October 1, 2019

Dear Plan Participant:

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

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

- a dental plan with MetLife
- a vision plan with EyeMed Vision Care
- family dental benefits for just $100/year; free family vision coverage
- a wellness reimbursement of up to $190 per year against your gym/fitness receipts
- a childcare reimbursement for on or off-campus childcare receipts
- subsidized childcare slots in the University's Center for Early Education & Care (administered by CEEC)

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

If you have any questions or concerns about any of your benefits or coverage, contact the Benefits Specialist 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 Benefits Specialist: (413) 345-2156

MetLife: (800) 942-0854

EyeMed Vision Care: (866) 299-1358

Graduate Employee Organization: (413) 545-0705

UAW Local 2322: (413) 534-7600

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

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

WHAT IS A SUMMARY PLAN DESCRIPTION (SPD)?

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

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

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

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

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

This booklet and the Trust Fund's Benefits Specialist 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 Benefits Specialist will be glad to help you. Since telephone conversations and other oral statements can easily be misunderstood, they cannot be relied upon if they are in conflict with what is stated in this Plan Document.

OVERVIEW of GHWP

The benefit plan year for the GHWP is October 1 to September 30 of each year.

The benefit application is available online at https://hwtrust.geouaw.org/ and opens September 1 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 require the Trust Fund to enroll you under a valid SSN and therefore you will be required to submit your SSN in order to complete your enrollment.

Your dental, vision, wellness and childcare benefits, administered by the Trust Fund, are completely separate from your student health plan, administered by University Health Services. Your plan elections for Trust Fund benefits are completely separate from your student health plan elections. Though not administered by the Trust Fund, you can find more information regarding your student health plan at https://consolidatedhealthplan.com/group/592/home

ELIGIBILITY (GHWP)

Individual Eligibility

You are eligible to participate in the GHWP if:

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

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

All qualified earnings between May 26, 2019 and May 23, 2020 will be used to calculate eligibility for GHWP benefits for plan year 2019-20. For plan year 2019-20, the minimum earnings required in a GEO-eligible position is $5762.70* This amount must be earned between May 26, 2019 and May 23, 2020 to make you eligible for 12 months of Trust Fund benefits between October 1, 2019 and September 30, 2020.

*This amount is subject to change whenever stipend increases are applied.

Continuing Education Earning Equivalent

If you are teaching in the Division of Continuing Education, teaching a 3-credit course for one semester/session is considered equivalent to earning $5762.70 and makes you eligible for benefits between October 1, 2019 and September 30, 2020.

Spring-Entering Graduate Employees

If you are a spring semester entering graduate student, and you earn at least $5762.70 between May 26, 2019 and May 23, 2020, you will be eligible as of the first official day of the spring 2020 semester, January 21, 2020 (as established by UMass) through the end of the plan year, September 30, 2020.

How Summer Earnings are Calculated

Summer earnings in a GEO-eligible position count "forward" toward your eligibility for the next plan year that starts in October. If your only earnings during an academic year occur in the summer, this will not make you eligible for coverage during the concurrent summer months. For example, if your only GEO-eligible earnings commence June 1, 2019, these will count toward your eligibility for benefits starting October 1, 2019.

You may also be eligible for benefits if:

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

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

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

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

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

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

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

● separation or divorce of a spouse,

● termination of a domestic partnership,

● failure to continue to meet the eligibility conditions set forth above, and/or

● change in status of your dependent children.

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

Enrollment for spouses, same and opposite sex domestic partners is also subject to any prevailing premiums established by the Trustees for a given plan year. For plan year 2019-20, the yearly premium for family dental coverage is $100 per year, due upon application. There is no premium due for single+1 or family vision coverage. Trustees reserve the right to terminate the family portion of any participant's coverage due to lack of payment of the applicable family premiums, retroactive to the start of coverage date or retroactive to the last month that was paid in full.

Eligibility for your children

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

They’re your biological children; or

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

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

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

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

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

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

After your Child Ages Out of Eligibility

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

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

Your child is not married; and

Your child became handicapped before age 19; and

You file a properly completed Disability Certification Form with the Trust Fund each year after your child reaches age 26.

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

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

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

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

Be issued by a court or authorized state agency;

Clearly specify the alternate recipient;

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

Clearly state the period to which such order applies; and

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

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

BENEFITS OF GHWP

The benefit plan descriptions for the dental and vision plans can be found below. Our dental plan is the MetLife Dental PDP Plus Plan. The benefits follow a plan year of 10/1 to 9/30 of each year. Each 10/1, the plan year maximum amount renews. Our vision plan is the EyeMed Select Plan. The benefits follow a point of service plan year, meaning that your benefit renews 12 months after the last time you utilized it. Both of our plans have nationwide networks of providers. You can locate providers at https://www.uawumasstrustfund.org/

Appeals

Both insurers have internal appeals processes for claims. These processes are completely separate from the Trust Fund. If a MetLife claim is denied, you can request an appeal by writing to MetLife within 180 days of receiving MetLife's decision. Send appeals to MetLife Dental Claims, PO Box 981282, El Paso, TX, 79998-1282 (see also pgs 99-11 below). 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 MetLife before having anything other than preventative or diagnostic procedures done. MetLife 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.

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.

Second Opinion Exams

For MetLife: Please contact MetLife customer service at (800) 942-0854.

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

Dental

Metropolitan Life Insurance Company

Network: PDP Plus

Coverage Type	In-Network % of Negotiated Fee*	Out-of-Network % of R&C Fee***
Type A: Preventive (cleanings, exams, X-rays)	100%	100%
Type B: Basic Restorative (fillings, extractions)	80%	80%
Type C: Major Restorative (bridges, dentures, TMJ)	65%	65%
Type D: Orthodontia	50%	50%
TMJ	65%	65%

Deductible†		
Individual	$75	$75
Family	$225	$225
Annual Maximum Benefit		
Per Person	$2,000	$2,000
Orthodontia Lifetime Maximum		
Per Person	$1,000	$1,000
TMJ Maximum		
Per Person	$500	$500

Child(ren)'s eligibility for dental coverage is from birth up to age 26.

*Negotiated Fee refers to the fees that participating dentists have agreed to accept as payment in full for covered services, subject to any copayments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change.

***R&C fee refers to the Reasonable and Customary (R&C) charge, which is based on the lowest of (1) the dentist's actual charge, (2) the dentist's usual charge for the same or similar services, or (3) the charge of most dentists in the same geographic area for the same or similar services as determined by MetLife.† Applies only to Type B & C Services (Out of Network)/No Deductible in Network including TMJ.

List of Primary Covered Services & Limitations

Type A - Preventive	How Many/How Often
Prophylaxis (cleanings)	• Two per fiscal year
Oral Examinations	• Two exams per fiscal year
Topical Fluoride Applications	• One fluoride treatment per every 6 months for dependent children up to 19th birthday
X-rays	• Full mouth X-rays: one per 60 months • Bitewing X-rays: one set per 6 months
Space Maintainers	• Space Maintainers for dependent children up to 14th birthday once per tooth area per lifetime
Sealants	• One application of sealant material for each non-restored, non-decayed 1st and 2nd molar of a dependent child up to 19th birthday
Type B - Basic Restorative	**How Many/How Often**
Fillings	• Replacement once every 24 months
Simple Extractions	
Crown, Denture, and Bridge Repair/Recementations	• Repair once every 12 months • Recementations once every 12 months
Endodontics	• Root canal treatment limited to once per tooth
General Anesthesia	• When dentally necessary in connection with oral surgery, extractions or other covered dental services
Oral Surgery	
Periodontics	• Periodontal scaling and root planing once every 24 months • Periodontal surgery once every 36 months • Total number of periodontal maintenance treatments and prophylaxis cannot exceed four treatments in a fiscal year
Type C - Major Restorative	**How Many/How Often**
Implants	• Replacement once every 60 months
Bridges and Dentures	• Dentures and bridgework replacement: one every 60 months • Replacement of an existing temporary full denture if the temporary denture cannot be repaired and the permanent denture is installed within 12 months after the temporary denture was installed
Crowns/Inlays/Onlays	• Replacement once every 60 months
Type D - Orthodontia	**How Many/How Often**
	• You, Your Spouse, and Your Children, up to age 19, are covered while Dental Insurance is in effect. • All dental procedures performed in connection with orthodontic treatment are payable as Orthodontia • Payments are on a repetitive basis • 20% of the Orthodontia Lifetime Maximum will be considered at initial placement of the appliance and paid based on the plan benefit's coinsurance level for Orthodontia as defined in the Plan Summary. • Orthodontic benefits end at cancellation of coverage

The service categories and plan limitations shown above represent an overview of your plan benefits. This document presents the majority of services within each category, but is not a complete description of the plan.

THIS IS ONLY A SUMMARY. Please see the full plan description, including exclusions and limitations, at https://www.uawumasstrustfund.org/geo-dental

Frequently Asked Questions

Who is a participating dentist?
A participating dentist is a general dentist or specialist who has agreed to accept negotiated fees as payment in full for covered services provided to plan members. Negotiated fees typically range from 15%-45% below the average fees charged in a dentist's community for the same or substantially similar services.[†]

How do I find a participating dentist?
There are thousands of general dentists and specialists to choose from nationwide --so you are sure to find one that meets your needs. You can receive a list of these participating dentists online at www.metlife.com/mybenefits or call 1-800-942-0854 to have a list faxed or mailed to you.

What services are covered under this plan?
All services defined under the group dental benefits plan are covered. Please review the enclosed plan benefits to learn more.

May I choose a non-participating dentist?
Yes. You are always free to select the dentist of your choice. However, if you choose a non-participating dentist, your out-of-pocket costs may be higher. He/she hasn't agreed to accept negotiated fees. So you may be responsible for any difference in cost between the dentist's fee and your plan's benefit payment.

Can my dentist apply for participation in the network?
Yes. If your current dentist does not participate in the network and you would like to encourage him/her to apply, ask your dentist to visit www.metdental.com, or call 1-866-PDP-NTWK for an application.[††] The website and phone number are for use by dental professionals only.

