when there is a qualifying event or subsequent open enrollment period.

If *you* marry, *you* may enroll *your spouse* within 60 days of marriage. *You* must wait until *your plan sponsor's* next open enrollment period if *your spouse* does not enroll when first eligible. *Your spouse* may also enroll when there is a qualifying event.

If *you* have family coverage, *your* newborn infant and the newborn infant of a *dependent* child are covered from birth. Adopted children are covered from the date of home placement. Foster children are covered from the date of the petition to adopt. Stepchildren and children are considered dependent children if they: are under *your* own or *your spouse's* legal custody; permanently live in *your* household; and, chiefly depend on *you* for support. *We* do not consider married children *dependents,* regardless of their age.

Coverage generally begins on the first of the month after *we* accept *your* enrollment form. If *you* don't enroll within 60 days, *you* must wait until the next open enrollment period to enroll *dependents. Dependents* may enroll when there is a qualifying event or when the plan sponsor determines eligibility.

Notify *us* and *your plan sponsor* of any changes in *your* or *your dependent's* status. This includes marriage; births; attainment of the *dependent* or student (if applicable) age limits; or, changes in *your* address. This will help us maintain up to date eligibility and billing records.

***Exceptions*.** If employment is the basis for membership, a Member must be in active service on the date the insurance, or any increase in insurance, is to take effect. If not, the insurance will not take effect until the day he or she returns to active service. Active service refers to the performance in the customary manner by an employee of all the regular duties of his or her employment with his or her employer on a full time basis at one of the employer's business establishments or at some location to which the employer's business requires the employee to travel.

A Member will be in active service on any regular non-working day if he or she is not totally disabled on that day and if he or she was in active service on the regular working day before that day.

If membership is by reason other than employment, a Member must not be totally disabled on the date the insurance, or any increase in insurance, is to take effect. The insurance will not take effect until the day after he or she ceases to be totally disabled.

Termination Dates

Insureds. The insurance for any Insured, will automatically terminate on the **earliest of:**

1. the date the Insured ceases to be a Member;
2. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
3. the date the policy is terminated.

Dependents. The insurance for all of an Insured's dependents will automatically terminate on the **earliest of:**

1. the date on which the Insured's coverage terminates;
2. the date on which the Insured ceases to be a Member;
3. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
4. the date all Dependent Insurance under the policy is terminated.

The insurance for any Dependent will automatically terminate on the day before the date on which the dependent no longer meets the definition of a dependent. See "Definitions."

Continuation Coverage. If coverage ceases according to TERMINATION DATE, some or all of the insurance coverages may be continued. Contact your plan administrator for details.

An employee or dependent whose insurance has stopped may be able to continue some or all of the insurance coverages. The sections below explain when and how insurance may be continued. If insurance is continued, it must be according to a plan which does not allow individual selection.

Thirty-One Day Continuation of Coverage in accordance with M.G.L. c.175, s. 110D

If an employee leaves his/her job for any reason (quit, terminated, laid off, plant closing, etc.) or if a child ceases to be a dependent under this policy, group coverages provided under this policy will be extended for 31 days in accordance with Massachusetts Law, chapter 175, section 110D. The employer/employee contributions will remain the same for the 31-day period as during employment. The 31-day continuation period begins the date the employee actually terminates employment or the date the child ceases to be considered a dependent under the policy.

This continuation of coverage is in addition to any other continuation periods applicable under Massachusetts law as defined below. This benefit does not extinguish eligibility for benefits available under the Federal Consolidated Omnibus budget Reconciliation Act. (COBRA).

Federally Required Continuation For Employees and/or Dependents

Through the Consolidated Omnibus Budget Reconciliation Act (COBRA) the federal government requires the Policyholder to provide continuation of coverages to employees and/or dependents who would otherwise lose their coverages. There are some groups which are not subject to the law. They are:

1. groups of less than 20 employees.

2. certain church plans.

When a person is eligible for both state benefits and federal COBRA benefits, certain state and federal benefits overlap and run concurrently. Please note the election of continued coverage under certain state laws may extinguish eligibility for benefits under federal law.

For details the employee and/or dependent(s) must contact the person who handles the Policyholder's insurance matters.

Leave of Absence For Employees Only

If membership is because of employment and an Insured's active service terminates because of a leave of absence, the insurance will stay in force for two months only if the Policyholder pays his or her premiums and does not cancel the insurance.

If the Policyholder is subject to COBRA, the rules applicable to COBRA will supersede the continuation due to a leave of absence.

Separation or Divorce For Dependents Only

The Insured's spouse may continue coverage without additional premium (unless the divorce or separation judgment specifies otherwise) if the Insured and the spouse:

a. become legally separated; or

b. dissolve the marriage;

unless the judgment of separation or divorce excludes such continuation. For purposes of

this continuation provision such spouse is called "former spouse." The former spouse may also continue to insure his or her dependent children. Coverage may be continued if the judgment of dissolution or separation was entered prior to the effective date of this plan.

Benefits
This continuation applies to all benefits provided under this policy covering the former spouse.

Termination
Such insurance will stop on the earliest of:

1. the last day of the period for which the premium is paid;

2. the date coverage would normally stop under the terms of the policy;

3. the date specified in the judgment of separation or dissolution;

4. the date either party remarries*;

5. the date insurance terminates for the Insured;

6. the date the policy terminates.

*In the event of the remarriage of the Insured, the former spouse shall have the right, if so provided in said judgment, to continue to be covered as a member of the group.

We will send notice of termination of continuation coverage, and any right to reinstate coverage to the former spouse at the last known address.

Premium
We may charge the full premium, i.e., the employee and employer's portion, during the continuation period.

We may change the premium rate at any time the Insured's group plan premium rate is changed. Any part of the premium to be paid by the former spouse should be paid to the employer. The employer may stop coverage if any premium is not received within 30 days following the due date.

Claims
Claims incurred by the former spouse will be paid to the former spouse or the provider. Claims incurred by dependent children not living with the Insured will be paid to the provider or the parent with custody.

Benefits After Cancellation
All services must be complete to qualify for benefits. For example, permanent crowns must be cemented; bridges or dentures must be inserted. Once *your* coverage is cancelled, *you* will not have benefits for services finished after *your* cancellation date. *Your* covered family *members* will not have benefits either.

Dental Expense Benefits

We will determine dental expense benefits according to the terms of the group policy for dental expenses incurred by an Insured. An Insured person has the freedom of choice to receive treatment from any Provider.

Determining Benefits. The benefits payable will be determined by totaling all of the Covered Expenses submitted into each benefit type as shown in the Table of Dental Procedures. This amount is reduced by the Deductible, if any. The result is then multiplied by the Coinsurance Percentage(s) shown in the Schedule of Benefits. Benefits are subject to the Maximum Amount, if any, shown in the Schedule of Benefits.

Benefit Period. Benefit Period refers to the period shown in the Table of Dental Procedures.

Deductible. The Deductible is shown on the Schedule of Benefits and is a specified amount of Covered Expenses that must be incurred and paid by each Insured person prior to any benefits being paid.

Maximum Amount. The Maximum Amount shown in the Schedule of Benefits is the maximum amount that may be paid for the Covered Expenses incurred by an Insured.

Covered Expenses. Covered Expenses include:

1. only those expenses for dental procedures performed by a Provider; and
2. only those expenses for dental procedures listed and outlined on the Table of Dental Procedures.

Covered Expenses are subject to "Limitations." See Limitations and

Table of Dental Procedures. Benefits payable for Covered Expenses

also will be based on the lesser of:

1. the actual charge of the Provider.
2. the usual and customary ("U&C") as covered under your plan, if services are provided by a Non Participating Provider.

Usual and Customary (“U&C”) describes those dental charges that we have determined to be the usual and customary charge for a given dental procedure within a particular ZIP code area. The U&C is based upon a combination of dental charge information taken from our own database as well as from data received from nationally recognized industry databases. From the array of charges ranked by amount, your Policyholder (in most cases your employer) has selected a percentile that will be used to determine the maximum U&C for your plan. The U&C is reviewed and updated periodically. The U&C can differ from the actual fee charged by the provider and is not indicative of the appropriateness of the provider’s fee. Instead, the U&C is simply a plan provision used to determine the extent of benefit coverage purchased by your Policyholder.

In no event will Covered Persons be held liable for payment denials by us for improper utilization of covered services caused by Participating Providers.

Emergency Care. Services provided in or by a hospital emergency facility to a covered person after the development of a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient

severity that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the covered person's or another person's health in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part.

If a covered person receives Emergency Care and cannot reasonably reach a Participating Provider, payment for care related to the emergency shall be made at the same level and in the same manner as if the covered person had been treated by a Participating Provider.

