September 1, 2021

Dear Plan Participant:

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

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

- a dental plan with Ameritas
- a vision plan with EyeMed Vision Care
- family dental plan with a participant contribution
- free family vision coverage
- a childcare reimbursement for on or off-campus childcare receipts

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

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

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

Employer funded means that the Trust Fund is entirely funded by the University.

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

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

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

YOUR EMPLOYER PAYS FOR YOUR BENEFITS

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

IMPORTANT PHONE NUMBERS

Trust Fund Director of Benefits: (413) 345-2156

Ameritas: (800) 487-5553

EyeMed Vision Care: (866) 299-1358

UAW Local 2322: (413) 534-7600

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

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

OVERVIEW of PHWP

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

The benefit application is available online at https://hwtrust.geouaw.org/ and opens August 15 of each year.

To complete the application, submit all of the information requested and make sure to complete the final step of the process, which is to electronically sign your benefits authorization form according to the online instructions. Without this e-signed form on file, we cannot verify your eligibility or complete the processing of your application. The online application requests a Social Security Number (SNN). You may bypass this step initially by checking the box indicating that you have not yet received an SSN. Ultimately, the insurance companies may require the Trust Fund to enroll you under a valid SSN and therefore you may be required to submit your SSN in order to complete your enrollment.

Your dental, vision, and childcare benefits, administered by the Trust Fund, are completely separate from your health plan, managed by UMass Human Resources. Your plan elections for Trust Fund benefits are completely separate from your health plan elections. Though not administered by the Trust Fund, you can find more information regarding your health plan at https://www.umass.edu/humres/health-insurance

ELIGIBILITY (PHWP)

Individual Eligibility

You are eligible to participate in the PHWP if:

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

You may also be eligible for benefits if:

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

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

Your spouse, same-sex or opposite sex domestic partner is eligible for dental and vision coverage under the PHWP as long as they are legally married to you, in the case of a spouse; or are in a committed, long-term relationship, which is similar to marriage and live together at the same address and intend to do so indefinitely, in the case of a partner. If you and your spouse are legally divorced or legally separated, your spouse is not covered by the PHWP benefits, unless required by court order. The Trustees reserve the right, in their sole and absolute discretion, to determine all questions relating to the eligibility of partners.

Changes within your family that relate to eligibility must be reported to the Trust Fund immediately and in no case more than thirty (30) days from the date of the event. Such changes include:

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

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

Enrollment for spouses, same and opposite sex domestic partners is also subject to any prevailing premiums established by the Trustees for a given plan year. For plan year 2020-21, the monthly premium for single +1 dental coverage is $13.50 and the monthly premium for family dental coverage is $27, with initial payment due upon application. There is no premium due for single+1 or family vision coverage. Premiums must be paid via credit card or debit card using PayPal's automatic, recurring payment feature. Recurring payments may be ended at any time by either the participant or the Trust Fund. Trustees reserve the right to terminate the family portion of any participant's coverage due to lack of payment of the applicable family premiums, retroactive to the start of coverage date or retroactive to the last month that was paid in full.

Eligibility for your children

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

They're your biological children; or

They're your legally adopted children (coverage starts from placement); or

They're your stepchildren (including the child of a domestic partner); or

They're a child who resides with you and is fully supported by you; or

You're their legal parent identified on their birth certificate; and

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

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

After your Child Ages Out of Eligibility

Your child's Ameritas 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 Ameritas dental coverage for your child to continue after age 26 if all of the following additional conditions are met:

There is no other coverage available from either a government agency or through a special organization; and

- Your child is not married; and
- Your child became handicapped before age 19; and
- You file a properly completed Disability Certification Form with the Trust Fund each year after your child reaches age 26.

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

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

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

In order to be a qualified order, the medical child support order must:

Be issued by a court or authorized state agency;

Clearly specify the alternate recipient;

Reasonably describe the type of coverage to be provided to such alternate recipient;

Clearly state the period to which such order applies; and

Indicate the name and last known address of the member who is required to provide the coverage and the name and mailing address of each child covered by the order.

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

BENEFITS OF PHWP

The benefit plan descriptions for the dental and vision plans can be found below. Our dental plan is the Ameritas Classic PPO & Plus Plan. The benefits follow a plan year of 9/1 to 8/31 of each year. Every September 1, the plan year maximum amount and any deductible responsibility renews. Our vision plan is the EyeMed Select Plan. The 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 Ameritas claim is denied, you can request an appeal by writing to Ameritas. Appeals information can be found at https://www.ameritas.com/OCM/GetFile?doc=372304. 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
To locate benefit subscriber certificates and member guides, please go to https://www.uawumasstrustfund.org/

Pre-treatment estimates
Ask your dentist to submit a pre-treatment estimate to Ameritas before having anything other than preventative or diagnostic procedures done. Ameritas 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 Ameritas: Please contact customer service at (800) 487-5553

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://hwtrust.geouaw.org/ This decision cannot be changed until the next open enrollment period. If you wish to enroll later during an open enrollment period, return to the website and complete the enrollment application.

UAW UMass Health & Welfare Trust Fund

Policy # 010-53791 Dental Fusion Highlight Sheet

FUSION: THE ULTIMATE CHOICE[SM] combines dental and eye care benefits in one easy-to-administer plan. This plan combines the annual maximum between the dental and eye care plans.

For the maximum:

- The member can use up to $2,250 Non PPO - $2,250 PPO toward any covered dental expense.
- The member can use up to $150 towards any covered eye care expense.
- Total benefits paid between the two coverages will not exceed $2,250.

Dental Plan Summary *subject to FUSION plan design listed above*

Plan Benefit	**In Network**	**Out of Network**
Type 1	100%	100%
Type 2	80%	80%
Type 3	65%	65%
Deductible	None	$75/Plan Year Type 2 & 3 Waived Type 1 3 Family Maximum
Maximum *(per person)*	$2,250 per Plan Year	$2,250 per Plan Year
TMJ Maximum *(Per Person)*	$500 Lifetime	$500 Lifetime
Preventive Plus[SM]	Included	Included
Allowance	Discounted Fee	95th U&C
Waiting Period	None	None
Annual Open Enrollment	Included	Included

Orthodontia Summary

	In Network	**Out of Network**
Allowance	Discounted Fee	U&C
Adult Orthodontia Included	Yes	Yes
Plan Benefit	50%	50%
Lifetime Maximum *(per person)*	$1,000	$1,000
Waiting Period	None	None

***Maximum is lifetime for both in network and out of network.*

Fusion Eye Care Summary – *You can use part of your dental plan year maximum towards vision materials costs.**

Each member of the dental plan is eligible for up to $150 per plan year reimbursement on out of pocket vision materials expenses. (i.e.: contact lenses, eye glass frames and eye glass lenses).	***Any amounts reimbursed are deducted from your dental plan year maximum.**

UAW UMass Health & Welfare Trust Fund

Policy # 010-53791 Dental Fusion Highlight Sheet

Dental Procedure Summary (*Current Dental Terminology* © American Dental Association.)

In & Out of Network

Type 1	Type 2	Type 3
• Routine Exam (2 in 12 months) • Bitewing X-rays (1 in 6 months) • Full Mouth/Panoramic X-rays (1 in 5 years) • Periapical X-rays • Cleaning (4 in 12 months) • Fluoride for Children 18 and under (1 in 6 months) • Sealants (age 18 and under) • Space Maintainers • Pre-Diagnostic Test (age 35 and over) (1 in 2 years)	• Restorative Amalgams • Restorative Composites (anterior and posterior teeth) • Endodontics (nonsurgical) • Endodontics (surgical) • Periodontics (nonsurgical) • Periodontics (surgical) • Denture Repair • Simple Extractions • Complex Extractions • Anesthesia	• Onlays • Crowns (1 in 5 years per tooth) • Crown Repair • Implants • Occlusal Guards • Prosthodontics (fixed bridge; removable complete/partial dentures) (1 in 5 years)

Ameritas Information

We're Here to Help

This plan was designed specifically for the associates of UAW UMass Health & Welfare Trust Fund. At Ameritas Group, we do more than provide coverage - we make sure there's always a friendly voice to explain your benefits, listen to your concerns, and answer your questions. Our customer relations associates will be pleased to assist you 7 a.m. to midnight (Central Time) Monday through Thursday, and 7 a.m. to 6:30 p.m. on Friday. You can speak to them by calling toll-free: 800-487-5553. For plan information any time, access our automated voice response system or go online to ameritas.com.

Dental Health Scorecard

How would you rate your dental health?

In 2016, you can receive your Dental Health Report Card by signing into your secure member account online. Your assessment is based on claims submitted. The report card also offers suggestions if you strive to improve your dental health. Ameritas members can access the personalized report card by going to ameritas.com, click Account Access in the top right corner and choose the Dental/Vision/Hearing drop down. Select the Secure Member Account link and sign in to see your report.

Rx Savings

Our valued plan members and their covered dependents can save on prescription medications at over 60,000 pharmacies across the nation including CVS, Walgreens, Rite Aid and Walmart. This Rx discount is offered at no additional cost, and it is not insurance.

To receive this Rx discount, Ameritas plan members just need to visit us at ameritas.com and sign into (or create) a secure member account where they can access and print an online-only Rx discount savings ID card.

Eyewear Savings

Ameritas plan members may receive up to 10% off eyewear frames and lenses purchased at any Walmart Vision Center nationwide. Members may also bring in their current vision prescription from any vision care provider and purchase eyewear at Walmart. This savings arrangement is not insurance: it is available to members at no additional cost to their plan premium.

To receive the eyewear savings identification card, Ameritas plan members can visit ameritas.com and sign-in (or create) a secure member account. Members must present the Ameritas Eyewear Savings Card at time of purchase to receive the discount.

Preventive Plus℠

With this plan option, benefits for Type 1/Preventive procedures are not deducted from the plan member's annual maximum benefit. This saves the entire annual maximum for the Type 2/Basic and Type 3/Major procedures that are covered by your plan.

UAW UMass Health & Welfare Trust Fund

Policy # 010-53791 Dental Fusion Highlight Sheet

Ameritas

Dental Network Information

To find a provider, visit ameritas.com and select **FIND A PROVIDER,** then **DENTAL**. Enter your criteria to search by location or for a specific dentist or practice. California Residents: When prompted to select your network, choose the Ameritas Network found on your ID Card or contact Customer Connections at 800-487-5553.

Pretreatment

While we don't require a pretreatment authorization form for any procedure, we recommend them for any dental work you consider expensive. As a smart consumer, it's best for you to know your share of the cost up front. Simply ask your dentist to submit the information for a pretreatment estimate to our customer relations department. We'll inform both you and your dentist of the exact amount your insurance will cover and the amount that you will be responsible for. That way, there won't be any surprises once the work has been completed.

Open Enrollment

If a member does not elect to participate when initially eligible, the member may elect to participate at the policyholder's next enrollment period. If you do not enroll during your company's open enrollment period, then you will be subject to the Late Entrant Provision.

Dental Cost Estimator

Ever wonder what a dental procedure usually costs? The answer can be found using the Ameritas group division's Dental Cost Estimator tool located in our Secure Member Account portal.

Members can search by ZIP Code for a specific dental procedure and see fee range estimates for out-of-network general dentists in that area. Of course, we always suggest that members partner with their dentists, so they know what's involved in any recommended treatment plan.

The estimator tool is powered by Go2Dental and uses FAIR Health data that is updated annually. Please note, cost estimates do not reflect discounted rates available through provider networks, and the estimator does not include orthodontic estimates at this time.

In addition, when members are in their Secure Member Account, they can:

- Go paperless with electronic Explanation of Benefits statements and reduce the clutter in their mailboxes
- View their certificate of insurance and specific plan benefits information
- Access value-added extras like the Rx discount ID card

Worldwide Support

When our members travel abroad, they'll have peace of mind knowing that should a dental or vision need arise, help is just a phone call away. Through AXA Assistance, Ameritas offers its dental and vision plan members 24-hour access to dental or vision provider referrals when traveling outside the U.S.

Immediately after a call is made to AXA, an assistance coordinator assesses the situation, provides credible provider referrals and can even assist with making the appointment. Within 48 hours following the appointment, the coordinator calls the member to find out if additional assistance is needed. If all is well, the case is closed. Then, the plan member may submit a claim to Ameritas for reimbursement consideration based on applicable plan benefits. Contact AXA Assistance USA toll free by calling 866-662-2731, or call collect from anywhere in the world by dialing 1-312-935-3727.

Language Services

We recognize the importance of communicating with our growing number of multilingual customers. That is why we offer a language assistance program that gives you access to: Spanish-speaking claims contact center representatives, telephone interpretation services in a wide range of languages, online dental network provider search in Spanish and a variety of Spanish documents such as enrollment forms, claim forms and certificates of insurance.

This document is a highlight of plan benefits provided by Ameritas Life Insurance Corp. as selected by your employer. It is not a certificate of insurance and does not include exclusions and limitations. For exclusions and limitations, or a complete list of covered procedures, contact your benefits administrator.

UAW/UMass Hw-Post Doc Unit Group #9878760

Additional discounts

40% OFF
Complete pair of prescription eyeglasses

20% OFF
Non-prescription sunglasses

20% OFF
Remaining balance beyond plan coverage

These discounts are not insured benefits and are for in-network providers only

Take a sneak peek before enrolling

- You're on the SELECT Network
- For a complete list of in-network providers near you, use our Enhanced Provider Locator on eyemed.com or call 1.866.299.1358.
- For LASIK providers, call 1.877.5LASER6.

SUMMARY OF BENEFITS

Vision Care Services	In-Network Member Cost	Out-of-Network Reimbursement
Exam With Dilation as Necessary	$10 Co-pay	Up to $50
Retinal Imaging	Up to $39	N/A
Frames	$0 Co-pay, $150 Allowance, 20% off balance over $150	Up to $90
Standard Plastic Lenses		
Single Vision	$10 Co-pay	Up to $42
Bifocal	$10 Co-pay	Up to $78
Trifocal	$10 Co-pay	Up to $130
Standard Progressive Lens	$10 Co-pay	Up to $78
Premium Progressive Lens[Δ]	$30 Co-pay - $55 Co-pay	
Tier 1	$30 Co-pay	Up to $78
Tier 2	$40 Co-pay	Up to $78
Tier 3	$55 Co-pay	Up to $78
Tier 4	$10 Co-pay, 80% of charge less $120 Allowance	Up to $78
Lens Options		
UV Treatment	$15 Co-pay	N/A
Tint (Solid and Gradient)	$15 Co-pay	N/A
Standard Plastic Scratch Coating	$15 Co-pay	N/A
Standard Polycarbonate	$40 Co-pay	N/A
Standard Polycarbonate–Kids under 26	$40 Co-pay	N/A
Standard Anti-Reflective Coating	$45 Co-pay	N/A
Premium Anti-Reflective Coating[Δ]	$57 Co-pay-$68 Co-pay	
Tier 1	$57 Co-pay	N/A
Tier 2	$68 Co-pay	N/A
Tier 3	80% of charge	N/A
Photochromic (Plastic)	80% of Retail	N/A
Polarized	20% off retail	N/A
Other Add-Ons and Services	20% off retail	N/A
Contact Lens Fit and Follow-Up (Contact lens fit and follow up visits are available once a comprehensive eye exam has been completed)		
Standard Contact Lens Fit & Follow-Up	Up to $40	N/A
Premium Contact Lens Fit & Follow-Up	10% off retail price	N/A
Contact Lenses (Contact lens allowance includes materials only.)		
Conventional	$0 Co-pay, $150 Allowance, 15% off balance over $150	Up to $120
Disposable	$0 Co-pay, $150 Allowance; plus balance over $150	Up to $120
Medically Necessary	$0 Co-pay, paid-in-full	Up to $210
Laser Vision Correction		
LASIK or PRK from U.S. Laser Network	15% off the retail price or 5% off the promotional price	N/A
Hearing Care		
Hearing Health Care from Amplifon Hearing Network	40% off hearing exams and a low price guarantee on discounted hearing aids	N/A
Frequency		
Examination	Once every 12 months	
Lenses	Once every 12 months	
Contact Lenses	Once every 12 months	
Frame	Once every 12 months	

Benefits are not provided from services or materials arising from: Orthopic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses, medical and/or surgical treatment of the eye, eyes or supporting structures; Any Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; safety eyewear; Services provided as a result of any workers' compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; Plano (non-prescription) lenses; Non-prescription sunglasses; Two pair of glasses in lieu of bifocals; Services or materials provided by any other group benefit plan providing vision care; 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. 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. Benefits may not be combined with any discount, promotional offering, or other group benefit plans. Standard/Premium Progressive lens not covered – fund as a Bifocal lens. Standard Progressive lens covered – fund Premium Progressive as a Standard. Benefit allowance provides no remaining balance for future use within the same benefits year. Fees charged for a non-insured benefit must be paid in full to the Provider. Such fees or materials are not covered. [Δ]Premium progressives and premium anti-reflective designations are subject to annual review by EyeMed's Medical Director and are subject to change based on market conditions. Fixed pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels. Not available in all states. Some provisions, benefits, exclusions or limitations listed herein may vary.

What's in it for me?

Options. It's simple really. We're dedicated to helping you see clearly – and that's why we've built a network that gives you lots of choices and flexibility. You can choose from thousands of independent and retail providers to find the one that best fits your needs and schedule. No matter which one you choose, our plan is designed to be easy-to-use and help you access the care you need. Welcome to EyeMed.

Benefits Snapshot

	With EyeMed	Out-of-Network Reimbursement
Exam, with dilation as necessary (once every 12 months)	$10 Co-pay	Up to $50
Frames (once every 12 months)	$0 Co-pay, $150 Allowance; 20% off balance over $150	Up to $90
Single Vision Lenses (once every 12 months)	$10 Co-pay	Up to $42
or Contacts (once every 12 months)	$0 Co-pay, $150 Allowance; plus balance over $150	Up to $120

And now it's time for the breakdown . . .

Here's an example of what you might pay for a pair of glasses with us vs. what you'd pay without vision coverage. So, let's say you get an eye exam and choose a frame that costs $163 with single vision lenses that have UV and scratch protection. Now let's see the difference...

85% SAVINGS with us*

With EyeMed		Without Insurance**	
Exam	$10 Co-pay	Exam	$106
Frame	$163 -$150 Allowance $13 -$2.60 (20% discount off balance) $10.40	Frame	$163
Lens	$10 Co-pay $15 UV treatment add-on +$15 scratch coating add-on $40	Lens	$78 $23 UV treatment add-on +$25 scratch coating add-on $126
Total	$60.40	Total	$395

Download the EyeMed Members App

It's the easy way to view your ID card, see benefit details and find a provider near you.

EyeMed | Independent Provider Network + LensCrafters | Pearle Vision | Target Optical

*This is a snapshot of your benefits. Actual savings will depend on provider, frame and lens selections. **Based on industry averages.

BOOST YOUR SAVINGS

$20 OFF

at ContactsDirect.com

Good things happen when you use your EyeMed benefits at ContactsDirect.com

contactsdirect

SAVINGS FOR EYEMED MEMBERS

Extra $20 off contacts and free shipping at ContactsDirect.com

As an EyeMed member, you'll save $20 off contact lenses (and free shipping!) above and beyond your regular contact lens benefit. Just create an account at ContactsDirect.com and an extra $20 will be deducted at checkout. No coupons. No codes. No problem.

0 Register at ContactsDirect.com using your EyeMed member information

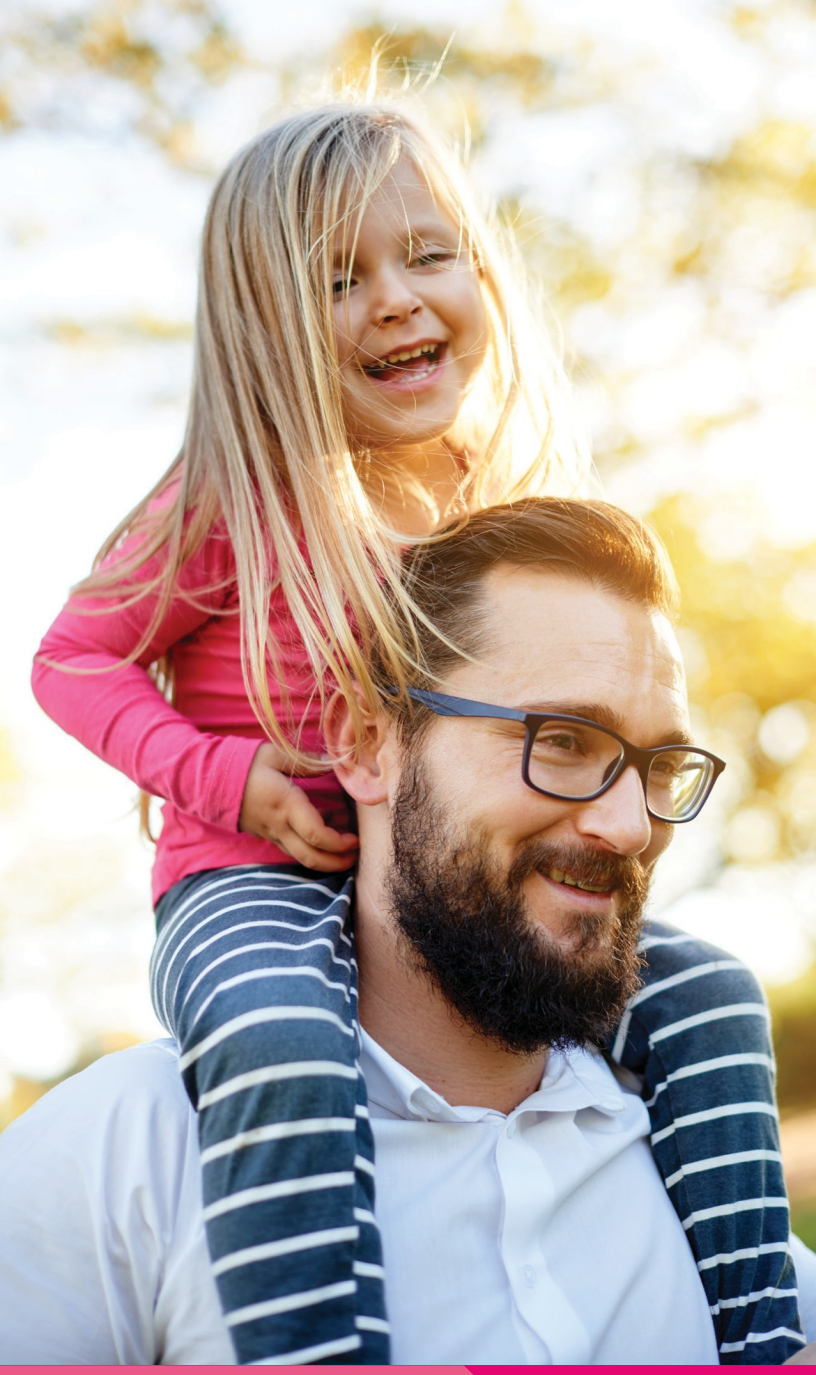
0 Log in when shopping for contacts

0 We'll apply your savings automatically and take another $20 off

contactsdirect

Expiration dates may vary. Log into your member account at eyemed.com for full offer exclusions and expiration details. Offer valid for select EyeMed groups. Must be an active enrolled EyeMed member to redeem. No promo or coupon code needed. One time use only. Must be combined with your EyeMed vision benefits, which can be applied online in the cart at ContactsDirect. May not be combined with other offers. Valid prescription required. Void where prohibited by law. No cash value. Some exclusions may apply. Offer subject to change.

B-1802-M-395



Freedom Pass

YOUR ST YLE. YOUR PERSONALIT Y.
YOUR CHOICE IN FR AMES.

When you enroll in EyeMed, you'll enjoy a special offer from Sears® Optical and Target® Optical. For $0 out-of-pocket expense get any available frame, any brand— no matter the original retail price point— even top brands like Ray-Ban® and Oakley®. Plus, you get extra savings on lenses through your EyeMed vision benefits to complete your look.

Stylish and savvy? That fits you perfectly.

Any frame, any price for $0 out-of-pocket

at Sears® Optical or Target® Optical

PLUS ENJOY SAVINGS ON LENSES

SHOP THESE TOP BR ANDS AND MORE

Ray-Ban · A|X ARMANI EXCHANGE · OAKLEY · COACH · DKNY · VOGUE

Take advantage of this perk and many more when you enroll in EyeMed today.

Once enrolled, present this to the store associate to redeem this offer: 755288

Offer not valid at Sears® Optical stores affiliated with US Vision. This offer is valid for frames only and must be used in conjunction with your EyeMed frame benefit of $130 or more. Lenses are covered based on the benefits outlined in the member's benefit summary and may include an additional copay.

sears OPTICAL · OPTICAL

B-1707-M-518

WELLNESS BENEFITS

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

For the 2021-22 plan year, the Trust Fund will offer 20 pre-paid, 4-month gym memberships at Central Rock Gym (CRG) in Hadley, MA, and 20 5-packs of 30 minutes massages at The Healing ZONE (THZ) in Hadley, MA, as a pilot program. CRG memberships and THZ packages are awarded on a first-come, first-served basis to an eligible Postdoc employee who has completed the online benefits application and completed the separate Prepaid User Agreement.

Pre-Paid Daily Burn Subscriptions

For the 2021-22 plan year, The Trust Fund is offering prepaid 12-month subscriptions to the online fitness platform, Daily Burn. These subscriptions are limited and are available on a first-come first-served basis. Daily Burn subscriptions may be claimed on the dashboard of your Trust Fund benefits account at hwtrust.geouaw.org

Calm Subscriptions

Eligible Postdoc employees can access ***Calm***, the world's #1 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 hwtrust.geouaw.org, where you will find a code to be used on the Calm website.

CHILDCARE REIMBURSEMENT BENEFIT

The Trust Fund will distribute at least 60,000 during the 2020-21 plan year in reimbursements across eligible Postdoc employees for their costs for on or off-campus licensed childcare.

Eligibility

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

Eligible childcare includes:

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

How we Distribute Funds

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

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

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

The Trust Fund's first priority is to provide the highest possible reimbursement of childcare expenses to applicants who fall in the lowest income levels (levels 1-11 on the Parent Co- Payment Table). The Trust Fund determines reimbursements for applicants with incomes higher than level 11 by calculating their expected parent co-pay, which can be calculated using the Flat Fee Expected Parent Copayment Chart (see below). Receipts for any costs in excess of the expected parent co-pay are potentially eligible for reimbursement. The Trust Fund then applies any remaining funds across applicants with incomes higher than level 11, again prioritizing funding those from lowest to highest income.

The Trust Fund crosschecks receipts provided for care at the Center for Early Education and Care (CEEC) with CEEC records from the same period. If an applicant family has received a GEO, GSS or CCAMPIS childcare subsidy for the same period, this will reduce the possible reimbursement.

When considering childcare reimbursement applications, should an applicant claim that their income has changed significantly since their last tax return, which we use for income verification, we will process any eligible reimbursement based on the current tax return and the income level that places the applicant in, per our usual process. However, upon presentation of the next year's tax return, we will re-examine the reimbursement in light of the new return once it is furnished to us. In order to qualify for a retroactive additional reimbursement, the applicant will need to: 1) provide us with page 1 of the new federal tax return as soon as it is available, but no later than the next IRS established deadline, and 2) the adjusted gross income on the new return will need to be such that it would have changed the percentage reimbursement bracket the applicant occupied when we first reviewed the application. It is the applicant's responsibility to supply the new return once it is available.

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

Maximum Annual Reimbursement

There is a $6,000 per child (for whom receipts are submitted) annual cap on the amount a family can be reimbursed.