How are claims processed?
Dentists may submit your claims for you which means you have little or no paperwork. You can track your claims online and even receive email alerts when a claim has been processed. If you need a claim form, visit www.metlife.com/mybenefits or request one by calling 1-800-942-0854

Can I find out what my out-of-pocket expenses will be before receiving a service?
Yes. You can ask for a pretreatment estimate. Your general dentist or specialist usually sends MetLife a plan for your care and requests an estimate of benefits. The estimate helps you prepare for the cost of dental services. We recommend that you request a pre-treatment estimate for services in excess of $300. Simply have your dentist submit a request online at www.metdental.com or call 1-877-MET-DDS9. You and your dentist will receive a benefit estimate for most procedures while you are still in the office. Actual payments may vary depending upon plan maximums, deductibles, frequency limits and other conditions at time of payment.

Can MetLife help me find a dentist outside of the U.S. if I am traveling?
Yes. Through international dental travel assistance services[*] you can obtain a referral to a local dentist by calling +1-312-356-5970 (collect) when outside the U.S. to receive immediate care until you can see your dentist. Coverage will be considered under your out-of-network benefits.[**] Please remember to hold on to all receipts to submit a dental claim.

How does MetLife coordinate benefits with other insurance plans?
Coordination of benefits provisions in dental benefits plans are a set of rules that are followed when a patient is covered by more than one dental benefits plan. These rules determine the order in which the plans will pay benefits. If the MetLife dental benefit plan is primary, MetLife will pay the full amount of benefits that would normally be available under the plan, subject to applicable law. If the MetLife dental benefit plan is secondary, most coordination of benefits provisions require MetLife to determine benefits after benefits have been determined under the primary plan. The amount of benefits payable by MetLife may be reduced due to the benefits paid under the primary plan, subject to applicable law.

Do I need an ID card?
No. You do not need to present an ID card to confirm that you are eligible. You should notify your dentist that you are enrolled in the MetLife Preferred Dentist Program. Your dentist can easily verify information about your coverage through a toll-free automated Computer Voice Response system.

†Based on internal analysis by MetLife. Negotiated Fees refer to the fees that in-network dentists have agreed to accept as payment in full for covered services, subject to any co-payments, deductibles, cost sharing and benefits maximums. Negotiated fees are subject to change.
††Due to contractual requirements, MetLife is prevented from soliciting certain providers.
*AXA Assistance USA, Inc. provides Dental referral services only. AXA Assistance is not affiliated with MetLife, and the services and benefits they provide are separate and apart from the insurance provided by MetLife. Referral services are not available in all locations.
**Refer to your dental benefits plan summary for your out-of-network dental coverage.

Exclusions

This plan does not cover the following services, treatments and supplies:

- Services which are not Dentally Necessary, those which do not meet generally accepted standards of care for treating the particular dental condition, or which we deem experimental in nature;
- Services for which you would not be required to pay in the absence of Dental Insurance;
- Services or supplies received by you or your Dependent before the Dental Insurance starts for that person;
- Services which are primarily cosmetic (for Texas residents, see notice page section in Certificate);
- Services which are neither performed nor prescribed by a Dentist except for those services of a licensed dental hygienist which are supervised and billed by a Dentist and which are for:
  - Scaling and polishing of teeth; or
  - Fluoride treatments;
- Services or appliances which restore or alter occlusion or vertical dimension;
- Restoration of tooth structure damaged by attrition, abrasion or erosion;
- Restorations or appliances used for the purpose of periodontal splinting;
- Counseling or instruction about oral hygiene, plaque control, nutrition and tobacco;
- Personal supplies or devices including, but not limited to: water picks, toothbrushes, or dental floss;
- Decoration, personalization or inscription of any tooth, device, appliance, crown or other dental work;
- Missed appointments;
- Services:
  - Covered under any workers' compensation or occupational disease law;
  - Covered under any employer liability law;
  - For which the employer of the person receiving such services is not required to pay; or
  - Received at a facility maintained by the Employer, labor union, mutual benefit association, or VA hospital;
- Services covered under other coverage provided by the Employer;
- Temporary or provisional restorations;
- Temporary or provisional appliances;
- Prescription drugs;
- Services for which the submitted documentation indicates a poor prognosis;
- The following when charged by the Dentist on a separate basis:
  - Claim form completion;
  - Infection control such as gloves, masks, and sterilization of supplies; or
  - Local anesthesia, non-intravenous conscious sedation or analgesia such as nitrous oxide.
- Dental services arising out of accidental injury to the teeth and supporting structures, except for injuries to the teeth due to chewing or biting of food;
- Caries susceptibility tests;
- Other fixed Denture prosthetic services not described elsewhere in the certificate;
- Precision attachments, except when the precision attachment is related to implant prosthetics;

- Adjustment of a Denture made within 6 months after installation by the same Dentist who installed it;
- Fixed and removable appliances for correction of harmful habits;
- Appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards;
- Repair or replacement of an orthodontic device;
- Duplicate prosthetic devices or appliances;
- Replacement of a lost or stolen appliance, Cast Restoration, or Denture; and
- Intra and extraoral photographic images

Limitations

Alternate Benefits: Where two or more professionally acceptable dental treatments for a dental condition exist, reimbursement is based on the least costly treatment alternative. If you and your dentist have agreed on a treatment that is more costly than the treatment upon which the plan benefit is based, you will be responsible for any additional payment responsibility. To avoid any misunderstandings, we suggest you discuss treatment options with your dentist before services are rendered, and obtain a pre-treatment estimate of benefits prior to receiving certain high cost services such as crowns, bridges or dentures. You and your dentist will each receive an Explanation of Benefits (EOB) outlining the services provided, your plan's reimbursement for those services, and your out-of-pocket expense. Procedure charge schedules are subject to change each plan year. You can obtain an updated procedure charge schedule for your area via fax by calling 1-800-942-0854 and using the MetLife Dental Automated Information Service. Actual payments may vary from the pretreatment estimate depending upon annual maximums, plan frequency limits, deductibles and other limits applicable at time of payment.

Cancellation/Termination of Benefits: Coverage is provided under a group insurance policy (Policy form GPNP99) issued by MetLife. Coverage terminates when your membership ceases, when your dental contributions cease or upon termination of the group policy by the Policyholder or MetLife. The group policy terminates for non-payment of premium and may terminate if participation requirements are not met or if the Policyholder fails to perform any obligations under the policy. The following services that are in progress while coverage is in effect will be paid after the coverage ends, if the applicable installment or the treatment is finished within 31 days after individual termination of coverage: Completion of a prosthetic device, crown or root canal therapy.

Like most group benefit programs, benefit programs offered by MetLife and its affiliates contain certain exclusions, exceptions, reductions, limitations, waiting periods and terms for keeping them in force. For complete details of coverage and availability, please refer to the group policy form GPNP99 or contact MetLife.

UAW UMass H&W Trust Fund

Group # 9794348 UMass Grad Employees

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.

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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.

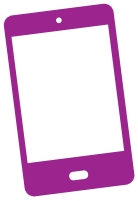
Benefits Snapshot	With EyeMed	Out-of-Network Reimbursement
Exam, with dilation as necessary (once every 12 months)	$10 Co-pay	Up to $50
Frames (once every 12 months)	$0 Co-pay, $150 Allowance; 20% off balance over $150	Up to $90
Single Vision Lenses (once every 12 months)	$10 Co-pay	Up to $42
or Contacts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

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

WELLNESS REIMBURSEMENT BENEFITS

Eligible graduate employees can be reimbursed for up to $190 per plan year towards expenses for wellness/fitness receipts. Only eligible grad employees' receipts are eligible; family members' receipts are not eligible. If you have a joint membership with a family member, we will prorate the receipt to address just your individual cost.

The wellness reimbursement application is accessed through the same online enrollment process as the dental & vision plans, except that you must include a copy of a valid receipt demonstrating your payment of membership fees/fees/tuition to a gym, physical fitness institution or organization. This benefit follows the same plan year of October 1-September 30 of each year. If you are eligible for dental & vision benefits, you are eligible for a maximum reimbursement of $190 per plan year.

Reimbursements are made for receipts dated during our plan year, 10/1 to 9/30 of each year. If you pay on a monthly basis, charges dated after 10/1 are eligible. If you purchase semester or yearly plans, the period of the receipt must include a majority of the plan year to be eligible (i.e. though dated in Sept, UMass Fall 2019 gym receipts are eligible; receipts for the previous summer are not).

Eligible Wellness Activities

Eligible activities promote fitness and stress reduction through physical exercise. Examples include: gym memberships, yoga, dance, aerobics and martial arts classes, golf and ski fees, marathon, road race and "tough mudder" fees, swim fees, intramural sport fees, court fees and ice rental fees for related sport, state and national park passes and camping fees. Both on campus and off-campus programs are eligible. Yearly membership fees, monthly service fees, locker fees and on-site equipment rentals required for the activity are eligible; late fees are not. Receipts from nationally recognized weight loss programs with an exercise component, as well as DVD programs (if connected to an online/in person program that you enroll in/interact with, such as having an online coach, a nutrition program component or an online team/ community) are eligible for reimbursement. Wearable personal coaching/fitness tracking devices (excludes accessories and only 1 per person per plan year) are eligible for reimbursement. Examples of eligible devices include: Fitbit Alta, Charge & Ionic, Moov Now, Misfit Ray, Garmin Vivosmart & Forerunner and Apple Watch. Online subscriptions to fitness tracking/coaching apps are also eligible. Activities that aren't eligible include: massage, acupuncture, health costs, spa treatments, facials, and equipment purchases. Receipts for family members or other individuals are not eligible. Individuals who have special medical or disability needs and have requests that certain adaptive programs be deemed eligible may submit requests on a case by case basis. Documentation supporting the request must be provided and final approval is per the decision of the Trustees.

Pre-Paid Central Rock Gym Memberships and The Healing ZONE therapeutic massage packages as an Alternative to Reimbursement

For the 2019-20 plan year, the Trust Fund will offer 100 pre-paid, 4-month gym memberships at Central Rock Gym (CRG) in Hadley, MA, and 130 5-packs of 30 minute massages at The Healing ZONE (THZ) in Hadley, MA, which can be accepted by eligible grad employees in lieu of receiving a reimbursement of eligible receipts. CRG memberships and THZ packages are awarded on a first-come, first-served basis to an eligible grad employee who has completed the online benefits application and completed the separate Prepaid User Agreement. Receiving a pre-paid membership constitutes a full and complete wellness reimbursement for the plan year and recipients are not eligible for any additional wellness reimbursement for that plan year. If you accept a pre-paid membership and then fail to claim the membership by appearing at the facility and completing their registration, you will not be eligible for any other reimbursement for that plan year and will forfeit eligibility for reimbursement for the next plan year.

How & When You'll Receive Reimbursement

Valid reimbursements can be distributed either by emailed check, or by deposit into your PayPal or Amazon.com account.