Alternative Procedures. If two or more procedures are considered adequate and appropriate treatment to correct a certain condition under generally accepted standards of dental care, the amount of the Covered Expense will be equal to the charge for the least expensive procedure. This provision is NOT intended to dictate a course of treatment. Instead, this provision is designed to determine the amount of the plan allowance for a submitted treatment when an adequate and appropriate alternative procedure is available. Accordingly, you may choose to apply the alternate benefit amount determined under this provision toward payment of the submitted treatment.

We may request pre-operative dental radiographic images, periodontal charting and/or additional diagnostic data to determine the plan allowance for the procedures submitted. We strongly encourage pre-treatment estimates so you understand your benefits before any treatment begins. Ask your provider to submit a claim form for this purpose.

Expenses Incurred. An expense is incurred at the time the impression is made for an appliance or change to an appliance. An expense is incurred at the time the tooth or teeth are prepared for a dental prosthesis or prosthetic crown. For root canal therapy, an expense is incurred at the time the pulp chamber is opened. All other expenses are incurred at the time

When You May Rejoin the Plan

A *member* who voluntarily cancels membership in the group *plan* may not re-enroll in that group *plan* until at least one year after the date of cancellation. The re-enrollment must occur during the group's open enrollment period. If *your Benefits Summary* notes that there is a *waiting period* applicable to any services, this *waiting period* begins again with the new *effective date.* No reinstatement of coverage back to the original *effective date* is allowed.

You may rejoin through a different group plan anytime *you* become eligible for that plan. *Lifetime maximums* and claim history accumulated while covered under a previous plan or any other plan may be carried forward to the new plan.

Features of the Plan

Your plan is designed to help *you* maintain good dental health through regular dental care. It will help *you* to pay for dental expenses. *We* describe *your* exact coverage in the *Benefits Summary.*

Utilization Review Guidelines

Our Dental Case Management area performs clinical claims reviews. These reviews help *us* decide if the service meets *our* review guidelines. Analysts who review claims are registered dental *hygienists;* or, dental assistants with clinical experience. The analysts review claims. They can approve services. Only a dental consultant, who is a licensed *dentist,* can deny a claim.

We review claims using written review guidelines. *We* base *our* guidelines on accepted standards of care in the dental profession. They are backed by statistical studies of practice patterns. These guidelines, as well as contract limits, are the basis for review decisions. *We* create clinical guidelines and utilization review standards with guidance from the Dental Director; in-house dental consultants; and, a dental advisory committee. The committee is made up of licensed *dentists. Our* dental consultants and dental advisory committee study trends in dentistry; the proven value of new materials and procedures; treatment longevity; and, local and national practice patterns.

Quality Management Programs

We strive to provide high quality products and services. *We* do this by monitoring, identifying, and tracking key issues over time. *We* deal with these issues as part of *our* review of *our* Quality Program.

Assessment of New Dental Materials and Treatments

We study new dental materials and treatments. *We* also study how effective they are and the cost. Then, *we* decide if *we* will cover the material or treatment.

Continuity of Care

If *your dentist* moves or ever decides not to participate, *you* can choose a new *dentist* from the network. There will not be any disruption in *your* coverage or benefits. If *you* change from an *in-network dentist* to an *out-of-network dentist,* the treatment or procedure would still be covered. This is true so long as it is a *covered service*; but, *you* will be responsible for any difference between *our* payment and the *dentist's* charge.

Pre-treatment Estimate / Prior Authorization

A pre-treatment estimate / prior authorization is a claim that is filed before *you* have a dental service.

Pre-treatment Estimate

When treatment is likely to cost more than $300, *you* and *your dentist* are strongly encouraged to get an estimate before *you* receive treatment. This includes treatment such as crowns; *periodontic; prosthodontic;* and *orthodontic* services.

After *your dentist* sends a request, *we* will review the treatment plan. After reviewing the treatment plan, *we* will tell *you* and *your dentist* what the estimated payment will be for those services.

NOTE: Estimates are based on available benefits. The patient must be an Altus Dental *member* at the time the service is done. The estimate shows what money is available at the time the estimate is done. Estimates can change because services may no longer be available on the date the service is done. For example, if *you* had other services paid for after the estimate, and *you* reach *your annual maximum,* there will be no money left to pay for the new service. Another example is if *you* lose coverage before the new service is finished.

How to Use Altus Dental

You pay a set dollar amount or a percentage thereof for each *covered service* (or nothing for some services). The amount *we* pay is shown in the *Benefits Summary. You* may go to any *dentist you* choose. You must first pay the *deductible* amount, if applicable, for *covered services* before *we* make any payment. There are advantages to going to a *dentist* that is part of the *network.* When *you* visit a *network dentist,* after the *deductible* is met, *you* pay only the *copayment/coinsurance* amount for *covered services.* However, if *you* visit an *out-of-network dentist,* after *you* pay the *deductible* and any *copayment/coinsurance* amount; *you* also pay the difference between the *out-of-network dentist's* charge and the amount *we* pay. *Our* payment varies. See the *Definitions* section of this *Certificate* for a detailed explanation of how *we* pay claims for services done by *out-of-network dentists*.

Maximize Your Coverage with In-Network Dentists

If *you* go to an *in-network dentist, your* out-of-pocket expenses will generally be less. The *dentist* will file claims on *your* behalf. *We* will pay *in-network dentists* directly. By choosing an *in-network dentist, you* get the best value from *your* dental *plan*.

You can go to a *dentist* that is not in the *network.* When *you* go to an *out-of-network dentist, you* are responsible for filing the claim; and, for paying the *dentist.* Most *out-of- network dentists* will file the claim on *your* behalf. *Your* out-of-pocket cost will be more; because, after you pay the deductible and any *copayment/coinsurance* amount, *you* also pay the difference between the *out-of-network dentist's* charge and the amount *we* pay.

Finding an In-Network Dentist

To find a *dentist* participating in the *network,* visit *our* website – www.altusdental.com. The Altus Dental *network* includes general *dentists* and specialists throughout Massachusetts and Rhode Island, and in New Hampshire and Vermont border towns.

If *your plan* has access to *network dentists* in other states including Vermont, the additional *network(s)* will be noted on *your* Altus Dental member identification card. In addition to *dentists* in *our* Altus Dental *network, you* can choose a *dentist* from one of these *networks* and get the advantages of visiting an *in-network dentist.* Follow the instructions in *our* "Find a Dentist" tool on *our* website to find a *dentist* in the *network.*

Network dentists will file claims on *your* behalf; and, *we* will pay them directly. They also agree to accept the *allowance* as payment in full for *covered services.*

We do not require *you* or *your dentist* to get referrals to see a specialist; however, not all services done by a specialist may be covered under *your plan.* Check *your Benefits Summary* for a list of *covered services.*

Payments for Services

In-network dentists will accept *your co-pay/coinsurance* plus *our* payment as payment in full for *covered services*. *We* will pay *in-network dentists* directly. When *your network dentist* provides services that are not covered; or, *covered services* that do not meet *dental necessity* criteria as per *our* review guidelines, *you* may be liable for the *dentist's* charge.

Y*our network dentist* may charge *you* more than the *allowance* when:

- *You* or *your dependents* receive *covered services;* and, *you* have gone over the

annual maximum.

- *You* and *your dentist* decide to use non-covered services; such as, treatments or materials that cost more than those normally given by most *dentists;* or, that are being done to improve *your* appearance. In these cases, *we* may pay an *allowance* suitable for a less costly, generally accepted material or service.

Out-of-network dentists have not agreed to accept *your co-pay/coinsurance* plus *our* payment as payment in full for *covered services. You* will pay more. That's because, after you pay the *deductible* and any *copayment/coinsurance* amount, *you* also pay the difference between the *out-of-network dentist's* charge and the amount *we* pay. *Our* payment varies. See the *Definitions* section of this *Certificate* for a detailed explanation of how *we* pay claims for services done by *out-of-network dentists*.

When an *out-of-network dentist* treats *you, we* will make benefit payments to *you;* unless, *you* and *your dentist* agree to assign benefit payment to *your dentist*. *Your dentist* may not agree to this; and, he/she may request payment from *you.*

Y*our Benefits Summary* indicates *you* have Altus Dental Point of Service, therefore, the Plan will pay for services rendered by *out-of-network dentists* at the Fair Health 95th percentile based on the *usual and customary charge* for *your dentist's* area*,* less any applicable *deductible(s), copayments* or *coinsurance* that are *your* responsibility. *You* are responsible for any difference between *our* payment and the *out-of-network dentist's* charge.

Emergency Services

If *you or your covered dependents* require *emergency care* and 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 p*lan*.