Deadlines

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

- Application opens Aug 15 & deadline is Sept 15, 2021 for June-August 2021 receipts
- Application opens Dec 15 & deadline is Dec 31, 2021 for Sept-Dec 2021 receipts
- Application opens May 15 & deadline is May 30, 2022 for Jan-May 2022 receipts
- Application opens Aug 15 & deadline is Sept 15, 2022 for June-August 2022 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://hwtrust.geouaw.org/ 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 Family Wallet

For plan year 2021-22, the Trust Fund will maintains a wallet of funds accessible to eligible employees to access educational content for their pre-school and school-aged children. The wallet can be used by parents to purchase Outschool content, is limited and available on a first-come first-served basis. Access to the wallet is capped at $250 per year per household. The wallet is shared across Graduate Employee Unit and Postdoctoral Unit families.

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

Commonwealth of Massachusetts

Department of Early Education and Care (EEC)

SHERRI KILLINS
COMMISSIONER

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				
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	FEE LEVEL
$ 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

EFFECTIVE 7/01/10
ISSUED 6/28/06

METLAW PREPAID LEGAL BENEFIT

Effective plan year 2021-22, eligible Postdocs who have submitted a benefits application receive the MetLife group legal plan at no cost.

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

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

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

Using the Benefit
You can go to www.legalplans.com to learn about the plan and to log in and you can also search for attorneys at https://members.legalplans.com/Home/

Enrollees are free to use an attorney outside the network; when your legal matter has concluded you can contact the Client Service Center (800-821-6400) to apply for fee reimbursement up to set dollar limits. A schedule of these limits is attached.

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.

MetLife

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

MetLife

Supplemental Term Life

Metropolitan Life Insurance Company

Plan Design for: UAW/UMass Health & Welfare Trust Fund
Date Prepared: June 8, 2021
For All Active Full-Time Employees working at least 20 hours per week

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

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

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

To request coverage:

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

200 Park Ave., New York, NY 10166

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

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

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

Features available with Supplemental Life

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

Funeral Discounts and Planning Services[4]: As a MetLife group life policyholder, you and your family may have access to funeral discounts, planning and support to help honor a loved one's life - at no additional cost to you. Dignity Memorial provides you and your loved ones access to discounts of up to 10% off of funeral, cremation and cemetery services through the largest network of funeral homes and cemeteries in the United States.

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

Will Preparation[5]:Like life insurance, a carefully prepared Will is important. With a Will, you can define your most important decisions such as who will care for your children or inherit your property. By enrolling for Supplemental Term Life coverage, you will have in person access to MetLife Legal Plans' network of 14,000+ participating attorneys for preparing or updating a will, living will and power of attorney. When you enroll in this plan, you may take advantage of this benefit at no additional cost to you if you use a participating plan attorney. To obtain the legal plan's toll-free number and your company's group access number, contact your employer or your plan administrator for this information.

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

Portability[6]: If your present employment ends, you can choose to continue your current life benefits.

What Is Not Covered?

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

Accidental Death & Dismemberment insurance does not include payment for any loss which is caused by or contributed to by: physical or mental illness, diagnosis of or treatment of the illness; an infection, unless caused by an external wound accidentally

sustained; suicide or attempted suicide; injuring oneself on purpose; the voluntary intake or use by any means of any drug, medication or sedative, unless taken as prescribed by a doctor or an over-the-counter drug taken as directed; voluntary intake of alcohol in combination with any drug, medication or sedative; war, whether declared or undeclared, or act of war, insurrection, rebellion or riot; committing or trying to commit a felony; any poison, fumes or gas, voluntarily taken, administered or absorbed; service in the armed forces of any country or international authority, except the United States National Guard; operating, learning to operate, or serving as a member of a crew of an aircraft; while in any aircraft for the purpose of descent from such aircraft while in flight (except for self preservation); or operating a vehicle or device while intoxicated as defined by the laws of the jurisdiction in which the accident occurs.

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

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

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

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

6. Subject to state availability and the maturity age specified in the certificate.

NO COST BASIC LIFE INSURANCE

Effective 9/1/2021, eligible Postdoc employees who work at least 20 hours per week and have a benefits application on file will receive a $10,000 individual basic life insurance and accidental death & dismemberment (AD&D) policy at no cost. This policy is portable according to the terms established by MetLife. You can opt out of this benefit if you so choose using the enrollment portal at hwtrust.geouaw.org

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

OPTIONAL GROUP LIFE INSURANCE

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

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

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

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

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

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

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

Is there anything else I need to know?

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

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

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

what If I still have questions?

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

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

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

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

MetLife

Metropolitan Life Insurance Company

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FPO

1401-0036 1900030188(0114)NewPort
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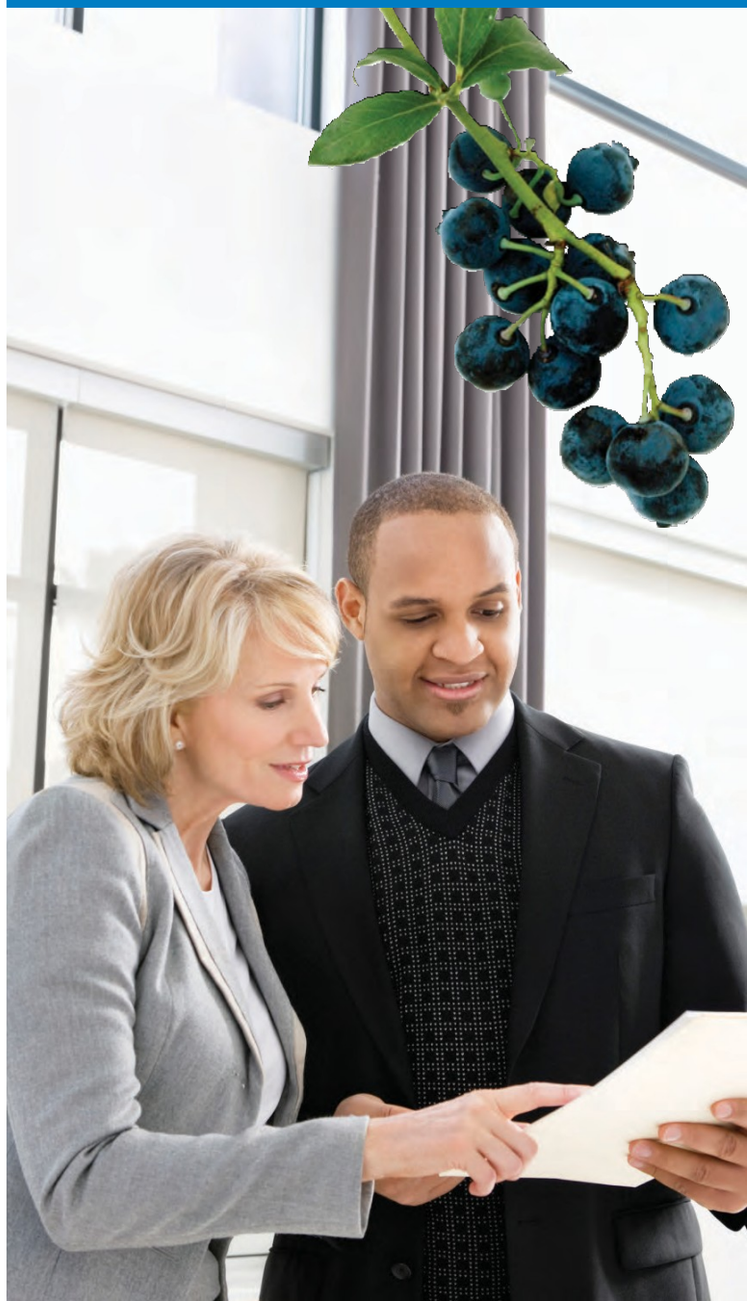
Understanding your Options

Portability and Conversion

MetLife



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

	portability[1]	conversion
what are the basics of each option?	You can continue your **group life** and **ad&d*** insurance coverage with MetLife if your coverage terminates in whole or in part due to: **employee qualifying events**: • Termination of employment or retirement • A change in your employee class • Your Group Policy is amended to end coverage, unless coverage is replaced by a similar insurance under another group insurance policy • Your Group policy ends with or without a successor plan • Reduced coverage due to age or change in plan for your employee class **dependent qualifying events**: • Employee is eligible to exercise portability option • Spouse can port upon the Death of the Employee, Divorce, Annulment, Civil Union or Reciprocal Beneficiary relationship ends • Dependent no longer eligible as a Dependent You are not eligible for Portability if you received approval for Premium Waiver Death Benefits. *Your plan may not include the Portability feature on every product presented on the Election of Portable Coverage Form. The Recordkeeper for your plan will identify which coverage(s) and coverage amount(s) you are eligible to port.[2]	You can generally convert your **group life** insurance benefits to an **Individual whole life** insurance policy[5] if your coverage terminates in whole or in part due to: • Retirement or termination of employment • A change in your employee class Conversion is available on all Group Life insurance coverages. Conversion is **not** available on AD&D coverage.
does coverage reduce or terminate?	• **employee**: Reduces 50% at age 70, and terminates at age 100. • **spouse**: Terminates at age 70. • **child(ren)**: Terminates at age 25. At age 25, each child may apply to continue their portable coverage by completing a NewPort election form. They will also have the option to apply for Preferred Life Rates (lower preferred rates).	Coverage reductions and termination are subject to the terms of the policy chosen.
will I have to answer medical questions?	No. However, medical questions must be answered to apply for Preferred Life Rates (lower preferred rates). If approved by MetLife, you will be billed using the Preferred Life Rates (lower preferred rates).	No.
what are the minimum and maximum amounts of coverage?	The standard coverage minimum amounts are: • $10,000 for employees • $ 2,500 for spouses • $10,000 for Spouse Only (no portable employee coverage) • $1,000 for children Your coverage maximum amount is generally limited to the amount you had at the time group benefits terminated and may vary, depending on the type of coverage you had. The standard maximum coverage amount is $2 million. Details about your specific coverage can be found on the Election of Portable Coverage form.	The coverage minimum under Conversion is subject to the Individual Life plan features. The maximum coverage amount under Conversion varies based on the following: • The reason group benefits ended. • The amount of group insurance you have. • Your eligibility for any other group benefits within 31 days after current benefits terminate. • Specific state regulations.
can I increase or decrease coverage amounts after the initial application period?	Coverage can be increased in $25,000 increments up to $250,000 with Evidence of Insurability (EOI) at the initial application and annually at the insured's portability anniversary date. Portable coverage may also be decreased, as needed.	Coverage cannot be increased at any time and cannot be decreased on Whole Life policies.
what additional features/ services are available?	• Accelerated Benefits Option (ABO) for Life coverage(s) only.[3] • Total Control Account® (TCA) for beneficiaries.[4]	Total Control Account® (TCA) for beneficiaries.[4]
how do I enroll/apply for coverage?	• You will receive an Election of Portable Coverage form from your Group Life Benefits Recordkeeper. • You have 31 days from the date on the Election form to complete and return this form to MetLife. • Coverage will take effect 32 days after your group coverage ends.	• You will receive a Notice of Conversion form from your Group Life Benefits Recordkeeper. • You have 31 days from the date your coverage ends to contact MetLife to convert your coverage. You **must** contact MetLife within this 31-day period to begin the conversion process. • A MetLife agent will consult with you on your specific needs and assist you with the application process.
will the rates be different from the rates I paid while I was working?	• Rates are based on your current age and differ from the rates you paid while employed. As with any group of insureds, rates may change based on the financial experience of the group. • MetLife will bill you monthly for your coverage. The option to make monthly payments via Electronic Funds Transfer is available by contacting MetLife at 1-888-252-3607. • There is a $1 administrative fee added to each monthly premium if Employee Life coverage is $20,000 or more. If Employee Life coverage is less than $20,000, the monthly administrative fee is $3. The monthly administrative fee is waived for insureds who use Electronic Funds Transfer. • Employee or Spouse can apply for Preferred Life (lower preferred rates) premium rates by answering medical questions. If not approved, Employee and Spouse can still participate in portable coverage at the Non-Preferred (higher) premium rates.	• Rates for Conversion are based on your age at the time you convert your coverage and remain level throughout the life of the policy. • The MetLife agent will discuss your payment options with you.

1 Subject to state availability. To take advantage of this benefit, coverage of at least $10,000 must be elected. Increases, decreases, minimum and maximum coverage amounts are subject to state availability.
2 You may later convert ported coverage when ported benefits end, or if the portable plan is terminated by MetLife. Conversion is not available on AD&D coverage. Conversion rates are based on your age at the time you convert.
3 When life expectancy is certified by a physician to be 12 months (24 months in IL, TX or WA) or less. The Accelerated Benefits Option (ABO) is subject to state availability and regulation. The ABO benefits are intended to qualify for favorable federal tax treatment, in which case the benefits will not be subject to federal taxation. This information was written as a supplement to the marketing of life insurance products. Tax laws relating to accelerated benefits are complex and limitations may apply. You are advised to consult with and rely on an independent tax advisor about your own particular circumstances. Receipt of ABO benefits may affect your eligibility, or that of your spouse or your family, for public assistance programs such as medical assistance (Medicaid), Temporary Assistance to Needy Families (TANF), Supplementary Social Security Income (SSI) and drug assistance programs. You are advised to consult with social service agencies concerning the effect that receipt of ABO benefits will have on public assistance eligibility for you, your spouse or your family.
4 Subject to state law, and/or group policyholder direction, the Total Control Account is provided for all Life and AD&D benefits of $5,000 or more. The TCA is not insured by the Federal Deposit Insurance Corporation or any government agency. The assets backing TCA are maintained in MetLife's general account and are subject to MetLife's creditors. MetLife bears the investment risk of the assets backing the TCA, and expects to earn income sufficient to pay interest to TCA Accountholders and to provide a profit on the operation of the TCAs. Guarantees are subject to the financial strength and claims-paying ability of MetLife.
5 A non-renewable term life policy may precede a whole life conversion policy if your group coverage is issued in New York or West Virginia.

MetLife®

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

What is Portability?

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

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

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

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

Why is Portable Coverage Important?

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

How Much Time Do I Have To Elect Portability?

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

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

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

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

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

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

1. Complete Part B beginning on page 1 of the attached Election of Portable Coverage Form and be sure to answer all sections.

2. Complete the enclosed medical questions (Statement of Health Form) only if:
   a) You are applying for Preferred Life Rates (lower) for you or your Spouse/Domestic Partner; or
   b) You wish to increase the amount of life insurance that you previously had under your former employer's plan, either for yourself, your Spouse/Domestic Partner, or both.

3. Complete, sign and date the Designation of Beneficiary for Your Life Benefits (Part C of the attached Election of Portable Coverage Form).

What Needs To Be Mailed To Complete My Enrollment?

You must return:

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

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

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

Mail all correspondence to:

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

Or Fax to: 1-866-545-7517

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

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

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ELECTION OF PORTABLE COVERAGE FORM

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

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

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

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

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

(Continued on Following Page)

Part B (continued) – ELECTION OF PORTABLE COVERAGE FORM

To be Completed by the Recordkeeper (Shaded areas to be completed by the Recordkeeper).		**To be Completed by the Employee** (For each Type of Coverage, please indicate whether you want to continue, discontinue, increase, or decrease the amount of insurance in the shaded column. Select just one option for each Type of Coverage).			
		Continue coverage	**Discontinue coverage**	**Increase coverage**	**Decrease coverage**
Type of Coverage	**Amount of Insurance Terminated or Reduced** Insert the actual $$ amount of coverage (i.e. $50,000)	**I want to continue the same amount of insurance in the shaded column.**	**I want to discontinue the insurance in the shaded column.**	**I want to increase my insurance in the shaded column by the following amount.** [1] (Ex. $25,000 means you want to increase your insurance amount in column 1 by $25,000).	**I want to decrease my insurance in the shaded column by the following amount.** (Ex. $30,000 means you want to decrease your insurance amount in column 1 by $30,000).
Employee [2,3]					
Basic Life	$_____	☐	☐	+ $_____	– $_____
Basic AD&D [4]	$_____	☐	☐	+ $_____	– $_____
Supplemental/Optional Life	$_____	☐	☐	+ $_____	– $_____
Supplemental/Optional AD&D [4]	$_____	☐	☐	+ $_____	– $_____
Voluntary AD&D [4]	$_____	☐	☐	+ $_____	– $_____
☐ Employee Only ☐ Employee + Dependents					
Dependent Spouse/Domestic Partner [2,3,5]					
Dependent Life	$_____	☐	☐	+ $_____	– $_____
Dependent AD&D [4]	$_____	☐	☐	+ $_____	– $_____
Voluntary AD&D [4,6]	$_____	☐	☐	+ $_____	– $_____
Dependent Child(ren) [3,5]					
Dependent Life	$_____	☐	☐	+ $_____	– $_____
Dependent AD&D [4]	$_____	☐	☐	+ $_____	– $_____
Voluntary AD&D [4,6]	$_____	☐	☐	+ $_____	– $_____

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

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

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

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

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

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

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

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

(Continued on Following Page)

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

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

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

Part C – TO BE COMPLETED BY THE EMPLOYEE

DESIGNATION OF BENEFICIARY FOR YOUR LIFE INSURANCE (Dependent Life Insurance is payable as specified in the Certificate)
Only check one of the following boxes.

☐ I designate the following person(s) as my primary beneficiary(ies) for my portable term coverage(s). With such designation any previous designation of a beneficiary for such coverage is hereby revoked.

☐ My designation of beneficiary is on a separate form which is signed, dated and attached.

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

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

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

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

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

FRAUD WARNING

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

DECLARATION AND SIGNATURE

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

Signature of Insured/Owner

Date Signed (MM/DD/YYYY)

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

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

(Continued on Following Page)

TABLE A
LIFE INSURANCE ONLY PREFERRED MONTHLY TERM RATES

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

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

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

$50,000	÷	$1,000	=	50	x	$0.150	=	$7.50	+	$1.00	=	$8.50
Amount of coverage selected	÷	$1,000	=	# of units	x	Rate based on age 45	=	Monthly insurance premium	+	Admin fee*	=	Monthly total due

* Varies by amount of insurance and payment method

AGE	INSURED RATE	DEPENDENT SPOUSE/ DOMESTIC PARTNER RATE
15	$0.050	$0.050
16	$0.050	$0.050
17	$0.050	$0.050
18	$0.050	$0.050
19	$0.050	$0.050
20	$0.050	$0.050
21	$0.050	$0.050
22	$0.050	$0.050
23	$0.050	$0.050
24	$0.050	$0.050
25	$0.060	$0.060
26	$0.060	$0.060
27	$0.060	$0.060
28	$0.060	$0.060
29	$0.060	$0.060
30	$0.080	$0.080
31	$0.080	$0.080
32	$0.080	$0.080
33	$0.080	$0.080
34	$0.080	$0.080
35	$0.090	$0.090
36	$0.090	$0.090
37	$0.090	$0.090
38	$0.090	$0.090
39	$0.090	$0.090
40	$0.100	$0.100
41	$0.108	$0.108
42	$0.118	$0.118
43	$0.128	$0.128
44	$0.138	$0.138
45	$0.150	$0.150
46	$0.163	$0.163
47	$0.178	$0.178
48	$0.194	$0.194
49	$0.211	$0.211
50	$0.230	$0.230
51	$0.261	$0.261
52	$0.295	$0.295
53	$0.335	$0.335
54	$0.379	$0.379
55	$0.430	$0.430
56	$0.468	$0.468
57	$0.510	$0.510
58	$0.556	$0.556
59	$0.606	$0.606
60	$0.660	$0.660
61	$0.752	$0.752
62	$0.858	$0.858
63	$0.977	$0.977
64	$1.114	$1.114
65	$1.270	$1.270
66	$1.399	$1.399
67	$1.541	$1.541
68	$1.698	$1.698
69	$1.870	$1.870
70	$2.060	N/A
71	$2.228	N/A
72	$2.409	N/A
73	$2.605	N/A
74	$2.818	N/A
75	$3.047	N/A
76	$3.295	N/A
77	$3.564	N/A
78	$3.854	N/A
79	$4.168	N/A
80	$4.460	N/A
81	$4.910	N/A
82	$5.410	N/A
83	$5.960	N/A
84	$6.560	N/A
85	$7.220	N/A
86	$7.950	N/A
87	$8.760	N/A
88	$9.650	N/A
89	$10.630	N/A
90	$11.710	N/A
91	$12.900	N/A
92	$14.190	N/A
93	$15.630	N/A
94	$17.210	N/A
95	$18.950	N/A
96	$20.870	N/A
97	$22.990	N/A
98	$25.320	N/A
99	$27.880	N/A

TABLE B
LIFE INSURANCE ONLY NON-PREFERRED MONTHLY TERM RATES

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

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

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

$50,000	÷	$1,000	=	50	x	$0.538	=	$26.90	+	$1.00	=	$27.90
Amount of coverage selected	÷	$1,000	=	# of units	x	Rate based on age 45	=	Monthly insurance premium	+	Admin fee*	=	Monthly total due

* Varies by amount of insurance and payment method

AGE	INSURED RATE	DEPENDENT SPOUSE/ DOMESTIC PARTNER RATE
15	$0.162	$0.162
16	$0.190	$0.190
17	$0.208	$0.208
18	$0.224	$0.224
19	$0.232	$0.232
20	$0.234	$0.234
21	$0.256	$0.256
22	$0.242	$0.242
23	$0.202	$0.202
24	$0.184	$0.184
25	$0.170	$0.170
26	$0.170	$0.170
27	$0.154	$0.154
28	$0.150	$0.150
29	$0.146	$0.146
30	$0.142	$0.142
31	$0.138	$0.138
32	$0.150	$0.150
33	$0.148	$0.148
34	$0.160	$0.160
35	$0.176	$0.176
36	$0.188	$0.188
37	$0.216	$0.216
38	$0.244	$0.244
39	$0.274	$0.274
40	$0.308	$0.308
41	$0.350	$0.350
42	$0.396	$0.396
43	$0.440	$0.440
44	$0.484	$0.484
45	$0.538	$0.538
46	$0.600	$0.600
47	$0.670	$0.670
48	$0.742	$0.742
49	$0.818	$0.818
50	$0.906	$0.906
51	$1.006	$1.006
52	$1.116	$1.116
53	$1.216	$1.216
54	$1.312	$1.312
55	$1.442	$1.442
56	$1.584	$1.584
57	$1.752	$1.752
58	$1.932	$1.932
59	$2.134	$2.134
60	$2.372	$2.372
61	$2.634	$2.634
62	$2.932	$2.932
63	$3.192	$3.192
64	$3.500	$3.500
65	$3.846	$3.846
66	$4.216	$4.216
67	$4.538	$4.538
68	$4.850	$4.850
69	$5.212	$5.212
70	$5.638	N/A
71	$6.142	N/A
72	$6.740	N/A
73	$7.340	N/A
74	$8.012	N/A
75	$8.742	N/A
76	$9.634	N/A
77	$10.576	N/A
78	$11.416	N/A
79	$12.356	N/A
80	$13.564	N/A
81	$14.806	N/A
82	$16.234	N/A
83	$17.844	N/A
84	$19.202	N/A
85	$20.573	N/A
86	$22.137	N/A
87	$23.932	N/A
88	$25.745	N/A
89	$27.876	N/A
90	$30.427	N/A
91	$31.876	N/A
92	$34.257	N/A
93	$37.304	N/A
94	$39.972	N/A
95	$42.821	N/A
96	$45.858	N/A
97	$49.095	N/A
98	$52.551	N/A
99	$55.858	N/A

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

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

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

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

$50,000	÷	$1,000	=	50	x	$0.185	=	$9.25	+	$1.00	=	$10.25
Amount of coverage selected	÷	$1,000	=	# of units	x	Rate based on age 45	=	Monthly insurance premium	+	Admin fee*	=	Monthly total due

* Varies by amount of insurance and payment method

AGE	INSURED RATE	DEPENDENT SPOUSE/ DOMESTIC PARTNER RATE
15	$0.085	$0.075
16	$0.085	$0.075
17	$0.085	$0.075
18	$0.085	$0.075
19	$0.085	$0.075
20	$0.085	$0.075
21	$0.085	$0.075
22	$0.085	$0.075
23	$0.085	$0.075
24	$0.085	$0.075
25	$0.095	$0.085
26	$0.095	$0.085
27	$0.095	$0.085
28	$0.095	$0.085
29	$0.095	$0.085
30	$0.115	$0.105
31	$0.115	$0.105
32	$0.115	$0.105
33	$0.115	$0.105
34	$0.115	$0.105
35	$0.125	$0.115
36	$0.125	$0.115
37	$0.125	$0.115
38	$0.125	$0.115
39	$0.125	$0.115
40	$0.135	$0.125
41	$0.143	$0.133
42	$0.153	$0.143
43	$0.163	$0.153
44	$0.173	$0.163
45	$0.185	$0.175
46	$0.198	$0.188
47	$0.213	$0.203
48	$0.229	$0.219
49	$0.246	$0.236
50	$0.265	$0.255
51	$0.296	$0.286
52	$0.330	$0.320
53	$0.370	$0.360
54	$0.414	$0.404
55	$0.465	$0.455
56	$0.503	$0.493
57	$0.545	$0.535
58	$0.591	$0.581
59	$0.641	$0.631
60	$0.695	$0.685
61	$0.787	$0.777
62	$0.893	$0.883
63	$1.012	$1.002
64	$1.149	$1.139
65	$1.305	$1.295
66	$1.434	$1.424
67	$1.576	$1.566
68	$1.733	$1.723
69	$1.905	$1.895
70	$2.095	N/A
71	$2.263	N/A
72	$2.444	N/A
73	$2.640	N/A
74	$2.853	N/A
75	$3.082	N/A
76	$3.330	N/A
77	$3.599	N/A
78	$3.889	N/A
79	$4.203	N/A
80	$4.495	N/A
81	$4.945	N/A
82	$5.445	N/A
83	$5.995	N/A
84	$6.595	N/A
85	$7.255	N/A
86	$7.985	N/A
87	$8.795	N/A
88	$9.685	N/A
89	$10.665	N/A
90	$11.745	N/A
91	$12.935	N/A
92	$14.225	N/A
93	$15.665	N/A
94	$17.245	N/A
95	$18.985	N/A
96	$20.905	N/A
97	$23.025	N/A
98	$25.355	N/A
99	$27.915	N/A

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

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

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

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

$50,000	÷	$1,000	=	50	x	$0.573	=	$28.65	+	$1.00	=	$29.65
Amount of coverage selected	÷	$1,000	=	# of units	x	Rate based on age 45	=	Monthly insurance premium	+	Admin fee*	=	Monthly total due