1) Emailed check: You can alternatively opt for payment via emailed check. We use a secure payment processor, Checkbook, that will email a digital check to the address we have on file for you. It generally takes 4 weeks to receive your reimbursement using this method. The email from Checkbook will include instructions to:

a) Direct deposit the check online with your banking institution. If you choose this method, please type your account number with care. Mistyped account numbers will cause your bank to reject the check. In this case, Checkbook will email you instructions on correcting the error -OR-

b) Print and cash the check: no special ink or paper is required.

2) PayPal: In the online application, you can opt for payment via PayPal and provide your email address or cell phone number, and you'll receive an email/text when your reimbursement is available. Then you can log into PayPal and transfer your payment to any bank account of your choosing or if you prefer, you can request that PayPal send you a check for a $1.50 fee. It generally takes 4 weeks to receive your reimbursement using this method.

3) Deposit into your Amazon.com account, using the email address you provide.

With any of these methods, it is the employee's responsibility to provide the correct email address and to collect the payment once it is emailed, or deposited into my PayPal or Amazon.com account. The Trust Fund and its trustees are not responsible in any way for reimbursements by any of these methods after they are emailed or sent via PayPal or Amazon. The Trust Fund is not responsible if your individual email, PayPal or Amazon.com account is hacked and your check or these deposits are accessed by an unauthorized user. You agree to abide by the terms and conditions set forth by PayPal and Amazon.com with regard to claiming any reimbursements that the Trust Fund deposits into your account. In the case of PayPal, deposits are returned to the Trust Fund after 30 days if they remain unclaimed. Reimbursements deposited into Amazon.com accounts cannot be cashed out, must be used for purchases at Amazon.com and do not expire. Payment elections are final and cannot be altered. Receipts for plan year 2019-2020 are due by June 30, 2020.

How to Submit Your Receipt

Even if you are declining dental & vision benefits, you still need to apply for the wellness reimbursement on our website at https://hwtrust.geouaw.org/ Once you complete the application, submit your receipt by uploading it with your application into our system or providing it by email. The Trust Fund is unable to issue a wellness reimbursement without an electronically signed application on file for you. You may submit receipts up to two times per year. If you have multiple receipts, you will need to group them together across two submissions. In no case will the Trust Fund issue your reimbursement in more than two payments per year.

CHILDCARE REIMBURSEMENT BENEFIT

The Trust Fund will distribute at least $115,000 during the 2019-20 plan year in reimbursements across eligible graduate employees for their costs for on or off-campus licensed childcare.

Eligibility

To be eligible you must be 1) a UMass graduate student employee 2) working in a GEO-eligible position earning at least $5762.70* during the plan year and 3) use licensed childcare. Eligible childcare must be state-licensed (or equivalent), and includes infant, toddler or pre-school care, as well as after-school and summer camp care purchased for a school-aged dependent. Trust Fund Trustees reserve the right to ultimately determine eligibility.

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.

Childcare reimbursement applicants who file tax returns as citizens from a country with a tax treaty with the US that artificially lowers their tax return's Gross Adjusted Income will be required to use and provide the output of an approved Adjusted Gross Income (AGI) Calculator to arrive at an approximation of what their AGI would be for purposes of ranking their application by household income and family size.

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. In addition, the Trust Fund receives information from the Graduate Student Senate (GSS) and the CCAMPIS grant administrator for the same period regarding childcare awards families receive from GSS, Student Affairs and CCAMPIS for the same period and reduces reported costs accordingly.

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

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 emailed check, PayPal or allowance via Amazon.com.

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 Sept 1 & deadline is Sept 15, for June-August receipts
- Application opens Jan 1 & deadline is Jan 15, for Sept-Dec receipts
- Application opens June 1 & deadline is June 15, for Jan-May 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, you 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.

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

EFFECTIVE 7/01/10
ISSUED 6/26/08

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

OPTIONAL METLAW PREPAID LEGAL BENEFIT

Eligible grad employees can elect to enroll in the *optional, 100% employee paid* group legal plan, MetLaw. The employee premium to participate in MetLaw is $216/year paid in 6 monthly installments of $36 and the minimum enrollment period is 12 months.

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 this benefit, available at http://www.uawumasstrustfund.org

Payments
MetLaw 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.

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.

MetLaw® Benefit Definitions & Reimbursements

	Network	
ADVICE AND CONSULTATION	IN	OUT-OF
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 definition above)	Fully Covered	$70
CONSUMER PROTECTION MATTERS	IN	OUT-OF
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	OUT-OF
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

	Network	
DEFENSE OF CIVIL LAWSUITS (continued)	IN	OUT-OF
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	OUT-OF
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 themto 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	OUT-OF
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

	Network	
ESTATE PLANNING DOCUMENTS (continued)	IN	OUT-OF
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
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	OUT-OF
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 plan member and includes the negotiation, preparation, review and execution of a prenuptial agreement between the plan member and his or her fiancé/partner prior to their marriage or legal union (where allowed by law). It does not include subsequent litigation arising out of a prenuptial agreement. The fiancé/partner must either have separate counsel or waive his/her right to representation.	Fully Covered	$750
Protection from Domestic Violence This service covers the employee only, not the spouse or dependents, as the victim of domestic violence. It provides the employee 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
IMMIGRATION	IN	OUT-OF
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

	Network	
FINANCIAL MATTERS	**IN**	**OUT-OF**
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
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
Personal Bankruptcy or Wage Earner Plan This service covers the plan member and spouse in pre-bankruptcy planning, the preparation and filing of a personal bankruptcy or Wage Earner petition, and representation at all court hearings and trials. This service is not available if a creditor is affiliated with the sponsor or employer, even if the plan member or spouse chooses to reaffirm that specific debt.		
• 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
JUVENILE MATTERS	**IN**	**OUT-OF**
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

	Network	
PERSONAL INJURY	IN	OUT-OF
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.		
PROBATE	IN	OUT-OF
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	OUT-OF
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
Security Deposit Assistance 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 witness; and preparing the participant for the small claims 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.		
• Demand Letter/Negotiations	Fully Covered	$250
• Counseling on Preparing Small Claims Complaint and Trial Preparation	Fully Covered	$150
Home Equity Loan for Primary Residence, or Second or Vacation Home This service covers the review or preparation of a home equity loan on the participant's primary residence, or 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 primary 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

	Network	
REAL ESTATE MATTERS (continued)	IN	OUT-OF
Refinancing of Home (Primary Residence) This service covers the review or preparation, by an attorney representing the participant, of all relevant documents (including the refinance agreement, mortgage and deed, and documents pertaining to title, insurance, recordation and taxation), which are involved in the refinancing of or obtaining a home equity loan on a participant's primary residence. The benefit also includes attendance of an attorney at closing. This benefit includes obtaining a permanent mortgage on a newly constructed home. It does not include services provided by any attorney representing a lending institution or title company. The benefit does not include the refinancing of a second home, vacation property or property that is held for any rental, business, investment or income purpose.	Fully Covered	$350
Refinancing of Home (Second or Vacation Home) This service covers the review or preparation, by an attorney representing the participant, of all relevant documents (including the refinance agreement, mortgage and deed, and documents pertaining to title, insurance, recordation and taxation), which are involved in the refinancing of or obtaining a home equity loan on a participant's second home or vacation home. The benefit also includes attendance of an attorney at closing. This benefit includes obtaining a permanent mortgage on a newly constructed home. It does not include services provided by any attorney representing a lending institution or title company. The benefit does not include the refinancing of a second home, vacation property or property that is held for any rental, business, investment or income purpose.	Fully Covered	$350
Sale or Purchase of Home (Primary Residence) This service covers the review or preparation, by an attorney representing the participant, of all relevant documents (including the construction documents for a new home, the purchase agreement, mortgage and deed, and documents pertaining to title, insurance, recordation and taxation) which are involved in the purchase or sale of a participant's primary residence or a vacant property to be used for building a primary residence.The benefit also includes attendance of the attorney at closing. It does not include services provided by any attorney representing a lending institution or title company. The benefit does not include the sale or purchase of a second home, vacation property, rental property, property held for business or investment or leases with an option to buy.	Fully Covered	$500
Sale or Purchase of Home (Secondary or Vacation Home) This service covers the review or preparation, by an attorney representing the participant, of all relevant documents (including the construction documents for a new second home or vacation home, the purchase agreement, mortgage and deed, and documents pertaining to title, insurance, recordation and taxation), which are involved in the purchase or sale of a participant's second home, vacation home or of a vacant property to be used for building a second home or vacation home. The benefit also includes attendance of an attorney at closing. It does not include services provided by any attorney representing a lending institution or title company. The benefit does not include the sale or purchase of a second home or vacation home held for rental purpose, business, investment or income or leases with an option to buy.	Fully Covered	$500
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 OFFENSES	IN	OUT-OF
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 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 second day of trial up to a maximumof $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 Company, MetLife® and affiliates, or 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, business or investment matters, and matters involving property held for investment or rental or issues when the Participant is the landlord; (6) patent, trademark and copyright matters; (7) costs or fines; (8) frivolous or unethical matters and (9) matters for which an attorney-client relationship exists prior to the Participant becoming eligible for Plan benefits. L0514376171[exp0715][All States][DC,PR]

HOW TO ENROLL

You must complete the online enrollment form and electronically sign the benefits authorization form before you will be eligible for benefits. Enrollment occurs online only at https://hwtrust.geouaw.org/ If you have any difficulty with the online application, please contact the Benefits Specialist 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 Benefits Specialist at uawdental@external.umass.edu or (413) 345-2156 so that your records can be updated.

Your Benefits Authorization Form

Electronically signing your benefits authorization form certifies that all information you submit to the UAW/UMass Health & Welfare Trust Fund is true and correct to the best of your knowledge. By signing the form, you agree to and understand the following: 1) the effective date and termination date of your membership and benefits will be determined by your employer and/or the Trustees of the UAW/UMass Health & Welfare Trust Fund and/or plan sponsor in accordance with the

underwriting of any and all vendors employed by the Trust for the purpose of providing benefits; 2) the email address and campus mail address you provide to the Trust Fund will be the primary methods used to communicate with you about your benefits; 3) you release to the administrative employees and Trustees of the UAW/UMass Health & Welfare Trust Fund, to GEO/UAW Local 2322, and to any and all vendors employed by the Trust Fund for the purpose of providing benefits, information necessary to provide you with, and to verify your eligibility for, any and all benefits offered by the Trust Fund (including but not limited to dental, vision, wellness, and childcare assistance).