When *you* are covered by more than one Plan, one Plan is the "primary" Plan and the others are "secondary" Plans. When *you* file a claim, the primary Plan pays benefits first, up to the limits of the Plan. The secondary Plans adjust their benefits so that the total amount paid does not exceed the cost of *covered services*. This process is called "Coordination of Benefits" (COB). If *you,* or a family *member,* are also covered by other medical or dental plans, *we* will coordinate payment with them. *We* use standard

insurance industry guidelines in most cases. The standard guidelines that govern this process are set forth below. If other guidelines apply to *your Plan,* they will be noted on *your Benefits Summary.* As used in these rules, the terms "Plan" and "Allowable Expenses" are defined as follows:

- "Plan" means any plan providing dental benefits or services, including government and insured or self-insured group or group-type coverages through an HMO or other prepayment, group practice or individual practice plan.

- "Allowable Expenses" means a necessary, *usual and customary* item of expense for dental care, all or part of which is covered by at least one Plan covering the person for whom the claim is made. Where a Plan provides dental benefits in the form of services rather than cash payments, the reasonable cash value of each service received will be considered both an Allowable Expense and a benefit paid.

The effect of the COB rules on benefits payable during any particular claim period is as follows: If *you* are covered under more than one Plan, the total payment *you* receive will never be more than *your* Allowable Expenses.

The National Association of Insurance Commissioners sets the rules that decide which Plan is primary. They are, in part, as follows:

- The Plan without a coordination of benefits provision is primary.
- When another Plan's rules and this *plan's* rules require this *plan* to pay its benefits first, this *plan* is primary.
- The Plan covering the patient directly rather than as an employee's *dependent* is primary.
- If a child is covered under both parents' Plans, the Plan of the parent whose birthday falls earlier in the calendar year is primary (the "birthday" rule) unless the other Plan has a "gender" rule.
- If a child is covered under both parents' Plans and the other Plan has a "gender" rule, the rule in the other Plan determines benefits. (The "gender" rule says that if a child is covered under both parents' Plans, the Plan of the male parent is primary).
- If the "birthday" rule applies, and both parents have the same birthday, the Plan covering a parent longest is primary.
- If the parents are separated or divorced, benefits for the child are determined in this order:
  - ♦ The Plan of the parent with custody.
  - ♦ The Plan of the *spouse* of the parent with custody.
  - ♦ The Plan of the parent not having custody, unless one of the parents is made responsible for the child's health expenses by a court decree.
- If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the dental care expenses of the child, the Plans covering the child shall follow the order of benefit determination rules outlined above.
- If a full-time student is eligible for coverage as a *dependent* under this *Certificate*, the benefits of any other coverage available because of student enrollment (except accident-only type coverage) will be determined before the benefits under this *plan*.
- The benefits of a Plan which covered a person as an employee who is neither laid off nor retired are determined before those of a Plan which covers that person as a laid off or retired employee. The same is true if a person is a *dependent* of a person covered as a retiree and an employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.
- If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another Plan, the benefits are determined in the following order:
  - ♦ First, the benefits of a Plan covering the person as an employee, *member* or *subscriber* (or as that person's *dependent*);
  - ♦ Second, the benefits under the continuation coverage.
  - ♦ If the other plan does not have the rule described above, and if, as a result, the Plans do not

agree on the order of benefits, this rule is ignored.

- If payment responsibility is still unresolved, the Plan covering the patient longest is primary.

In general, if *you* use more benefits than *you* are covered for during a calendar year, the insurer covering *you* first will cover *you* up to its *allowance.* The secondary insurer will cover any allowable benefit *you* use over that amount. The insurers will never pay more than the total amount of coverage that would have been provided if benefits were not coordinated.

Subrogation

If someone caused *your* illness or injury, *you* may have the legal right to get back some of *your* dental care costs. When *you* have this right, *you* must let *us* use it if *we* decide to recoup any payments *we* made for services related to the illness or injury. If *you* use this right to recoup money from someone else, *you* must repay *us* for the payments *we* made. *Our* right to repayment comes first. It can be reduced only by *our* share of *your* reasonable cost of collecting *your* claim against the other person; or, if the payment received is for other than dental expenses. *You* must give *us* information and assistance and sign documents needed to help *us* receive *our* repayment. *You* must not do anything that might limit *our* repayment.

Facility of Payment

If another Plan pays a benefit that should have been paid under this *plan, we* may reimburse the other Plan for that amount. It will be considered a benefit paid by this *plan*.

Right of Recovery

If *we* pay more than *we* should have paid under the COB provision, *we* have the right to recoup the excess amount *we* paid. This includes recouping from other insurance companies and organizations. The amount that can be recouped includes the reasonable cash value of any benefits provided in the form of services.

When You Have a Claim

When to File a Claim

You should send *us* completed claim forms for services covered under this *Certificate. You* have up to one year from the date *you* get services. All services must be complete to qualify for benefits; e.g., permanent crowns cemented; bridge or denture inserted. *In- network dentists* will send claim forms on *your* behalf. *You* will not be responsible for payment on *covered services* when a *network dentist* sends claims more than one year after the date *you* get the service; except, for any *deductibles; copayments; coinsurance;* or amounts in excess of the *annual dollar maximum. We* will deny claims that an *out-of-network dentist* sends to *us* more than one year after *you* get the services. *You* must pay such claims, unless the failure to send a claim within one year was because of a legal incapacity.

How to File a Claim

In-Network Dentist

When *you* go to a *dentist* who has agreed to participate in the *network, your* claim will be filed for *you*. *Network dentists* are encouraged to file claims within six (6) months from the *date of service.* In no event may a *network dentist* file a claim more than one year after the *date of service.* It must include all necessary supporting information such as x-rays. *We* accept claims from *dentists* on paper and in an electronic, HIPAA compliant format.

Out-of-Network Dentist

When *you* go to a *dentist* who is not participating in the *network,* y*ou* must mail the claim to the following address. *You* don't have to do this if the *dentist* agrees to file it for *you*. Dental claim forms are available by signing into *your* account on *our* website at: **www.altusdental.com** or from *your dentist***.**

Mail Claims To:
Altus Dental Insurance Company, Inc.
P.O. Box 1557
Providence, RI 02901-1557

Claims Procedures

Call Customer Service if *you* have a question about how a claim was paid, or why *we* denied it. The number is 877-223-0588. Customer Service representatives are available Monday – Friday from 8 a.m. to 5 p.m. ET. *You* have a right to request a full and fair review of *your* claim. **To consider a claim for payment, *we* must get it within one year of the date *you* get the service.**

Pre-treatment Estimates

A pre-treatment estimate is a claim that is filed before *you* have a dental service.

Pre-treatment Estimate

When treatment is likely to cost more than $300, *you* and *your dentist* are strongly encouraged to get an estimate before *you* receive treatment. This includes treatment such as crowns; *periodontic; prosthodontic*; and elective *orthodontic* services.

After *your dentist* sends a request, *we* will review the treatment plan. After reviewing the treatment plan, *we* will tell *you* and *your dentist* what the estimated payment will be for those services.

NOTE: Estimates are based on available benefits. The patient must be an Altus Dental *member* at the time the service is done. The estimate shows what money is available at the time the estimate is done. Estimates can change because services may no longer be available on the date the service is done. For example, if *you* had other services paid for after the estimate, and *you* reach *your annual maximum,* there will be no money left to pay for the new service. Another example 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	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

	$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%
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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/calcific repair of perforations, root resorption, etc.).
D3352 Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.).
D3353 Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.).
D3357 Pulpal regeneration - completion of treatment.
D3430 Retrograde filling - per root.
D3450 Root amputation - per root.
D3920 Hemisection (including any root removal), not including root canal therapy.
ENDODONTICS MISCELLANEOUS: D3333, D3430, D3450, D3920

- Procedure D3333 is limited to permanent teeth only.

ENDODONTIC THERAPY (ROOT CANALS)
D3310 Endodontic therapy, anterior tooth.
D3320 Endodontic therapy, premolar tooth (excluding final restorations).
D3330 Endodontic therapy, molar tooth (excluding final restorations).
D3332 Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth.
D3346 Retreatment of previous root canal therapy - anterior.
D3347 Retreatment of previous root canal therapy - premolar.
D3348 Retreatment of previous root canal therapy - molar.
ROOT CANALS: D3310, D3320, D3330, D3332

- Benefits are considered on permanent teeth only.
- Allowances include intraoperative radiographic images and cultures but exclude final restoration.

RETREATMENT OF ROOT CANAL: D3346, D3347, D3348

- Coverage is limited to 1 of any of these procedures per 12 month(s).
- D3310, D3320, D3330, also contribute(s) to this limitation.
- Benefits are considered on permanent teeth only.
- Coverage is limited to service dates more than 12 months after root canal therapy. Allowances include intraoperative radiographic images and cultures but exclude final restoration.