* Varies by amount of insurance and payment method

AGE	INSURED RATE	DEPENDENT SPOUSE/ DOMESTIC PARTNER RATE
15	$0.197	$0.187
16	$0.225	$0.215
17	$0.243	$0.233
18	$0.259	$0.249
19	$0.267	$0.257
20	$0.269	$0.259
21	$0.291	$0.281
22	$0.277	$0.267
23	$0.237	$0.227
24	$0.219	$0.209
25	$0.205	$0.195
26	$0.205	$0.195
27	$0.189	$0.179
28	$0.185	$0.175
29	$0.181	$0.171
30	$0.177	$0.167
31	$0.173	$0.163
32	$0.185	$0.175
33	$0.183	$0.173
34	$0.195	$0.185
35	$0.211	$0.201
36	$0.223	$0.213
37	$0.251	$0.241
38	$0.279	$0.269
39	$0.309	$0.299
40	$0.343	$0.333
41	$0.385	$0.375
42	$0.431	$0.421
43	$0.475	$0.465
44	$0.519	$0.509
45	$0.573	$0.563
46	$0.635	$0.625
47	$0.705	$0.695
48	$0.777	$0.767
49	$0.853	$0.843
50	$0.941	$0.931
51	$1.041	$1.031
52	$1.151	$1.141
53	$1.251	$1.241
54	$1.347	$1.337
55	$1.477	$1.467
56	$1.619	$1.609
57	$1.787	$1.777
58	$1.967	$1.957
59	$2.169	$2.159
60	$2.407	$2.397
61	$2.669	$2.659
62	$2.967	$2.957
63	$3.227	$3.217
64	$3.535	$3.525
65	$3.881	$3.871
66	$4.251	$4.241
67	$4.573	$4.563
68	$4.885	$4.875
69	$5.247	$5.237
70	$5.673	N/A
71	$6.177	N/A
72	$6.775	N/A
73	$7.375	N/A
74	$8.047	N/A
75	$8.777	N/A
76	$9.669	N/A
77	$10.611	N/A
78	$11.451	N/A
79	$12.391	N/A
80	$13.599	N/A
81	$14.841	N/A
82	$16.269	N/A
83	$17.879	N/A
84	$19.237	N/A
85	$20.608	N/A
86	$22.172	N/A
87	$23.967	N/A
88	$25.780	N/A
89	$27.911	N/A
90	$30.462	N/A
91	$31.911	N/A
92	$34.292	N/A
93	$37.339	N/A
94	$40.007	N/A
95	$42.856	N/A
96	$45.893	N/A
97	$49.130	N/A
98	$52.586	N/A
99	$55.893	N/A

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

TABLE E
CHILD MONTHLY TERM RATES

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

$10,000 ÷ $1,000 = 10 x $0.162 = $1.62

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

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

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

TABLE F
AD&D INSURANCE ONLY MONTHLY TERM RATES

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

$50,000 ÷ $1,000 = 50 x $0.035 = $1.75

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

AD&D TERM RATES

AD&D INSURED RATE	AD&D DEPENDENT SPOUSE/ DOMESTIC PARTNER RATE	AD&D CHILD(REN) RATE
$0.035	$0.025	$0.047

VAD&D TERM RATES

VAD&D INSURED ONLY RATE	VAD&D INSURED + DEPENDENTS RATE
$0.035	$0.050

INSTRUCTIONS

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

INSTRUCTIONS TO THE EMPLOYEE
A Statement of Health Form is required if you are:

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

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

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

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

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

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

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

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

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

STATEMENT OF HEALTH FORM

MetLife
Metropolitan Life Insurance Company, New York, NY

GROUP CUSTOMER INFORMATION (To be Completed by MetLife)

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

YOUR INFORMATION (To be Completed by the Proposed Insured)

Name (First, Middle, Last)		Relationship to Employee ☐ Self ☐ Spouse/Domestic Partner	☐ Male ☐ Female
Street Address	City	State	Zip Code

Date of Birth (MM/DD/YYYY)	Daytime Phone #	Home Phone #	Email Address

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ADM

HEALTH INFORMATION

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

Your name_____Employee's Social Security/Identification# _____

1. Your height____feet____inches Your weight_____pounds

	Yes	No
2. Are you now on a diet prescribed by a physician or other health care provider? If "yes" indicate type _____	☐	☐
3. Are you now pregnant? If "yes," what is your due date (month/day/year)? _____	☐	☐
4. Are you now, or have you in the past 5 years, used tobacco in any form?	☐	☐
5. In the past 5 years, have you received medical treatment or counseling by a physician or other health care provider for, or been advised by a physician or other health care provider to discontinue, the use of alcohol or prescribed or non-prescribed drugs?	☐	☐
6. In the past 5 years, have you been convicted of driving while intoxicated or under the influence of alcohol and/or any drug? If "yes", specify "date(s) of conviction(s) (month/day/year) _____	☐	☐
7. Have you had any application for life, accidental death and dismemberment or disability insurance declined, postponed, withdrawn, rated, modified, or issued other than as applied for?	☐	☐
8. Are you now receiving or applying for any disability benefits, including workers' compensation?	☐	☐
9. Have you been **Hospitalized** as defined below (not including well-baby delivery) in the past 90 days?	☐	☐

Hospitalized means admission for inpatient care in a hospital; receipt of care in a hospice facility, intermediate care facility, or long term care facility; or receipt of the following treatment wherever performed: chemotherapy, radiation therapy, or dialysis.

10. Have you ever been diagnosed or treated by a physician or other health care provider for Acquired Immunodeficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	☐	☐
11. Have you ever been diagnosed, treated or given medical advice by a physician or other health care provider for:	Yes	No
a. cardiac or cardiovascular disorder?	☐	☐
b. stroke or circulatory disorder?	☐	☐
c. high blood pressure?	☐	☐
d. cancer, Hodgkins disease, lymphoma or tumors? Indicate type _____	☐	☐
e. anemia, leukemia or other blood disorder? Indicate type _____	☐	☐
f. diabetes? Your age at diagnosis?_____ ☐ Check if insulin treated	☐	☐
g. asthma, COPD, emphysema or other lung disease? Indicate type _____	☐	☐
h. ulcers, stomach, hepatitis or other liver disorder? Indicate type _____	☐	☐
i. colitis, Crohn's, diverticulitis or other intestinal disorder? Indicate type _____	☐	☐
j. memory loss?	☐	☐
k. epilepsy, paralysis, seizures, dizziness or other neurological disorder?	☐	☐
Specify date of last seizure (month/year)_____Indicate type _____	☐	☐
l. Epstein-Barr, chronic fatigue syndrome or fibromyalgia?	☐	☐
m. multiple sclerosis, ALS or muscular dystrophy?	☐	☐
n. lupus, scleroderma, auto immune disease or connective tissue disorder?	☐	☐
o. arthritis? ☐ osteoarthritis ☐ rheumatoid ☐ other/type _____	☐	☐
p. back, neck, knee, spinal, joint or other musculosketal disorder?	☐	☐
q. carpal tunnel syndrome?	☐	☐
r. kidney, urinary tract or prostate disorder? Indicate type _____	☐	☐
s. thyroid or other gland disorder? Indicate type _____	☐	☐
t. mental, anxiety, depression, attempted suicide or nervous disorder?	☐	☐
u. sleep apnea		

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

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

Question Number	Condition/Diagnosis	Medication Prescribed
		☐ Yes __________ ☐ No
Date of Diagnosis (Month/Year)	**Date of Last Treatment (Month/Year)**	**Type of Treatment**

Treating Health Professional

Personal Physician's Name: ____________________
Date of last visit:__________ Reason for visit: ____________________
Address ____________________
Street City State Zip Code
Telephone: (____) ____ - ______

Question Number	Condition/Diagnosis	Medication Prescribed
		☐ Yes __________ ☐ No
Date of Diagnosis (Month/Year)	**Date of Last Treatment (Month/Year)**	**Type of Treatment**

Treating Health Professional

Personal Physician's Name: ____________________
Date of last visit:__________ Reason for visit: ____________________
Address ____________________
Street City State Zip Code
Telephone: (____) ____ - ______

Question Number	Condition/Diagnosis	Medication Prescribed
		☐ Yes __________ ☐ No
Date of Diagnosis (Month/Year)	**Date of Last Treatment (Month/Year)**	**Type of Treatment**

Treating Health Professional

Personal Physician's Name: ____________________
Date of last visit:__________ Reason for visit: ____________________
Address ____________________
Street City State Zip Code
Telephone: (____) ____ - ______

SECTION 3

1. Personal Physician's Name: ____________________ Telephone: (_____) ____ – ______
   Address (Street, City, State, Zip Code): ____________________
   Date of last visit (MM/DD/YYYY): __________ Reason for visit: ____________________
2. Are you currently taking any other prescribed medications? ☐ Yes ☐ No
   Medication:____________________ Condition/Diagnosis: ____________________
   Prescribing Physician's Name: ____________________ Telephone: (_____) ____ – ______
   Address (Street, City, State, Zip Code): __________

FRAUD WARNINGS

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

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

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

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

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

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

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

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

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

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

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

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

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

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FW

DECLARATIONS AND SIGNATURES

By signing below, I acknowledge:

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

Signature of Proposed Insured	Print Name	Date Signed (MM/DD/YYYY)

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

Signature of Personal Representative	Print Name	Date Signed (MM/DD/YYYY)

Relationship of Personal Representative

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DEC

AUTHORIZATION

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

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

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

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

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

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

Signature of Employee		Date Signed (Mo./Day/Yr.)
Print Name	State of Birth	Country of Birth

Signature of Spouse		Date Signed (Mo./Day/Yr.)
Print Name	State of Birth	Country of Birth

MetLife

Our Privacy Notice

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

Plan Sponsors and Group Insurance Contract Holders

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

Protecting Your Information

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

Collecting Your Information

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

How We Get Your Information

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

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

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

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

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

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

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

Using Your Information

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

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

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

Sharing Your Information With Others

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

Other reasons we may share your information include:

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

HIPAA

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

Accessing and Correcting Your Information

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

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

Questions

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

Send privacy questions to:

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

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

Metropolitan Life Insurance Company
General American Life Insurance Company
SafeHealth Life Insurance Company
MetLife Insurance Company of Connecticut
SafeGuard Health Plans, Inc.

HOW TO APPLY FOR BENEFITS

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

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

Your name; Your address; Your Social Security Number; Your birth date; The names and birth dates of each member of your family you wish to enroll;

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

Notify the Trust Fund About Any Changes

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

You must notify the Trust Fund when:

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

If any of these situations occurs, please contact the Director of Benefits at uawdental@external.umass.edu or (413) 345-2156 so that your records can be updated.

Your Benefits Authorization Form

Electronically signing your benefits authorization form certifies that all information you submit to the UAW/UMass Health & Welfare Trust Fund is true and correct to the best of your knowledge. By signing the form, you agree to and understand the following: 1) the effective date and termination date of your membership and benefits will be determined by your employer and/or the Trustees of the UAW/UMass Health & Welfare Trust Fund and/or plan sponsor in accordance with the underwriting of any and all vendors employed by the Trust for the purpose of providing benefits; 2) the email address and campus mail address you provide to the Trust Fund will be the primary methods used to communicate with you about your benefits; 3) you release to the administrative employees and Trustees of the UAW/UMass Health & Welfare Trust Fund, to UAW Local 2322, and to any and all vendors employed by the Trust Fund for the purpose of providing benefits, information necessary to provide you with, and to verify your eligibility for, any and all benefits offered by the Trust Fund (including but not limited to dental, vision, and childcare assistance).

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

WHEN YOUR COVERAGE BEGINS

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

If you are a new employee

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

If you are an existing employee

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

Open Enrollment Periods

When you enroll, you enroll for your entire term of your employment and do not need to re-enroll each year. If you need to make changes to your plans, you can do so during the annual open enrollment period which occurs each June 15-30 (check website for any changes).

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

If you return to work after a leave

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

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

If you have Family Coverage

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

YOUR ID CARDS

If you are eligible for benefits and have completed the online application, you will first receive an email confirming your eligibility and enrollment. Then, within 10 days of your first date of enrollment you should receive an ID card directly from EyeMed Vision Care if you have opted into vision benefits. Ameritas does not issue hard-copy ID cards but you can download a digital ID by registering at www.ameritas.com

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

Ameritas Group #: 010-53791

EyeMed Group #: 9878760

If you are uncomfortable with providing your SSN to your provider, other identifying information can be used to pull up your record:

-Ameritas assigns you an alternate ID—if you need this number, please contact the Director of Benefits or register at www.ameritas.com

-your date of birth can be used to locate your enrollment in the EyeMed system

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

MetLife and EyeMed do not issue ID cards in the names of dependents enrolled on your plan. This is not an indication that they are not covered. Your dependents should use your ID cards and your Member ID numbers and providers should be able to find their enrollment under the main subscriber's enrollment (you). If you are no longer eligible for benefits, you may not use any ID card from the Trust Fund, regardless of any expiration date that may appear on the card. If you do, you will be personally responsible for all charges. Your ID cards are for use by you and your eligible dependents only. You should not allow anyone else to use your ID cards to obtain Trust Fund benefits. If you do, the Trust Fund will deny payment and you may be personally responsible to the provider for the charges. If the Trust Fund has already paid for these benefits, you will be required to reimburse the Trust Fund. The Trust Fund may deny benefits to you and your eligible dependents and/or may initiate civil or criminal actions against you until you repay the Benefit Fund. If you suspect that someone is using an ID card fraudulently, contact the Trust Fund.

WHEN YOUR ELIGIBILITY ENDS

You will lose your eligibility 30 days after your official end of employment date.

COBRA CONTINUATION COVERAGE

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

Once your PHWP eligibility is lost, 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 PHWP are subject to COBRA continuation coverage.

Continuation coverage is the same coverage that the PHWP gives to other participants or beneficiaries under the PHWP who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the PHWP as other participants or beneficiaries covered under the PHWP.

Be sure to share the information in this COBRA notice with all qualified beneficiaries in your household, including spouses/partners & dependents, as they may have COBRA rights under the law.

How can you elect COBRA continuation coverage?
To elect continuation coverage, you must complete the Election Form and furnish it according to the directions on the form. The form is available at https://www.uawumasstrustfund.org/pd-cobra Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee's spouse may elect continuation coverage even if the employee does not.

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

First, you can lose the right to avoid having preexisting condition exclusions applied to you by other group health plans if you have a 63-day gap in health coverage, and election of continuation coverage

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

How much does COBRA continuation coverage cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage, not to exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent of the cost to the group plan (including both employer and employee contributions for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. The required payment for each continuation coverage period for each option is available at https://www.uawumasstrustfund.org/pd-cobra

Length of COBRA coverage

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

Continuation coverage will be terminated before the end of the maximum period if:

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

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

Extensions to the length of COBRA continuation coverage

If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify the Director of Benefits at uawdental@external.umass.edu or (413) 345-2156 of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

-Disability

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

-Second Qualifying Event

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

When and how must payment for COBRA continuation coverage be made?

First payment for continuation coverage: If you elect continuation coverage, you do not have to send any payment with the Election Form. However, you must make your first payment for continuation coverage not later than 45 days after the date of your election. (This is the date the Election Notice is post-marked, if mailed. If you do not make your first payment for continuation coverage in full not later than 45 days after the date of your election, you will lose all continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact the Director of Benefits at uawdental@external.umass.edu or (413) 345-2156 to confirm the correct amount of your first payment or to discuss payment issues related to the ARRA premium reduction.

Periodic payments for continuation coverage: After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The amount due for each coverage period for each qualified beneficiary is shown in this notice. The

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

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

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

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

For more information
Please see https://www.uawumasstrustfund.org/pd-cobra or http://www.dol.gov/dol/topic/health-plans/cobra.htm

POLICIES FOR PAYMENT ISSUED FROM THE TRUST FUND

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

If the Trust Fund issued a payment to you via check or PayPal, we will reissue your payment once with no penalty if you do not receive your check or you do not claim your PayPal payment within 30 days and it is subsequently returned to the Trust Fund's account. If you require a second reissue of the same payment, we will deduct a $25 processing fee from the total amount of your reissued payment. No fee deduction shall apply if the reissue is processed via PayPal. The Trust Fund will only reissue payments after 1) the original check has been returned to us in hard copy form and remains uncashed, in the case of damaged checks or checks marked as undeliverable by the Postal Service, or 2) the original check's expiration date (90 or 180 days) has passed and the funds have been returned to the Trust Fund's bank account or 3) the original payment has been refunded to our PayPal account due to not being claimed within 30 days. If you've elected to be reimbursed via PayPal and the Trust Fund incurs an additional fee because your PayPal email is associated with a non-US account, this additional fee (typically nominal) will be your responsibility, and we will reduce your reimbursement by this fee accordingly.

NOTICE OF PRIVACY PRACTICES

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

Disclosure and Use of Protected Health Information

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

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

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

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

To Conduct Health Care Operations. The Fund may use or disclose PHI for its own operations to facilitate the administration of the Fund and as necessary to provide coverage and services to all of the Fund's participants and beneficiaries. Health care operations includes such activities as:
a. Quality assessment and improvement activities.
b. Activities designed to improve health or reduce health care costs.
c. Clinical guideline and protocol development, case management and care coordination.
d. Contacting health care providers, participants and beneficiaries with information about treatment alternatives and other related functions.
e. Health care professional competence or qualifications review and performance evaluation.
f. Accreditation, certification, licensing or credentialing activities.
g. Underwriting, premium rating or related functions to create, renew or replace health insurance or health benefits.
h. Review and auditing, including compliance reviews, medical reviews, legal services and compliance programs.
i. Business planning and development including cost management and planning related analysis and formulary development.
j. Business management and general administrative activities of the Fund, including member services and resolution of internal grievances.
k. Certain marketing activities.
For example, the Fund may use your PHI to conduct case management, quality improvement, disease management, utilization review, or to engage in member service and grievance resolution activities. However, in no case will the Fund disclose genetic information as part of any of the above conduct of health care operations.

For Treatment Alternatives. The Fund may use or disclose your PHI to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

For Distribution of Health Related Benefits and Services. The Fund may use or disclose your PHI

to provide to you information on health related benefits and services that may be of interest to you.

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

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

Authorization to Use or Disclose Protected Health Information

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

Your Rights With Respect to Your Protected Health Information

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

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

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

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

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

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

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

Duties of the Fund

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

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

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

Contact

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

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

By email: uawdental@external.umass.edu

By phone: (413) 345-2156

Ameritas

Ameritas Life Insurance Corp.

A STOCK COMPANY
LINCOLN, NEBRASKA

CERTIFICATE
GROUP DENTAL INSURANCE

The Policyholder **UAW/UMASS HEALTH & WELFARE TRUST FUND**

Policy Number **10-53791** **Insured Person**

Plan Effective Date **July 1, 2020** **Certificate Effective Date**
Refer to Exceptions on 9070

Plan Change Effective Date **September 1, 2020**

Class Number 1

Ameritas Life Insurance Corp. certifies that you will be insured for the benefits described on the following pages, according to all the terms of the group policy numbered above which has been issued to the Policyholder.

Possession of this certificate does not necessarily mean you are insured. You are insured only if you meet the requirements set out in this certificate.

The group policy may be amended or cancelled without the consent of the insured person.

The group policy and this certificate are governed by the laws of the state in which the group policy was delivered.

This plan does not include pre-existing condition limitations or exclusions.

President

Massachusetts Notice of Inquiry and Grievance Procedures

Quality Control
P.O. Box 82657
Lincoln, NE 68501-2657
877-897-4328 (Toll-Free) 402-309-2579 (FAX)

Please read this notice carefully. This notice contains important information about how to make inquiries and/or file grievances with your insurer. Also, you always have the right to contact the Massachusetts Division of Insurance if you have a question or concern regarding your coverage under this contract. The Massachusetts Division of Insurance may be contacted through their Consumer Hotline at 1-617-521-7794.

I. Definitions

"Grievance" means any written complaint submitted to the insurer by or on behalf of an insured person concerning any aspect or action of the insurer, including, but not limited to, review of adverse determinations regarding scope of coverage, denial of services and administrative operations.

"Adverse Determination" means a determination by a carrier to deny, reduce, or modify the availability of any health care services, for failure to meet the requirements for coverage based on medical necessity, appropriateness, level of care or effectiveness.

II. Internal Grievance Process

1. Filing a Grievance

You may file a grievance by phone, in person, by mail, or by electronic means. We will provide you or your authorized representative, if any, a written resolution of a grievance within thirty (30) business days of receipt of the oral or written grievance.

2. Written Decision

In the case of a grievance which involves an adverse determination, our written response shall include a substantive clinical justification that is consistent with generally accepted principles of professional dental and/or vision practice philosophy and will also include:

1. An identification of the specific information upon which the adverse determination was based;
2. Discuss the insured's presenting symptoms or condition, diagnosis and treatment interventions and the specific reasons such medical evidence fails to meet the relevant medical review criteria; and
3. Reference and include applicable clinical practice guidelines and review criteria.

3. Reconsideration

We will always provide the opportunity to reconsider a final decision where relevant information was received too late to review within the thirty (30) business day time limit or was not received but expected to become available within a reasonable time period.

We will review a reconsideration and provide our written response as soon as possible following receipt of the additional information but we agree to provide such response no later than thirty (30) business days following your request for reconsideration.

You always have the right to contact the Department of Insurance:

Division of Insurance
1000 Washington St., Ste 810
Boston, MA 02118-6200
(617) 521-7794
(877) 563-4467

Massachusetts Health Policy Commission – Office of Patient Protection
50 Milk Street, 8th Floor
Boston, MA 02109
(800) 436-7757

Upon request, interpreter and translation services related to administrative procedures are available.

متوفر تحت الطلب خدمات ترجمة، كتابية وشفهية، تختص بالإجراءات الإدارية.

ដែលអាចស្នើសុំ សេវាអ្នកបកប្រែភាសា និងបកប្រែអក្សរ ទាក់ទងនឹងនីតិវិធីរដ្ឋបាល មានផ្តល់ជូន

若您提出要求，我們可以提供與行政程序有關的語言翻譯服務。

Sur demande, des services d'interprétation et
de traduction concernant les procédures administratives sont
disponibles.

Κατόπιν αίτησης διαθέτονται ερμηνευτικές και μεταφραστικές
υπηρεσίες για διαχειριστικές υποθέσεις.

Sévis entépret ak tradiksyon ki ginyin rapo ak fonksyônman
administrasyon an, la pou ou depi ou mande-l.

A richeste, servizi di intepretazione e traduzione rigardo a procedura
aministrativi sono disponibile.

ເມື່ອໄດ້ມີການຮ້ອງຂໍ, ຈະມີບໍລິການບາຍພາສາແລະແປພາສາໄວ້ສຳຫລັບເລື່ອງຕ່າງໆ ທີ່ກ່ຽວຂ້ອງກັບ
ກະບວນການຕ່າງ ໆ ທາງດ້ານການບໍລິຫານ.

Sob requerimento, disponibilizamos serviços de interpretação e
traduçao relacionados a procedimentos administrativos.

По заявкам предлагаются услуги по переводу, связанному с
административными порядками.

A pedido, están disponibles servicios de interpretación y
traducción relacionados a procedimientos administrativos.

IMPORTANT INFORMATION

The following provides summary information regarding your rights as well as summary descriptions of the practices of Ameritas Life Insurance Corp. with regard to your dental and/or eye care coverage's provided to you under an Ameritas Life Insurance Corp. certificate of coverage.

CONSUMER RIGHTS

- ✓ **Termination of Individual Coverage.** Coverage is provided to you as a member of a group contract based on the eligibility requirements established by the group policyholder. As long as you maintain your eligibility, your coverage may only be canceled, or its renewal refused, in the following circumstances:

  (1) Non-renewal or cancellation of the group contract through which the insured receives coverage;
  (2) Failure by the insured or other responsible party to make payments required under the contract;
  (3) Misrepresentation or fraud on the part of the insured; or
  (4) Commission of acts of physical or verbal abuse by the insured which pose a threat to providers or other insureds of the carrier and which are unrelated to the mental or physical condition of the insured.

  The involuntary termination rate for Massachusetts's insureds during the previous calendar year was 0%. "Involuntary disenrollment" means those insureds whose coverage was terminated as a result of conditions (3) or (4) listed above.

  The voluntary termination rate for Massachusetts's insureds during the previous calendar year was 8%. "Voluntary disenrollment' means that an insureds whose coverage was terminated as a result of conditions (1) or (2) above.

- ✓ **Grievance Process.** You have the right to make inquiries and/or file a complaint with your insurer. Please review the attached notice entitled "Notice of Inquiry and Grievance Procedures" so that you understand your rights and the responsibilities of your carrier in handling your specific inquiry and/or complaint.

- ✓ **Interpreter/Translation Services.** Upon request, interpreter and translation services related to administrative procedures are available. This service is provided through AT&T Language Line, which supports 140 languages.

OUR PRACTICES

- ✓ **Communication.** As a group contract, the coverages under the group plan renew annually. Notices of any modifications or changes to the plan design will be provided to the policyholder 60 days prior to the effective date of the change. In addition to any coverage changes, notice will also be provided of a material change in clinical review criteria and a statement of the effect of such changes on the personal liability of the insured for the cost of any such changes. If changes are material, notice of the change will be provided to at least one adult insured in each household. This notice may be in the form of a rider, amendment or endorsement to the certificate of coverage.

- ✓ **Quality.** Depending upon the benefit plan the policyholder has selected, you may have the option to seek services from a participating provider. Please refer to your certificate of coverage for benefit plan information.
  Whether your plan provides for a participating provider option ("PPO") or not, you have the freedom of choice to seek services from any provider and benefits will be paid for all services which are considered covered expenses as defined within your certificate.

  For PPO network plans we have established a Quality Management Program with policies and procedures to ensure that minimum standards are met and that proper evaluations are conducted in order to provide insureds with access to quality care.

The Quality Management Program addresses the following standards:

< Provider and Member Services
< Provider Credentialing
< The Patient Record/File
< Sterilization and Infection Control
< Medical Emergency Preparedness
< Environmental and Radiology Safety
< Professional Standards
< Utilization Review Program
< Accessibility of Services
< Member and Provider Satisfaction

The Quality Management Program has been developed in conjunction with individual practitioners and individual practitioners actively within the program to ensure the program's overall effectiveness.

✓ **Utilization Review Program.** Generally, utilization review means a set of formal criteria designed to monitor the use of, or evaluate the medical necessity, appropriateness, or efficiency of health care services. We have established a utilization review program to ensure that any guidelines and criteria used to evaluate the medical necessity of a dental care service are clearly documented and include procedures for applying such criteria based on the needs of the individual patients. The program was developed in conjunction with actively practicing providers in all specialty areas of expertise and is reviewed at least annually to ensure that criteria are applied consistently and are current with dental technology, evidence-based research and any dental trends.

In order for a submitted procedure to be covered, the procedure must be included on the List of Covered Procedures contained within your certificate. If a procedure is not a covered procedure, then the claim for that procedure will be denied in accordance with the terms of your certificate and the group policy. Frequency, age, effective dates of coverage, etc may also limit coverage of certain covered procedures, these limitations are stated within your certificate.

There are also a limited number of listed procedures which are only considered a covered expense if the patient presents with a specified health history and/or has been diagnosed with a specified condition. During the claims review of these specific procedures, there may be a determination by a licensed practitioner that the procedure that was performed was not determined to be medically necessary in accordance with the criteria that has been established in accordance with our utilization review program. In these situations, the claim for that procedure may be denied or partially reimbursed in accordance with the benefit for an alternate procedure.

All claims will be processed within at most 30 working days of obtaining all the necessary information. Our standard turn-around times are generally below 10 working days for claim review. For all claims submissions, you and your provider will receive an explanation of benefits which details how each submitted procedure was reimbursed and/or the reason for denial.

When a claim has been denied or partially denied based on medical necessity, this is considered an adverse determination. These decisions are reviewed by qualified and appropriately licensed health professionals and only after receiving any relevant clinical information necessary to make the decision.

For any questions you have regarding how a claim was paid, please feel free to contact us at the following:

Ameritas Life Insurance Corp.
Attention: Quality Control
P.O. Box 82657
Lincoln, NE 68501-2657

877-897-4328 (Toll-Free)

NOTICE

1) You can access your specific evidence of coverage and any amendments by visiting our on-line portal1 located at ameritas.com

Information that can be accessed at this location includes:

Benefit Summary – A highlight of the benefit information for the plan you've purchased.

Certificate of Coverage – A document that can be viewed or printed showing all parameters of your plans benefit information.