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

WHEN YOUR COVERAGE BEGINS

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

If you are a new employee

If you are an incoming graduate student employee for academic year 2019-20 the earliest start date for your benefits is October 1, 2019.

If you are an existing employee

If you are a graduate student employee during academic year 2019-20, and are otherwise eligible, you can still enroll in the 19-20 plan up to August 31, 2020. After that date, the application is closed.

Open Enrollment Periods

Each year, there are five open enrollment periods during which you can submit a benefits application online at www.hwtrust.geouaw.org For plan year 2019-20, open enrollment occurs according to the following schedule with the following applicable coverage start dates:

Sept 1-Sept 24, 2019, for a coverage start date of 10/1/19

Nov 1-Nov 15, 2019, for a coverage start date of 11/1/19

Feb 1-Feb 15, 2020, for a coverage start date of 2/1/20

April 1-April 15, 2020, for a coverage start date of 4/1/20

June 15-June 30, 2020; for a coverage start date of 7/1/20

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 GHWP benefits if you would have been eligible prior to the leave.

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

If you have Family Coverage

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

YOUR ID CARDS

If you are eligible for benefits and have completed the online application, you will first receive an email confirming your eligibility and enrollment. Then, within 10 days of your first date of enrollment you should receive an ID card directly from EyeMed Vision Care if you have opted into vision benefits. MetLife does not issue hard-copy ID cards but you can download a digital ID by registering at www.metlife.com/mybenefits Our group name for the registration is UAW UMass Health and Welfare Trust Fund, *not* University of Massachusetts. Once you're registered, you can also download a virtual ID card to your smartphone. Just search "MetLife" at the iTunes App Store or Google Play to download the app. Then use your MyBenefits log in information to access these features and your ID card can be downloaded.

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

MetLife Group #: 161474

EyeMed Group #: 9794348

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

-your student ID is linked to your MetLife enrollment as your "employee ID" and can be used to locate your enrollment in their system

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

Call the Benefits Specialist 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 at the end of the plan year on 9/30 if you do not have GEO-qualified earnings meeting the minimum required for the next academic year. If you fail to enroll as a student, withdraw from student status, or fail to meet the minimum earnings requirement due to early termination of employment, your coverage ends 30 days after the date of the aforementioned event.

COBRA CONTINUATION COVERAGE

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

Once your GHWP eligibility is lost, graduate employees are eligible to apply for COBRA continuation coverage, where you can maintain dental and/or vision coverage for up to eighteen (18 months by paying the premium yourself. No benefits other than the dental & vision plans offered under the GHWP are subject to COBRA continuation coverage.

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

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

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

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

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

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

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

2019-20 rates effective 10/1/19-9/30/20: Single: $34.37/month, Single + 1: Not Available, Family $101.99/month

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

PAYMENT POLICIES

If we issued a payment to you via personal 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.

We 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

YOUR BENEFIT PLAN

UAW UMass Health and Welfare Trust Fund

All Actively At Work Graduate Student Employees Working at Least 10 Hours and Earning at Least $4,632 per the 12 Month Period Between the Final Pay Period of May and the Final Pay Period of May in the Subsequent Year

Dental Insurance for You and Your Dependents

Certificate Date: October 1, 2015

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

TO OUR EMPLOYEES:

All of us appreciate the protection and security insurance provides.

This certificate describes the benefits that are available to you. We urge you to read it carefully.

UAW UMass Health and Welfare Trust Fund

MetLife

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

CERTIFICATE OF INSURANCE

Metropolitan Life Insurance Company ("MetLife"), a stock company, certifies that You and Your Dependents 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 legal contract between MetLife and the Policyholder and may be changed or ended without Your consent or notice to You.

Policyholder:	UAW UMass Health and Welfare Trust Fund
Group Policy Number:	161474-1-G
Type of Insurance:	Dental Insurance
MetLife Toll Free Number(s): For Claim Information	FOR DENTAL CLAIMS: 1-800-942-0854

THIS CERTIFICATE ONLY DESCRIBES DENTAL INSURANCE.

THE BENEFITS OF THE POLICY PROVIDING YOUR COVERAGE ARE GOVERNED PRIMARILY BY THE LAWS 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 ALASKA, MINNESOTA, NEW HAMPSHIRE, NEW MEXICO, UTAH AND WASHINGTON

The Definition Of Child Is Modified For The Coverages Listed Below:

For Alaska Residents (Dental Insurance):

The term also includes newborns.

For Minnesota Residents (Dental Insurance):

The term also includes:

- Your grandchildren who are financially dependent upon You and reside with You continuously from birth;
- children for whom You or Your Spouse is the legally appointed guardian; and
- children for whom You have initiated an application for adoption.

The age limit for children and grandchildren will not be less than 25 regardless of the child's or grandchild's student status or full-time employment status. Your natural child, adopted child stepchild or children for whom You or Your Spouse is the legally appointed guardian under age 25 will not need to be supported by You to qualify as a Child under this insurance.

For New Hampshire Residents (Dental Insurance):

The age limit for children will not be less than 26, regardless of the child's marital status, student status, or full-time employment status. Your natural child, adopted child or stepchild under age 26 will not need to be supported by You to qualify as a Child under this insurance.

For New Mexico Residents (Dental Insurance):

The age limit for children will not be less than 25, regardless of the child's student status or full-time employment status. Your natural child, adopted child or stepchild will not be denied dental insurance coverage under this certificate because:

- that child was born out of wedlock;
- that child is not claimed as Your dependent on Your federal income tax return; or
- that child does not reside with You.

For Utah Residents (Dental Insurance):

The age limit for children will not be less than 26, regardless of the child's student status or full-time employment status. Your natural child, adopted child or stepchild under age 26 will not need to be supported by You to qualify as a Child under this insurance. The term includes an unmarried child who is incapable of self-sustaining employment because of a mental or physical handicap as defined by applicable law and who has been continuously covered under a Dental plan since reaching age 26, with no break in coverage of more than 63 days, and who otherwise qualifies as a Child except for the age limit. Proof of such handicap must be sent to Us within 31 days after:

- the date the Child attains the limiting age in order to continue coverage; or
- You enroll a Child to be covered under this provision;

and at reasonable intervals after such date, but no more often than annually after the two-year period immediately following the date the Child qualifies for coverage under this provision.

NOTICE FOR RESIDENTS OF ALASKA, MINNESOTA, MONTANA, NEW HAMPSHIRE, NEW MEXICO, UTAH AND WASHINGTON (continued)

For Washington Residents (Dental Insurance):

The age limit for children will not be less than 26, regardless of the child's marital status, student status, or full-time employment status. Your natural child, adopted child or stepchild under age 26 will not need to be supported by You to qualify as a Child under this insurance.

NOTICE FOR RESIDENTS OF ALL STATES WHO ARE INSURED FOR DENTAL INSURANCE

Notice Regarding Your Rights and Responsibilities

Rights:

- We will treat communications, financial records and records pertaining to Your care in accordance with all applicable laws relating to privacy.
- Decisions with respect to dental treatment are the responsibility of You and the Dentist. We neither require nor prohibit any specified treatment. However, only certain specified services are covered for benefits. Please see the Dental Insurance sections of this certificate for more details.
- You may request a pre-treatment estimate of benefits for the dental services to be provided. However, actual benefits will be determined after treatment has been performed.
- You may request a written response from MetLife to any written concern or complaint.
- You have the right to receive an explanation of benefits which describes the benefit determinations for Your dental insurance.

Responsibilities:

- You are responsible for the prompt payment of any charges for services performed by the Dentist. If the dentist agrees to accept part of the payment directly from MetLife, You are responsible for prompt payment of the remaining part of the dentist's charge.
- You should consult with the Dentist about treatment options, proposed and potential procedures, anticipated outcomes, potential risks, anticipated benefits and alternatives. You should share with the Dentist the most current, complete and accurate information about Your medical and dental history and current conditions and medications.
- You should follow the treatment plans and health care recommendations agreed upon by You and the Dentist.

NOTICE FOR RESIDENTS OF ALASKA

Reasonable and Customary Charges

Reasonable and Customary Charges for Out-of-Network services will not be based less than an 80th percentile of the dental charges.

Reasonable Access to an In-Network Dentist

If You do not have an In-Network Dentist within 50 miles of Your legal residence, We will reimburse You for the cost of Covered Services and materials provided by an Out-of-Network Dentist at the same benefit level as an In-Network Dentist.

Exclusions

The exclusion of services which are primarily cosmetic will not apply to the treatment or correction of a congenital defect of a newborn child.

Coordination of Benefits or Non-Duplication of Benefits with a Secondary Plan:

If This Plan is Secondary, This Plan will determine benefits as if the services were obtained from This Plan's In-Network provider under the following circumstances:

- the Primary Plan does not provide benefits through a provider network;
- both the Primary Plan and This Plan provide benefits through provider networks but the covered person obtains services through a provider in the Primary plan's network who is not in This Plan's network; or
- both the Primary Plan and This Plan provide benefits through provider networks but the covered person obtains services from a provider that is not part of the provider network of the Primary Plan or This Plan because no provider in the Primary Plan's provider network or This Plan's network is able to meet the particular health need of the covered person.

Procedures For Dental Claims

Procedures for Presenting Claims for Dental Insurance Benefits

All claim forms needed to file for Dental Insurance benefits under the group insurance program can be obtained from the Employer who can also answer questions about the insurance benefits and to assist You or, if applicable, Your beneficiary in filing claims. Dental claim forms can also be downloaded from www.metlife.com/dental. 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.

Routine Questions on Dental Insurance Claims

If there is any question about a claim payment, an explanation may be requested from MetLife by dialing 1-800-942-0854.

Claim Submission

For claims for Dental Insurance benefits, the claimant must complete the appropriate claim form and submit the required proof as described in the FILING A CLAIM section of the certificate.

Claim forms must be submitted in accordance with the instructions on the claim form.

NOTICE FOR RESIDENTS OF ALASKA

Procedures For Dental Claims (Continued)

Initial Determination

After You submit a claim for Dental Insurance benefits to MetLife, 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 30 day period from the date You submitted Your claim; except for situations requiring an extension of time of up to 15 days because of matters beyond the control of MetLife. If MetLife needs such an extension, MetLife will notify You prior to the expiration of the initial 30 day period, 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 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. Further, if an internal rule, protocol, guideline or other criterion was relied upon in making the denial, the claims decision will state the rule, protocol, guideline or other criteria or indicate that such rule, protocol, guideline or other criteria was relied upon and that You may request a copy free of charge.