SURGICAL ENDODONTICS
D3355 Pulpal regeneration - initial visit.
D3356 Pulpal regeneration - interim medication replacement.
D3410 Apicoectomy - anterior.

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 Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.
D7311 Alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.
D7320 Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.

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 ostectomy/sequestrectomy for removal of non-vital bone.
D7560 Maxillary sinusotomy for removal of tooth fragment or foreign body.
D7910 Suture of recent small wounds up to 5 cm.
D7911 Complicated suture - up to 5 cm.
D7912 Complicated suture - greater than 5 cm.
D7961 Buccal/labial frenectomy (frenulectomy).
D7962 Lingual frenectomy (frenulectomy).
D7963 Frenuloplasty.
D7970 Excision of hyperplastic tissue - per arch.
D7972 Surgical reduction of fibrous tuberosity.
D7979 Non-surgical sialolithotomy.
D7980 Surgical sialolithotomy.
D7983 Closure of salivary fistula.

REMOVAL OF BONE TISSUE: D7471, D7472, D7473

- Coverage is limited to 5 of any of these procedures per lifetime.

BIOPSY OF ORAL TISSUE

D7285 Incisional biopsy of oral tissue - hard (bone, tooth).
D7286 Incisional biopsy of oral tissue - soft.
D7287 Exfoliative cytological sample collection. D7288
Brush biopsy - transepithelial sample collection.

PALLIATIVE

D9110 Palliative (emergency) treatment of dental pain - minor procedure.

PALLIATIVE TREATMENT: D9110

- Not covered in conjunction with other procedures, except diagnostic x-ray radiographic images.

ANESTHESIA-GENERAL/IV

D9219 Evaluation for moderate sedation, deep sedation or general anesthesia.
D9222 Deep sedation/general anesthesia - first 15 minutes.
D9223 Deep sedation/general anesthesia - each subsequent 15 minute increment.
D9239 Intravenous moderate (conscious) sedation/analgesia - first 15 minutes.
D9243 Intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment.

GENERAL ANESTHESIA: D9222, D9223, D9239, D9243

- Coverage is only available with a cutting procedure. A maximum of four (D9222, D9223, D9239 or D9243) will be considered.

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 matierals, rests, and teeth), mandibular.
D5863 Overdenture - complete maxillary.
D5864 Overdenture - partial maxillary.
D5865 Overdenture - complete mandibular.
D5866 Overdenture - partial mandibular.
D5876 Add metal substructure to acrylic full denture (per arch).
D6110 Implant/abutment supported removable denture for edentulous arch - maxillary.
D6111 Implant/abutment supported removable denture for edentulous arch - mandibular.
D6112 Implant/abutment supported removable denture for partially edentulous arch - maxillary.
D6113 Implant/abutment supported removable denture for partially edentulous arch - mandibular.
D6114 Implant/abutment supported fixed denture for edentulous arch - maxillary.
D6115 Implant/abutment supported fixed denture for edentulous arch - mandibular. D6116 Implant/abutment supported fixed denture for partially edentulous arch - maxillary.
D6117 Implant/abutment supported fixed denture for partially edentulous arch - mandibular.
D6118 Implant/abutment supported interim fixed denture for edentulous arch - mandibular.
D6119 Implant/abutment supported interim fixed denture for edentulous arch - maxillary.

COMPLETE DENTURE: D5110, D5120, D5130, D5140, D5863, D5865, D5876, D6110, D6111, D6114, D6115

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months after placement date. Procedures D5863, D5865, D6110, D6111, D6114 and D6115 are considered at an alternate benefit of a D5110/D5120. Benefits for procedure D5876 is contingent upon the related denture being covered.

PARTIAL DENTURE: D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5282, D5283, D5284, D5286, D5670, D5671, D5864, D5866, D6112, D6113, D6116, D6117

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D6010, D6040, D6050, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months of placement date. Procedures D5864, D5866, D6112, D6113, D6116 and D6117 are considered at an alternate benefit of a D5213/D5214.

DENTURE ADJUSTMENTS

D5410 Adjust complete denture - maxillary.
D5411 Adjust complete denture - mandibular.
D5421 Adjust partial denture - maxillary.
D5422 Adjust partial denture - mandibular.

DENTURE ADJUSTMENT: D5410, D5411, D5421, D5422

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

TYPE 3 PROCEDURES

IMPLANTS
D6010 Surgical placement of implant body: endosteal implant.
D6040 Surgical placement: eposteal implant.
D6050 Surgical placement: transosteal implant.
D6051 Interim abutment.
D6055 Connecting bar-implant supported or abutment supported.
D6056 Prefabricated abutment - includes placement.
D6057 Custom abutment - includes placement.
D6191 Semi-precision abutment-placement.
D6192 Semi-precision attachment-placement.
IMPLANT: D6010, D6040, D6050

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D5211, D5212, D5213, D5214, D5225, D5226, D5282, D5283, D5284, D5286, D6094, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Benefits for procedures D6051, D6055, D6056, D6057, D6191 and D6192 will be contingent upon the implant being covered. Replacement for procedures D6056, D6057, D6191 and D6192 are limited to 1 of any of these procedures in 5 years.

IMPLANT SERVICES
D6080 Implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prostheses and abutments.
D6081 Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure.
D6090 Repair implant supported prosthesis, by report.
D6091 Replacement of replaceable part of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment.
D6095 Repair implant abutment, by report.
D6096 Remove broken implant retaining screw.
D6100 Implant removal, by report.
D6190 Radiographic/surgical implant index, by report.
IMPLANT SERVICES: D6080, D6081, D6090, D6091, D6095, D6096, D6100, D6190

- Coverage for D6080 and D6081 is limited to 2 of any of these procedures in a 12 month period. Coverage for D6090, D6091, D6095 and D6096 is limited to service dates more than 6 months after placement date. Coverage for D6190 is limited to 1 per arch in a 24 month period.

PROSTHODONTICS - FIXED
D6058 Abutment supported porcelain/ceramic crown.
D6059 Abutment supported porcelain fused to metal crown (high noble metal).
D6060 Abutment supported porcelain fused to metal crown (predominantly base metal).
D6061 Abutment supported porcelain fused to metal crown (noble metal).
D6062 Abutment supported cast metal crown (high noble metal).
D6063 Abutment supported cast metal crown (predominantly base metal).
D6064 Abutment supported cast metal crown (noble metal).
D6065 Implant supported porcelain/ceramic crown.
D6066 Implant supported crown - porcelain fused to high noble alloys.
D6067 Implant supported crown - high noble alloys.
D6068 Abutment supported retainer for porcelain/ceramic FPD.
D6069 Abutment supported retainer for porcelain fused to metal FPD (high noble metal).
D6070 Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal).
D6071 Abutment supported retainer for porcelain fused to metal FPD (noble metal).
D6072 Abutment supported retainer for cast metal FPD (high noble metal).
D6073 Abutment supported retainer for cast metal FPD (predominantly base metal).
D6074 Abutment supported retainer for cast metal FPD (noble metal).
D6075 Implant supported retainer for ceramic FPD.
D6076 Implant supported retainer for FPD - porcelain fused to high noble alloys.