Claims Information – Shows action taken on submitted claims including paper and electronic Explanation of Benefits (EEOB) and the amount of remaining benefit your plan has for the current benefit period.

ID Card – This item may be presented at the provider's office to identify you as an Ameritas member

Provider Lookup – The Member may access our provider directory to access an in-network provider.

Dental Cost Estimator – You may use this tool to find out what a specific procedure could cost with an out-of network general dentist in your Zip Code.

Dental Health Card – An insured may access this tool to receive a score on their dental health.

Resource Center – Access valuable information such as the glossary of terms, frequently asked questions and how to nominate a dentist or specialist.

2) You have the right to receive, free of charge, a paper copy of evidences of coverage and any amendments thereto at any time.

3) For questions regarding your plan, or to request a paper copy of your Policy at no charge to you, please call 1-800-487-5553.

1Creation of a user name and password required.

THIS DISCOUNT ACCESS IS NOT INSURANCE

Non-Insurance Products/Services

From time to time we may arrange, at no additional cost to you or your group, for third-party service providers to provide you access to discounted goods and/or services, such as purchase of pharmacy prescriptions and eye wear. These discounted goods or services are not insurance. While we have arranged these discounts, we are not responsible for delivery, failure or negligence issues associated with these goods and services. The third-party service providers would be liable.

These non-insurance goods and services will discontinue upon termination of your insurance or the termination of our arrangements with the providers, whichever comes first.

Dental procedures not covered under your plan (not listed in the Table of Dental Procedures) may also be subject to a discounted fee in accordance with a participating provider's contract and subject to state law. Contact Your Participating Provider to confirm discounts or call our Customer Service area at 1-800-487-5553.

If you are traveling outside the United States and require emergency care for a service that would be covered under this Policy, you may contact AXA Assistance USA, Inc. for an appointment with a qualified provider. Such services would be considered as an out-of-network claim.

Pharmacy prescriptions are subject to a discount at CVS, Walgreens, Rite Aid and Walmart pharmacies. Access your prescription discount ID card by logging into your secure member account.

If you have received an identification card describing Walmart EyeWear Savings, you are eligible for discounts of up to 15% on frames and lenses at participating Walmart Vision Centers. You must bring a current prescription from any vision care provider.

TABLE OF CONTENTS

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

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:

When a Participating Provider is used:	
Type 1, Type 2, Type 3, and Type 4 Procedures	$0
When a Non-Participating Provider is used:	
Type 1 and Type 4 Procedures	$0
Combined Type 2 and Type 3 Procedures - Each Benefit Period	$75

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.

	Participating Provider	Non-Participating Provider
Coinsurance Percentage:		
Type 1 Procedures	100%	100%
Type 2 Procedures	80%	80%
Type 3 Procedures	65%	65%
Type 4 Procedures	65%	65%
When a Non-Participating Provider is used:		
Maximum Amount - Each Benefit Period		$2,250*
When a Participating Provider is used:		
Maximum Amount - Each Benefit Period		$2,250*

In no event will expenses incurred for Type 1 Procedures count toward the Maximum Benefit.

Eligible Dental Expense 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

The Maximum Benefit shown above will be modified for:

a. any person who was insured for an Orthodontic Expense Benefit under the prior carrier on June 30, 2020, and
b. on July 1, 2020 is both:

    i. insured under the policy, and

    ii. currently undergoing a Treatment Program which would have been a covered Treatment Program under the prior carrier had the prior carrier's coverage remained in force.

The modification will result in a reduction of the Maximum Benefit based on:

a. the normal benefit payable under the policy for the current Treatment Program, minus

b. any amounts to which the person is entitled from the prior carrier for such Treatment Program.

Nothing stated above, however, will act to provide coverage or increase benefits, when the Treatment Program is subject to any limitation shown on 9260.

COMBINED EXPENSE BENEFITS

*Combined Dental and Eye Care Maximum - Each Benefit Period	$2,250

The maximums listed with the (*) above are subject to the maximum amount listed here.

DEFINITIONS

COMPANY refers to Ameritas Life Insurance Corp. The words "we", "us" and "our" refer to Company. Our Home Office address is 5900 "O" Street, Lincoln, Nebraska 68510.

POLICYHOLDER refers to the Policyholder stated on the face page of the policy.

INSURED refers to a person:

a. who is a Member of the eligible class; and

b. who has qualified for insurance by completing the eligibility period, if any; and

c. for whom the insurance has become effective.

DOMESTIC PARTNER: Refers to two unrelated individuals who share the necessities of life, live together, and have an emotional and financial commitment to one another, similar to that of a spouse.

CHILD. Child refers to the child of the Insured , a child of the Insured's spouse or a child of the Insured's Domestic Partner, if they otherwise meet the definition of Dependent.

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.

PROVIDER refers to any person who is licensed by the law of the state in which treatment is provided within the scope of the license.

PARTICIPATING AND NON-PARTICIPATING PROVIDERS. A Participating Provider is a Provider who has a contract with Us to provide services to Insureds at a discount. A Participating Provider is also referred to as a "Network Provider". The terms and conditions of the agreement with our network providers are available upon request. Members are required to pay the difference between the plan payment and the Participating Provider's contracted fees for covered services. A Non-Participating Provider is any other provider and may also be referred

to as an “Out-of-Network Provider.” Members are required to pay the difference between the plan payment and the provider’s actual fee for covered services. Therefore, the out-of-pocket expenses may be lower if services are provided by a Participating Provider.

LATE ENTRANT refers to any person:

a. whose Effective Date of insurance is more than 31 days from the date the person becomes eligible for insurance; or

b. who has elected to become insured again after canceling a premium contribution agreement.

PLAN EFFECTIVE DATE refers to the date coverage under the policy becomes effective. The Plan Effective Date for the Policyholder is shown on the policy cover. The effective date of coverage for an Insured is shown in the Policyholder's records.

All insurance will begin at 12:01 A.M. on the Effective Date. It will end after 11:59 P.M. on the Termination Date. All times are stated as Standard Time of the residence of the Insured.

PLAN CHANGE EFFECTIVE DATE refers to the date that the policy provisions originally issued to the Policyholder change as requested by the Policyholder. The Plan Change Effective date for the Policyholder will be shown on the policy cover, if the Policyholder has requested a change. The plan change effective date for an Insured is shown in the Policyholder’s records or on the cover of the certificate.

CONDITIONS FOR INSURANCE COVERAGE

ELIGIBILITY

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 post doctoral researcher working at least 20 hours per week. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

ELIGIBLE CLASS FOR DEPENDENT INSURANCE. Each Member of the eligible class(es) for dependent coverage is eligible for the Dependent Insurance under the policy and will qualify for this Dependent Insurance on the latest of:

1. the day he or she qualifies for coverage as a Member;

2. the day he or she first becomes a Member; or

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

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

If employment is the basis for membership, a member of the Eligible Class for Dependent Insurance is any post doctoral researcher 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.

ELIMINATION PERIOD. Certain covered expenses may be subject to a elimination period, the period between the effective date of the policy and the effective date of coverage of benefits. Please refer to the TABLE OF DENTAL PROCEDURES, DENTAL EXPENSE BENEFITS and if applicable, the ORTHODONTIC EXPENSE BENEFITS pages for details.

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.

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."

NOTICE REQUIREMENTS. If an Insured's coverage terminates due to non-payment of premiums, then each Insured will be provided a notice of such termination. The notice will be mailed to the last known address of the Insured. Any claims for services will be paid in accordance with the terms of the contract for any health care service received by the Insured prior to the date of notification.

CONTINUATION OF 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.

Notice

We are required to send notice of name, address and policy numbers of persons electing this continuation to the Massachusetts Department of Public Welfare. We must send the notice within 30 days of the date continuation coverage starts.

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.
3. the Maximum Allowable Charge ("MAC") as covered under your plan, if services are provided by a Participating Provider, who is a general dentist.

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.

MAC - The Maximum Allowable Charge is derived from the array of provider charges within a particular ZIP code area. These allowances are the charges accepted by dentists who are Participating Providers. The MAC is reviewed and updated periodically to reflect increasing provider fees within the ZIP code area.

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 reasonable 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 the service is rendered or a supply furnished.

PRE-EXISTING CONDITION. A medical condition for which a Covered Person received medical advice or treatment or displayed symptoms which would have led an ordinarily prudent person to seek medical advice or treatment for that medical conditions during a specific period prior to the effective date of coverage.

This coverage does not restrict or limit coverage for any pre-existing conditions as defined above. Contract limitations are listed below.

LIMITATIONS. Covered Expenses will not include and benefits will not be payable for expenses incurred:

1. in the first 12 months that a person is insured if the person is a Late Entrant; except for evaluations, prophylaxis (cleanings), and fluoride application.

2. a. for initial placement of any dental prosthesis or prosthetic crown unless such placement is needed because of the extraction of one or more teeth while the insured person is covered under this contract. But the extraction of a third molar (wisdom tooth) will not qualify under the above. Any such dental prosthesis or prosthetic crown must include the replacement of the extracted tooth or teeth unless the insured person is covered on July 1, 2020. For those Insureds covered on July 1, 2020, see b.

    b. Limitation a. will be waived for those Insureds whose coverage was effective on July 1, 2020 and

        i. the person has the tooth extracted while insured under the prior contract: and

        ii. has a dental prosthesis or prosthetic crown installed to replace the extracted tooth while insured under our contract;

but such extraction and installation must take place within a twelve-month period; and

iii. the dental prosthesis or prosthetic crown noted above must be an initial placement.

3. for appliances, restorations, or procedures to:

   a. alter vertical dimension;
   b. restore or maintain occlusion; or
   c. splint or replace tooth structure lost as a result of abrasion or attrition.

4. for any procedure begun after the insured person's insurance under this contract terminates; or for any prosthetic dental appliances installed or delivered more than 90 days after the Insured's insurance under this contract terminates.

5. to replace lost or stolen appliances.

6. for any treatment which is for cosmetic purposes.

7. for any procedure not shown in the Table of Dental Procedures. (There may be additional frequencies and limitations that apply, please see the Table of Dental Procedures for details.)

8. for orthodontic treatment under this benefit provision. (If orthodontic expense benefits have been included in this policy, please refer to the Schedule of Benefits and Orthodontic Expense Benefits provision found on 9260).

9. for which the Insured person is entitled to benefits under any workmen’s compensation or similar law, or charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.

10. for charges which the Insured person is not liable or which would not have been made had no insurance been in force.

11. for services that are not required for necessary care and treatment or are not within the generally accepted parameters of care.

12. because of war or any act of war, declared or not.

TABLE OF DENTAL PROCEDURES

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY FOR YOUR PROCEDURE FREQUENCIES AND PROVISIONS.

The attached is a list of dental procedures for which benefits are payable under this section; and is based upon the Current Dental Terminology © American Dental Association. **No benefits are payable for a procedure that is not listed.**

- 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.
- Covered procedures are subject to all plan provisions, procedure and frequency limitations, and/or consultant review.
- Reference to "traumatic injury" under this plan is defined as injury caused by external forces (ie. outside the mouth) and specifically excludes injury caused by internal forces such as bruxism (grinding of teeth).
- Benefits for replacement dental prosthesis or prosthetic crown will be based on the prior placement date. Frequencies which reference Benefit Period will be measured forward within the limits defined as the Benefit Period. All other frequencies will be measured forward from the last covered date of service.
- Radiographic images, periodontal charting and supporting diagnostic data may be requested for our review.
- We recommend that a pre-treatment estimate be submitted for all anticipated work that is considered to be expensive by our insured.
- A pre-treatment estimate is not a pre-authorization or guarantee of payment or eligibility; rather it is an indication of the estimated benefits available if the described procedures are performed.

TYPE 1 PROCEDURES

PAYMENT BASIS - NON PARTICIPATING PROVIDERS - Usual and Customary

BENEFIT PERIOD - Benefit Year

For Additional Limitations - See Limitations

ROUTINE ORAL EVALUATION

D0120 Periodic oral evaluation - established patient.

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.

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.

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

TYPE 1 PROCEDURES

Coverage is limited to 1 of any of these procedures per 2 year(s).
Benefits are considered for persons from age 35 and over.

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.

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.
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

TYPE 1 PROCEDURES

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

PAYMENT BASIS - NON PARTICIPATING PROVIDERS - Usual and Customary

BENEFIT PERIOD - Benefit Year

For Additional Limitations - See Limitations

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.

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.

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.

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.

TYPE 2 PROCEDURES

D2933 Prefabricated stainless steel crown with resin window.
D2934 Prefabricated esthetic coated stainless steel crown - primary tooth.
STAINLESS STEEL CROWN: D2390, D2928, D2929, D2930, D2931, D2932, D2933, D2934
Replacement is limited to 1 of any of these procedures per 12 month(s).
Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

RECEMENT
D2910 Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration.
D2915 Re-cement or re-bond indirectly fabricated or prefabricated post and core.
D2920 Re-cement or re-bond crown.
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.

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.

TYPE 2 PROCEDURES

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.

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).

TYPE 2 PROCEDURES

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).

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).

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.

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.

TYPE 2 PROCEDURES

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.

REMOVAL OF BONE TISSUE: D7471, D7472, D7473

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

TYPE 2 PROCEDURES

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.

PROFESSIONAL CONSULT/VISIT/SERVICES

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.

CONSULTATION: D9310

Coverage is limited to 1 of any of these procedures per provider.

OFFICE VISIT: D9430, D9440

Procedure D9430 is allowed for accidental injury only. Procedure D9440 will be allowed on the basis of services rendered or visit, whichever is greater.

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.

TYPE 3 PROCEDURES

PAYMENT BASIS - NON PARTICIPATING PROVIDERS - Usual and Customary

BENEFIT PERIOD - Benefit Year

For Additional Limitations - See Limitations

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.

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.

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.
D6980 Fixed partial denture repair necessitated by restorative material failure.
D9120 Fixed partial denture sectioning.

CROWN LENGTHENING
D4249 Clinical crown lengthening - hard tissue.

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.

ADD TOOTH/CLASP TO EXISTING PARTIAL

TYPE 3 PROCEDURES

D5650 Add tooth to existing partial denture.
D5660 Add clasp to existing partial denture-per tooth.

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

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

TYPE 3 PROCEDURES

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

TYPE 4 PROCEDURES

PAYMENT BASIS - NON PARTICIPATING PROVIDERS - Usual and Customary

BENEFIT PERIOD - Benefit Year

For Additional Limitations - See Limitations

NON-SURGICAL MISCELLANEOUS

D0160	Detailed and extensive oral evaluation - problem focused, by report.
D0320	Temporomandibular joint arthrogram, including injection.
D0321	Other temporomandibular joint radiographic images, by report.
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.

TYPE 1 PROCEDURES

PAYMENT BASIS - PARTICIPATING PROVIDERS - Maximum Allowable Charge

BENEFIT PERIOD - Benefit Year

For Additional Limitations - See Limitations

ROUTINE ORAL EVALUATION

D0120 Periodic oral evaluation - established patient.

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.

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.

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

TYPE 1 PROCEDURES

Coverage is limited to 1 of any of these procedures per 2 year(s).
Benefits are considered for persons from age 35 and over.

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.

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.
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

TYPE 1 PROCEDURES

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

PAYMENT BASIS - PARTICIPATING PROVIDERS - Maximum Allowable Charge

BENEFIT PERIOD - Benefit Year

For Additional Limitations - See Limitations

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.

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.

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.

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.

TYPE 2 PROCEDURES

D2933 Prefabricated stainless steel crown with resin window.
D2934 Prefabricated esthetic coated stainless steel crown - primary tooth.
STAINLESS STEEL CROWN: D2390, D2928, D2929, D2930, D2931, D2932, D2933, D2934
Replacement is limited to 1 of any of these procedures per 12 month(s).
Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

RECEMENT
D2910 Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration.
D2915 Re-cement or re-bond indirectly fabricated or prefabricated post and core.
D2920 Re-cement or re-bond crown.
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.

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.

TYPE 2 PROCEDURES

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.

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).

TYPE 2 PROCEDURES

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).

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).

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.

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.

TYPE 2 PROCEDURES

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.

REMOVAL OF BONE TISSUE: D7471, D7472, D7473

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

TYPE 2 PROCEDURES

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.

PROFESSIONAL CONSULT/VISIT/SERVICES

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.

CONSULTATION: D9310

Coverage is limited to 1 of any of these procedures per provider.

OFFICE VISIT: D9430, D9440

Procedure D9430 is allowed for accidental injury only. Procedure D9440 will be allowed on the basis of services rendered or visit, whichever is greater.

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.

TYPE 3 PROCEDURES

PAYMENT BASIS - PARTICIPATING PROVIDERS - Maximum Allowable Charge

BENEFIT PERIOD - Benefit Year

For Additional Limitations - See Limitations

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.

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.

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.
D6980 Fixed partial denture repair necessitated by restorative material failure.
D9120 Fixed partial denture sectioning.

CROWN LENGTHENING
D4249 Clinical crown lengthening - hard tissue.

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.

ADD TOOTH/CLASP TO EXISTING PARTIAL

TYPE 3 PROCEDURES

D5650 Add tooth to existing partial denture.
D5660 Add clasp to existing partial denture-per tooth.

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

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

TYPE 3 PROCEDURES

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

TYPE 4 PROCEDURES

PAYMENT BASIS - PARTICIPATING PROVIDERS - Maximum Allowable Charge

BENEFIT PERIOD - Benefit Year

For Additional Limitations - See Limitations

NON-SURGICAL MISCELLANEOUS

D0160	Detailed and extensive oral evaluation - problem focused, by report.
D0320	Temporomandibular joint arthrogram, including injection.
D0321	Other temporomandibular joint radiographic images, by report.
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.

ORTHODONTIC EXPENSE BENEFITS

Orthodontic expense benefits will be determined according to the terms of the policy for orthodontic expenses incurred by an Insured.

DETERMINING BENEFITS. The benefits payable will be determined by totaling all of the Covered Expenses submitted. This amount is reduced by the Deductible, if any. The result is then multiplied by the Coinsurance Percentage shown in the Schedule of Benefits. Benefits are subject to the Maximum Amount shown in the Schedule of Benefits.

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 Benefit During Lifetime shown in the Schedule of Benefits is the maximum amount that may be paid for the Covered Expenses incurred by an Insured during his or her lifetime.

COVERED EXPENSES. Covered Expenses refer to the usual and customary charges made by a provider for necessary orthodontic treatment rendered while the person is insured under this section. Expenses are limited to the Maximum Amount shown in the Schedule of Benefits and Limitations. All benefits are subject to the definitions, limitations and exclusions and are payable only when we determine they are necessary for prevention, diagnosis, care or treatment of a covered condition and meet generally accepted dental protocols.

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.

ORTHODONTIC TREATMENT. Orthodontic Treatment refers to the movement of teeth by means of active appliances to correct the position of maloccluded or malpositioned teeth.

TREATMENT PROGRAM. Treatment Program ("Program") means an interdependent series of orthodontic services prescribed by a provider to correct a specific dental condition. A Program will start when the bands, brackets or appliances are placed. A Program will end when the services are done, or after eight calendar quarters starting with the day the appliances were inserted, whichever is earlier.

EXPENSES INCURRED. Benefits will be payable when a Covered Expense is incurred:

a. at the end of every quarter (three-month period) of a Program for an Insured who pursues a Program, but not beyond the date the Program ends; or

b. at the time the service is rendered for an Insured who incurs Covered Expenses but does not pursue a Program.

The Covered Expenses for a Program are based on the estimated cost of the Insured's Program. They are pro-rated by quarter (three-month periods) over the estimated length of the Program, up to a maximum of eight quarters. The last quarterly payment for a Program may be changed if the estimated and actual cost of the Program differ.

LIMITATIONS. Covered Expenses will not include and benefits will not be payable for expenses incurred:

1. for a Program begun before the Insured became covered under this section, unless the Insured was covered for Orthodontic Expense Benefits under the prior carrier on June 30, 2020 and are both:

   a. insured under this policy; and
   b. currently undergoing a Treatment Program on July 1, 2020.

2. in the first 12 months that a person is insured if the person is a Late Entrant.

3. in any quarter of a Program if the Insured was not covered under this section for the entire quarter.

4. if the Insured's insurance under this section terminates.

5. for which the Insured is entitled to benefits under any workmen’s compensation or similar law, or for charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.

6. for charges the Insured is not legally required to pay or would not have been made had no insurance been in force.

7. for services not required for necessary care and treatment or not within the generally accepted parameters of care.

8. because of war or any act of war, declared or not.

9. To replace lost, missing or stolen orthodontic appliances.

COORDINATION OF BENEFITS

This section applies if an Insured person has dental coverage under more than one Plan definition below. All benefits provided under this policy are subject to this section.

EFFECT ON BENEFITS. The Order of Benefit Determination rules below determine which Plan will pay as the primary Plan. If all or any part of an Allowable Expense under this Plan is an Allowable Expense under any other Plan, then benefits will be reduced so that, when they are added to benefits payable under any other Plan for the same service or supply, the total does not exceed 100% of the total Allowable Expense.

If another Plan is primary and this Plan is considered secondary, the amount by which benefits have been reduced during the Claim Determination Period will be used by us to pay the Allowable Expenses not otherwise paid which were incurred by you in the same Claim Determination Period. We will determine our obligation to pay for Allowable Expenses as each claim is submitted, based on all claims submitted in the current Claim Determination Period.

DEFINITIONS. The following apply only to this provision of the policy.

1. "Plan" refers to the group policy and any of the following plans, whether insured or uninsured, providing benefits for dental services or supplies:

    a. Any group or blanket insurance policy.

    b. Any group Blue Cross, group Blue Shield, or group prepayment arrangement.

    c. Any labor/management, trusteed plan, labor organization, employer organization, or employee organization plan, whether on an insured or uninsured basis.

    d. Any coverage under a governmental plan that allows coordination of benefits, or any coverage required or provided by law. This does not include a state plan under Medicaid (TitleXVIII and XIX of the Social Security Act as enacted or amended). It also does not include any plan whose benefits by law are excess to those of any private insurance program or other non-governmental program.

2. "Plan" does **not** include the following:

    a. Individual or family benefits provided through insurance contracts, subscriber contracts, coverage through individual HMOs or other prepayment arrangements.

    b. Coverages for school type accidents only, including athletic injuries.

3. "Allowable Expense" refers to any necessary, reasonable and customary item of expense at least a portion of which is covered under at least one of the Plans covering the Insured person for whom that claim is made. When a Plan provides services rather than cash payments, the reasonable cash value of each service will be both an Allowable Expense and a benefit paid. Benefits payable under another Plan include benefits that would have been payable had a claim been made for them.

4. "Claim Determination Period" refers to a Benefit Period, but does not include any time during which a person has no coverage under this Plan.

5. "Custodial Parent" refers to a parent awarded custody of a minor child by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than half of the calendar year without regard to any temporary visitation.

ORDER OF BENEFIT DETERMINATION. When two or more Plans pay benefits, the rules for determining the order of payment are as follows:

1. A Plan that does not have a coordination of benefits provision is always considered primary and will pay benefits first.

2. If a Plan also has a coordination of benefits provision, the first of the following rules that describe which Plan pays its benefits before another Plan is the rule to use:

    a. The benefits of a Plan that covers a person as an employee, member or subscriber are determined before those of a Plan that covers the person as a dependent.

    b. If a Dependent child is covered by more than one Plan, then the primary Plan is the Plan of the parent whose birthday is earlier in the year if:

        i. the parents are married;

        ii. the parents are not separated (whether or not they ever have been married); or

        iii. a court decree awards joint custody without specifying that one party has the responsibility to provide Dental coverage.

        If both parents have the same birthday, the Plan that covered either of the parents longer is primary.

    c. If the Dependent child is covered by divorced or separated parents under two or more Plans, benefits for that Dependent child will be determined in the following order:

        i. the Plan of the Custodial Parent;

        ii. the Plan of the spouse of the Custodial Parent;

        iii. the Plan of the non-Custodial Parent; and then

        iv. the Plan of the spouse of the non-Custodial Parent.

        However, if the specific terms of a court decree establish a parent's responsibility for the child's Dental expenses and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to Claim Determination Periods or Benefit Periods commencing after the Plan is given notice of the court decree.

    d. The benefits of a Plan that cover a person as an employee who is neither laid-off nor retired (or as that employee's dependent) are determined before those of a Plan that covers that person as a laid-off or retired employee (or as that employee's dependent). 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 will be ignored.

    e. If a person whose coverage is provided under a right of continuation provided by a federal or state law also is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. 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 will be ignored.

    f. The benefits of a Plan that has covered a person for a longer period will be determined first.

If the preceding rules do not determine the primary Plan, the allowable expenses shall be shared equally between the Plans meeting the definition of Plan under this provision. In addition, this Plan will not pay more than what it would have paid had it been primary.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION. We may without your consent and notice to you:

1. Release any information with respect to your coverage and benefits under the policy; and

2. Obtain from any other insurance company, organization or person any information with respect to your coverage and benefits under another Plan.

You must provide us with any information necessary to coordinate benefits.

FACILITY OF PAYMENT. When other Plans make payments that should have been made under this Plan according to the above terms, we will, at our discretion, pay to any organizations making these payments any amounts that we decide will satisfy the intent of the above terms. Amounts paid in this way will be benefits paid under this Plan. We will not be liable to the extent of these payments.

RIGHT OF RECOVERY. When we make payments for Allowable Expenses in excess of the amount that will satisfy the intent of the above terms, we will recover these payments, to the extent of the excess, from any persons or organizations to or for whom these payments were made. The amount of the payments made includes the reasonable cash value of any benefits provided in the form of services.

GENERAL PROVISIONS

NOTICE OF CLAIM. Written notice of a claim must be given to us within 90 days after the incurred date of the services provided for which benefits are payable.

Notice must be given to us at our Home Office, or to one of our agents. Notice should include the Policyholder's name, Insured's name, and policy number. If it was not reasonably possible to give written notice within the 90 day period stated above, we will not reduce or deny a claim for this reason if notice is filed as soon as is reasonably possible.

CLAIM FORMS. When we receive the notice of a claim, we will send the claimant forms for filing proof of loss. If these forms are not furnished within 15 days after the giving of such notice, the claimant will meet our proof of loss requirements by giving us a written statement of the nature and extent of loss within the time limit for filing proofs of loss.

PROOF OF LOSS. Written proof of loss must be given to us within 90 days after the incurred date of the services provided for which benefits are payable. If it is impossible to give written proof within the 90 day period, we will not reduce or deny a claim for this reason if the proof is filed as soon as is reasonably possible.

TIME OF PAYMENT. We will pay all benefits within 45 days of when we receive all information necessary to pay the claim. If a claim cannot be paid within 45 days of receipt, we will notify you within that 45-day period providing you with a list of information necessary for us to pay the claim. If payment is not made within the required time frame, we will pay interest at the rate of eighteen percent per year on benefits for valid claims. Interest will begin to accrue 45 days after we receive notice of the claim and will accrue until the claim is settled.

PAYMENT OF BENEFITS. Participating Providers have agreed to accept assignment of benefits for services and supplies performed or furnished by them. When a Non-Participating Provider performs services, all benefits will be paid to the Insured unless otherwise indicated by the Insured's authorization to pay the Non-Participating Provider directly.

FACILITY OF PAYMENT. If an Insured or beneficiary is not capable of giving us a valid receipt for any payment or if benefits are payable to the estate of the Insured, then we may, at our option, pay the benefit up to an amount not to exceed $1,000, to any relative by blood or connection by marriage of the Insured who is considered by us to be equitably entitled to the benefit.