Within 30 days after We receive Proof of Your claim, We will approve and pay the claim or We will deny the claim. If We deny the claim, We will provide You with the basis of Our denial or the specific additional information that We need to adjudicate Your claim. If We request additional information, We will approve and pay the claim or We will deny the claim within 15 days after We receive the additional information. If the claim is approved and not paid within the time period provided, the claim will accrue at an interest rate of 15 percent per year until the claim is paid.

Appealing the Initial Determination

If MetLife denies Your claim, You may appeal the denial. 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, or as soon as reasonably possible for situations in which You cannot reasonably meet the deadline. 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
- Whether the appeal is the first or second appeal of the initial determination
- An explanation why You are appealing the initial determination.

As part of each appeal, You may submit any written comments, documents, records, or other information relating to Your claim.

After MetLife receives Your written request, MetLife will conduct a full and fair review of Your claim. Deference will not be given to initial denials, 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. Your appeal will be reviewed by a person holding the same professional license as the treating Dental provider. 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.

NOTICE FOR RESIDENTS OF ALASKA

Procedures For Dental Claims (Continued)

MetLife will notify You in writing of its final decision within 18 days after MetLife's receipt of Your written request for review.

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 and references any specific Plan provision(s) on which the denial is based. If an internal rule, protocol, guideline or other criterion was relied upon in denying the claim on appeal, the final written decision will state the rule, protocol, guideline or other criteria or indicate that such rule, protocol, guideline or other criteria was relied upon and that You may request a copy free of charge. Upon written request, MetLife will provide You free of charge with copies of documents, records and other information relevant to Your claim.

Second Level Appeal

If You disagree with the response to the initial appeal of the denied claim, You have the right to a second level appeal. We shall communicate Our final determination to You within 18 calendar days from receipt of the request, or as required by any applicable state or federal laws or regulations. Our communication to You shall include the specific reasons for the determination.

External Appeal

If You disagree with the response to the second appeal of the denied claim, You have the right to an external appeal. We will communicate the decision of the external appear agency in Writing. The decision will be made in accordance with the medical exigencies of the case involved, but in no event later than 21 working days after the appeal is filed, or, in the case of an expedited appeal, 72 hours after the time of requesting an external appeal of the health care insurer's decision. Decisions made by an external appeal agency are binding on Us and You unless the aggrieved party files suit in superior court within 6 months from the decision of the external appeal agency. All costs of the external appeal process, except those incurred by You or the treating professional in support of the appeal, will be paid by Us.

Overpayments

Recovery of Overpayments

We have the right to recover any amount that is determined to be an overpayment, within 180 days from the date of service, whether for services received by You or Your Dependents.

An overpayment occurs if it is determined that:

- the total amount paid by Us on a claim for Dental Insurance benefits is more than the total of the benefits due to You under this certificate; or

- payment We made should have been made by another group plan.

If such overpayment occurs, You have an obligation to reimburse Us.

NOTICE FOR RESIDENTS OF ALASKA

Overpayments (Continued)

How We Recover Overpayments

We may recover the overpayment, within 180 days from the date of service, from You by:

- stopping or reducing any future benefits payable for Dental Insurance;
- demanding an immediate refund of the overpayment from You; and
- taking legal action.

If the overpayment results from Our having made a payment to You that should have been made under another group plan, We may recover such overpayment within 180 days from the date of service, from one or more of the following:

- any other insurance company;
- any other organization; or
- any person to or for whom payment was made.

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.

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

Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, Arkansas 72201
(501) 371-2640 or (800) 852-5494

NOTICE FOR RESIDENTS OF CALIFORNIA

IMPORTANT NOTICE

TO OBTAIN ADDITIONAL INFORMATION, OR TO MAKE A COMPLAINT, CONTACT THE POLICYHOLDER OR THE METLIFE CLAIM OFFICE SHOWN ON THE EXPLANATION OF BENEFITS YOU RECEIVE AFTER FILING A CLAIM.

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 INSURANCE DEPARTMENT AT:

DEPARTMENT OF INSURANCE
300 SOUTH SPRING STREET
LOS ANGELES, CA 90013
1 (800) 927-4357

NOTICE FOR RESIDENTS OF THE STATE OF CALIFORNIA

California law provides that for dental insurance, domestic partners of California's residents must be treated the same as spouses. If the certificate does not already have a definition of domestic partner, then the following definition applies:

> **"Domestic Partner** means each of two people, one of whom is an Employee of the Employer, a resident of California and who have registered as domestic partners or members of a civil union with the California government or another government recognized by California as having similar requirements."

If the certificate already has a definition of domestic partner, that definition will apply to California residents, as long as it recognizes as a domestic partner any person registered as the Employee's domestic partner with the California government or another government recognized by California as having similar requirements.

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

Wherever the term step-child appears, it is replaced by step-child or child of Your Domestic Partner.

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 Policyholder. 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 Policyholder 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 (for calls placed within Idaho) or 208-334-4250 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

1-800-638-5433

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 MAINE

You have the right to designate a third party to receive notice if Your insurance is in danger of lapsing due to a default on Your part, such as for nonpayment of a contribution that is due. The intent is to allow reinstatements where the default is due to the insured person's suffering from cognitive impairment or functional incapacity. You may make this designation by completing a "Third-Party Notice Request Form" and sending it to MetLife. Once You have made a designation, You may cancel or change it by filling out a new Third-Party Notice Request Form and sending it to MetLife. The designation will be effective as of the date MetLife receives the form. Call MetLife at the toll-free telephone number shown on the face page of this certificate to obtain a Third-Party Notice Request Form. Within 90 days after cancellation of coverage for nonpayment of premium, You, any person authorized to act on Your behalf, or any covered Dependent may request reinstatement of the certificate on the basis that You suffered from cognitive impairment or functional incapacity at the time of cancellation.

NOTICE FOR MASSACHUSETTS RESIDENTS

The following provisions are required by Massachusetts law.

Translation Services

Translation services are available by calling 1-800-638-3368. We shall make available upon request interpreter and translation services related to administrative procedures by calling member services.

سنقوم عند الطلب بتوفير مترجمين وخدمات ترجمة تتعلق بالإجراءات الإدارية وذلك بالإتصال بخدمات العملاء.

យើងនឹងមានផ្តល់អ្នកបកប្រែ និងកិច្ចការបកប្រែ ដែលជាប់ទាក់ទងទៅនឹង
វិធីចាត់ចែងការ តាមការស្នើ ដោយទូរស័ព្ទទៅកន្លែងបំរើសមាជិក ។

我們提供協助辦理行政手續的翻譯服務，您若需要翻譯人員，請電洽
會員服務處。

Nous assurerons sur demande, les services d'interprétariat et de traduction en connexion avec les procédures administratives, en appelant les services aux membres.

Θα διαθέσουμε μετά από αίτηση υπηρεσίες διερμηνέα και μεταφραστή σχετικά με διοικητικές διαδικασίες ερχόμενοι σε επαφή με τις υπηρεσίες μελών..

Si w rele depatman sèvis kliyan an, epi w mande sèvis entèprèt ak tradiksyon pou pwosede administratif, sèvis la ap disponib pou w.

A richiesta metteremo a disposizione servizi di interpretariato e traduzione riguardo le procedure amministrative. Telefonare all'ufficio di Assistenza soci.

ถ้าท่านร้องขอ, เราจะจัดการบริการล่ามและบริการแปลภาษาให้กับท่าน สำหรับขั้นตอนที่เกี่ยวข้องกับขั้นตอนการบริหาร โดยท่านสามารถโทรติดต่อกับฝ่ายบริการสมาชิก.

Disponibilizaremos, a seu pedido, os serviços de um(a) tradutor(a)/intérprete para os procedimentos administrativos, contactando os serviços para membros.

По Вашему требованию будут предоставлены услуги устного и письменного перевода, связанные с административными процедурами, если Вы позвоните в отдел по обслуживанию членов.

Si usted lo solicita, pondremos a su disposición servicios de interpretación y traducción para asistirle en los procedimientos administrativos. Si necesita estos servicios, comuníquese con servicios a los miembros.

NOTICE FOR MASSACHUSETTS RESIDENTS (Continued)

The following provisions are required by Massachusetts law.

Summary of Utilization Review Procedures

MetLife reviews claims for evidence of need for certain dental procedures. These reviews are conducted by licensed dentists. If there is no evidence of need MetLife will deny benefits for a claim. MetLife also reviews claims to determine whether there exists a less costly treatment for a dental condition that is generally considered effective to treat the condition. If a less costly alternative treatment exists, MetLife will determine benefits based on the alternative treatment. If you want to determine the status of any such claim review, you can call MetLife at 1-800-942-0854.

Summary of Quality Assurance Programs

MetLife performs a check on certain credentials of any dentist applying to participate in the MetLife Preferred Dentist Program. If the credentials do not meet MetLife's standards, for example if a dentist does not have a valid license, the dentist will not be permitted to participate in the MetLife Preferred Dentist Program. MetLife does not interfere with the traditional relationship between MetLife Preferred Dentist Program dentists and their patients, or any determination between the patient and dentist as to what the appropriate dental treatment may be. MetLife dental plans also allow you to choose between any dentist, whether they participate in the MetLife Preferred Dentist Program or not. Therefore you should choose your dentist carefully, and you are responsible to be sure that your dentist delivers quality dental care.

Involuntary Disenrollment Rate

The involuntary disenrollment rate among insureds of MetLife is 0.

NOTICE FOR NEW HAMPSHIRE RESIDENTS

CONTINUATION OF YOUR DENTAL INSURANCE

If You are a resident of New Hampshire, Your Dental Insurance may be continued if it ends because Your employment ends unless:

- Your employment ends due to Your gross misconduct;
- this Dental Insurance ends for all employees;
- this Dental Insurance is changed to end Dental Insurance for the class of employees to which You belong;
- You are entitled to enroll in Medicare; or
- Your Dental Insurance ends because You failed to pay the required premium.

The Employer must give You written notice of:

- Your right to continue Your Dental Insurance;
- the amount of premium payment that is required to continue Your Dental Insurance;
- the manner in which You must request to continue Your Dental Insurance and pay premiums; and
- the date by which premium payments will be due.