TYPE 3 PROCEDURES

D6077	Implant supported retainer for metal FPD - high noble alloy.
D6082	Implant supported crown-porcelain fused to predominantly base alloys.
D6083	Implant supported crown-porcelain fused to noble alloys.
D6084	Implant supported crown-porcelain fused to titanium and titanium alloys.
D6086	Implant supported crown-predominantly base alloys.
D6087	Implant supported crown-noble alloys.
D6088	Implant supported crown-titanium and titanium alloys.
D6094	Abutment supported crown - titanium and titanium alloys.
D6097	Abutment supported crown-porcelain fused to titanium and titanium alloys.
D6098	Implant supported retainer-porcelain fused to predominantly base alloys.
D6099	Implant supported retainer for FPD-porcelain fused to noble alloys. D6120
	Implant supported retainer-porcelain fused to titanium and titanium alloys.
D6121	Implant supported retainer for metal FPD-predominantly base alloys.
D6122	Implant supported retainer for metal FPD-noble alloys.
D6123	Implant supported retainer for metal FPD-titanium and titanium alloys. D6194
	Abutment supported retainer crown for FPD - titanium and titanium alloys.
D6195	Abutment supported retainer-porcelain fused to titanium and titanium alloys.
D6205	Pontic - indirect resin based composite.
D6210	Pontic - cast high noble metal.
D6211	Pontic - cast predominantly base metal.
D6212	Pontic - cast noble metal.
D6214	Pontic - titanium and titanium alloys. D6240
	Pontic - porcelain fused to high noble metal.
D6241	Pontic - porcelain fused to predominantly base metal.
D6242	Pontic - porcelain fused to noble metal.
D6243	Pontic-porcelain fused to titanium and titanium alloys.
D6245	Pontic - porcelain/ceramic.
D6250	Pontic - resin with high noble metal.
D6251	Pontic - resin with predominantly base metal.
D6252	Pontic - resin with noble metal.
D6545	Retainer - cast metal for resin bonded fixed prosthesis.
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis.
D6549	Resin retainer - for resin bonded fixed prosthesis.
D6600	Retainer inlay - porcelain/ceramic, two surfaces.
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces.
D6602	Retainer inlay - cast high noble metal, two surfaces.
D6603	Retainer inlay - cast high noble metal, three or more surfaces.
D6604	Retainer inlay - cast predominantly base metal, two surfaces.
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces.
D6606	Retainer inlay - cast noble metal, two surfaces.
D6607	Retainer inlay - cast noble metal, three or more surfaces.
D6608	Retainer onlay - porcelain/ceramic, two surfaces.
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces.
D6610	Retainer onlay - cast high noble metal, two surfaces.
D6611	Retainer onlay - cast high noble metal, three or more surfaces.
D6612	Retainer onlay - cast predominantly base metal, two surfaces.
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces.
D6614	Retainer onlay - cast noble metal, two surfaces.
D6615	Retainer onlay - cast noble metal, three or more surfaces.
D6624	Retainer inlay - titanium.
D6634	Retainer onlay - titanium.
D6710	Retainer crown - indirect resin based composite.
D6720	Retainer crown - resin with high noble metal.
D6721	Retainer crown - resin with predominantly base metal.
D6722	Retainer crown - resin with noble metal.
D6740	Retainer crown - porcelain/ceramic.
D6750	Retainer crown - porcelain fused to high noble metal.
D6751	Retainer crown - porcelain fused to predominantly base metal.
D6752	Retainer crown - porcelain fused to noble metal.
D6753	Retainer crown-porcelain fused to titanium and titanium alloys.
D6780	Retainer crown - 3/4 cast high noble metal.

TYPE 3 PROCEDURES

D6781 Retainer crown - 3/4 cast predominantly base metal.
D6782 Retainer crown - 3/4 cast noble metal.
D6783 Retainer crown - 3/4 porcelain/ceramic.
D6784 Retainer crown 3/4-titanium and titanium alloys.
D6790 Retainer crown - full cast high noble metal.
D6791 Retainer crown - full cast predominantly base metal.
D6792 Retainer crown - full cast noble metal.
D6794 Retainer crown - titanium and titanium alloys.
D6940 Stress breaker.

FIXED PARTIAL CROWN: D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.
- Benefits will not be considered if procedure D2390, D2928, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL INLAY: D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.
- Benefits will not be considered if procedure D2390, D2928, D2929, D2930, D2931, D2932. D2933 or D2934 has been performed within 12.

FIXED PARTIAL ONLAY: D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.
- Benefits will not be considered if procedure D2390, D2928, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL PONTIC: D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252

TYPE 3 PROCEDURES

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5282, D5283, D5284, D5286, D6010, D6040, D6050, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6082, D6083, D6084, D6086, D6087, D6088, D6094, D6097, D6098, D6099, D6120, D6121, D6122, D6123, D6194, D6195, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

IMPLANT SUPPORTED CROWN: D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6082, D6083, D6084, D6086, D6087, D6088, D6094, D6097

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5282, D5283, D5284, D5286, D6194, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

IMPLANT SUPPORTED RETAINER: D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6098, D6099, D6120, D6121, D6122, D6123, D6194, D6195

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5282, D5283, D5284, D5286, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6082, D6083, D6084, D6086, D6087, D6088, D6094, D6097, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, also contribute(s) to this limitation
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

BONE AUGMENTATION

D6104 Bone graft at time of implant placement.
D7950 Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla - autogenous or nonautogenous, by report.
D7951 Sinus augmentation with bone or bone substitutes via a lateral open approach.
D7952 Sinus augmentation via a vertical approach.
D7953 Bone replacement graft for ridge preservation - per site.

BONE AUGMENTATION: D6104, D7950, D7951, D7952, D7953

- Each quadrant is limited to 1 of any of these procedures per 5 year(s).
- Coverage of D6104, D7950, D7951, D7952 and D7953 is limited to the treatment and placement of endosteal implant D6010, D6040 eposteal implant or D6050 transosteal implant.

OCCLUSAL GUARD

D9944 Occlusal guard - hard appliance, full arch.
D9945 Occlusal guard - soft appliance, full arch.
D9946 Occlusal guard - hard appliance, partial arch.

OCCLUSAL GUARD: D9944, D9945, D9946

- Coverage is limited to 1 of any of these procedures per 3 year(s).
- Benefits will not be available if performed for athletic purposes.

OCCLUSAL ADJUSTMENT

D9951 Occlusal adjustment - limited.
D9952 Occlusal adjustment - complete.

OCCLUSAL ADJUSTMENT: D9951, D9952

- Coverage is considered only when performed in conjunction with periodontal procedures for the treatment of periodontal disease.

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): ុរបយ័ត្ន៖ េបើសិន�អ�កនិ�យ ��ែខ្មែរ, េស�ជំនួយែផ�ក�ភ
េ�យមិនគិតឈ�ល
គឺ�ច�នស់ំ ក។ ចូរ ទូរស័ព 1-877-223-0588.
ប់ប់ំេរអ

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: ຖ້ າຫ າ ທ ານເອ້ າພາສາ ລາວ, ອຸ ານພາສາ, ໂດຍ ບ ເສ ງ ຫ າ, ແມ ນ ການ ບ ລິ ການຊ ອຍ ເຫ ອ ໂທ ຫ ານ. ໂທຣ 1-877-223-0588.

ية **(Arabic):**

ملحوظة: إذا كنت تتحدث اللغة الويتنامية، فإن خدمات المساعدة اللغوية المجانية متاحة لك. اتصل برقم 1-877-223-0588 (رقم الهاتف المصاحب: 1-877-223-0588).

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-223-0588.

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-223-0588.

Bàsɔ̀ ɔ̀-wùqù-po-nyɔ̀ (Bassa): Dè qɛ nià kɛ dyéqé gbo: Ɔ jǔ ké m̀[Bàsɔ́ ɔ̀-wùqù-po-nyɔ̀] jǔ ní, nìí, à wuqu kà kò qò po-poɔ̀ bɛ́ìn m̀gbo kpáa. Đá 1-877-223-0588.

Igbo asusu (Ibo): Ige nti: O buru na asu Ibo asusu, enyemaka diri gi site na call 1-877-223-0588.

èdè Yorùbá (Yoruba): AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi 1-877-223-0588.

Polski (Polish): UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-223-0588.

한국어 (Korean): 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-223-0588 번으로 전화해 주십시오.

Tagalog (Tagalog – Filipino): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-223-0588.

ह ंद (Hindi): ध्य ान द : य द आप ह ंद ब ोलत े ह त ो आपक े ल ए म ु फ्त म भ ाष ा सह ायत ा स ेव ाए ं उपलब्ध ह । 1-877-223-0588 पर कॉल क ।

જ ર ાત ી (Gujarati): ચ ન ા: જ ો તમ ે જ ર ાત ી બ ોલત ા હ ો, ત ો ન ી:ુ ક ભ ાષ ા સહ ાય સવ ો ઓ

તમ ારા મ ાટ ે ઉપલબ્ધ છ ે. ફ ોન કર ો 1-877-223-0588.

Ελληνικά (Greek): ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-877-223-0588.

SCHEDULE OF BENEFITS
OUTLINE OF COVERAGE

The Insurance for each Insured and each Insured Dependent will be based on the Insured's class shown in this Schedule of Benefits.

Benefit Class	Class Description
Class 2	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*.** **Eac**h Member of the eligible class(es) for dependent coverage is eligible for the Dependent Insurance under the policy and will qualify for this

Dependent Insurance on the latest of:

1. the day he or she qualifies for coverage as a Member;
2. the day he or she first becomes a Member; or
3. the day he or she first has a dependent. For dependent children, a newborn child will be considered an eligible dependent upon reaching their 2nd birthday. The child may be added at birth or within 31 days of the 2nd birthday.

A Member must be an Insured to also insure his or her dependents.

If employment is the basis for membership, a member of the Eligible Class for Dependent Insurance is any graduate employee working at least 20 hours per week and has eligible dependents. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

When a member of the Eligible Class for Dependent Insurance dies and, if at the date of death, has dependents insured, the Policyholder has the option of offering the dependents of the deceased employee continued coverage. If elected by the Policyholder and the affected dependents, the name of such deceased member will continue to be listed as a member of the Eligible Class for Dependent Insurance.