Any equitable payment made in good faith will release us from liability to the extent of payment.

PROVIDER-PATIENT RELATIONSHIP. The Insured may choose any Provider who is licensed by the law of the state in which treatment is provided within the scope of their license. We will in no way disturb the provider-patient relationship.

LEGAL PROCEEDINGS. No legal action can be brought against us until 60 days after the Insured sends us the required proof of loss. No legal action against us can start more than five years after proof of loss is required.

INCONTESTABILITY. Any statement made by the Policyholder to obtain the Policy is a representation and not a warranty. No misrepresentation by the Policyholder will be used to deny a claim or to deny the validity of the Policy unless:

1. The Policy would not have been issued if we had known the truth; and

2. We have given the Policyholder a copy of a written instrument signed by the Policyholder that contains the misrepresentation.

The validity of the Policy will not be contested after it has been in force for one year, except for nonpayment of premiums or fraudulent misrepresentations.

WORKER'S COMPENSATION. The coverage provided under the Policy is not a substitute for coverage under a workmen's compensation or state disability income benefit law and does not relieve the Policyholder of any obligation to provide such coverage.

As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at 1-877-MA-ENROLL or visit the Connector website (www.mahealthconnector.org). This plan is not intended to provide comprehensive health care coverage and does not meet Minimum Creditable Coverage standards, even if it does include services that are not available in the insured's other health plans.

If you have questions about this notice, you may contact the Division of Insurance by calling (617) 521-7794 or visiting its website at www.mass.gov/doi.

ERISA INFORMATION AND NOTICE OF YOUR RIGHTS

A. General Plan Information

Name of Plan:	Dental Insurance
Name, Address of Plan Sponsor:	UAW/UMASS HEALTH & WELFARE TRUST FUND 6 UNIVERSITY DR STE 206-226 AMHERST, MA 01002
Plan Sponsor Tax Id Number:	04-3538613
Plan Number:	501
Type of Plan:	Group Insurance Plan
Name, Address, Phone Number of Plan Administrator:	LESLIE EDWARDS DAVIS UAW/UMASS HEALTH & WELFARE TRUST FUND 6 UNIVERSITY DR STE 206-226 AMHERST, MA 01002 413-345-2156
Name, Address of Registered Agent for Service of Legal Process:	Plan Sponsor
If Legal Process Involves Claims For Benefits Under The Group Policy, Additional Notification of Legal Process Must Be Sent To:	Ameritas Life Insurance Corp. P.O. Box 82595 Lincoln, NE 68501
Sources of Contributions:	Employer/Member
Funding Method:	Ameritas Life Insurance Corp.--Fully Insured
Plan Fiscal Year End:	September 30
Type of Administration:	
General Administration	Plan Sponsor
Contract & Claim Administration	Ameritas Life Insurance Corp.

B. Notice of Legal Process

Service of legal process may be made upon the plan administrator at the address listed above.

C. Eligibility and Benefits Provided Under the Group Policy

Please refer to the **Conditions for Insurance** within the Group Policy and Certificate of Coverage for a detailed description of the eligibility for participation under the plan as well as the benefits provided. If this plan includes a participating provider (PPO) option, provider lists are furnished without charge, as a separate document.

If you have any questions about your benefits or concerns about our services related to this Group Policy, you may call Customer Service Toll Free at 1-800-487-5553.

D. Qualified Medical Child Support Order ("QMCSO")

QMCSO Determinations. A Plan participant or beneficiary can obtain, without charge, a copy of the Plan's procedures governing Qualified Medical Child Support Order determinations from the Plan Administrator.

E. Termination Of The Group Policy

The Group Policy which provides benefits for this plan may be terminated by the Policyholder at any time with prior written notice to Ameritas Life Insurance Corp. It will terminate automatically if the Policyholder fails to pay the required premium. Ameritas Life Insurance Corp. may terminate the Group Policy on any Premium Due Date if the number of persons insured is less than the required minimum, or if Ameritas Life Insurance Corp. believes the Policyholder has failed to perform its obligations relating to the Group Policy.

After the first policy year, Ameritas Life Insurance Corp. may also terminate the Group Policy on any Premium Due Date for any reason by providing a 60-day advance written notice to the Policyholder.

The Group Policy may be changed in whole or in part. No change or amendment will be valid unless it is approved in writing by a Ameritas Life Insurance Corp. executive officer.

F. Claims For Benefits

Claims procedures are furnished automatically, without charge, as a separate document.

G. Continuation of Coverage Provisions (COBRA)

COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) gives Qualified Beneficiaries the right to elect COBRA continuation after insurance ends because of a Qualifying Event. The law generally covers group health plans maintained by employers with 20 or more employees in the prior year. The law does not, however, apply to plans sponsored by the Federal government and certain church-related organizations.

i. Definitions For This Section

Qualified Beneficiary means an Insured Person who is covered by the plan on the day before a qualifying event. Any child born to or placed for adoption with a covered employee during the period of COBRA coverage is considered a qualified beneficiary.

A Qualifying Event occurs when:

1. The Member dies (hereinafter referred to as Qualifying Event 1);
2. The Member's employment terminates for reasons other than gross misconduct as determined by the Employer (hereinafter referred to as Qualifying Event 2);
3. The Member's work hours fall below the minimum number required to be a Member (hereinafter referred to as Qualifying Event 3);
4. The Member becomes divorced or legally separated from a Spouse (hereinafter referred to as Qualifying Event 4);
5. The Member becomes entitled to receive Medicare benefits under Title XVII of the Social Security Act (hereinafter referred to as Qualifying Event 5);
6. The Child of a Member ceases to be a Dependent (hereinafter referred to as Qualifying Event 6);

7. The Employer files a petition for reorganization under Title 11 of the U.S. Bankruptcy Code, provided the Member is retired from the Employer and is insured on the date the petition is filed (hereinafter referred to as Qualifying Event 7).

ii. Electing COBRA Continuation

A. Each Qualified Beneficiary has the right to elect to continue coverage that was in effect on the day before the Qualifying Event. The Qualified Beneficiary must apply in writing within 60 days of the later of:

1. The date on which Insurance would otherwise end; and

2. The date on which the Employer or Plan Administrator gave the Qualified Beneficiary notice of the right to COBRA continuation.

B. A Qualified Beneficiary who does not elect COBRA Continuation coverage during their original election period may be entitled to a second election period if the following requirements are satisfied:

1. The Member's Insurance ended because of a trade related termination of their employment, which resulted in being certified eligible for trade adjustment assistance;

2. The Member is certified eligible for trade adjustment assistance (as determined by the appropriate governmental agency) within 6 months of the date Insurance ended due to the trade related termination of their employment; and

3. The Qualified Beneficiary must apply in writing within 60 days after the first day of the month in which they are certified eligible for trade adjustment assistance.

iii. Notice Requirements

1. When the Member becomes insured, the Plan Administrator must inform the Member and Spouse in writing of the right to COBRA continuation.

2. The Qualified Beneficiary must notify the Plan Administrator in writing of Qualifying Event 4 or 6 above within 60 days of the later of:

a. The date of the Qualifying Event; or

b. The date the Qualified Beneficiary loses coverage due to the Qualifying Event.

3. A Qualified Beneficiary, who is entitled to COBRA continuation due to the occurrence of Qualifying Event 2 or 3 and who is disabled at any time during the first 60 days of continuation coverage as determined by the Social Security Administration pursuant to Title II or XVI of the Social Security Act, must notify the Plan Administrator of the disability in writing within 60 days of the later of:

a. The date of the disability determination;

b. The date of the Qualifying Event; or

c. The date on which the Qualified Beneficiary loses coverage due to the Qualifying Event.

4. Each Qualified Beneficiary who has become entitled to COBRA continuation with a maximum duration of 18 or 29 months must notify the Plan Administrator of the occurrence of a second Qualifying Event within 60 days of the later of:

   a. The date of the Qualifying Event; or

   b. The date the Qualified Beneficiary loses coverage due to the Qualifying Event.

5. The Employer must give the Plan Administrator written notice within 30 days of the occurrence of Qualifying Event 1, 2, 3, 5, or 7.

6. Within 14 days of receipt of the Employer's notice, the Plan Administrator must notify each Qualified Beneficiary in writing of the right to elect COBRA continuation.

In order to protect your rights, Members and Qualified Beneficiaries should inform the Plan Administrator in writing of any change of address.

iv. COBRA Continuation Period

1. 18-month COBRA Continuation

   Each Qualified Beneficiary may continue Insurance for up to 18 months after the date of Qualifying Event 2 or 3.

2. 29-month COBRA Continuation

   Each Qualified Beneficiary, who is entitled to COBRA continuation due to the occurrence of Qualifying Event 2 or 3 and who is disabled at any time during the first 60 days of continuation coverage as determined by the Social Security Administration pursuant to Title II or XVI of the Social Security Act, may continue coverage for up to 29 months after the date of the Qualifying Event. All Insured Persons in the Qualified Beneficiary's family may also continue coverage for up to 29 months.

3. 36-Month COBRA Continuation

   If you are a Dependent, you may continue Coverage for up to 36 months after the date of Qualifying Event 1, 4, 5, or 6. Each Qualified Beneficiary who is entitled to continue Insurance for 18 or 29 months may be eligible to continue coverage for up to 36 months after the date of their original Qualifying Event if a second Qualifying Event occurs while they are on continuation coverage.

Note: The total period of COBRA continuation available in 1 through 3 will not exceed 36 months.

4. COBRA Continuation For Certain Bankruptcy Proceedings

   If the Qualifying Event is 7, the COBRA continuation period for a retiree or retiree's Spouse is the lifetime of the retiree. Upon the retiree's death, the COBRA continuation period for the surviving Dependents is 36 months from the date of the retiree's death.

v. Premium Requirements

Insurance continued under this provision will be retroactive to the date insurance would have ended because of a Qualifying Event. The Qualified Beneficiary must pay the initial required premium not later than 45 days after electing COBRA continuation, and monthly premium on or before the Premium Due Date thereafter. The monthly premium is a percentage of the total premium (both the portion paid by the employee and any portion paid by the employer) currently in effect on each Premium Due Date. The premium rate may change after you cease to be Actively at Work. The percentage is as follows:

18 month continuation - 102%

29 month continuation - 102% during the first 18 months, 150% during the next 11 months

36 month continuation - 102%

vi. When COBRA Continuation Ends

COBRA continuation ends on the earliest of:

1. The date the Group Policy terminates;

2. 31 days after the date the last period ends for which a required premium payment was made;

3. The last day of the COBRA continuation period.

4. The date the Qualified Beneficiary first becomes entitled to Medicare coverage under Title XVII of the Social Security Act;

5. The first date on which the Qualified Beneficiary is: (a) covered under another group Dental policy and (b) not subject to any preexisting condition limitation in that policy.

H. Your Rights under ERISA

As a participant in this Plan, you are entitled to certain rights and protections under the Employment Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits
Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work-sites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to operate and administer this plan prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Rights

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling those publications hotline of the Employee Benefits Security Administration

CLAIMS REVIEW PROCEDURES
AS REQUIRED UNDER
EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

The following provides information regarding the claims review process and your rights to request a review of any part of a claim that is denied. Please note that certain state laws may also require specified claims payment procedures as well as internal appeal procedures and/or independent external review processes. Therefore, in addition to the review procedures defined below, you may also have additional rights provided to you under state law. If your state has specific grievance procedures, an additional notice specific to your state will also be included within the group policy and your certificate.

CLAIMS FOR BENEFITS

Claims may be submitted by mailing the completed claim form along with any requested information to:

Ameritas Life Insurance Corp.
PO Box 82520
Lincoln, NE 68501

NOTICE OF DECISION OF CLAIM

We will evaluate your claim promptly after we receive it.

Dental Utilization Review Program. Generally, utilization review means a set of criteria designed to monitor the use of, or evaluate the medical necessity, appropriateness, or efficiency of health care services. We have established a utilization review program to ensure that any guidelines and criteria used to evaluate the medical necessity of a health care service are clearly documented and include procedures for applying such criteria based on the needs of the individual patients. The program was developed in conjunction with licensed dentists and is reviewed at least annually to ensure that criteria are applied consistently and are current with dental technology, evidence-based research and any dental trends.

We will provide you written notice regarding the payment under the claim within 30 calendar days following receipt of the claim. This period may be extended for an additional 15 days, provided that we have determined that an extension is necessary due to matters beyond our control, and notify you, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which we expect to render a decision. If the extension is due to your failure to provide information necessary to decide the claim, the notice of extension shall specifically describe the required information we need to decide the claim.

If we request additional information, you will have 45 days to provide the information. If you do not provide the requested information within 45 days, we may decide your claim based on the information we have received.

If we deny any part of your claim, you will receive a written notice of denial containing:

a. The reasons for our decision.
b. Reference to the parts of the Group Policy on which our decision is based.
c. Reference to any internal rule or guideline relied upon in making our decision, along with your right to receive a copy of these guidelines, free of charge, upon request.
d. A statement that you may request an explanation of the scientific or clinical judgment we relied upon to exclude expenses that are experimental or investigational, or are not necessary or accepted according to generally accepted standards of Dental practice.
e. A description of any additional information needed to support your claim and why such information is necessary.
f. Information concerning your right to a review of our decision.
g. Information concerning your right to bring a civil action for benefits under section 502(a) of ERISA following an adverse benefit determination on review.

APPEAL PROCEDURE

If all or part of a claim is denied, you may request a review in writing within 180 days after receiving notice of the benefit denial.

You may send us written comments or other items to support your claim. You may review and receive copies of any non-privileged information that is relevant to your appeal. There will be no charge for such copies. You may request the names of the experts we consulted who provided advice to us about your claim.

The appeal review will be conducted by the Plan's named fiduciary and will be someone other than the person who denied the initial claim and will not be subordinate to that person. The person conducting the review will not give deference to the initial denial decision. If the denial was based in whole or in part on a medical judgment, including determinations with regard to whether a service was considered experimental, investigational, and/or not medically necessary, the person conducting the review will consult with a qualified health care professional. This health care professional will be someone other than the person who made the original judgment and will not be subordinate to that person. Our review will include any written comments or other items you submit to support your claim.

We will review your claim promptly after we receive your request.

If your appeal is about urgent care, you may call Toll Free at 877-897-4328, and an Expedited Review will be conducted. Verbal notification of our decision will be made within 72 hours, followed by written notice within 3 calendar days after that.

If your appeal is about benefit decisions related to clinical or medical necessity, a Standard Consultant Review will be conducted. A written decision will be provided within 30 calendar days of the receipt of the request for appeal.

If your appeal is about benefit decisions related to coverage, a Standard Administrative Review will be conducted. A written decision will be provided within 60 calendar days of the receipt of the request for appeal.

If we deny any part of your claim on review, you will receive a written notice of denial containing:

a. The reasons for our decision.
b. Reference to the parts of the Group Policy on which our decision is based.
c. Reference to any internal rule or guideline relied upon in making our decision along with your right to receive a copy of these guidelines, free of charge, upon request.
d. Information concerning your right to receive, free of charge, copies of non-privileged documents and records relevant to your claim.
e. A statement that you may request an explanation of the scientific or clinical judgment we relied upon to exclude expenses that are experimental or investigational, or are not necessary or accepted according to generally accepted standards of Dental practice.
f. Information concerning your right to bring a civil action for benefits under section 502(a) of ERISA.

Certain state laws also require specified internal appeal procedures and/or external review processes. In addition to the review procedures defined above, you may also have additional rights provided to you under state law. Please review your certificate for such information, call us, or contact your state insurance regulatory agency for assistance. In any event, you need not exhaust such state law procedures prior to bringing civil action under Section 502(a) of ERISA.

Any request for appeal should be directed to:

Quality Control, P.O. Box 82657, Lincoln, NE 68501-2657.

Your Information. Your Rights. Our Responsibilities.

THIS NOTICE OF PRIVACY PRACTICES ("NOTICE") DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice describes how the Group Divisions of Ameritas Life Insurance Corp. and Ameritas Life Insurance Corp. of New York use and disclose your protected health information, and how we guard that information. We are required to abide by the terms of this notice as long as it remains in effect. We reserve the right to change the terms of this Notice as necessary, and to make a new Notice effective for all protected health information maintained by us. If we do make changes to this Notice, a copy of the new Notice will be placed on our web site at www.ameritas.com and/or sent to you if the changes are material. If you reside in a state whose law provides stricter privacy protections than those provided by HIPAA, we will maintain the privacy of your health information as required by your stricter state law.

how we use or disclose information

We must use and disclose your health information to provide that information:

- To you, or someone who has the legal right to act for you (your personal representative), in order to administer your rights as described in this notice; and
- To the Secretary of the Department of Health and Human Services, if necessary, to see that we are complying with federal privacy law and administrative simplification provisions of HIPAA.

We have the right to use and disclose your health information for your treatment, to pay for your health care, and to operate our business. For example, we typically use your information in the following ways:

- **For Payment.** We may use or disclose health information to collect premiums due to us, to determine your coverage, or to process claims for health care services you receive. For example, we may tell a provider whether you are eligible for coverage and what percentage of the bill may be covered.
- **For Treatment.** We may use or disclose health information to aid in your treatment or the coordination of your care. For example, we may disclose information to your provider to help them provide health care services to you.
- **For Health Care Operations.** We may use or disclose health information as necessary to operate and manage our business activities related to providing and managing your health care coverage. For example, we may use health information for operational activities such as quality assessment and improvement.
- **For Plan Sponsors.** If your coverage is through an employer sponsored group health plan, we may share summary health information and enrollment and disenrollment information with the plan sponsor. In addition, we may share other health information with the plan sponsor for plan administration purposes if the plan sponsor agrees to special restrictions on the use and disclosure of the information in accordance with federal law.

We may use or disclose your health information for the following purposes under limited circumstances:

- **As Required by Law.** We may disclose information about you if state or federal laws require it.
- **To Persons Involved With Your Care.** We may use or disclose your health information a person involved in your care or who helps you pay for your care, such as a family member or close personal friend, when you are incapacitated, emergency situations, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object, we will use our best judgment to decide if the disclosure is in your best interests.
- **To Law Enforcement.** We may disclose your health information to a law enforcement official to provide limited information to locate a missing person or report a crime.
- **To Correctional Institutions or Law Enforcement Officials.** We may disclose your health information if you are an inmate of a correctional institution or under the custody of law enforcement, but only if necessary for the institution to provide you with health care; to protect your health and safety, or the health and safety of others; or for the safety and security of the correctional institution.
- **To Avoid a Serious Threat to Health or Safety** to you, another person, or the public. For example, we may disclose information to a public health agency or law enforcement in the event of a natural disaster.
- **For Public Health Activities** such as reporting disease outbreaks to a valid public health authority.
- **For Reporting Victims of Abuse, Neglect, or Domestic Violence** to government authorities that are authorized by law to receive such information, including a social services or protective service agencies.
- **For Health Oversight Activities** to a health oversight agency for activities authorized by law, such as licensure, governmental audits, and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings** to respond to a court order, search warrant, or subpoena.
- **For Specialized Government Functions** such as national security and intelligence activities, the protective services for the President and others, or if you are a member of the military, as required by the armed forces.
- **To Business Associates** that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates are required, under contract with us and federal law, to protect the privacy of your information and are not allowed to use or disclose any information other than allowed by the contract and federal law.
- **For Workers' Compensation** as authorized by, or to the extent necessary to comply with, state workers' compensation laws that govern job-related injuries or illness.

- **To Provide Information Regarding Decedents.** We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties.
- **For Cadaveric Organ, Eye, or Tissue Donation.** We may disclose information to entities that handle procurement, banking, or transplantation of organs, eyes, or tissue to facilitate donation and transplantation.

Except for uses and disclosures described and limited as explained in this notice, we will use and disclose your health information only with written permission from you. We will not share your personal information for marketing purposes or sell your personal information unless you give us written permission to do so.

our responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this Notice, and give you a copy of it.
- We will not use or share your information other than as described in this Notice, unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing at the contact information below if you change your mind.

your rights

- **Right to Inspect and Copy.** You have the right to inspect and copy certain protected health information that may be used to make decisions about your plan benefits. Your request must be in writing and submitted to the Ameritas Privacy Office at the contact information below. We will usually provide access to your protected health information within 30 days of receiving the request. We reserve the right to charge a fee for the costs of copying, mailing, or other supplies associated with your request. You may also ask your providers for access to your records. We may deny your request in very limited circumstances. If we deny your request to inspect or obtain a copy of your protected health information, we will inform you in writing of the reason(s) within 30 days.
- **Right to Amend.** You have the right to request that we amend, correct, or delete your protected health information in our records if you believe that it is inaccurate or incomplete. Your request must be in writing and sent to the Ameritas Privacy Office at the contact information below. In addition, you must provide a reason that supports your request. We will respond to your request in writing within 30 days. We may deny your request for an amendment if it is not in writing, or does not include a reason to support the request. If we deny your request, we will communicate the reason(s) for denial. If we deny your request, you have the right to file a written statement of disagreement and any future disclosures of the disputed information will include your statement.
- **Right to Request Confidential Communication.** You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. Your request must be in writing and submitted to the Ameritas Privacy Office at the contact information below. We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.
- **Right to an Accounting of Disclosures of Your Protected Health Information.** You have the right to receive a list of the times we've shared your health information for up to six years prior to the date you ask, who we share it with, and why. Your request must be in writing and submitted to the Ameritas Privacy Office at the contact information below. We will include all the disclosures, except those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We will provide one accounting a year for free, but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
- **Know the Reasons for an Unfavorable Underwriting Decision.** You have the right to know the reason(s) for an unfavorable underwriting decision. Your request must be in writing, and must be asked for within 90 days from when the adverse underwriting decision is sent. We will respond within 21 days. Previous unfavorable underwriting decisions may not be used as a basis for future underwriting decisions unless we make an independent evaluation of basic facts. Your genetic information cannot be used for underwriting purposes.
- **Ask Us to Limit the Information We Share.** You can send us a written request at the contact information below to not use or share certain health information for treatment, payment, or health care operations. We are not required to agree to these requests.
- **Get a Copy of this Privacy Notice.** You can ask us for a paper copy of this Notice at any time, even if you have agreed to receive the Notice electronically. We will provide you with a paper copy promptly.

exercising your rights

- Submitting a Written Request. If you have any questions about this Notice, want more information about exercising your rights, or want to obtain an authorization form please contact us at: The Privacy Office, Attn. HIPAA Privacy, P.O. Box 82520, Lincoln, NE 68501-2520, e-mail us at privacy@ameritas.com, or call 1-800-487-5553
- Filing a Complaint. If you believe your privacy rights have been violated, you may file a complaint with us at the contact information listed above. You may also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C., 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

This revised notice is effective 9/30/17.

Ameritas

Ameritas Life Insurance Corp.

A STOCK COMPANY
LINCOLN, NEBRASKA

CERTIFICATE
GROUP EYE CARE INSURANCE

The Policyholder **UAW/UMASS HEALTH & WELFARE TRUST FUND**

Policy Number **10-53791** **Insured Person**

Plan Effective Date **July 1, 2020** **Certificate Effective Date**
Refer to Exceptions on 9070

Plan Change Effective Date **September 1, 2020**

Class Number 1

Ameritas Life Insurance Corp. certifies that you will be insured for the benefits described on the following pages, according to all the terms of the group policy numbered above which has been issued to the Policyholder.

Possession of this certificate does not necessarily mean you are insured. You are insured only if you meet the requirements set out in this certificate.

The group policy may be amended or cancelled without the consent of the insured person.

The group policy and this certificate are governed by the laws of the state in which the group policy was delivered.

This plan does not include pre-existing condition limitations or exclusions.

President

Massachusetts Notice of Inquiry and Grievance Procedures

Quality Control
P.O. Box 82657
Lincoln, NE 68501-2657
877-897-4328 (Toll-Free) 402-309-2579 (FAX)

Please read this notice carefully. This notice contains important information about how to make inquiries and/or file grievances with your insurer. Also, you always have the right to contact the Massachusetts Division of Insurance if you have a question or concern regarding your coverage under this contract. The Massachusetts Division of Insurance may be contacted through their Consumer Hotline at 1-617-521-7794.

I. Definitions

"Grievance" means any written complaint submitted to the insurer by or on behalf of an insured person concerning any aspect or action of the insurer, including, but not limited to, review of adverse determinations regarding scope of coverage, denial of services and administrative operations.

"Adverse Determination" means a determination by a carrier to deny, reduce, or modify the availability of any health care services, for failure to meet the requirements for coverage based on medical necessity, appropriateness, level of care or effectiveness.

II. Internal Grievance Process

1. Filing a Grievance

You may file a grievance by phone, in person, by mail, or by electronic means. We will provide you or your authorized representative, if any, a written resolution of a grievance within thirty (30) business days of receipt of the oral or written grievance.

2. Written Decision

In the case of a grievance which involves an adverse determination, our written response shall include a substantive clinical justification that is consistent with generally accepted principles of professional dental and/or vision practice philosophy and will also include:

1. An identification of the specific information upon which the adverse determination was based;
2. Discuss the insured's presenting symptoms or condition, diagnosis and treatment interventions and the specific reasons such medical evidence fails to meet the relevant medical review criteria; and
3. Reference and include applicable clinical practice guidelines and review criteria.

3. Reconsideration

We will always provide the opportunity to reconsider a final decision where relevant information was received too late to review within the thirty (30) business day time limit or was not received but expected to become available within a reasonable time period.

We will review a reconsideration and provide our written response as soon as possible following receipt of the additional information but we agree to provide such response no later than thirty (30) business days following your request for reconsideration.

You always have the right to contact the Department of Insurance:

Division of Insurance
1000 Washington St., Ste 810
Boston, MA 02118-6200
(617) 521-7794
(877) 563-4467

Massachusetts Health Policy Commission – Office of Patient Protection
50 Milk Street, 8th Floor
Boston, MA 02109
(800) 436-7757

Upon request, interpreter and translation services related to administrative procedures are available.

متوفر تحت الطلب خدمات ترجمة، كتابية وشفهية، تختص بالإجراءات الإدارية.

ដែលអាចស្នើសុំ សេវាអ្នកបកប្រែភាសា និងបកប្រែអក្សរ ទាក់ទងនឹងនីតិវិធីរដ្ឋបាល មានផ្តល់ជូន

若您提出要求，我們可以提供與行政程序有關的語言翻譯服務。

Sur demande, des services d'interprétation et
de traduction concernant les procédures administratives sont
disponibles.

Κατόπιν αίτησης διαθέτονται ερμηνευτικές και μεταφραστικές
υπηρεσίες για διαχειριστικές υποθέσεις.

Sévis entépret ak tradiksyon ki ginyin rapo ak fonksyônman
administrasyon an, la pou ou depi ou mande-l.

A richeste, servizi di intepretazione e traduzione rigardo a procedura
aministrativi sono disponibile.

ເມື່ອໄດ້ມີການຮ້ອງຂໍ, ຈະມີບໍລິການບາຍພາສາແລະແປພາສາໄວ້ສຳຫລັບເລື່ອງຕ່າງໆ ທີ່ກ່ຽວຂ້ອງກັບ
ກະບວນການຕ່າງ ໆ ທາງດ້ານການບໍລິຫານ.

Sob requerimento, disponibilizamos serviços de interpretação e
traduçao relacionados a procedimentos administrativos.

По заявкам предлагаются услуги по переводу, связанному с
административными порядками.

A pedido, están disponibles servicios de interpretación y
traducción relacionados a procedimientos administrativos.

NOTICE

1) You can access your specific evidence of coverage and any amendments by visiting our on-line portal[1] located at ameritas.com

Information that can be accessed at this location includes:

Benefit Summary – A highlight of the benefit information for the plan you've purchased.