The premium that You must pay for Your continued Dental Insurance may include:

- any amount that You contributed for Your Dental Insurance before it ended;
- any amount the Employer paid; and
- an administrative charge which will not to exceed two percent of the rest of the premium.

To continue Your Dental Insurance, You must:

- send a written request to continue Your Dental Insurance; and
- pay the first premium within 30 days after the date Your employment ends.

The maximum continuation period will be the longest of:

- 36 months if Your employment ends because You retire, and within 12 months of retirement You have a substantial loss of coverage because the employer files for bankruptcy protection under Title 11 of the United States Code;
- 29 months if You become entitled to disability benefits under Social Security within 60 days of the date Your Employment ends; or
- 18 months.

Your continued Dental Insurance will end on the earliest of the following to occur:

- the end of the maximum continuation period;
- the date this Dental Insurance ends;
- the date this Dental Insurance is changed to end Dental Insurance for the class of employees to which You belong;
- the date You are entitled to enroll for Medicare;
- if You do not pay the required premium to continue Your Dental Insurance; or
- the date You become eligible for coverage under any other group Dental coverage.

NOTICE FOR NEW HAMPSHIRE RESIDENTS (continued)

CONTINUATION OF YOUR DEPENDENT'S DENTAL INSURANCE

If You are a resident of New Hampshire, Your Dental Insurance for Your Dependents may be continued if it ends because Your employment ends, Your marriage ends in divorce or separation, or You die, unless:

- Your employment ends due to Your gross misconduct;
- this Dental Insurance ends for all Dependents;
- this Dental Insurance is changed, for the class of employees to which You belong, to end Dental Insurance for Dependents;
- the Dependent is entitled to enroll in Medicare; or
- Your Dental Insurance for Your Dependents ends because You fail to pay a required premium.

If Dental Insurance for Your Dependents ends because Your marriage ends in divorce or separation, the party responsible under the divorce decree or separation agreement for payment of premium for continued Dental Insurance must notify the employer, in writing, within 30 days of the date of the divorce decree or separation agreement that the divorce or separation has occurred. If You and Your divorced or separated Spouse share responsibility for payment of the premium for continued Dental Insurance, both You and Your divorced or separated Spouse must provide the notification.

The Employer must give You, or Your former Spouse if You have died or Your marriage has ended, written notice of:

- Your right to continue Your Dental Insurance for Your Dependents;
- the amount of premium payment that is required to continue Your Dental Insurance for Your Dependents;
- the manner in which You or Your former Spouse must request to continue Your Dental Insurance for Your Dependents and pay premiums; and
- the date by which premium payments will be due.

The premium that You or Your former Spouse must pay for continued Dental Insurance for Your Dependents may include:

- any amount that You contributed for Your Dental Insurance before it ended; and
- any amount the Employer paid.

To continue Dental Insurance for Your Dependents, You or Your former Spouse must:

- send a written request to continue Dental Insurance for Your Dependents; and
- must pay the first premium within 30 days of the date Dental Insurance for Your Dependents ends.

If You, and Your former Spouse, if applicable, fail to provide any required notification, or fail to request to continue Dental Insurance for Your Dependents and pay the first premium within the time limits stated in this section, Your right to continue Dental Insurance for Your Dependents will end.

NOTICE FOR NEW HAMPSHIRE RESIDENTS (continued)

CONTINUATION OF YOUR DEPENDENT'S DENTAL INSURANCE (Continued)

The maximum continuation period will be the longest of the following that applies:

- 36 months if Dental Insurance for Your Dependents ends because Your marriage ends in divorce or separation, except that with respect to a Spouse who is age 55 or older when your marriage ends in divorce or separation the maximum continuation period will end when the divorced or separated Spouse becomes eligible for Medicare or eligible for participation in another employer's group plan;
- 36 months if Dental Insurance for Your Dependents ends because You die, except that with respect to a Spouse who is age 55 or older when You die, the maximum continuation period will end when Your surviving Spouse becomes eligible for Medicare or eligible for participation in another employer's group dental coverage;
- 36 months if Dental Insurance for Your Dependents ends because You become entitled to benefits under Title XVIII of Social Security, except that with respect to a Spouse who is age 55 or older when You become entitled to benefits under Title XVIII of Social Security, the maximum continuation period will end when the divorced or separated Spouse becomes eligible for Medicare or eligible for participation in another employer's group dental coverage;
- 36 months if You become entitled to benefits under Title XVIII of Social Security while You are already receiving continued benefits under this section, except that with respect to a Spouse who is age 55 or older when You first become entitled to continue Your Dental Insurance the maximum continuation period will end when the divorced or separated Spouse becomes eligible for Medicare or eligible for participation in another employer's group dental coverage;
- 36 months with respect to a Dependent Child if Dental Insurance ends because the Child ceases to be a Dependent Child;
- 36 months if Your employment ends because You retire, and within 12 months of retirement You have a substantial loss of coverage because the employer files for bankruptcy protection under Title 11 of the United States Code;
- 29 months if Dental Insurance for Your Dependents ends because Your employment ends, and within 60 days of the date Your employment ends you become entitled to disability benefits under Social Security; or
- 18 months if Dental Insurance for Your Dependents ends because Your employment ends.

A Dependent's continued Dental Insurance will end on the earliest of the following to occur:

- the end of the maximum continuation period;
- the date this Dental Insurance ends;
- the date this Dental Insurance is changed to end Dental Insurance for Dependents for the class of employees to which You belong;
- the date the Dependent becomes entitled to enroll for Medicare;
- if You do not pay a required premium to continue Dental Insurance for Your Dependents; or
- the date the Dependent becomes eligible for coverage under any other group dental coverage.

NOTICE FOR NEW HAMPSHIRE RESIDENTS

The following service will be a Covered Service for New Hampshire residents whether or not general anesthesia or intravenous sedation is already specified elsewhere as covered:

General anesthesia or intravenous sedation in connection with oral surgery, extractions or other Covered Services, when

- the covered person is a Child under the age of 6 who is determined by a licensed Dentist in conjunction with a licensed Physician to have a dental condition of significant complexity which requires the Child to receive general anesthesia for the treatment of such condition;

- the covered person has exceptional medical circumstances or a developmental disability as determined by a licensed Physician which place the person at serious risk; or

- We determine such anesthesia is necessary in accordance with generally accepted dental standards.

NOTICE FOR RESIDENTS OF PENNSYLVANIA

Dental Insurance for a Dependent Child may be continued past the age limit if that Child is a full-time student and insurance ends due to the Child being ordered to active duty (other than active duty for training) for 30 or more consecutive days as a member of the Pennsylvania National Guard or a Reserve Component of the Armed Forces of the United States.

Insurance will continue if such Child:

- re-enrolls as a full-time student at an accredited school, college or university that is licensed in the jurisdiction where it is located;
- re-enrolls for the first term or semester, beginning 60 or more days from the child's release from active duty;
- continues to qualify as a Child, except for the age limit; and
- submits the required Proof of the child's active duty in the National Guard or a Reserve Component of the United States Armed Forces.

Subject to the Date Insurance For Your Dependents Ends subsection of the section entitled ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS, this continuation will continue until the earliest of the date:

- the insurance has been continued for a period of time equal to the duration of the child's service on active duty; or
- the child is no longer a full-time student.

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 lA, 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 TO 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 any questions regarding an appeal or grievance concerning the dental services that You have been provided that have not been satisfactorily addressed by this Dental Insurance, You may contact the Virginia Office of the Managed Care Ombudsman for assistance.

The Office of the Managed Care Ombudsman
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218
1-877-310-6560 - toll-free
1-804-371-9944 - locally
www.scc.virginia.gov - web address
ombudsman@scc.virginia.gov - email

Or:

Office of Licensure and Certification
Division of Acute Care Services
Virginia Department of Health
9960 Mayland Drive
Suite 401
Henrico, Virginia 23233-1463
Phone number: 1-800-955-1819/ local: 804-367-2106
Fax: (804) 527-4503
MCHIP@vdh.virginia.gov

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.

DENTAL INSURANCE: PROCEDURES FOR DENTAL CLAIMS

Claim Submission

For claims for Dental Insurance benefits, the claimant must complete the appropriate claim form and submit the required proof as described in the FILING A CLAIM section of the certificate.

Claim forms must be submitted in accordance with the instructions on the claim form.

Appealing the Initial Determination

If MetLife denies Your claim, You may take two appeals of the initial determination. 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;
- Whether the appeal is the first or second appeal of the initial determination;
- An explanation why You are appealing the initial determination.

As part of each 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 or determination on the first appeal, MetLife will conduct a full and fair review of Your claim. Deference will not be given to initial denials, 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 dentistry involved in the 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 determination within 30 days after MetLife's receipt of Your written request for review, except that under special circumstances MetLife may have up to an additional 30 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 30 day period, state the reason(s) why an extension is needed, and state when it will make its determination.

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 and references any specific Plan provision(s) on which the denial is based. If an internal rule, protocol, guideline or other criterion was relied upon in denying the claim on appeal, the final written decision will state the rule, protocol, guideline or other criteria or indicate that such rule, protocol, guideline or other criteria was relied upon and that You may request a copy free of charge. Upon written request, MetLife will provide You free of charge with copies of documents, records and other information relevant to Your claim.

Policies and Procedures for Emergency and Urgent Care

Urgent care and Emergency services: All member dentists of the MetLife Preferred Dentist Program are required to have 24-hour emergency coverage or have alternate arrangements for emergency care for their patients. Since the MetLife Preferred Dentist Program is a freedom-of-choice PPO program, there is no primary care physician. No authorization of a service is necessary by a Primary Care Physician, nor is it necessary to obtain a pre-authorization of services. The patient is free to use the dentist of their choice.

An important distinction to be made for this section is the difference between Urgent Care in a dental situation versus that found in medical. Urgent care is defined more narrowly in dental to mean the alleviation of severe pain (as there are no life-threatening situations in dental). Additionally, the alleviation of pain in dental is a simple palliative treatment, which is not subject to claim review.

The benefit amount will be consistent with the terms contained in the insured's contract.