***Contribution Requirements*.** Member Insurance: An Insured is not required to contribute to the payment of his or her insurance premiums. An insured may or may not be required to contribute to the payment of insurance premiums if he or she is both covered under this policy and also covered under another plan.

Dependent Insurance: An Insured is required to contribute to the payment of insurance premiums for his or her dependents.

***Eligibility Period*.** For Members on the Plan Effective Date of the policy, qualification will occur after an eligibility period defined by the Policyholder is satisfied. The same eligibility period will be applied to all members.

For persons who become Members after the Plan Effective Date of the policy, qualification will occur after an eligibility period defined by the Policyholder is satisfied. The same eligibility period will be applied to all members.

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.

Y*our network dentist* may charge *you* more than the *allowance* when:

- *You* or *your dependents* receive *covered services;* and, *you* have gone over the *annual maximum*.

- *You* and *your dentist* decide to use non-covered services; such as, treatments or materials that cost more than those normally given by most *dentists;* or, that are being done to improve *your* appearance. In these cases, *we* may pay an *allowance* suitable for a less costly, generally accepted material or service.

Out-of-network dentists have not agreed to accept *your co-pay/coinsurance* plus *our* payment as payment in full for *covered services. You* will pay more. That's because, after you pay the *deductible* and any *copayment/coinsurance* amount, *you* also pay the difference between the *out-of-network dentist's* charge and the amount *we* pay. *Our* payment varies. See the *Definitions* section of this *Certificate* for a detailed explanation of how *we* pay claims for services done by *out-of-network dentists*.

When an *out-of-network dentist* treats *you, we* will make benefit payments to *you;* unless, *you* and *your dentist* agree to assign benefit payment to *your dentist*. *Your dentist* may not agree to this; and, he/she may request payment from *you.*

Y*our Benefits Summary* indicates *you* have Altus Dental Point of Service, therefore, the Plan will pay for services rendered by *out-of-network dentists* at the Fair Health 95th percentile based on the *usual and customary charge* for *your dentist's* area*,* less any applicable *deductible(s), copayments* or *coinsurance* that are *your* responsibility. *You* are responsible for any difference between *our* payment and the *out-of-network dentist's* charge.

Emergency Services

If *you or your covered dependents* require *emergency care* and 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 p*lan*.

When *you* are covered by more than one Plan, one Plan is the "primary" Plan and the others are "secondary" Plans. When *you* file a claim, the primary Plan pays benefits first, up to the limits of the Plan. The secondary Plans adjust their benefits so that the total amount paid does not exceed the cost of *covered services*. This process is called "Coordination of Benefits" (COB). If *you,* or a family *member,* are also covered by other medical or dental plans, *we* will coordinate payment with them. *We* use standard

insurance industry guidelines in most cases. The standard guidelines that govern this process are set forth below. If other guidelines apply to *your Plan,* they will be noted on *your Benefits Summary.* As used in these rules, the terms "Plan" and "Allowable Expenses" are defined as follows:

- "Plan" means any plan providing dental benefits or services, including government and insured or self-insured group or group-type coverages through an HMO or other prepayment, group practice or individual practice plan.

- "Allowable Expenses" means a necessary, *usual and customary* item of expense for dental care, all or part of which is covered by at least one Plan covering the person for whom the claim is made. Where a Plan provides dental benefits in the form of services rather than cash payments, the reasonable cash value of each service received will be considered both an Allowable Expense and a benefit paid.

The effect of the COB rules on benefits payable during any particular claim period is as follows: If *you* are covered under more than one Plan, the total payment *you* receive will never be more than *your* Allowable Expenses.

The National Association of Insurance Commissioners sets the rules that decide which Plan is primary. They are, in part, as follows:

- The Plan without a coordination of benefits provision is primary.
- When another Plan's rules and this *plan's* rules require this *plan* to pay its benefits first, this *plan* is primary.
- The Plan covering the patient directly rather than as an employee's *dependent* is primary.
- If a child is covered under both parents' Plans, the Plan of the parent whose birthday falls earlier in the calendar year is primary (the "birthday" rule) unless the other Plan has a "gender" rule.
- If a child is covered under both parents' Plans and the other Plan has a "gender" rule, the rule in the other Plan determines benefits. (The "gender" rule says that if a child is covered under both parents' Plans, the Plan of the male parent is primary).
- If the "birthday" rule applies, and both parents have the same birthday, the Plan covering a parent longest is primary.
- If the parents are separated or divorced, benefits for the child are determined in this order:
  - ♦ The Plan of the parent with custody.
  - ♦ The Plan of the *spouse* of the parent with custody.
  - ♦ The Plan of the parent not having custody, unless one of the parents is made responsible for the child's health expenses by a court decree.
- If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the dental care expenses of the child, the Plans covering the child shall follow the order of benefit determination rules outlined above.
- If a full-time student is eligible for coverage as a *dependent* under this *Certificate*, the benefits of any other coverage available because of student enrollment (except accident-only type coverage) will be determined before the benefits under this *plan*.
- The benefits of a Plan which covered a person as an employee who is neither laid off nor retired are determined before those of a Plan which covers that person as a laid off or retired employee. The same is true if a person is a *dependent* of a person covered as a retiree and an employee. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.
- If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another Plan, the benefits are determined in the following order:
  - ♦ First, the benefits of a Plan covering the person as an employee, *member* or *subscriber* (or as that person's *dependent*);
  - ♦ Second, the benefits under the continuation coverage.
  - ♦ If the other plan does not have the rule described above, and if, as a result, the Plans do not

agree on the order of benefits, this rule is ignored.

- If payment responsibility is still unresolved, the Plan covering the patient longest is primary.

In general, if *you* use more benefits than *you* are covered for during a calendar year, the insurer covering *you* first will cover *you* up to its *allowance.* The secondary insurer will cover any allowable benefit *you* use over that amount. The insurers will never pay more than the total amount of coverage that would have been provided if benefits were not coordinated.

Subrogation

If someone caused *your* illness or injury, *you* may have the legal right to get back some of *your* dental care costs. When *you* have this right, *you* must let *us* use it if *we* decide to recoup any payments *we* made for services related to the illness or injury. If *you* use this right to recoup money from someone else, *you* must repay *us* for the payments *we* made. *Our* right to repayment comes first. It can be reduced only by *our* share of *your* reasonable cost of collecting *your* claim against the other person; or, if the payment received is for other than dental expenses. *You* must give *us* information and assistance and sign documents needed to help *us* receive *our* repayment. *You* must not do anything that might limit *our* repayment.

Facility of Payment

If another Plan pays a benefit that should have been paid under this *plan, we* may reimburse the other Plan for that amount. It will be considered a benefit paid by this *plan*.

Right of Recovery

If *we* pay more than *we* should have paid under the COB provision, *we* have the right to recoup the excess amount *we* paid. This includes recouping from other insurance companies and organizations. The amount that can be recouped includes the reasonable cash value of any benefits provided in the form of services.

When You Have a Claim

When to File a Claim

You should send *us* completed claim forms for services covered under this *Certificate. You* have up to one year from the date *you* get services. All services must be complete to qualify for benefits; e.g., permanent crowns cemented; bridge or denture inserted. *In- network dentists* will send claim forms on *your* behalf. *You* will not be responsible for payment on *covered services* when a *network dentist* sends claims more than one year after the date *you* get the service; except, for any *deductibles; copayments; coinsurance;* or amounts in excess of the *annual dollar maximum. We* will deny claims that an *out-of-network dentist* sends to *us* more than one year after *you* get the services. *You* must pay such claims, unless the failure to send a claim within one year was because of a legal incapacity.

How to File a Claim

In-Network Dentist

When *you* go to a *dentist* who has agreed to participate in the *network, your* claim will be filed for *you*. *Network dentists* are encouraged to file claims within six (6) months from the *date of service.* In no event may a *network dentist* file a claim more than one year after the *date of service.* It must include all necessary supporting information such as x-rays. *We* accept claims from *dentists* on paper and in an electronic, HIPAA compliant format.