Certificate of Coverage – A document that can be viewed or printed showing all parameters of your plans benefit information.

ID Card – This item may be presented at the provider's office to identify you as an Ameritas member

Resource Center – Access valuable information such as the glossary of terms, frequently asked questions and how to nominate a dentist or specialist.

2) You have the right to receive, free of charge, a paper copy of evidences of coverage and any amendments thereto at any time.

3) For questions regarding your plan, or to request a paper copy of your Policy at no charge to you, please call 1-800-487-5553.

[1]Creation of a user name and password required.

THIS DISCOUNT ACCESS IS NOT INSURANCE

Non-Insurance Products/Services

From time to time we may arrange, at no additional cost to you or your group, for third-party service providers to provide you access to discounted goods and/or services, such as purchase of pharmacy prescriptions and eye wear. These discounted goods or services are not insurance. While we have arranged these discounts, we are not responsible for delivery, failure or negligence issues associated with these goods and services. The third-party service providers would be liable.

These non-insurance goods and services will discontinue upon termination of your insurance or the termination of our arrangements with the providers, whichever comes first.

If you are traveling outside the United States and require emergency care for a service that would be covered under this Policy, you may contact AXA Assistance USA, Inc. for an appointment with a qualified provider. Such services would be considered as an out-of-network claim.

Pharmacy prescriptions are subject to a discount at CVS, Walgreens, Rite Aid and Walmart pharmacies. Access your prescription discount ID card by logging into your secure member account.

If you have received an identification card describing Walmart EyeWear Savings, you are eligible for discounts of up to 15% on frames and lenses at participating Walmart Vision Centers. You must bring a current prescription from any vision care provider.

TABLE OF CONTENTS

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

EYE CARE EXPENSE BENEFITS

Deductible Amount:	$0
Maximum Amount - Each Benefit Period	$150*

Please refer to the EYE CARE EXPENSE BENEFITS page for details regarding frequency, limitations, and exclusions.

COMBINED EXPENSE BENEFITS

*Combined Dental and Eye Care Maximum - Each Benefit Period	$2,250

The maximums listed with the (*) above are subject to the maximum amount listed here.

DEFINITIONS

COMPANY refers to Ameritas Life Insurance Corp. The words "we", "us" and "our" refer to Company. Our Home Office address is 5900 "O" Street, Lincoln, Nebraska 68510.

POLICYHOLDER refers to the Policyholder stated on the face page of the policy.

INSURED refers to a person:

a. who is a Member of the eligible class; and

b. who has qualified for insurance by completing the eligibility period, if any; and

c. for whom the insurance has become effective.

DOMESTIC PARTNER: Refers to two unrelated individuals who share the necessities of life, live together, and have an emotional and financial commitment to one another, similar to that of a spouse.

CHILD. Child refers to the child of the Insured , a child of the Insured's spouse or a child of the Insured's Domestic Partner, if they otherwise meet the definition of Dependent.

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.

PROVIDER refers to any person who is licensed by the law of the state in which treatment is provided within the scope of the license.

LATE ENTRANT refers to any person:

a. whose Effective Date of insurance is more than 31 days from the date the person becomes eligible for insurance; or

b. who has elected to become insured again after canceling a premium contribution agreement.

PLAN EFFECTIVE DATE refers to the date coverage under the policy becomes effective. The Plan Effective Date for the Policyholder is shown on the policy cover. The effective date of coverage for an Insured is shown in the Policyholder's records.

All insurance will begin at 12:01 A.M. on the Effective Date. It will end after 11:59 P.M. on the Termination Date. All times are stated as Standard Time of the residence of the Insured.

PLAN CHANGE EFFECTIVE DATE refers to the date that the policy provisions originally issued to the Policyholder change as requested by the Policyholder. The Plan Change Effective date for the Policyholder will be shown on the policy cover, if the Policyholder has requested a change. The plan change effective date for an Insured is shown in the Policyholder's records or on the cover of the certificate.

BENEFIT PERIOD
Benefit Period means the period from January 1 of any year through December 31 of the same year. But during the first year a person is insured, a benefit period means the period from his or her effective date through December 31 of that year.

CONDITIONS FOR INSURANCE COVERAGE

ELIGIBILITY

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 post doctoral researcher working at least 20 hours per week. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

ELIGIBLE CLASS FOR DEPENDENT INSURANCE. Each Member of the eligible class(es) for dependent coverage is eligible for the Dependent Insurance under the policy and will qualify for this Dependent Insurance on the latest of:

1. the day he or she qualifies for coverage as a Member;

2. the day he or she first becomes a Member; or

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

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

If employment is the basis for membership, a member of the Eligible Class for Dependent Insurance is any post doctoral researcher 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.

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."

NOTICE REQUIREMENTS. If an Insured's coverage terminates due to non-payment of premiums, then each Insured will be provided a notice of such termination. The notice will be mailed to the last known address of the Insured. Any claims for services will be paid in accordance with the terms of the contract for any health care service received by the Insured prior to the date of notification.

CONTINUATION OF 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.

Notice

We are required to send notice of name, address and policy numbers of persons electing this continuation to the Massachusetts Department of Public Welfare. We must send the notice within 30 days of the date continuation coverage starts.

EYE CARE INSURANCE

If an Insured under this section incurs Covered Expenses, we will pay benefits as stated below.

COVERED EXPENSES. Covered Expenses include the charge for the covered procedure furnished up to the maximum amount.

COVERED EXPENSES. Covered Expenses means the Eye Care expenses incurred by an Insured for the procedures shown in the Schedule of Eye Care Services, up to the Maximum Covered Expense shown for each procedure and the Eye Care Maximum as shown in the Schedule of Benefits, if applicable. Such expenses will be Covered Expenses only to the extent that they are incurred for procedures done by a physician, optometrist, or optician. These expenses are subject to the "Limitations" below.

DEDUCTIBLE AMOUNT. The Deductible Amount shown in the Schedule of Benefits is an amount of Covered Expenses for which no benefits are payable. It applies separately to the Covered Expenses incurred by each Insured. Benefits will be paid only for those Covered Expenses that are over the deductible amount.

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.

EXPENSES INCURRED. An expense is incurred at the time a service is rendered or a supply furnished.

EXTENSION OF BENEFITS. Should an Insured's coverage under this section terminate, we will pay Covered Expenses for frames or lenses which were ordered while coverage was in force, provided such frames or lenses are delivered within 30 days from the date the Insured's coverage ceases.

LIMITATIONS: Covered Expenses will not include and no benefits will be payable for expenses incurred for:

1. vision examinations.
2. frames or lenses ordered before the Insured was covered under this section.
3. subject to Extension of Benefits, frame or lens ordered after the Insured's coverage under this section ceases.
4. sub-normal vision aids; orthoptic or vision training or any associated testing.
5. non-prescription lenses.
6. replacement or repair of lost or broken lenses or frames except at normal intervals.
7. any corrective eyewear required by an employer as a condition of employment.
8. medical or surgical treatment of the eyes.
9. any service or supply not shown on the Schedule of Eye Care Services.
10. coated lenses; oversize lenses (exceeding 71 mm); photo-gray lenses; polished edges; UV-400 coating and facets, and tints other than solid.

SCHEDULE OF EYE CARE SERVICES

The following is a complete list of eye care services for which benefits are payable. No benefits are payable for a service which is not listed.

SERVICE	MAXIMUM COVERED EXPENSE
Maximum Amount -- Each Benefit Period	$150*

The Maximum Amount is the most the plan will provide for all services subject to any plan frequencies, limitations, and/or deductible.

Materials

Frame

Lenses

- Single Vision
- Bifocal
- Trifocal
- No line bifocal or progressive power
- Lenticular
- Contact Lenses

GENERAL PROVISIONS

NOTICE OF CLAIM. Written notice of a claim must be given to us within 90 days after the incurred date of the services provided for which benefits are payable.

Notice must be given to us at our Home Office, or to one of our agents. Notice should include the Policyholder's name, Insured's name, and policy number. If it was not reasonably possible to give written notice within the 90 day period stated above, we will not reduce or deny a claim for this reason if notice is filed as soon as is reasonably possible.

CLAIM FORMS. When we receive the notice of a claim, we will send the claimant forms for filing proof of loss. If these forms are not furnished within 15 days after the giving of such notice, the claimant will meet our proof of loss requirements by giving us a written statement of the nature and extent of loss within the time limit for filing proofs of loss.

PROOF OF LOSS. Written proof of loss must be given to us within 90 days after the incurred date of the services provided for which benefits are payable. If it is impossible to give written proof within the 90 day period, we will not reduce or deny a claim for this reason if the proof is filed as soon as is reasonably possible.

TIME OF PAYMENT. We will pay all benefits within 45 days of when we receive all information necessary to pay the claim. If a claim cannot be paid within 45 days of receipt, we will notify you within that 45-day period providing you with a list of information necessary for us to pay the claim. If payment is not made within the required time frame, we will pay interest at the rate of eighteen percent per year on benefits for valid claims. Interest will begin to accrue 45 days after we receive notice of the claim and will accrue until the claim is settled.

PAYMENT OF BENEFITS. Participating Providers have agreed to accept assignment of benefits for services and supplies performed or furnished by them. When a Non-Participating Provider performs services, all benefits will be paid to the Insured unless otherwise indicated by the Insured's authorization to pay the Non-Participating Provider directly.

FACILITY OF PAYMENT. If an Insured or beneficiary is not capable of giving us a valid receipt for any payment or if benefits are payable to the estate of the Insured, then we may, at our option, pay the benefit up to an amount not to exceed $1,000, to any relative by blood or connection by marriage of the Insured who is considered by us to be equitably entitled to the benefit.

Any equitable payment made in good faith will release us from liability to the extent of payment.

PROVIDER-PATIENT RELATIONSHIP. The Insured may choose any Provider who is licensed by the law of the state in which treatment is provided within the scope of their license. We will in no way disturb the provider-patient relationship.

LEGAL PROCEEDINGS. No legal action can be brought against us until 60 days after the Insured sends us the required proof of loss. No legal action against us can start more than five years after proof of loss is required.

INCONTESTABILITY. Any statement made by the Policyholder to obtain the Policy is a representation and not a warranty. No misrepresentation by the Policyholder will be used to deny a claim or to deny the validity of the Policy unless:

1. The Policy would not have been issued if we had known the truth; and

2. We have given the Policyholder a copy of a written instrument signed by the Policyholder that contains the misrepresentation.

The validity of the Policy will not be contested after it has been in force for one year, except for nonpayment of premiums or fraudulent misrepresentations.

WORKER'S COMPENSATION. The coverage provided under the Policy is not a substitute for coverage under a workmen's compensation or state disability income benefit law and does not relieve the Policyholder of any obligation to provide such coverage.

As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at 1-877-MA-ENROLL or visit the Connector website (www.mahealthconnector.org). This plan is not intended to provide comprehensive health care coverage and does not meet Minimum Creditable Coverage standards, even if it does include services that are not available in the insured's other health plans.

If you have questions about this notice, you may contact the Division of Insurance by calling (617) 521-7794 or visiting its website at www.mass.gov/doi.

ERISA INFORMATION AND NOTICE OF YOUR RIGHTS

A. General Plan Information

Name of Plan:	Eye Care Insurance
Name, Address of Plan Sponsor:	UAW/UMASS HEALTH & WELFARE TRUST FUND 6 UNIVERSITY DR STE 206-226 AMHERST, MA 01002
Plan Sponsor Tax Id Number:	04-3538613
Plan Number:	501
Type of Plan:	Group Insurance Plan
Name, Address, Phone Number of Plan Administrator:	LESLIE EDWARDS DAVIS UAW/UMASS HEALTH & WELFARE TRUST FUND 6 UNIVERSITY DR STE 206-226 AMHERST, MA 01002 413-345-2156
Name, Address of Registered Agent for Service of Legal Process:	Plan Sponsor
If Legal Process Involves Claims For Benefits Under The Group Policy, Additional Notification of Legal Process Must Be Sent To:	Ameritas Life Insurance Corp. P.O. Box 82595 Lincoln, NE 68501
Sources of Contributions:	Employer/Member
Funding Method:	Ameritas Life Insurance Corp.--Fully Insured
Plan Fiscal Year End:	September 30
Type of Administration:	
General Administration	Plan Sponsor
Contract & Claim Administration	Ameritas Life Insurance Corp.

B. Notice of Legal Process

Service of legal process may be made upon the plan administrator at the address listed above.

C. Eligibility and Benefits Provided Under the Group Policy

Please refer to the **Conditions for Insurance** within the Group Policy and Certificate of Coverage for a detailed description of the eligibility for participation under the plan as well as the benefits provided. If this plan includes a participating provider (PPO) option, provider lists are furnished without charge, as a separate document.

D. Qualified Medical Child Support Order ("QMCSO")

QMCSO Determinations. A Plan participant or beneficiary can obtain, without charge, a copy of the Plan's procedures governing Qualified Medical Child Support Order determinations from the Plan Administrator.

E. Termination Of The Group Policy

The Group Policy which provides benefits for this plan may be terminated by the Policyholder at any time with prior written notice to Ameritas Life Insurance Corp. It will terminate automatically if the Policyholder fails to pay the required premium. Ameritas Life Insurance Corp. may terminate the Group Policy on any Premium Due Date if the number of persons insured is less than the required minimum, or if Ameritas Life Insurance Corp. believes the Policyholder has failed to perform its obligations relating to the Group Policy.

After the first policy year, Ameritas Life Insurance Corp. may also terminate the Group Policy on any Premium Due Date for any reason by providing a 60-day advance written notice to the Policyholder.

The Group Policy may be changed in whole or in part. No change or amendment will be valid unless it is approved in writing by a Ameritas Life Insurance Corp. executive officer.

F. Claims For Benefits

Claims procedures are furnished automatically, without charge, as a separate document.

G. Continuation of Coverage Provisions (COBRA)

COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) gives Qualified Beneficiaries the right to elect COBRA continuation after insurance ends because of a Qualifying Event. The law generally covers group health plans maintained by employers with 20 or more employees in the prior year. The law does not, however, apply to plans sponsored by the Federal government and certain church-related organizations.

i. Definitions For This Section

Qualified Beneficiary means an Insured Person who is covered by the plan on the day before a qualifying event. Any child born to or placed for adoption with a covered employee during the period of COBRA coverage is considered a qualified beneficiary.

A Qualifying Event occurs when:

1. The Member dies (hereinafter referred to as Qualifying Event 1);

2. The Member's employment terminates for reasons other than gross misconduct as determined by the Employer (hereinafter referred to as Qualifying Event 2);

3. The Member's work hours fall below the minimum number required to be a Member (hereinafter referred to as Qualifying Event 3);

4. The Member becomes divorced or legally separated from a Spouse (hereinafter referred to as Qualifying Event 4);

5. The Member becomes entitled to receive Medicare benefits under Title XVII of the Social Security Act (hereinafter referred to as Qualifying Event 5);

6. The Child of a Member ceases to be a Dependent (hereinafter referred to as Qualifying Event 6);

7. The Employer files a petition for reorganization under Title 11 of the U.S. Bankruptcy Code, provided the Member is retired from the Employer and is insured on the date the petition is filed (hereinafter referred to as Qualifying Event 7).

ii. Electing COBRA Continuation

A. Each Qualified Beneficiary has the right to elect to continue coverage that was in effect on the day before the Qualifying Event. The Qualified Beneficiary must apply in writing within 60 days of the later of:

1. The date on which Insurance would otherwise end; and

2. The date on which the Employer or Plan Administrator gave the Qualified Beneficiary notice of the right to COBRA continuation.

B. A Qualified Beneficiary who does not elect COBRA Continuation coverage during their original election period may be entitled to a second election period if the following requirements are satisfied:

1. The Member's Insurance ended because of a trade related termination of their employment, which resulted in being certified eligible for trade adjustment assistance;

2. The Member is certified eligible for trade adjustment assistance (as determined by the appropriate governmental agency) within 6 months of the date Insurance ended due to the trade related termination of their employment; and

3. The Qualified Beneficiary must apply in writing within 60 days after the first day of the month in which they are certified eligible for trade adjustment assistance.

iii. Notice Requirements

1. When the Member becomes insured, the Plan Administrator must inform the Member and Spouse in writing of the right to COBRA continuation.

2. The Qualified Beneficiary must notify the Plan Administrator in writing of Qualifying Event 4 or 6 above within 60 days of the later of:

a. The date of the Qualifying Event; or

b. The date the Qualified Beneficiary loses coverage due to the Qualifying Event.

3. A Qualified Beneficiary, who is entitled to COBRA continuation due to the occurrence of Qualifying Event 2 or 3 and who is disabled at any time during the first 60 days of continuation coverage as determined by the Social Security Administration pursuant to Title II or XVI of the Social Security Act, must notify the Plan Administrator of the disability in writing within 60 days of the later of:

a. The date of the disability determination;

b. The date of the Qualifying Event; or

c. The date on which the Qualified Beneficiary loses coverage due to the Qualifying Event.

4. Each Qualified Beneficiary who has become entitled to COBRA continuation with a maximum duration of 18 or 29 months must notify the Plan Administrator of the occurrence of a second Qualifying Event within 60 days of the later of:

   a. The date of the Qualifying Event; or

   b. The date the Qualified Beneficiary loses coverage due to the Qualifying Event.

5. The Employer must give the Plan Administrator written notice within 30 days of the occurrence of Qualifying Event 1, 2, 3, 5, or 7.

6. Within 14 days of receipt of the Employer's notice, the Plan Administrator must notify each Qualified Beneficiary in writing of the right to elect COBRA continuation.

In order to protect your rights, Members and Qualified Beneficiaries should inform the Plan Administrator in writing of any change of address.

iv. COBRA Continuation Period

1. 18-month COBRA Continuation

   Each Qualified Beneficiary may continue Insurance for up to 18 months after the date of Qualifying Event 2 or 3.

2. 29-month COBRA Continuation

   Each Qualified Beneficiary, who is entitled to COBRA continuation due to the occurrence of Qualifying Event 2 or 3 and who is disabled at any time during the first 60 days of continuation coverage as determined by the Social Security Administration pursuant to Title II or XVI of the Social Security Act, may continue coverage for up to 29 months after the date of the Qualifying Event. All Insured Persons in the Qualified Beneficiary's family may also continue coverage for up to 29 months.

3. 36-Month COBRA Continuation

   If you are a Dependent, you may continue Coverage for up to 36 months after the date of Qualifying Event 1, 4, 5, or 6. Each Qualified Beneficiary who is entitled to continue Insurance for 18 or 29 months may be eligible to continue coverage for up to 36 months after the date of their original Qualifying Event if a second Qualifying Event occurs while they are on continuation coverage.

Note: The total period of COBRA continuation available in 1 through 3 will not exceed 36 months.

4. COBRA Continuation For Certain Bankruptcy Proceedings

   If the Qualifying Event is 7, the COBRA continuation period for a retiree or retiree's Spouse is the lifetime of the retiree. Upon the retiree's death, the COBRA continuation period for the surviving Dependents is 36 months from the date of the retiree's death.

v. Premium Requirements

Insurance continued under this provision will be retroactive to the date insurance would have ended because of a Qualifying Event. The Qualified Beneficiary must pay the initial required premium not later than 45 days after electing COBRA continuation, and monthly premium on or before the Premium Due Date thereafter. The monthly premium is a percentage of the total premium (both the portion paid by the employee and any portion paid by the employer) currently in effect on each Premium Due Date. The premium rate may change after you cease to be Actively at Work. The percentage is as follows:

18 month continuation - 102%

29 month continuation - 102% during the first 18 months, 150% during the next 11 months

36 month continuation - 102%

vi. When COBRA Continuation Ends

COBRA continuation ends on the earliest of:

1. The date the Group Policy terminates;

2. 31 days after the date the last period ends for which a required premium payment was made;

3. The last day of the COBRA continuation period.

4. The date the Qualified Beneficiary first becomes entitled to Medicare coverage under Title XVII of the Social Security Act;

5. The first date on which the Qualified Beneficiary is: (a) covered under another group Eye Care policy and (b) not subject to any preexisting condition limitation in that policy.

H. Your Rights under ERISA

As a participant in this Plan, you are entitled to certain rights and protections under the Employment Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits
Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work-sites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to operate and administer this plan prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Rights

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling those publications hotline of the Employee Benefits Security Administration

CLAIMS REVIEW PROCEDURES
AS REQUIRED UNDER
EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

The following provides information regarding the claims review process and your rights to request a review of any part of a claim that is denied. Please note that certain state laws may also require specified claims payment procedures as well as internal appeal procedures and/or independent external review processes. Therefore, in addition to the review procedures defined below, you may also have additional rights provided to you under state law. If your state has specific grievance procedures, an additional notice specific to your state will also be included within the group policy and your certificate.

CLAIMS FOR BENEFITS

Claims may be submitted by mailing the completed claim form along with any requested information to:

Ameritas Life Insurance Corp.
PO Box 82520
Lincoln, NE 68501

NOTICE OF DECISION OF CLAIM

We will evaluate your claim promptly after we receive it.

We will provide you written notice regarding the payment under the claim within 30 calendar days following receipt of the claim. This period may be extended for an additional 15 days, provided that we have determined that an extension is necessary due to matters beyond our control, and notify you, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which we expect to render a decision. If the extension is due to your failure to provide information necessary to decide the claim, the notice of extension shall specifically describe the required information we need to decide the claim.

If we request additional information, you will have 45 days to provide the information. If you do not provide the requested information within 45 days, we may decide your claim based on the information we have received.

If we deny any part of your claim, you will receive a written notice of denial containing:

a. The reasons for our decision.
b. Reference to the parts of the Group Policy on which our decision is based.
c. Reference to any internal rule or guideline relied upon in making our decision, along with your right to receive a copy of these guidelines, free of charge, upon request.
d. A statement that you may request an explanation of the scientific or clinical judgment we relied upon to exclude expenses that are experimental or investigational, or are not necessary or accepted according to generally accepted standards of Eye Care practice.
e. A description of any additional information needed to support your claim and why such information is necessary.
f. Information concerning your right to a review of our decision.
g. Information concerning your right to bring a civil action for benefits under section 502(a) of ERISA following an adverse benefit determination on review.

APPEAL PROCEDURE

If all or part of a claim is denied, you may request a review in writing within 180 days after receiving notice of the benefit denial.

You may send us written comments or other items to support your claim. You may review and receive copies of any non-privileged information that is relevant to your appeal. There will be no charge for such copies. You may request the names of the experts we consulted who provided advice to us about your claim.

The appeal review will be conducted by the Plan's named fiduciary and will be someone other than the person who denied the initial claim and will not be subordinate to that person. The person conducting the review will not give deference to the initial denial decision. If the denial was based in whole or in part on a medical judgment, including determinations with regard to whether a service was considered experimental, investigational, and/or not medically necessary, the person conducting the review will consult with a qualified health care professional. This health care professional will be someone other than the person who made the original judgment and will not be subordinate to that person. Our review will include any written comments or other items you submit to support your claim.

We will review your claim promptly after we receive your request.

If your appeal is about urgent care, you may call Toll Free at 877-897-4328, and an Expedited Review will be conducted. Verbal notification of our decision will be made within 72 hours, followed by written notice within 3 calendar days after that.

If your appeal is about benefit decisions related to clinical or medical necessity, a Standard Consultant Review will be conducted. A written decision will be provided within 30 calendar days of the receipt of the request for appeal.

If your appeal is about benefit decisions related to coverage, a Standard Administrative Review will be conducted. A written decision will be provided within 60 calendar days of the receipt of the request for appeal.

If we deny any part of your claim on review, you will receive a written notice of denial containing:

a. The reasons for our decision.
b. Reference to the parts of the Group Policy on which our decision is based.
c. Reference to any internal rule or guideline relied upon in making our decision along with your right to receive a copy of these guidelines, free of charge, upon request.
d. Information concerning your right to receive, free of charge, copies of non-privileged documents and records relevant to your claim.
e. A statement that you may request an explanation of the scientific or clinical judgment we relied upon to exclude expenses that are experimental or investigational, or are not necessary or accepted according to generally accepted standards of Eye Care practice.
f. Information concerning your right to bring a civil action for benefits under section 502(a) of ERISA.

Certain state laws also require specified internal appeal procedures and/or external review processes. In addition to the review procedures defined above, you may also have additional rights provided to you under state law. Please review your certificate for such information, call us, or contact your state insurance regulatory agency for assistance. In any event, you need not exhaust such state law procedures prior to bringing civil action under Section 502(a) of ERISA.

Any request for appeal should be directed to:

Quality Control, P.O. Box 82657, Lincoln, NE 68501-2657.

Your Information. Your Rights. Our Responsibilities.

THIS NOTICE OF PRIVACY PRACTICES ("NOTICE") DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice describes how the Group Divisions of Ameritas Life Insurance Corp. and Ameritas Life Insurance Corp. of New York use and disclose your protected health information, and how we guard that information. We are required to abide by the terms of this notice as long as it remains in effect. We reserve the right to change the terms of this Notice as necessary, and to make a new Notice effective for all protected health information maintained by us. If we do make changes to this Notice, a copy of the new Notice will be placed on our web site at www.ameritas.com and/or sent to you if the changes are material. If you reside in a state whose law provides stricter privacy protections than those provided by HIPAA, we will maintain the privacy of your health information as required by your stricter state law.

how we use or disclose information

We must use and disclose your health information to provide that information:

- To you, or someone who has the legal right to act for you (your personal representative), in order to administer your rights as described in this notice; and
- To the Secretary of the Department of Health and Human Services, if necessary, to see that we are complying with federal privacy law and administrative simplification provisions of HIPAA.

We have the right to use and disclose your health information for your treatment, to pay for your health care, and to operate our business. For example, we typically use your information in the following ways:

- **For Payment.** We may use or disclose health information to collect premiums due to us, to determine your coverage, or to process claims for health care services you receive. For example, we may tell a provider whether you are eligible for coverage and what percentage of the bill may be covered.
- **For Treatment.** We may use or disclose health information to aid in your treatment or the coordination of your care. For example, we may disclose information to your provider to help them provide health care services to you.
- **For Health Care Operations.** We may use or disclose health information as necessary to operate and manage our business activities related to providing and managing your health care coverage. For example, we may use health information for operational activities such as quality assessment and improvement.
- **For Plan Sponsors.** If your coverage is through an employer sponsored group health plan, we may share summary health information and enrollment and disenrollment information with the plan sponsor. In addition, we may share other health information with the plan sponsor for plan administration purposes if the plan sponsor agrees to special restrictions on the use and disclosure of the information in accordance with federal law.

We may use or disclose your health information for the following purposes under limited circumstances:

- **As Required by Law.** We may disclose information about you if state or federal laws require it.
- **To Persons Involved With Your Care.** We may use or disclose your health information a person involved in your care or who helps you pay for your care, such as a family member or close personal friend, when you are incapacitated, emergency situations, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object, we will use our best judgment to decide if the disclosure is in your best interests.
- **To Law Enforcement.** We may disclose your health information to a law enforcement official to provide limited information to locate a missing person or report a crime.
- **To Correctional Institutions or Law Enforcement Officials.** We may disclose your health information if you are an inmate of a correctional institution or under the custody of law enforcement, but only if necessary for the institution to provide you with health care; to protect your health and safety, or the health and safety of others; or for the safety and security of the correctional institution.
- **To Avoid a Serious Threat to Health or Safety** to you, another person, or the public. For example, we may disclose information to a public health agency or law enforcement in the event of a natural disaster.
- **For Public Health Activities** such as reporting disease outbreaks to a valid public health authority.
- **For Reporting Victims of Abuse, Neglect, or Domestic Violence** to government authorities that are authorized by law to receive such information, including a social services or protective service agencies.
- **For Health Oversight Activities** to a health oversight agency for activities authorized by law, such as licensure, governmental audits, and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings** to respond to a court order, search warrant, or subpoena.
- **For Specialized Government Functions** such as national security and intelligence activities, the protective services for the President and others, or if you are a member of the military, as required by the armed forces.
- **To Business Associates** that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates are required, under contract with us and federal law, to protect the privacy of your information and are not allowed to use or disclose any information other than allowed by the contract and federal law.
- **For Workers' Compensation** as authorized by, or to the extent necessary to comply with, state workers' compensation laws that govern job-related injuries or illness.

- **To Provide Information Regarding Decedents.** We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties.
- **For Cadaveric Organ, Eye, or Tissue Donation.** We may disclose information to entities that handle procurement, banking, or transplantation of organs, eyes, or tissue to facilitate donation and transplantation.

Except for uses and disclosures described and limited as explained in this notice, we will use and disclose your health information only with written permission from you. We will not share your personal information for marketing purposes or sell your personal information unless you give us written permission to do so.

our responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this Notice, and give you a copy of it.
- We will not use or share your information other than as described in this Notice, unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing at the contact information below if you change your mind.

your rights

- **Right to Inspect and Copy.** You have the right to inspect and copy certain protected health information that may be used to make decisions about your plan benefits. Your request must be in writing and submitted to the Ameritas Privacy Office at the contact information below. We will usually provide access to your protected health information within 30 days of receiving the request. We reserve the right to charge a fee for the costs of copying, mailing, or other supplies associated with your request. You may also ask your providers for access to your records. We may deny your request in very limited circumstances. If we deny your request to inspect or obtain a copy of your protected health information, we will inform you in writing of the reason(s) within 30 days.
- **Right to Amend.** You have the right to request that we amend, correct, or delete your protected health information in our records if you believe that it is inaccurate or incomplete. Your request must be in writing and sent to the Ameritas Privacy Office at the contact information below. In addition, you must provide a reason that supports your request. We will respond to your request in writing within 30 days. We may deny your request for an amendment if it is not in writing, or does not include a reason to support the request. If we deny your request, we will communicate the reason(s) for denial. If we deny your request, you have the right to file a written statement of disagreement and any future disclosures of the disputed information will include your statement.
- **Right to Request Confidential Communication.** You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. Your request must be in writing and submitted to the Ameritas Privacy Office at the contact information below. We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.
- **Right to an Accounting of Disclosures of Your Protected Health Information.** You have the right to receive a list of the times we've shared your health information for up to six years prior to the date you ask, who we share it with, and why. Your request must be in writing and submitted to the Ameritas Privacy Office at the contact information below. We will include all the disclosures, except those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We will provide one accounting a year for free, but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
- **Know the Reasons for an Unfavorable Underwriting Decision.** You have the right to know the reason(s) for an unfavorable underwriting decision. Your request must be in writing, and must be asked for within 90 days from when the adverse underwriting decision is sent. We will respond within 21 days. Previous unfavorable underwriting decisions may not be used as a basis for future underwriting decisions unless we make an independent evaluation of basic facts. Your genetic information cannot be used for underwriting purposes.
- **Ask Us to Limit the Information We Share.** You can send us a written request at the contact information below to not use or share certain health information for treatment, payment, or health care operations. We are not required to agree to these requests.
- **Get a Copy of this Privacy Notice.** You can ask us for a paper copy of this Notice at any time, even if you have agreed to receive the Notice electronically. We will provide you with a paper copy promptly.

exercising your rights

- Submitting a Written Request. If you have any questions about this Notice, want more information about exercising your rights, or want to obtain an authorization form please contact us at: The Privacy Office, Attn. HIPAA Privacy, P.O. Box 82520, Lincoln, NE 68501-2520, e-mail us at privacy@ameritas.com, or call 1-800-487-5553
- Filing a Complaint. If you believe your privacy rights have been violated, you may file a complaint with us at the contact information listed above. You may also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C., 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

This revised notice is effective 9/30/17.

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 - Rated 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 Eyefitad 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 not 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 this 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

8/21/2018
Date

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

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

CERTIFICATE RIDER

Group Policy No.: **TM 05993054-G**

Employer: **UAW/UMass Health & Welfare Trust Fund**

Effective Date: **September 1, 2021**

The Certificate is changed as shown below:

The Certificate is revised to add the following:

"**How We Will Pay Benefits**

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

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

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

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

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

CERTIFICATE OF INSURANCE

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

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

Employer:	UAW/UMass Health & Welfare Trust Fund
Group Policy Number:	TM 05993054-G
Type of Insurance:	Basic Term Life & Accidental Death and Dismemberment Insurance
MetLife Toll Free Number(s):	
For General Information	1-800-275-4638

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

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

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

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

NOTICE FOR RESIDENTS OF TEXAS

Have a complaint or need help?

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

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

Metropolitan Life Insurance Company

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

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

Toll-free: 1-800-438-6388

Email: Johnstown_Complaint_Referrals@metlife.com

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

The Texas Department of Insurance

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

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

File a complaint: www.tdi.texas.gov

Email: ConsumerProtection@tdi.texas.gov

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

¿Tiene una queja o necesita ayuda?

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

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

Metropolitan Life Insurance Company

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

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

Teléfono gratuito: 1-800-438-6388

Correo electrónico: Johnstown_Complaint_Referrals@metlife.com

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

El Departamento de Seguros de Texas

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

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

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

Correo electrónico: ConsumerProtection@tdi.texas.gov

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

NOTICE FOR RESIDENTS OF ARKANSAS

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

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

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

NOTICE FOR RESIDENTS OF CALIFORNIA

IMPORTANT NOTICE

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

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

1-800-438-6388

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

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

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

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

NOTICE FOR RESIDENTS OF CALIFORNIA

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

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

NOTICE FOR RESIDENTS OF GEORGIA

IMPORTANT NOTICE

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

NOTICE FOR RESIDENTS OF IDAHO

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

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

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

NOTICE FOR RESIDENTS OF ILLINOIS

IMPORTANT NOTICE

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

MetLife
200 Park Avenue
New York, New York 10166

The address of the Illinois Department of Insurance is:

Illinois Department of Insurance
Public Services Division
Springfield, Illinois 62767

NOTICE FOR RESIDENTS OF INDIANA

Questions regarding your policy or coverage should be directed to:

Metropolitan Life Insurance Company
1-800-275-4638

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

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

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

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

NOTICE FOR RESIDENTS OF MISSOURI

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

EXCLUSIONS

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

"suicide or attempted suicide while sane"

LIFE INSURANCE

GENERAL PROVISIONS

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

Suicide

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

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

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

NOTICE FOR RESIDENTS OF NORTH DAKOTA

GENERAL PROVISIONS

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

Suicide

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

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

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

NOTICE FOR RESIDENTS OF NEW MEXICO

Consumer Complaint Notice

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

NOTICE FOR RESIDENTS OF TEXAS

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

NOTICE FOR RESIDENTS OF UTAH

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

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

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

The basic protections provided by the Association are:

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

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

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. Coverage is conditioned on residency in this state and there are substantial limitations and exclusions. For a complete description of coverage, consult Utah Code, Title 3 IA, Chapter 28.

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

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

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

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

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

NOTICE FOR RESIDENTS OF VIRGINIA

IMPORTANT INFORMATION REGARDING YOUR INSURANCE

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

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

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

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

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

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

NOTICE FOR RESIDENTS OF THE STATE OF WASHINGTON

Washington law provides that the following apply to Your certificate:

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

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

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

NOTICE FOR RESIDENTS OF WASHINGTON

LIFE INSURANCE

GENERAL PROVISIONS

The suicide provision is not applicable to residents of Washington.

NOTICE FOR RESIDENTS OF WASHINGTON

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

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

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

NOTICE FOR RESIDENTS OF WISCONSIN

KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

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

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

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

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

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SCHEDULE OF BENEFITS

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

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

BENEFIT	BENEFIT AMOUNT AND HIGHLIGHTS
Life Insurance For You	
Basic Life Insurance	
Basic Life Insurance for You is Portability Eligible Insurance	
For All Active Full-Time Employees.....	$10,000
Non-Medical Issue Amount.....	$10,000
Accelerated Benefit Option.....	None

If You Are Age 65 Or Older

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

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

Accidental Death and Dismemberment Insurance (AD&D) for You	
Basic Accidental Death and Dismemberment Insurance for You is Portability Eligible Insurance	
Full Amount for AD&D	
For All Active Full-Time Employees.....	An amount equal to Your Life Insurance

If You Are Age 65 Or Older

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

SCHEDULE OF BENEFITS (continued)

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

For All Active Full-Time Employees

Additional Benefits:

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

Schedule of Covered Losses for Accidental Death and Dismemberment Insurance

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

Covered Losses

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

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

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

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

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

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

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

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

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

Brain Damage…….. **100%**

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

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

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

Portability Eligible Life and AD&D Insurance

Life and AD&D Insurance For You:

Portability Eligible Life Insurance For You:

Basic Life Insurance:

Minimum Portability Eligible Life Insurance Amount……	$10,000
Maximum Portability Eligible Life Insurance Amount……..	The lesser of Your total Life Insurance in effect on the date You elect to Port or $2,000,000.

Portability Eligible Accidental Death and Dismemberment Insurance For You:

Basic Accidental Death and Dismemberment Insurance:

Minimum Portability Eligible AD&D Insurance Amount……	$10,000
Maximum Portability Eligible AD&D Insurance Amount……..	The lesser of Your total AD&D Insurance in effect on the date You elect to Port or $2,000,000.

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

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

DEFINITIONS

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

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

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

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

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

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

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

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

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

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

Physician means:

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

  The term does not include:

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

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

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

Proof must be provided at the claimant's expense.

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

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

Spouse means Your lawful Spouse.

The term does not include any person who:

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

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

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

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

ELIGIBILITY PROVISIONS: INSURANCE FOR YOU

ELIGIBLE CLASS(ES)
All Active Full-Time Employees

DATE YOU ARE ELIGIBLE FOR INSURANCE

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

All Active Full-Time Employees

Basic Life Insurance

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

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

Basic Accidental Death and Dismemberment Insurance

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

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

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

ENROLLMENT PROCESS

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

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

DATE YOUR INSURANCE TAKES EFFECT

Rules for Noncontributory Insurance

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

- if You are **not required** to give evidence of Your insurability, such insurance will take effect on the date You become eligible, provided You are Actively at Work on that date; or

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

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

Rules for Contributory Insurance

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

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

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

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

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

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

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

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

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

Enrollment Due to a Qualifying Event

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

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

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

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

Qualifying Event includes:

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

DATE YOUR INSURANCE ENDS

Your insurance will end on the earliest of:

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

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

CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT

FOR FAMILY AND MEDICAL LEAVE

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

AT YOUR OPTION: PORTABILITY

For Basic Life and Basic Accidental Death and Dismemberment Insurance

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

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

When Porting is an Option

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

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

1. You may choose to Port if Portability Eligible Insurance ends while You are Actively at Work or on an approved leave of absence because:

    - You retired from active service with the Employer; or
    - Your employment ends, due to a reason other than retirement; or
    - You cease to be in a class that is eligible for such insurance; or
    - The Policy is amended to end the Portability Eligible Insurance, unless such insurance is replaced by similar insurance under another group insurance policy issued to the Policyholder or its successor; or
    - This Policy has ended, unless such insurance is replaced by similar insurance under another group insurance policy issued to the Policyholder or its successor.

2. You may choose to Port the reduced amount of insurance if Your Portability Eligible Insurance is reduced due to:

    - Your age; or
    - An amendment to the Plan which affects the amount of insurance for Your class.

- the person making the request resides in a jurisdiction that permits this Portability feature.

Request Period

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

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

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

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

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

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

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

Amount of the New Certificate

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

Your Increase in Amount

For Portability Eligible Life Insurance

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

For Portability Eligible Accidental Death and Dismemberment Insurance

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

Your Decrease in Amount

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

Premiums for the New Certificate

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

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

Right to Convert Life Insurance Amounts Not Ported

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

If You Die Within 31 Days of the Date Portability Eligible Life Insurance Ends

If You die within 31 days of the date Portability Eligible Life Insurance ends and an application to Port is not received by Us during such period, We will determine whether Your life insurance qualifies for payment. This determination will be made in accordance with the section entitled LIFE INSURANCE: CONVERSION OPTION FOR YOU.

If You are Totally Disabled on the Date Your Employment Ends.

If You are Totally Disabled on the date Your employment ends and You elect to continue Portability Eligible Insurance as provided in this subsection, You may at a later date become approved for continuation of insurance under the section entitled ELIGIBILITY FOR CONTINUATION OF CERTAIN INSURANCE WHILE YOU ARE TOTALLY DISABLED. If You are so approved, all insurance continued under this subsection or any new certificate provided under this subsection will end and We will return any premium paid by You for such insurance.

AT THE EMPLOYER'S OPTION

The Employer has elected to continue insurance by paying premiums for employees who cease Active Work in an eligible class for any of the reasons specified below. You will be notified by the Employer how much You will be required to contribute.

Insurance will continue for the following periods:

1. for the period You cease Active Work in an eligible class due to injury or Sickness, up to 9 months;

2. for the period You cease Active Work in an eligible class due to part-time work, layoff or strike, up to 2 months;

3. for the period You cease Active Work in an eligible class due to any other Employer approved leave of absence, up to 2 months.

4. for the period You cease Active Work in an eligible class due to any Employer approved leave of absence because of a call-up to active military service, up to 24 months.

At the end of any of the continuation periods listed above, Your insurance will be affected as follows:

- if You resume Active Work in an eligible class at this time, You will continue to be insured under the Group Policy;

- if You do not resume Active Work in an eligible class at this time, Your employment will be considered to end and Your insurance will end in accordance with the DATE YOUR INSURANCE ENDS subsection of the section entitled ELIGIBILITY PROVISIONS: INSURANCE FOR YOU.

Option to Convert

In addition to the Continuation of Insurance options described above, You may have the right to convert to a policy of individual life insurance. We urge You to read the section entitled LIFE INSURANCE: CONVERSION OPTION FOR YOU.

CONTINUATION OF ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D)

Special Rules For Massachusetts Residents

1. If Your AD&D Insurance ends due to a Plant Closing or Covered Partial Closing, such insurance will be continued for 90 days after the date it ends.

2. If Your AD&D Insurance ends because:

- You cease to be in an Eligible Class; or
- Your employment terminates

for any reason other than a Plant Closing or Covered Partial Closing, such insurance will continue for 31 days after the date it ends.

Continuation of Your AD&D Insurance under this subsection will end before the end of continuation periods shown above if You become covered for similar benefits under another plan.

Plant Closing and **Covered Partial Closing** have the meaning set forth in Massachusetts Annotated Laws, Chapter 151A, Section 71A.

EVIDENCE OF INSURABILITY

We require evidence of insurability satisfactory to Us as follows:

1. In the case of transferred business, if You did not elect coverage under the prior plan for which You were eligible.

   If You do not give Us evidence of insurability or the evidence of insurability is not accepted by Us as satisfactory, You will not be covered for Life Insurance.

The evidence of insurability is to be given at Your expense.

LIFE INSURANCE: FOR YOU

If You die, Proof of Your death must be sent to Us. When We receive such Proof with the claim, We will review the claim and if We approve it, will pay the Beneficiary the Life Insurance in effect on the date of Your death.

PAYMENT OPTIONS

We will pay the Life Insurance in one sum. Other modes of payment may be available upon request. For details, call Our toll free number shown on the Certificate Face Page.

LIFE INSURANCE: CONVERSION OPTION FOR YOU

If Your Life Insurance ends or is reduced for any of the reasons stated below, You have the option to buy an individual policy of life insurance ("new policy") from Us during the Application Period in accordance with the conditions and requirements of this section. This is referred to as the "option to convert". Evidence of Your insurability will not be required.

When You Will Have the Option to Convert

You will have the option to convert when:

- Your Life Insurance ends because:
    - You cease to be in an eligible class; or
    - Your employment ends; or
    - the Group Policy ends provided You have been insured for Life Insurance for at least 5 years; or
    - the Group Policy is amended to end Life Insurance for an eligible class of which You are a member, provided You have been insured for Life Insurance for at least 5 years; or

- Your Life Insurance is reduced:
    - on or after the date You attain age 60 in any increment or series of increments aggregating 20% or more of the amount of Your Life Insurance in effect before the first reduction due to Your age;
    - because You change from one eligible class to another; or
    - due to an amendment of the Group Policy.

If You opt not to convert a reduction in the amount of Your Life Insurance as described above, You will not have the option to convert that amount at a later date.

Application Period

If You opt to convert Your Life Insurance for any of the reasons stated above, We must receive a completed conversion application form from You within the Application Period described below.

If You are given Written notice of the option to convert within 15 days before or after the date Your Life Insurance ends or is reduced, the Application Period begins on the date that such Life Insurance ends or is reduced and expires 31 days after such date.

If You are given Written notice of the option to convert more than 15 days after but within 90 days of the date Your Life Insurance ends or is reduced, the Application Period begins on the date such Life Insurance ends or is reduced and expires 15 days from the date of such notice. In no event will the Application Period exceed 91 days from the date Your Life Insurance ends or is reduced.

Option Conditions

The option to convert is subject to these conditions:

1. Our receipt within the Application Period of:

- Your Written application for the new policy; and
- the premium due for such new policy;

2. The premium rates for the new policy will be based on:

- Our rates then in use;
- the form and amount of insurance;
- Your class of risk; and
- Your attained age when Your Life Insurance ends or is reduced;

3. the new policy may be on any form then customarily offered by Us excluding term insurance;

4. the new policy will be issued without an accidental death and dismemberment benefit, a continuation benefit, an accelerated benefit option, a waiver of premium benefit or any other rider or additional benefit; and

5. the new policy will take effect on the 32nd day after the date Your Life Insurance ends or is reduced; this will be the case regardless of the duration of the Application Period.

Maximum Amount of the New Policy

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

- the amount of Your Life Insurance that ends under the Group Policy less the amount of life insurance for which You become eligible under any group policy within 31 days after the date insurance ends under the Group Policy; or

- $2,000

If Your Life Insurance ends for any other reason, the maximum amount of insurance that You may elect for the new policy is the amount of Your Life Insurance that ends under the Group Policy.

If You Die Within 31 Days After Your Life Insurance Ends or is reduced

If You die within 31 days after Your Life Insurance ends or is reduced by an amount You are entitled to convert, Proof of Your death must be sent to Us. When We receive such Proof with the claim, We will review the claim and if We approve it will pay the Beneficiary the amount of Life Insurance You were entitled to convert.

Effect of Previous Conversion

If You obtained a new policy through this conversion option and Your Life Insurance is later continued under the section entitled ELIGIBILITY FOR CONTINUATION OF CERTAIN INSURANCE WHILE YOU ARE TOTALLY DISABLED. We will only pay Your Life Insurance under such section if the new policy is returned to Us. If the new policy is returned to us, We will refund to Your estate the premium paid for such policy without interest, less any debt incurred under such policy. If the new policy is not returned to Us, We will only pay the life insurance in effect under such new policy.

We will not pay insurance under both the Group Policy and the new policy.

ELIGIBILITY FOR CONTINUATION OF CERTAIN INSURANCE WHILE YOU ARE TOTALLY DISABLED

If You become Totally Disabled while You are insured for Continuation Eligible Insurance under this policy, You may qualify to continue certain insurance under this section. If continued, premium payment will not be required. We will determine if You qualify for this continuation after We receive Proof that You have satisfied the conditions of this section.

Total Disability must start before You attain age 60 and while You are insured for Continuation Eligible Insurance.

Your Total Disability must continue without interruption from the date You became Totally Disabled through the end of the Continuation Waiting Period.

DEFINITIONS

For the purpose of this section, "Continuation Eligible Insurance" means Your

- Basic Life Insurance;
- Basic Accidental Death and Dismemberment Insurance if You continue Basic Life Insurance;

to the extent that such insurance was in effect for You on the date Your Total Disability began.

Continuation Waiting Period means the period which starts on the date You become Totally Disabled and ends 9 consecutive months later.

Total Disability or **Totally Disabled** means, for purposes of this section, that due to an injury or sickness:

- You are unable to perform the material and substantial duties of Your regular job; and
- You are unable to perform any other job for which You are fit by education, training or experience.

TOTAL DISABILITY AND PROOF REQUIREMENTS

If You become disabled You should contact Us as soon as reasonably possible. After the Continuation Waiting Period ends, You must send Us Proof that You were Totally Disabled with no interruption throughout the Continuation Waiting Period. You must do this within the time frame specified in the section entitled FILING A CLAIM.

As part of such Proof, We may choose a Physician to examine You to verify that You are Totally Disabled. We will pay for the exam.

After We receive and review Your Proof, We will determine if You qualify. We will notify You in writing of Our decision.

To verify that You continue to be Totally Disabled without interruption, We may require from time to time that You send Us Proof that You continue to be Totally Disabled. We will not ask for Proof more than once each year.

IF YOU DIE OR SUSTAIN A LOSS COVERED BY THE CONTINUED INSURANCE DURING CONTINUATION

If You die or sustain a loss for which you believe benefits may be payable during the continuation, Proof of the death must be sent to Us. In addition to the Proof which is otherwise required for the insurance, the Proof must show that Your Total Disability continued with no interruption from the date We informed You that the continuation was approved until the date of the death or the date of loss.

When We receive such Proof with the claim, We will review the claim and if We approve it, will pay any benefit payable under the insurance continued under this section.

ELIGIBILITY FOR CONTINUATION OF CERTAIN INSURANCE WHILE YOU ARE TOTALLY DISABLED

EFFECT OF PREVIOUS CONVERSION

If You converted any portion of Your Continuation Eligible Life Insurance to an individual policy, We will only pay the life insurance under this section if the individual policy is returned to Us. If it is returned to Us, We will refund to Your estate the premiums paid for such policy without interest, less any debt incurred under such policy.

If such individual policy is not returned to Us, We will pay the life insurance in effect under the individual policy.

We will not pay insurance under both the Group Policy and the individual policy.

EFFECT OF PREVIOUS ELECTION TO PORT COVERAGE

If You ported any portion of Your Continuation Eligible Insurance to a certificate under another policy, We will only pay insurance under this section if the other policy's certificate is surrendered to Us. If it is returned to Us, We will refund to Your estate the premiums paid under such policy without interest.

If that certificate is not returned to Us, We will pay any insurance which applies under the other policy's certificate.

We will not pay insurance under both this Group Policy and the other policy.

DATE CONTINUATION ENDS

The Continuation Eligible Insurance continued under this section may be continued in a reduced amount on account of Your age and will end at the earliest of:

1. the date You die;
2. the date Your Total Disability ends;
3. the date You do not give Us Proof of Total Disability, as required;
4. the date You refuse to be examined by Our Physician, as required;
5. if You become Totally Disabled before age 60, the date You reach age 65.

Option To Convert Your Continuation Eligible Life Insurance

When a continuation under this section ends, You may buy an individual policy of life insurance from Us. The details of this option are described in the section entitled LIFE INSURANCE: CONVERSION OPTION FOR YOU. For the purpose of that section, the end of this continuation will be considered the end of Your employment. You may not use the conversion option described in those sections if before the end of the Application Period for conversion You return to Active Work in an eligible class and become insured under the Group Policy. You will not be able to convert any of Your Continuation Eligible Life Insurance which You have already converted to an individual policy.

Option To Port Your Continuation Eligible Insurance

When a continuation under this section ends, You may elect to port to a different policy the insurance which has been continued under this section. The details of this option are described in the At Your Option: Portability subsection of the CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT section. For the purpose of that section, the end of this continuation will be considered the end of Your employment. You may not use the portability option described in that section if before the end of the Portability Request Period, You return to Active Work in an eligible class and become insured under the Group Policy. You will not be able to port any of Your Continuation Eligible Insurance which You have already converted to an individual policy.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

Applicable to Basic Accidental Death and Dismemberment Insurance

If You sustain an accidental injury that is the Direct and Sole Cause of a Covered Loss described in the SCHEDULE OF BENEFITS, Proof of the accidental injury and Covered Loss must be sent to Us. When We receive such Proof We will review the claim and, if We approve it, We will pay the insurance in effect on the date of the injury.

Direct and Sole Cause means that the Covered Loss occurs within 12 months of the date of the accidental injury and was a direct result of the accidental injury, independent of other causes.

We will deem a loss to be the direct result of an accidental injury if it results from unavoidable exposure to the elements and such exposure was a direct result of an accident.

PRESUMPTION OF DEATH

You will be presumed to have died as a result of an accidental injury if:

- the aircraft or other vehicle in which You were traveling disappears, sinks, or is wrecked; and
- the body of the person who has disappeared is not found within 1 year of:
  - the date the aircraft or other vehicle was scheduled to have arrived at its destination, if traveling in an aircraft or other vehicle operated by a Common Carrier; or
  - the date the person is reported missing to the authorities, if traveling in any other aircraft or vehicle.

EXCLUSIONS (See notice page for residents of Missouri)

We will not pay benefits under this section for any loss caused or contributed to by:

1. physical or mental illness or infirmity, or the diagnosis or treatment of such illness or infirmity;
2. infection, other than infection occurring in an external accidental wound;
3. suicide or attempted suicide;
4. intentionally self-inflicted injury;
5. service in the armed forces of any country or international authority, except the United States National Guard;
6. any incident related to:
   - travel in an aircraft as a pilot, crew member, flight student or while acting in any capacity other than as a passenger; or
   - travel in an aircraft for the purpose of parachuting or otherwise exiting from such aircraft while it is in flight;
   - parachuting or otherwise exiting from an aircraft while such aircraft is in flight except for self-preservation;
   - travel in an aircraft or device used:
     - for testing or experimental purposes; or
     - by or for any military authority; or
     - for travel or designed for travel beyond the earth's atmosphere;
7. committing or attempting to commit a felony;

8. the voluntary intake or use by any means of:

   - any drug, medication or sedative, unless it is:
     - taken or used as prescribed by a Physician, or
     - an “over the counter” drug, medication or sedative taken as directed; or
   - alcohol in combination with any drug, medication, or sedative; or
   - poison, gas, or fumes; or

9. war, whether declared or undeclared; or act of war, insurrection, rebellion, or riot.

Exclusion for Intoxication

We will not pay benefits under this section for any loss if the injured party is intoxicated at the time of the incident and is the operator of a vehicle or other device involved in the incident.

Intoxicated means that the injured person’s blood alcohol level met or exceeded the level that creates a legal presumption of intoxication under the laws of the jurisdiction in which the incident occurred.

BENEFIT PAYMENT

For loss of Your life, We will pay benefits to Your Beneficiary.

For any other loss sustained by You We will pay benefits to You.

If You sustain more than one Covered Loss due to an accidental injury, the amount We will pay, on behalf of any such injured person, will not exceed the Full Amount.

We will pay benefits in one sum. Other modes of payment may be available upon request. For details call Our toll free number shown on the Certificate Face Page.

APPLICABILITY OF PROVISIONS

The provisions set forth in this ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE section apply to all Accidental Death and Dismemberment Insurance – Additional Benefit sections included in this certificate except as may otherwise be provided in such Additional Benefit sections.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE -

ADDITIONAL BENEFIT: AIR BAG USE

If You die as a result of an accidental injury, We will pay this additional benefit if:

1. We pay a benefit for loss of life under the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE section;

2. this benefit is in effect on the date of the injury; and

3. We receive Proof that the deceased person:

    - was in an accident while driving or riding as a passenger in a Passenger Car equipped with an Air Bag(s);

    - was riding in a seat protected by an Air Bag;

    - was wearing a Seat Belt which was properly fastened at the time of the accident; and

    - died as a result of injuries sustained in the accident.