Out-of-Network Dentist

When *you* go to a *dentist* who is not participating in the *network,* y*ou* must mail the claim to the following address. *You* don't have to do this if the *dentist* agrees to file it for *you*. Dental claim forms are available by signing into *your* account on *our* website at: **www.altusdental.com** or from *your dentist***.**

Mail Claims To:
Altus Dental Insurance Company, Inc.
P.O. Box 1557
Providence, RI 02901-1557

Claims Procedures

Call Customer Service if *you* have a question about how a claim was paid, or why *we* denied it. The number is 877-223-0588. Customer Service representatives are available Monday – Friday from 8 a.m. to 5 p.m. ET. *You* have a right to request a full and fair review of *your* claim. **To consider a claim for payment, *we* must get it within one year of the date *you* get the service.**

Pre-treatment Estimates

A pre-treatment estimate is a claim that is filed before *you* have a dental service.
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 2	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 Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.
D7311 Alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.
D7320 Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.
D7321 Alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.
D7340 Vestibuloplasty - ridge extension (secondary epithelialization).
D7350 Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue).
D7410 Excision of benign lesion up to 1.25 cm.
D7411 Excision of benign lesion greater than 1.25 cm.
D7412 Excision of benign lesion, complicated.
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 matierals, rests, and teeth), mandibular.
D5863 Overdenture - complete maxillary.
D5864 Overdenture - partial maxillary.
D5865 Overdenture - complete mandibular.
D5866 Overdenture - partial mandibular.
D5876 Add metal substructure to acrylic full denture (per arch).
D6110 Implant/abutment supported removable denture for edentulous arch - maxillary.
D6111 Implant/abutment supported removable denture for edentulous arch - mandibular.
D6112 Implant/abutment supported removable denture for partially edentulous arch - maxillary.
D6113 Implant/abutment supported removable denture for partially edentulous arch - mandibular.
D6114 Implant/abutment supported fixed denture for edentulous arch - maxillary.
D6115 Implant/abutment supported fixed denture for edentulous arch - mandibular. D6116 Implant/abutment supported fixed denture for partially edentulous arch - maxillary.
D6117 Implant/abutment supported fixed denture for partially edentulous arch - mandibular.
D6118 Implant/abutment supported interim fixed denture for edentulous arch - mandibular.
D6119 Implant/abutment supported interim fixed denture for edentulous arch - maxillary.

COMPLETE DENTURE: D5110, D5120, D5130, D5140, D5863, D5865, D5876, D6110, D6111, D6114, D6115

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months after placement date. Procedures D5863, D5865, D6110, D6111, D6114 and D6115 are considered at an alternate benefit of a D5110/D5120. Benefits for procedure D5876 is contingent upon the related denture being covered.

PARTIAL DENTURE: D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5282, D5283, D5284, D5286, D5670, D5671, D5864, D5866, D6112, D6113, D6116, D6117

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D6010, D6040, D6050, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Allowances include adjustments within 6 months of placement date. Procedures D5864, D5866, D6112, D6113, D6116 and D6117 are considered at an alternate benefit of a D5213/D5214.

DENTURE ADJUSTMENTS

D5410 Adjust complete denture - maxillary.
D5411 Adjust complete denture - mandibular.
D5421 Adjust partial denture - maxillary.
D5422 Adjust partial denture - mandibular.

DENTURE ADJUSTMENT: D5410, D5411, D5421, D5422

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

TYPE 3 PROCEDURES

IMPLANTS
D6010 Surgical placement of implant body: endosteal implant.
D6040 Surgical placement: eposteal implant.
D6050 Surgical placement: transosteal implant.
D6051 Interim abutment.
D6055 Connecting bar-implant supported or abutment supported.
D6056 Prefabricated abutment - includes placement.
D6057 Custom abutment - includes placement.
D6191 Semi-precision abutment-placement.
D6192 Semi-precision attachment-placement.
IMPLANT: D6010, D6040, D6050

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D5211, D5212, D5213, D5214, D5225, D5226, D5282, D5283, D5284, D5286, D6094, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Benefits for procedures D6051, D6055, D6056, D6057, D6191 and D6192 will be contingent upon the implant being covered. Replacement for procedures D6056, D6057, D6191 and D6192 are limited to 1 of any of these procedures in 5 years.

IMPLANT SERVICES
D6080 Implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prostheses and abutments.
D6081 Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure.
D6090 Repair implant supported prosthesis, by report.
D6091 Replacement of replaceable part of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment.
D6095 Repair implant abutment, by report.
D6096 Remove broken implant retaining screw.
D6100 Implant removal, by report.
D6190 Radiographic/surgical implant index, by report.
IMPLANT SERVICES: D6080, D6081, D6090, D6091, D6095, D6096, D6100, D6190

- Coverage for D6080 and D6081 is limited to 2 of any of these procedures in a 12 month period. Coverage for D6090, D6091, D6095 and D6096 is limited to service dates more than 6 months after placement date. Coverage for D6190 is limited to 1 per arch in a 24 month period.

PROSTHODONTICS - FIXED
D6058 Abutment supported porcelain/ceramic crown.
D6059 Abutment supported porcelain fused to metal crown (high noble metal).
D6060 Abutment supported porcelain fused to metal crown (predominantly base metal).
D6061 Abutment supported porcelain fused to metal crown (noble metal).
D6062 Abutment supported cast metal crown (high noble metal).
D6063 Abutment supported cast metal crown (predominantly base metal).
D6064 Abutment supported cast metal crown (noble metal).
D6065 Implant supported porcelain/ceramic crown.
D6066 Implant supported crown - porcelain fused to high noble alloys.
D6067 Implant supported crown - high noble alloys.
D6068 Abutment supported retainer for porcelain/ceramic FPD.
D6069 Abutment supported retainer for porcelain fused to metal FPD (high noble metal).
D6070 Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal).
D6071 Abutment supported retainer for porcelain fused to metal FPD (noble metal).
D6072 Abutment supported retainer for cast metal FPD (high noble metal).
D6073 Abutment supported retainer for cast metal FPD (predominantly base metal).
D6074 Abutment supported retainer for cast metal FPD (noble metal).
D6075 Implant supported retainer for ceramic FPD.
D6076 Implant supported retainer for FPD - porcelain fused to high noble alloys.

TYPE 3 PROCEDURES

D6077	Implant supported retainer for metal FPD - high noble alloy.
D6082	Implant supported crown-porcelain fused to predominantly base alloys.
D6083	Implant supported crown-porcelain fused to noble alloys.
D6084	Implant supported crown-porcelain fused to titanium and titanium alloys.
D6086	Implant supported crown-predominantly base alloys.
D6087	Implant supported crown-noble alloys.
D6088	Implant supported crown-titanium and titanium alloys.
D6094	Abutment supported crown - titanium and titanium alloys.
D6097	Abutment supported crown-porcelain fused to titanium and titanium alloys.
D6098	Implant supported retainer-porcelain fused to predominantly base alloys.
D6099	Implant supported retainer for FPD-porcelain fused to noble alloys. D6120 Implant supported retainer-porcelain fused to titanium and titanium alloys.
D6121	Implant supported retainer for metal FPD-predominantly base alloys.
D6122	Implant supported retainer for metal FPD-noble alloys.
D6123	Implant supported retainer for metal FPD-titanium and titanium alloys. D6194 Abutment supported retainer crown for FPD - titanium and titanium alloys.
D6195	Abutment supported retainer-porcelain fused to titanium and titanium alloys.
D6205	Pontic - indirect resin based composite.
D6210	Pontic - cast high noble metal.
D6211	Pontic - cast predominantly base metal.
D6212	Pontic - cast noble metal.
D6214	Pontic - titanium and titanium alloys. D6240 Pontic - porcelain fused to high noble metal.
D6241	Pontic - porcelain fused to predominantly base metal.
D6242	Pontic - porcelain fused to noble metal.
D6243	Pontic-porcelain fused to titanium and titanium alloys.
D6245	Pontic - porcelain/ceramic.
D6250	Pontic - resin with high noble metal.
D6251	Pontic - resin with predominantly base metal.
D6252	Pontic - resin with noble metal.
D6545	Retainer - cast metal for resin bonded fixed prosthesis.
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis.
D6549	Resin retainer - for resin bonded fixed prosthesis.
D6600	Retainer inlay - porcelain/ceramic, two surfaces.
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces.
D6602	Retainer inlay - cast high noble metal, two surfaces.
D6603	Retainer inlay - cast high noble metal, three or more surfaces.
D6604	Retainer inlay - cast predominantly base metal, two surfaces.
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces.
D6606	Retainer inlay - cast noble metal, two surfaces.
D6607	Retainer inlay - cast noble metal, three or more surfaces.
D6608	Retainer onlay - porcelain/ceramic, two surfaces.
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces.
D6610	Retainer onlay - cast high noble metal, two surfaces.
D6611	Retainer onlay - cast high noble metal, three or more surfaces.
D6612	Retainer onlay - cast predominantly base metal, two surfaces.
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces.
D6614	Retainer onlay - cast noble metal, two surfaces.
D6615	Retainer onlay - cast noble metal, three or more surfaces.
D6624	Retainer inlay - titanium.
D6634	Retainer onlay - titanium.
D6710	Retainer crown - indirect resin based composite.
D6720	Retainer crown - resin with high noble metal.
D6721	Retainer crown - resin with predominantly base metal.
D6722	Retainer crown - resin with noble metal.
D6740	Retainer crown - porcelain/ceramic.
D6750	Retainer crown - porcelain fused to high noble metal.
D6751	Retainer crown - porcelain fused to predominantly base metal.
D6752	Retainer crown - porcelain fused to noble metal.
D6753	Retainer crown-porcelain fused to titanium and titanium alloys.
D6780	Retainer crown - 3/4 cast high noble metal.

TYPE 3 PROCEDURES

D6781 Retainer crown - 3/4 cast predominantly base metal.
D6782 Retainer crown - 3/4 cast noble metal.
D6783 Retainer crown - 3/4 porcelain/ceramic.
D6784 Retainer crown 3/4-titanium and titanium alloys.
D6790 Retainer crown - full cast high noble metal.
D6791 Retainer crown - full cast predominantly base metal.
D6792 Retainer crown - full cast noble metal.
D6794 Retainer crown - titanium and titanium alloys.
D6940 Stress breaker.

FIXED PARTIAL CROWN: D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.
- Benefits will not be considered if procedure D2390, D2928, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL INLAY: D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.
- Benefits will not be considered if procedure D2390, D2928, D2929, D2930, D2931, D2932. D2933 or D2934 has been performed within 12.

FIXED PARTIAL ONLAY: D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.
- Benefits will not be considered if procedure D2390, D2928, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL PONTIC: D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252

TYPE 3 PROCEDURES

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5282, D5283, D5284, D5286, D6010, D6040, D6050, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6082, D6083, D6084, D6086, D6087, D6088, D6094, D6097, D6098, D6099, D6120, D6121, D6122, D6123, D6194, D6195, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

IMPLANT SUPPORTED CROWN: D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6082, D6083, D6084, D6086, D6087, D6088, D6094, D6097

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5282, D5283, D5284, D5286, D6194, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

IMPLANT SUPPORTED RETAINER: D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6098, D6099, D6120, D6121, D6122, D6123, D6194, D6195

- Replacement is limited to 1 of any of these procedures per 5 year(s).
- D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5282, D5283, D5284, D5286, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6082, D6083, D6084, D6086, D6087, D6088, D6094, D6097, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, also contribute(s) to this limitation
- Frequency is waived for accidental injury.
- Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
- Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

BONE AUGMENTATION

D6104 Bone graft at time of implant placement.
D7950 Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla - autogenous or nonautogenous, by report.
D7951 Sinus augmentation with bone or bone substitutes via a lateral open approach.
D7952 Sinus augmentation via a vertical approach.
D7953 Bone replacement graft for ridge preservation - per site.

BONE AUGMENTATION: D6104, D7950, D7951, D7952, D7953

- Each quadrant is limited to 1 of any of these procedures per 5 year(s).
- Coverage of D6104, D7950, D7951, D7952 and D7953 is limited to the treatment and placement of endosteal implant D6010, D6040 eposteal implant or D6050 transosteal implant.

OCCLUSAL GUARD

D9944 Occlusal guard - hard appliance, full arch.
D9945 Occlusal guard - soft appliance, full arch.
D9946 Occlusal guard - hard appliance, partial arch.

OCCLUSAL GUARD: D9944, D9945, D9946

- Coverage is limited to 1 of any of these procedures per 3 year(s).
- Benefits will not be available if performed for athletic purposes.

OCCLUSAL ADJUSTMENT

D9951 Occlusal adjustment - limited.
D9952 Occlusal adjustment - complete.

OCCLUSAL ADJUSTMENT: D9951, D9952

- Coverage is considered only when performed in conjunction with periodontal procedures for the treatment of periodontal disease.

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.

EyeMed VISION CARE®

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 Heath 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 Administerator
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: _____
Kevin Thilst

Title: VP-Client Services

Date: 11-5-10

First American Administrators, Inc.

By: _____
Kevin Thilst

Title: VP Client Services

Date: 11-5-10

UAW/UMass Health & Welfare Trust Fund

By: Susan Chinman

Name: Susan Chinman

Title: University Trustee

Date: 10/22/10

Ronald R. Potwora

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

EyeMed Vision Care

UMASS/UAW - GEO Vision
EyeMed Select Plan H, Fee For Service
100% Employer Paid -OR- Bundled With Group Medical or Dental
Option 1

Version 4

Vision Care Services	Member Cost	Group Cost per Service	Out-of-Network
Exam with Dilation 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	$80	$130
Standard Progressive Lens**	$25	$95	$78
Premium Progressive Lens**	$25, 80% of Charge less $120 Allowance	$95	$78
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			
Lasik 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)	$0.93		

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 20% 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 Eyeshed Provider's professional services, or contact lenses.
Members also receive 15% off retail price or 5% off promotional price for Lasik or PRK from the US 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 for groups domiciled in the State of MA.
Fees quoted will be valid until the 11/1/2010 plan implementation date. Date quoted: 8/21/2010.
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; Aniseikonic 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 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 UMASS/UAW - 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 EYEMED 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

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: Jason M. Rum		Name: Jason M. Rum
Title: SVP		Title: SVP
Date: 8/24/16		Date: 8/24/16
UAW/UMass Health & Welfare Trust Fund		
By:		
Name: Leslie Edwards Davis		
Title: Senior Benefits Specialist		
Date: 8/11/2016		

Reviewed As to Form by EyeMed Legal:
Brenda Thomann

Exhibit B-Benefit Schedule

UMass Post Doctoral Unit
EyeMed Select Plan H. Fee For Service
Employer pays 00% 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	$10Copay, 80% at Charge Less $120 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 26	$40	N/A
Standard Anti Reflective Coating	$45	N/A
Polarized	20% off Retail Price	N/A
Other Add Ons	20% off Retail Price	N/A
Contact Lenses *(Contact lens allowance includes materials only)*		
Conventional	$0 Copay; $135 allowance, 15% off balance over $135	$108
Disposable	$0 Copay; $135 allowance, plus balance over $135	$108
Medically Necessary	$0 Copay, Paid in Full	$210
Laser Vision Correction		
Lasik 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	
Contacts	Once every 12 months	
Frame	Once every 12 months	
Monthly Administrative Fee		
Per Subscriber Per Month (Composite)	$0.93	

All plans are based on a 30-month contract term and 30-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 ask the negotiated discount rate with certain participating providers. Please use 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 Lasik or PRK from the US 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.
Fees quoted will be valid until the 7/1/2016 plan implementation date. Date quoted: 5/10/2016.
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; Aniseikonic 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 are 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 UMass Post Doctoral Unit has chosen this benefit design, sign here:

Signature _____ Date 5/13/2016

T09

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: Jeremy Pereira		By: Jeremy Pereira
Name: Jeremy Pereira		Name: Jeremy Pereira
Title: VP, Sales & Account Mgmt		Title: VP, Sales & Account Mgmt
Date: November 6, 2019		Date: November 6, 2019
UAW/UMass Health & Welfare Trust Fund		**UAW/UMass Health & Welfare Trust Fund**
By:		By:
Name: Leslie Edwards Davis		Name:
Title: Director of Benefit Programs		Title:
Date: 10/24/2019		Date:

Reviewed As to Form by EyeMed Legal:
Brenda Thomann

Exhibit B-Benefit Schedule – Page 1

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

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 $39	N/A
Exam Options:		
Standard Contact Lens Fit and Follow-Up:	Up to $49	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	See attached Fixed Premium Progressive price list	$78
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 list	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, Paid-In-Full	$210
Laser Vision Correction		
Lasik 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 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 Lenses	Once every 12 months	
Frame	Once every 12 months	
Monthly Administrative Fee		
Per Subscriber Per Month (Composite)	$0.93	
	UAW HCW 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 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

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 Lasik or PRK from the US 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.
If 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.
Fees quoted will be valid until the 7/1/2018 plan implementation date. Date quoted: 6/27/2018.
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; Anisekonic 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 are 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 _____ Date 8/21/2018

Leslie Edwards Davis, Director of Benefit Programs

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

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

By: _____

Name: Jason Rome

Title: Senior Vice President

Date: October 25, 2023

First American Administrators, Inc.

By: _____

Name: Jason Rome

Title: Senior Vice President

Date: October 25, 2023

UAW/UMass Health & Welfare Trust Fund

By: _____

Name: Leslie Edwards Davis

Title: Director of Benefits

Date: 10/24/23

Reviewed As to Form by EyeMed Legal:

Brenda Thomann

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 situsedin 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 Date

P201603 TC0 Q-C0042631 QL-0000095870

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.

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UAW/UMass Health & Welfare Trust Fund

Proposed benefits

Option Diabetic Exam & Materials Select Network ASO Employer Paid Funded 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**

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.