A police officer investigating the accident must certify that the Seat Belt was properly fastened and that the Passenger Car in which the deceased was traveling was equipped with Air Bags. A copy of such certification must be submitted to Us with the claim for benefits.

Passenger Car means any validly registered four-wheel private passenger car. It does not include any commercially licensed car or any private car being used for commercial purposes.

Seat Belt means any restraint device that:

- meets published United States government safety standards;
- is properly installed by the car manufacturer; and
- is not altered after the installation.

Air Bag means an inflatable restraint device that:

- meets published United States government safety standards;
- is properly installed by the car manufacturer; and
- is not altered after the installation.

BENEFIT AMOUNT

The Air Bag Use Benefit is an additional benefit equal to 5% of the Full Amount shown in the SCHEDULE OF BENEFITS. However, the amount We will pay for this benefit will not be less than $100 or more than $10,000.

BENEFIT PAYMENT

For loss of Your life We will pay benefits to Your Beneficiary.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE -

ADDITIONAL BENEFIT: SEAT BELT USE

If You die as a result of an accidental injury, We will pay this additional Seat Belt Use benefit if:

1. We pay a benefit for loss of life under the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE section;

2. this benefit is in effect on the date of the injury; and

3. We receive Proof that the deceased person:

    - was in an accident while driving or riding as a passenger in a Passenger Car;
    - was wearing a Seat Belt which was properly fastened at the time of the accident; and
    - died as a result of injuries sustained in the accident.

A police officer investigating the accident must certify that the Seat Belt was properly fastened. A copy of such certification must be submitted to Us with the claim for benefits.

Passenger Car means any validly registered four-wheel private passenger car. It does not include any commercially licensed car or any private car being used for commercial purposes.

Seat Belt means any restraint device that:

- meets published United States Government safety standards;
- is properly installed by the car manufacturer; and
- is not altered after the installation.

BENEFIT AMOUNT

The Seat Belt Use benefit is an additional benefit equal to **10%** of the Full Amount shown in the SCHEDULE OF BENEFITS. However, the amount We will pay for this benefit will not be less than **$1,000** or more than **$25,000**.

BENEFIT PAYMENT

For loss of Your life, We will pay benefits to Your Beneficiary.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE -

ADDITIONAL BENEFIT: CHILD CARE

If You die as a result of an accidental injury, We will pay this additional Child Care benefit if:

1. We pay a benefit for loss of life under the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE section;

2. This benefit is in effect on the date of the injury; and

3. We receive Proof that:

   - on the date of Your death a Child was enrolled in a Child Care Center; or

   - within 12 months after the date of Your death a Child was enrolled in a Child Care Center.

Child Care Center means a facility that:

- is operated and licensed according to the law of the jurisdiction where it is located; and

- provides care and supervision for children in a group setting on a regularly scheduled and daily basis.

BENEFIT AMOUNT

For each Child who qualifies for this benefit, We will pay an amount equal to the Child Care Center charges incurred for a period of up to 4 consecutive years, not to exceed:

- an annual maximum of $5,000; and

- an overall maximum of 12% of the Full Amount shown in the SCHEDULE OF BENEFITS.

We will not pay for Child Care Center charges incurred after the date a Child attains age 12.

We may require Proof of the Child's continued enrollment in a Child Care Center during the period for which a benefit is claimed.

BENEFIT PAYMENT

We will pay this benefit quarterly when We receive Proof that Child Care Center charges have been paid. Payment will be made to the person who pays such charges on behalf of the Child.

If this benefit is in effect on the date You die and there is no Child who could qualify for it, We will pay $1,000 to Your Beneficiary in one sum.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE -

ADDITIONAL BENEFIT: COMMON CARRIER

If You die as a result of an accidental injury, We will pay this additional benefit if:

1. We pay a benefit for loss of life under the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE section;

2. this benefit is in effect on the date of the injury; and

3. We receive Proof that the injury resulting in the deceased's death occurred while traveling in a Common Carrier.

BENEFIT AMOUNT

The Common Carrier Benefit is shown in the SCHEDULE OF BENEFITS.

BENEFIT PAYMENT

For loss of Your life We will pay benefits to Your Beneficiary.

FILING A CLAIM

The Employer should have a supply of claim forms. Obtain a claim form from the Employer and fill it out carefully. Return the completed claim form with the required Proof to the Employer. The Employer will certify Your insurance under the Group Policy and send the certified claim form and Proof to Us.

When we receive the claim form and Proof We will review the claim and, if We approve it, We will pay benefits subject to the terms and provisions of this certificate and the Group Policy.

CLAIMS FOR LIFE INSURANCE BENEFITS

When a claimant files a claim for Life Insurance benefits, Proof should be sent to Us as soon as is reasonably possible after the death of an insured.

CLAIMS FOR INSURANCE BENEFITS

When a claimant files a claim for insurance benefits described in this certificate, both the notice of claim and the required Proof should be sent to us within 90 days of the date of a loss.

Notice of claim and Proof may also be given to Us by following the steps set forth below:

Step 1
A claimant may give Us notice by calling Us at the toll free number shown in the Certificate Face Page within 20 days of the date of a loss.

Step 2
We will send a claim form to the claimant and explain how to complete it. The claimant should receive the claim form within 15 days of giving Us notice of claim.

Step 3
When the claimant receives the claim form, the claimant should fill it out as instructed and return it with the required Proof described in the claim form. If the claimant does not receive a claim form within 15 days after giving Us notice of claim, Proof may be sent using any form sufficient to provide Us with the required Proof.

Step 4
The claimant must give Us Proof not later than 90 days after the date of the loss.

If notice of claim or Proof is not given within the time limits described in this section, the delay will not cause a claim to be denied or reduced if such notice and Proof are given as soon as is reasonably possible.

Time Limit on Legal Actions. A legal action on a claim may only be brought against Us during a certain period. This period begins 60 days after the date Proof is filed and ends 3 years after the date such Proof is required.

GENERAL PROVISIONS

Assignment

You may assign Your Life Insurance rights and benefits under the Group Policy as a gift or as a viatical assignment. You may also assign Your Accidental Death and Dismemberment Insurance rights and benefits under the Group Policy as a gift.

We will recognize the assignee(s) under such assignment as owner(s) of Your right, title and interest in the Group Policy if:

1. a Written form satisfactory to Us, affirming this assignment, has been completed;
2. the Written form has been Signed by You and the assignee(s);
3. the Employer acknowledges that the Life Insurance and Accidental Death and Dismemberment Insurance being assigned is in force on the life of the assignor; and
4. the Written form is delivered to Us for recording.

Viatical assignments may only be made after Your Life Insurance has been in effect under this certificate for 2 years. However, you may make a viatical assignment before the end of the 2 year period if you are Terminally Ill.

Terminally Ill means that You are expected to die within 6 months. As Proof of Your Terminal Illness You or Your legal representative must send Us a signed Physician's certification that You are Terminally Ill. We may also request an exam by a Physician of Our choice, at Our expense.

Beneficiary

You may designate a Beneficiary in Your application or enrollment form. You may change Your Beneficiary at any time. To do so, You must send a Signed and dated, Written request to the Employer using a form satisfactory to Us. Your Written request to change the Beneficiary must be sent to the Employer within 30 days of the date You Sign such request.

You do not need the Beneficiary's consent to make a change. When We receive the change, it will take effect as of the date You Signed it. The change will not apply to any payment made in good faith by Us before the change request was recorded.

If two or more Beneficiaries are designated and their shares are not specified, they will share the insurance equally.

If there is no Beneficiary designated or no surviving designated Beneficiary at Your death, We may determine the Beneficiary to be one or more of the following who survive You:

1. Your Spouse;
2. Your child(ren);
3. Your parent(s); or
4. Your siblings(s)

- Instead of making payment to any of the above, we may pay Your estate. Any payment made in good faith will discharge our liability to the extent of such payment.

If a Beneficiary or payee is a minor or incompetent to receive payment, We will pay that person's guardian.

Entire Contract

Your insurance is provided under a contract of group insurance with the Employer. The entire contract with the Employer is made up of the following:

1. the Group Policy and its Exhibits, which include the certificate(s);
2. the Employer's application; and
3. any amendments and/or endorsements to the Group Policy.

GENERAL PROVISIONS (continued)

Incontestability: Statements Made by You

Any statement made by You will be considered a representation and not a warranty. We will not use such statement to avoid insurance, reduce benefits or defend a claim unless the following requirements are met:

1. the statement is in a Written application or enrollment form;
2. You have Signed the application or enrollment form; and
3. a copy of the application or enrollment form has been given to You or Your Beneficiary.

We will not use Your statements which relate to insurability to contest life insurance after it has been in force for 2 years during Your life. In addition, We will not use such statements to contest an increase or benefit addition to such insurance after the increase or benefit has been in force for 2 years during Your life.

Misstatement of Age

If Your age is misstated, the correct age will be used to determine if insurance is in effect and, as appropriate, We will adjust the benefits and/or premiums.

Conformity with Law

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

Physical Exams

If a claim is submitted for insurance benefits, We have the right to ask the insured to be examined by a Physician(s) of Our choice as often as is reasonably necessary to process the claim. We will pay the cost of such exam.

Autopsy

Subject to Your religious practices or beliefs, We have the right to make a reasonable request for an autopsy where permitted by law. Any such request will set forth the reasons We are requesting the autopsy.

THIS IS THE END OF THE CERTIFICATE. THE FOLLOWING IS ADDITIONAL INFORMATION

MetLife

Delaware American Life Insurance Company
MetLife Health Plans, Inc.
MetLife Legal Plans, Inc.
MetLife Legal Plans of Florida, Inc.
Metropolitan Life Insurance Company
Metropolitan Tower Life Insurance Company
SafeGuard Health Plans, Inc.
SafeHealth Life Insurance

Our Privacy Notice

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

SECTION 1: Plan Sponsors and Group Insurance Contract Holders

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

SECTION 2: Protecting Your Information

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

SECTION 3: Collecting Your Information

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

SECTION 4: How We Get Your Information

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

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

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

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

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

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

Another source of information is MIB, Inc. ("MIB"). It is a not-for-profit membership organization of insurance companies which operates an information exchange on behalf of its Members. We, or our reinsurers, may make a brief report to MIB. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted, MIB, upon request, will supply such company with the information in its file. Upon receipt of a request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. You may do so by writing to MIB, Inc., 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734 or go to MIB website at www.mib.com.

SECTION 5: Using Your Information

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

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

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

SECTION 6: Sharing Your Information With Others

We may share your personal information with others with your consent, by agreement, or as permitted or required by law. We may share your personal information without your consent if permitted or required by law. For example, we may share your information with businesses hired to carry out services for us. We may also share it with our affiliated or unaffiliated business partners through joint marketing agreements. In those situations, we share your information to jointly offer you products and services or have others offer you products and services we endorse or sponsor. Before sharing your information with any affiliate or joint marketing partner for their own marketing purposes, however, we will first notify you and give you an opportunity to opt out.

Other reasons we may share your information include:

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

SECTION 7: HIPAA

We will not share your health information with any other company – even one of our affiliates – for their own marketing purposes. The Health Insurance Portability and Accountability Act (“HIPAA”) protects your information if you request or purchase dental, vision, long-term care and/or medical insurance from us. HIPAA limits our ability to use and disclose the information that we obtain as a result of your request or purchase of insurance. Information about your rights under HIPAA will be provided to you with any dental, vision, long-term care or medical coverage issued to you.

You may obtain a copy of our HIPAA Privacy Notice by visiting our website at www.MetLife.com. For additional information about your rights under HIPAA; or to have a HIPAA Privacy Notice mailed to you, contact us at HIPAAprivacyAmericasUS@metlife.com, or call us at telephone number (212) 578-0299.

SECTION 8: Accessing and Correcting Your Information

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

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

SECTION 9: Questions

We want you to understand how we protect your privacy. If you have any questions or want more information about this notice, please contact us. A detailed notice shall be furnished to you upon request. When you write, include your name, address, and policy or account number.

Send privacy questions to:

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

We may revise this privacy notice. If we make any material changes, we will notify you as required by law. We provide this privacy notice to you on behalf of the MetLife companies listed at the top of the first page.

THIS SUMMARY PLAN DESCRIPTION IS EXPRESSLY MADE PART OF THE PLAN AND IS LEGALLY ENFORCEABLE AS PART OF THE PLAN WITH RESPECT TO ITS TERMS AND CONDITIONS. IN THE EVENT THERE IS NO OTHER PLAN DOCUMENT, THIS DOCUMENT SHALL SERVE AS A SUMMARY PLAN DESCRIPTION AND SHALL ALSO CONSTITUTE THE PLAN.

ERISA INFORMATION

NAME OF THE PLAN

UAW/UMass Health & Welfare Trust Fund Welfare Benefit Plan ("Plan")

NAME AND ADDRESS OF EMPLOYER

UAW/UMass Health & Welfare Trust Fund
6 University Dr.
Suite 206-229
Amherst, MA 01002
(413) 345-2156

EMPLOYER IDENTIFICATION NUMBER: 043538613

COVERAGE	**PLAN NAME**
Basic Life & Accidental Death and Dismemberment Insurance	UAW/UMass Health & Welfare Trust Fund Welfare Benefit Plan

TYPE OF ADMINISTRATION

The above listed benefits are insured by Metropolitan Life Insurance Company ("MetLife").

PLAN ADMINISTRATOR NAME, BUSINESS ADDRESS AND PHONE NUMBER

UAW/UMass Health & Welfare Trust Fund
6 University Dr.
Suite 206-229
Amherst, MA 01002
(413) 345-2156

AGENT FOR SERVICE OF LEGAL PROCESS

For disputes arising under the Plan, service of legal process may be made upon the Plan Administrator at the above address. For disputes arising under those portions of the Plan insured by MetLife, service of legal process may be made upon MetLife at one of its local offices, or upon the supervisory official of the Insurance Department in the state in which you reside.

ELIGIBILITY FOR PARTICIPATION; DESCRIPTION OR SUMMARY OF BENEFITS

Your MetLife certificate describes the eligibility requirements for insurance provided by MetLife under the Plan. It also includes a detailed description of the insurance provided by MetLife under the Plan.

PLAN TERMINATION OR CHANGES

Written notice of termination must be given to the Employer at least 31 days prior to the date such insurance will be terminated.

Premiums are due and payable on the first day of each month for which insurance coverage is to be provided. If a payment is not received within 31 days after the due date, coverage will terminate as follows:

a. with respect to coverages other than Life Insurance and Accidental Death or Dismemberment Insurance - on the earlier of the 31st day following the due date and the date requested in writing by the Employer, provided such request is made before such 31st day; and

b. with respect to Life Insurance and Accidental Death or Dismemberment Insurance -- on the later of the 31st day following the due date and the date MetLife's written notice of termination is received by the Employer.

The Employer is liable to MetLife for payment of the pro-rata premium which accrues while any coverage remains in force.

The group policy sets forth those situations in which the Employer and/or MetLife have the right to end the policy.

The Employer reserves the right to change or terminate the Plan at any time. Therefore, there is no guarantee that you will be eligible for the benefits described herein for the duration of your employment. Any such action will be taken only after careful consideration.

Your consent or the consent of your beneficiary is not required to terminate, modify, amend, or change the Plan.

In the event Your coverage ends in accord with the Date Your Insurance Ends provision of Your certificate, you may still be eligible to receive benefits. The circumstances under which benefits are available are described in Your MetLife certificate.

CONTRIBUTIONS TO PREMIUM

There are benefits insured under the group insurance coverages or the group insurance policy or policies which are combined for experience. This means that the costs of these coverages are determined on a combined basis, and the costs are accumulated from year to year. As a result, favorable experience under one or more coverages in a particular year may offset unfavorable experience on other coverages in the same year, or offset unfavorable experience of coverage in prior years.

No contribution is required for Basic Life Insurance and Accidental Death and Dismemberment Insurance.

PLAN YEAR

The Plan's fiscal records are kept on a Plan year basis beginning each January 1 and ending on the following December 31.

CLAIMS INFORMATION

Procedures for Presenting Claims for Benefits

All claim forms needed to file for benefits under the group insurance program can be obtained from the Employer who will also be ready to answer questions about the insurance benefits and to assist you or, if applicable, the claimant in filing claims. The instructions on the claim form should be followed carefully. This will expedite the processing of the claim. Be sure all questions are answered fully.

Life and Accidental Death and Dismemberment Benefits Claims

Claim Submission

In submitting claims for life and accidental death and dismemberment benefits ("Benefits"), the claimant must complete the appropriate claim form and submit the required proof as described in the certificate.

Claim forms must be submitted in accordance with the instructions on the claim form.

Initial Determination

After MetLife receives your claim for Benefits, MetLife will review your claim and notify you of its decision to approve or deny your claim.

Such notification will be provided to you within a reasonable period, not to exceed 90 days from the date we received your claim, unless MetLife notifies you within that period that there are special circumstances requiring an extension of time of up to 90 additional days.

If MetLife denies your claim in whole or in part, the notification of the claims decision will state the reason why your claim was denied and reference the specific Plan provision(s) on which the denial is based. If the claim is denied because MetLife did not receive sufficient information, the claims decision will describe the additional information needed and explain why such information is needed. The notification will also include a description of the Plan review procedures and time limits, including a statement of your right to bring a civil action if your claim is denied after an appeal.

Appealing the Initial Determination

In the event a claim has been denied in whole or in part, you or, if applicable, your beneficiary can request a review of your claim by MetLife. This request for review should be sent in writing to Group Insurance Claims Review at the address of MetLife's office which processed the claim within 60 days after you or, if applicable, your beneficiary received notice of denial of the claim. When requesting a review, please state the reason you or, if applicable, your beneficiary believe the claim was improperly denied and submit in writing any written comments, documents, records or other information you or, if applicable, your beneficiary deem appropriate. Upon your written request, MetLife will provide you free of charge with copies of relevant documents, records and other information.

MetLife will re-evaluate all the information, will conduct a full and fair review of the claim, and you or, if applicable, your beneficiary will be notified of the decision. Such notification will be provided within a reasonable period not to exceed 60 days from the date we received your request for review, unless MetLife notifies you within that period that there are special circumstances requiring an extension of time of up to 60 additional days.

If MetLife denies the claim on appeal, MetLife will send you a final written decision that states the reason(s) why the claim you appealed is being denied, references any specific Plan provision(s) on which

the denial is based, any voluntary appeal procedures offered by the Plan, and a statement of your right to bring a civil action if your claim is denied after an appeal. Upon written request, MetLife will provide you free of charge with copies of documents, records and other information relevant to your claim.

Claims Involving Disability Determinations in connection with Life and Accidental Death and Dismemberment Insurance

Claim Submission

For any claim which requires a determination of disability in connection with life insurance or accidental death and dismemberment insurance, the claimant must complete the appropriate claim form and submit the required proof as described in the certificate. For example, if your Plan provides that you are not required to continue paying for your life insurance coverage after you are found to be disabled, or if your plan provides that a portion of your life insurance benefits are payable to you after you are found to be disabled, your request for such determination is treated as a claim involving a disability determination.

Claim forms must be submitted in accordance with the instructions on the claim form.

Please note that for some plans such claims involving disability determination are decided by employers. If that is the case for your plan, your employer rather than MetLife may administer the procedure below.

Initial Determination

After MetLife receives your claim involving a disability determination, MetLife will review your claim and notify you of its decision to approve or deny your claim.

Such notification will be provided to you within a reasonable period, not to exceed 45 days from the date we received your claim; except for situations requiring an extension of time because of matters beyond the control of the Plan, in which case MetLife may have up to two (2) additional extensions of 30 days each to provide you such notification. If MetLife needs an extension, it will notify you prior to the expiration of the initial 45 day period (or prior to the expiration of the first 30 day extension period if a second 30 day extension period is needed), state the reason why the extension is needed, and state when it will make its determination. If an extension is needed because you did not provide sufficient information or filed an incomplete claim, the time from the date of MetLife's notice requesting further information and an extension until MetLife receives the requested information does not count toward the time period MetLife is allowed to notify you as to its claim decision. You will have 45 days to provide the requested information from the date you receive the extension notice requesting further information from MetLife.

If MetLife denies your claim in whole or in part, the notification of the claims decision will state the reason why your claim was denied and reference the specific Plan provision(s) on which the denial is based. If the claim is denied because MetLife did not receive sufficient information, the claims decision will describe the additional information needed and explain why such information is needed. The notification will also include a description of the Plan review procedures and time limits, including a statement of your right to bring a civil action if your claim is denied after an appeal.

Appealing the Initial Determination

If MetLife denies your claim, you may appeal the decision. Upon your written request, MetLife will provide you free of charge with copies of documents, records and other information relevant to your claim. You must submit your appeal to MetLife at the address indicated on the claim form within 180 days of receiving MetLife's decision. Appeals must be in writing and must include at least the following information:

- Name of Employee
- Name of the Plan
- Reference to the initial decision
- An explanation why you are appealing the initial determination

As part of your appeal, you may submit any written comments, documents, records, or other information relating to your claim.

After MetLife receives your written request appealing the initial determination, MetLife will conduct a full and fair review of your claim. Deference will not be given to the initial denial, and MetLife's review will look at the claim anew. The review on appeal will take into account all comments, documents, records, and other information that you submit relating to your claim without regard to whether such information was submitted or considered in the initial determination. The person who will review your appeal will not be the same person as the person who made the initial decision to deny your claim. In addition, the person who is reviewing the appeal will not be a subordinate of the person who made the initial decision to deny your claim. If the initial denial is based in whole or in part on a medical judgment, MetLife will consult with a health care professional with appropriate training and experience in the field of medicine involved in the medical judgment. This health care professional will not have consulted on the initial determination, and will not be a subordinate of any person who was consulted on the initial determination.

MetLife will notify you in writing of its final decision within a reasonable period of time, but no later than 45 days after MetLife's receipt of your written request for review, except that under special circumstances MetLife may have up to an additional 45 days to provide written notification of the final decision. If such an extension is required, MetLife will notify you prior to the expiration of the initial 45-day period, state the reason(s) why such an extension is needed, and state when it will make its determination. If an extension is needed because you did not provide sufficient information, the time period from MetLife's notice to you of the need for an extension to when MetLife receives the requested information does not count toward the time MetLife is allowed to notify you of its final decision. You will have 45 days to provide the requested information from the date you receive the notice from MetLife.

If MetLife denies the claim on appeal, MetLife will send you a final written decision that states the reason(s) why the claim you appealed is being denied, references any specific Plan provision(s) on which the denial is based, any voluntary appeal procedures offered by the Plan, and a statement of your right to bring a civil action if your claim is denied after an appeal. Upon written request, MetLife will provide you free of charge with copies of documents, records and other information relevant to your claim.

Routine Questions

If there is any question about a claim payment, an explanation may be requested from the Employer who is usually able to provide the necessary information.

Discretionary Authority of Plan Administrator and Other Plan Fiduciaries

In carrying out their respective responsibilities under the Plan, the Plan Administrator and other Plan fiduciaries shall have discretionary authority to interpret the terms of the Plan and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

STATEMENT OF ERISA RIGHTS

The following statement is required by federal law and regulation.

As a participant in The Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, all Plan documents governing the Plan, including insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor, and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the policyholder’s benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including the Employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees.

If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest Office of the Employee Benefits Security Administration, U.S. Department of Labor listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

FUTURE OF THE PLAN

It is hoped that This Plan will be continued indefinitely, but UAW/UMass Health & Welfare Trust Fund reserves the right to change or terminate the Plan in the future. Any such action would be taken only after careful consideration.

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

August 19, 2021

Group Number: TM 05993054-G

Dear Leslie Edwards Davis:

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

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

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

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

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

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

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

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

Sincerely,
Small Market Customer Service Team

Enclosures: Policy/Certificate
Cc: (Broker)

U.S. Business Intermediary and Producer Compensation Notice

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

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

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

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

Non-U.S. Coverage

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

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

POLICY ENDORSEMENT

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

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

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

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

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

Michel Khalaf
President

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

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

Policyholder: UAW/UMass Health & Welfare Trust Fund

Group Policy No.: TM 05993054-G

EFFECTIVE DATE:

This policy will take effect on September 1, 2021.

POLICY ANNIVERSARIES

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

PREMIUM PAYMENTS

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

POLICY SITUS

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

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

Timothy J. Ring
Secretary

Michel Khalaf
President

Signed by

Date: 10/4/2021

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

GROUP BASIC TERM LIFE AND ACCIDENT AND HEALTH INSURANCE POLICY

NON-DIVIDEND PAYING

TABLE OF CONTENTS

Section **Page**

DEFINITIONS

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

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

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

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

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

Employer means the Policyholder shown on page 1.

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

Policy Anniversary is defined on page 1.

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

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

Premium Due Date is defined on page 1.

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

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

SCHEDULE OF INSURANCE

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

ELIGIBILITY AND EFFECTIVE DATES OF INSURANCE

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

CONTRIBUTIONS

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

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

PREMIUM RATE(S)

Initial Rate(s)

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

Frequency of Premium Payment

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

Computation of Premium

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

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

Premiums for Changes in Insurance

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

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

PREMIUM RATES (continued)

Right to Change Premium Rates

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

1. when this policy is amended or endorsed;

2. when a class of eligible persons is added to or deleted from this policy for any reason including corporate restructuring, acquisition, spin-off or similar situations;

3. when a Policyholder's subsidiary, affiliate, division, branch or other similar entity is added to or deleted from this policy for any reason including corporate restructuring, acquisition, spin-off or similar situations;

4. when there is a significant change in the geographic distribution of insured Employees;

5. when applicable law requires a change in:

    a. the insurance provided by this policy; and/or

    b. the class of persons eligible for insurance under this policy; or

6. when a Premium Due Date coincides with or next follows:

    a. a change greater than 25% in the number of Covered Persons since the later of the policy Effective Date and the last date Premium rates were changed; or

    b. a change greater than 25% in the amount of insurance provided by this policy since the later of the policy Effective Date and the last date Premium rates were changed.

In addition, MetLife may change Premium rates:

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

2. on any other date agreed to by MetLife and the Policyholder.

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

GRACE PERIOD

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

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

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

GRACE PERIOD (continued)

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

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

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

END OF INSURANCE PROVIDED BY THIS POLICY

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

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

MetLife can end this policy as follows:

1. on the date Premium is not paid when due, subject to the Grace Period provisions; or

2. on any Premium Due Date, by giving the Policyholder 31 days advance Written notice, if less than:

    a. for Life Insurance and Accidental Death or Dismemberment Insurance for Employees, 75% of persons eligible under this policy are insured for Contributory Insurance;

    b. 100% of persons eligible under this policy are insured for Noncontributory Insurance; or

    c. 5 Employees are insured by this policy;

3. on any Premium Due Date, by giving the Policyholder 60 days advance Written notice, if the Policyholder fails to provide information on a timely basis or perform any obligations required by this policy or any applicable law; or

4. on any Policy Anniversary, except during a Rate Guarantee Period as may be provided in Exhibit 1, by giving the Policyholder 31 days advance Written notice.

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

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

REINSTATEMENT

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

GENERAL PROVISIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SCHEDULE OF EXHIBITS

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

EXHIBIT 1

SCHEDULE OF PREMIUM RATES

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

Rate Guarantee Period

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

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

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

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

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

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

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

EXHIBIT 2

CERTIFICATE FORMS

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