NOTICE TO RESIDENTS OF VIRGINIA (continued)

Urgent Care Submission:

A small number of claims for dental expense benefits may be urgent care claims. Urgent care claims for dental expense benefits are claims for reimbursement of dental expenses for services which a dentist familiar with the dental condition determines would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Of course any such claim may always be submitted in accordance with the normal claim procedures. However your dentist may also submit such a claim to MetLife by telephoning MetLife and informing MetLife that the claim is an Urgent Care Claim. Urgent Care Claims are processed according to the procedures set out above, however once a claim for urgent care is submitted MetLife will notify you of the determination on the claim as soon as possible, but no later than 72 hours after the claim is filed. If you or your covered dependent does not provide the claims administrator with enough information to decide the claim, MetLife will notify you within 24 hours after it receives the claim of the further information that is needed. You will have 48 hours to provide the information. If the needed information is provided, MetLife will then notify you of the claim decision within 48 hours after MetLife received the information. If the needed information is not provided, MetLife will notify you or your covered dependent of its decision within 120 hours after the claim was received.

If your urgent care claim is denied but you receive the care, you may appeal the denial using the normal claim procedures. If your urgent care claim is denied and you do not receive the care, you can request an expedited appeal of your claim denial by phone or in writing. MetLife will provide you any necessary information to assist you in your appeal. MetLife will then notify you of its decision within 72 hours of your request in writing. However, MetLife may notify you by phone within the same time frames above and then mail you a written notice.

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, New York 10166
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 and Your Dependents will only be insured for the benefits:

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

BENEFIT	BENEFIT AMOUNT AND HIGHLIGHTS	
Dental Insurance For You and Your Dependents		
Covered Percentage for:	In-Network based on the Maximum Allowed Charge	Out-of-Network based on the Reasonable and Customary Charge
Type A Services	100%	100%
Type B Services	80%	80%
Type C Services	65%	65%
Orthodontic Covered Services	50%	50%
Deductibles for:		
Yearly Individual Deductible	No Deductible	$75 for the following Covered Services Combined: Type B; Type C
Yearly Family Deductible	No Deductible	$225 for the following Covered Services Combined: Type B; Type C
Maximum Benefit:		
Yearly Individual Maximum	$2,000 for the following Covered Services: Type B; Type C	$2,000 for the following Covered Services: Type B; Type C
Lifetime Individual Maximum Benefit Amount for Orthodontic Covered Services	$1,000	$1,000
Lifetime Individual Maximum Benefit Amount for Temporomandibular Joint Disorder (TMJ)	$500	$500

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. This must be done at:

- the Employer's place of business;
- an alternate place approved by the Employer; or
- a place 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.

Cast Restoration means an inlay, onlay, or crown.

Child means the following: (for residents of Alaska, Minnesota, New Hampshire, New Mexico, Utah and Washington, the Child Definition is modified as explained in the Notice pages of this certificate - please consult the Notice)

Your natural or adopted child; Your stepchild (including the child of a Domestic Partner); or a child who resides with and is fully supported by You; and who, in each case, is under age 26 and unmarried.

An adopted child includes a child placed in Your physical custody for purpose of adoption. If prior to completion of the legal adoption the child is removed from Your custody, the child's status as an adopted child will end.

If You provide Us notice, a Child also includes a child for whom You must provide Dental Insurance due to a Qualified Medical Child Support Order as defined in the United States Employee Retirement Income Security Act of 1974 as amended.

For the purposes of determining who may become covered for insurance, 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.

Covered Percentage means:

- for a Covered Service performed by an In-Network Dentist, the percentage of the Maximum Allowed Charge that We will pay for such services after any required Deductible is satisfied; and
- for a Covered Service performed by an Out-of-Network Dentist, the percentage of the Reasonable and Customary Charge that We will pay for such services after any required Deductible is satisfied.

Covered Service means a dental service used to treat Your or Your Dependent's dental condition which is:

- prescribed or performed by a Dentist while such person is insured for Dental Insurance;
- Dentally Necessary to treat the condition; and
- described in the SCHEDULE OF BENEFITS or DENTAL INSURANCE sections of this certificate.

Deductible means the amount You or Your Dependents must pay before We will pay for Covered Services.

DEFINITIONS (continued)

Dental Hygienist means a person trained to:

- remove calcareous deposits and stains from the surfaces of teeth; and
- provide information on the prevention of oral disease.

Dentally Necessary means that a dental service or treatment is performed in accordance with generally accepted dental standards as determined by Us and is:

- necessary to treat decay, disease or injury of the teeth; or
- essential for the care of the teeth and supporting tissues of the teeth.

Dentist means:

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

For purposes of Dental Insurance, the term will include a Physician who performs a Covered Service.

Dentures means fixed partial dentures (bridgework), removable partial dentures and removable full dentures.

Dependent(s) means Your Spouse and/or Child.

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; or
- are of the same or opposite sex and have a mutually dependent relationship so that each has an insurable interest in the life of the other. Each person must be:

    1. 18 years of age or older;
    2. unmarried;
    3. the sole domestic partner of the other;
    4. sharing a primary residence with the other; and
    5. not related to the other in a manner that would bar their marriage in the jurisdiction in which they reside.

    A Domestic Partner declaration attesting to the existence of an insurable interest in one another's lives must be completed and Signed by the Employee.

Emergency Dental Condition means a dental condition the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including, but not limited to, bleeding, swelling or severe pain, that a prudent layperson, possessing an average knowledge of dentistry and health, could reasonably expect the absence of immediate dental attention to result in:

- placing the health of the person afflicted with such condition in serious jeopardy;
- serious impairment to such person's bodily functions;
- serious impairment or dysfunction of any bodily organ or part of such person; or

- serious disfigurement of such person.

If You cannot reasonably reach an In-Network Dentist, payment for services will be made in the same manner as if You had been treated by an In-Network Dentist. For most purposes, Benefits for Emergency Services are considered as In-Network Benefits subject to the In-Network Copay and all In-Network Maximum Amounts. As with all other services provided by an Out-of-Network Dentist, the amount of covered charges will be based on the Reasonable and Customary Charge. However, unlike with an In-Network Dentist, there is no agreement between an Out-of-Network Dentist and Us for the Dentist to limit what is being charged to You for the Emergency Services.

Employee means any person employed by the Employer and covered by a collective bargaining agreement with respect to which the Employer is obligated to make contributions to the Fund.

Employer means the Board of Trustees of the University of Massachusetts.

Fund means the Board of Trustees of the University of Massachusetts - International Union, United Automobile, Aerospace & Agricultural Implement Workers of America, UAW, and its Local 2322 Dental Fund.

In-Network Dentist means a Dentist who participates in the Preferred Dentist Program and has a contractual agreement with Us to accept the Maximum Allowed Charge as payment in full for a dental service.

Maximum Allowed Charge means the lesser of:

- the amount charged by the Dentist; or
- the maximum amount which the In-Network Dentist has agreed with Us to accept as payment in full for the dental service.

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

Out-of-Network Dentist means a Dentist who does not participate in the Preferred Dentist Program.

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 he performs the service and must act within the scope of that license. He must also be certified and/or registered if required by such jurisdiction.

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.

DEFINITIONS (continued)

Reasonable and Customary Charge is the lower of:

- the Dentist's actual charge for the services or supplies (or, if the provider of the service or supplies is not a Dentist, such other provider's actual charge for the services or supplies) (the 'Actual Charge'); or
- the usual charge of other Dentists or other providers in the same geographic area equal to the 99th percentile of charges as determined by MetLife based on charge information for the same or similar services or supplies maintained in MetLife's Reasonable and Customary Charge records (the 'Customary Charge'). Where MetLife determines that there is inadequate charge information maintained in MetLife's Reasonable and Customary Charge records for the geographic area in question, the Customary Charge will be determined based on actuarially sound principles.

  An example of how the 99th percentile is calculated is to assume one hundred (100) charges for the same service are contained in MetLife's Reasonable and Customary charge records. These one hundred (100) charges would be sorted from lowest to highest charged amount and numbered 1 through 100. The 99th percentile of charges is the charge that is equal to the charge numbered 99.

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

For the purposes of determining who may become covered for insurance, 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.

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.

Year or **Yearly**, for Dental Insurance, means the 12 month period that begins October 1.

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 Actively at Work graduate student Employees of the Employer working at least 10 hours and earning at least $4,632 per the 12 month period between the final pay period of May and the final pay period of May in the subsequent year

DATE YOU ARE ELIGIBLE FOR INSURANCE

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

If You are in an eligible class on October 1, 2015, You will be eligible for the insurance described in this certificate on that date.

If You enter an eligible class after October 1, 2015, You will be eligible for insurance on the date You enter that class.

ENROLLMENT PROCESS FOR DENTAL INSURANCE

If You are eligible for insurance, You may enroll for such insurance by completing an enrollment form in Writing.

DATE YOUR INSURANCE TAKES EFFECT

Rules for Noncontributory Insurance

When You complete the enrollment process for Dental Insurance, such insurance will take effect on the date You become eligible, provided You are Actively at Work on that date.

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

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;
4. at the end of the plan year in which You graduate;
5. thirty (30) days after You either:
    - fail to enroll as a student;
    - withdraw from student status; or
    - fail to meet the minimum earnings requirement due to early termination from employment;
6. the date 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.

In certain cases insurance may be continued as stated in the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT.

ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS

ELIGIBLE CLASS(ES) FOR DEPENDENT INSURANCE

All Actively at Work graduate student Employees of the Employer working at least 10 hours and earning at least $4,632 per the 12 month period between the final pay period of May and the final pay period of May in the subsequent year

DATE YOU ARE ELIGIBLE FOR DEPENDENT INSURANCE

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

If You are in an eligible class on October 1, 2015, You will be eligible for Dependent insurance on the later of:

1. October 1, 2015; and
2. the date You obtain a Dependent.

If You enter an eligible class after October 1, 2015, You will be eligible for Dependent insurance on the later of:

1. the date You enter a class eligible for insurance; and
2. the date You obtain a Dependent.

ENROLLMENT PROCESS FOR DEPENDENT DENTAL INSURANCE

If You are eligible for Dependent Insurance, You may enroll for such insurance by completing the required form in Writing for each Dependent to be insured.

In order to enroll for Dental Insurance for Your Dependents, You must either (a) already be enrolled for Dental Insurance for You or (b) enroll at the same time for Dental Insurance for You.

DATE DENTAL INSURANCE TAKES EFFECT FOR YOUR DEPENDENTS

Rules for Noncontributory Insurance

When You complete the enrollment process for Dependent Dental Insurance, such insurance will take effect on the date You become eligible, provided You are Actively at Work on that date.

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

Once You have enrolled one Child for Dependent insurance, each succeeding Child will automatically be insured for such insurance on the date that Dependent qualifies as a Dependent.

ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS (continued)

DATE YOUR INSURANCE FOR YOUR DEPENDENTS ENDS

A Dependent's insurance will end on the earliest of:

1. the date You die;
2. the date Dental Insurance for You ends;
3. the date the Group Policy ends;
4. the date insurance for Your Dependents ends under the Group Policy;
5. the date insurance for Your Dependents ends for Your class;
6. the date 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;
7. the end of the period for which the last premium has been paid;
8. the date the person ceases to be a Dependent, except that for Utah residents the coverage on a Child will cease at the end of the month in which that person ceases to be a Dependent.

In certain cases insurance may be continued as stated in the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT.

SPECIAL RULES FOR GROUPS PREVIOUSLY COVERED UNDER OTHER GROUP DENTAL COVERAGE

The following rules will apply if this Dental Insurance replaces other group dental coverage provided to You by the Policyholder.

Prior Plan means the group dental coverage provided to You by the Policyholder on the day before the Replacement Date.

Replacement Date means the effective date of this Dental Insurance under the Group Policy.

Rules if You or You and Your Dependents were Covered Under the Prior Plan on the Day Before the Replacement Date:

1. if You and Your Dependents were covered under the Prior Plan on the day before the Replacement Date, You will be eligible for this Dental Insurance on the Replacement Date if You are in an eligible class on such date;

2. if any of the following conditions occurred while coverage was in effect under the Prior Plan, We will treat such conditions as though they occurred while this Dental Insurance is in effect:

    - the loss of a tooth; and
    - the accumulation of amounts toward:
        a) Annual Deductibles;
        b) Annual Maximum Benefits;
        c) Lifetime Maximum Benefits;

3. if a dental service was received while the Prior Plan was in effect and such service would be a Covered Service subject to frequency and/or time limitations if performed while this Dental Insurance is in effect, the receipt of such prior service will be counted toward the time and frequency limitations under this Dental Insurance;

4. if a government mandated continuation of coverage under the Prior Plan was in effect on the Replacement Date, such coverage may be continued under this Dental Insurance if the required payment is made for the cost of such coverage. In such case, benefits will be available under this Dental Insurance until the earlier of:

    - the date the continued coverage ends as set forth in the provisions of the government-mandated requirements; or
    - the date this Dental Insurance ends.

Rules if You or You and Your Dependents were <u>NOT</u> covered under the Prior Plan on the Day Before the Replacement Date:

1. You will be eligible for this Dental Insurance when You meet the eligibility requirements for such insurance as described in ELIGIBILITY PROVISIONS: INSURANCE FOR YOU;

2. Your Dependents will be eligible for this Dental Insurance when they meet the eligibility requirements for such insurance as described in ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS; and

3. We will credit any time accumulated toward any eligibility waiting period under the Prior Plan to the satisfaction of any eligibility waiting period required to be met under this Dental Insurance.

CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT

FOR MENTALLY OR PHYSICALLY HANDICAPPED CHILDREN

Insurance for a Dependent Child may be continued past the age limit if the child is incapable of self-sustaining employment because of a mental or physical handicap as defined by applicable law. Proof of such handicap must be sent to Us within 31 days after the date the Child attains the age limit and at reasonable intervals after such date.

Subject to the DATE YOUR INSURANCE FOR YOUR DEPENDENTS ENDS subsection of the section entitled ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS, insurance will continue while such Child:

- remains incapable of self-sustaining employment because of a mental or physical handicap; and
- continues to qualify as a Child, except for the age limit.

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 Policyholder for information regarding such legally mandated leave of absence laws.

COBRA CONTINUATION FOR DENTAL INSURANCE

If Dental Insurance for You or a Dependent ends, You or Your Dependent may qualify for continuation of such insurance under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA). Please refer to the COBRA section of Your summary plan description or contact the Policyholder for information regarding continuation of insurance under COBRA.

AT THE POLICYHOLDER'S OPTION

The Policyholder 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. If Your insurance is continued, insurance for Your Dependents may also be continued.

Insurance will continue for the following periods:

1. for the period You cease Active Work in an eligible class due to injury or sickness, for a period in accordance with the Policyholder's general practice for an employee in Your job class;
2. for the period You cease Active Work in an eligible class due to any other Policyholder approved leave of absence, for a period in accordance with the Policyholder's general practice for an employee in Your job class.

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.

If Your insurance ends, Your Dependents' insurance will also end in accordance with the DATE YOUR INSURANCE FOR YOUR DEPENDENTS ENDS subsection of the section entitled ELIGIBILITY PROVISIONS: INSURANCE FOR YOUR DEPENDENTS.

CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT (continued)

CONTINUATION OF DENTAL INSURANCE

Special Rules For Massachusetts Residents

1. If Your Dental 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 Dental 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 Dental 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.

CONTINUATION OF DENTAL INSURANCE FOR YOUR FORMER SPOUSE

If the judgment of divorce dissolving Your marriage provides for continuation of insurance for Your former Spouse when You remarry, Dental Insurance for Your former Spouse that would otherwise end may be continued.

To continue Dental insurance under this provision:

1. You must make a written request to the Employer to continue such insurance;
2. You must make any required premium to the Employer for the cost of such insurance.

The request form will be furnished by the Employer.

Such insurance may be continued from the date Your marriage is dissolved until the earliest of the following:

- the date Your former Spouse remarries;
- the date of expiration of the period of time specified in the divorce judgment during which You are required to provide Dental Insurance for Your former Spouse;
- the date coverage is provided under any other group health plan;
- the date Your former Spouse becomes entitled to Medicare;
- the date Dental Insurance under the policy ends for all active Employees, or for the class of active Employees to which You belonged before Your employment terminated;
- the date of expiration of the last period for which the required premium payment was made; or
- the date such insurance would otherwise terminate under the policy;

If Your former Spouse is eligible to continue Dental Insurance under this provision and any other provision of this Policy, all such continuation periods will be deemed to run concurrently with each other and shall not be deemed to run consecutively.

DENTAL INSURANCE

If You or a Dependent incur a charge for a Covered Service, Proof of such service must be sent to Us. When We receive such Proof, We will review the claim and if We approve it, will pay the insurance in effect on the date that service was begun.

This Dental Insurance gives You access to Dentists through the MetLife Preferred Dentist Program. Dentists participating in the MetLife Preferred Dentist Program have agreed to limit their charge for a dental service to the Maximum Allowed Charge for such service. Under the MetLife Preferred Dentist Program, We pay benefits for Covered Services performed by either In-Network Dentists or Out-of-Network Dentists. However, You may be able to reduce Your out-of-pocket costs by using an In-Network Dentist because Out-of-Network Dentists have not entered into an agreement with Us to limit their charges. You are always free to receive services from any Dentist. You do not need any authorization from Us to choose a Dentist.

The MetLife Preferred Dentist Program does not provide dental services. Whether or not benefits are available for a particular service, does not mean You should or should not receive the service. You and Your Dentist have the right and are responsible at all times for choosing the course of treatment and services to be performed. After services have been performed, We will determine the extent to which benefits, if any, are payable.

When requesting a Covered Service from an In-Network Dentist, We recommend that You:

- identify Yourself as an insured in the Preferred Dentist Program; and
- confirm that the Dentist is currently an In-Network Dentist at the time that the Covered Service is performed.

The amount of the benefit will not be affected by whether or not You identify Yourself as a member in the Preferred Dentist Program.

You can obtain a customized listing of MetLife's In-Network Dentists either by calling 1-800-942-0854 or by visiting Our website at www.metlife.com/dental.

BENEFIT AMOUNTS

We will pay benefits in an amount equal to the Covered Percentage for charges incurred by You or a Dependent for a Covered Service as shown in the SCHEDULE OF BENEFITS, subject to the conditions set forth in this certificate.

In-Network

If a Covered Service is performed by an In-Network Dentist, We will base the benefit on the Covered Percentage of the Maximum Allowed Charge.

If an In-Network Dentist performs a Covered Service, You will be responsible for paying any other part of the Maximum Allowed Charge for which We do not pay benefits.

Out-of-Network

If a Covered Service is performed by an Out-of-Network Dentist, We will base the benefit on the Covered Percentage of the Reasonable and Customary Charge.

Out-of-Network Dentists may charge You more than the Reasonable and Customary Charge. If an Out-of-Network Dentist performs a Covered Service, You will be responsible for paying:

- the Deductible; and
- any other part of the Reasonable and Customary Charge for which We do not pay benefits; and
- any amount in excess of the Reasonable and Customary Charge charged by the Out-of-Network Dentist.

DENTAL INSURANCE (continued)

Emergency Dental Condition

Benefits for Covered Services performed by an Out-of-Network Dentist for Emergency Dental Conditions will be paid as if the Covered Service had been performed by an In-Network Dentist.

Maximum Benefit Amounts

The SCHEDULE OF BENEFITS sets forth Maximum Benefit Amounts We will pay for Covered Services received In-Network and Out-of-Network. We will never pay more than the greater of the In-Network Maximum Benefit Amount or the Out-of-Network Maximum Benefit Amount.

For example, if a Covered Service is received Out-of-Network and We pay $300 in benefits for such service, $300 will be applied toward both the In-Network and the Out-of-Network Maximum Benefit Amounts applicable to such service.

Deductibles

The Deductible amounts are shown in the SCHEDULE OF BENEFITS.

The Yearly Individual Deductible is the amount that You and each Dependent must pay for Covered Services to which such Deductible applies each Year before We will pay benefits for such Covered Services.

We apply amounts used to satisfy Yearly Individual Deductibles to the Yearly Family Deductible. Once the Yearly Family Deductible is satisfied, no further Yearly Individual Deductibles are required to be met.

The amount We apply toward satisfaction of a Deductible for a Covered Service is the amount We use to determine benefits for such service. The Deductible Amount will be applied based on when Dental Insurance claims for Covered Services are processed by Us. The Deductible Amount will be applied to Covered Services in the order that Dental Insurance claims for Covered Services are processed by Us regardless of when a Covered Service is "incurred". When several Covered Services are incurred on the same date and Dental Insurance benefits are claimed as part of the same claim, the Deductible Amount is applied based on the Covered Percentage applicable to each Covered Service. The Deductible Amount will be applied in the order of highest Covered Percentage to lowest Covered Percentage.

Alternate Benefit

If We determine that a service, less costly than the Covered Service the Dentist performed, could have been performed to treat a dental condition, We will pay benefits based upon the less costly service if such service:

- would produce a professionally acceptable result under generally accepted dental standards; and
- would qualify as a Covered Service.

For example:

- when a filling and an inlay are both professionally acceptable methods for treating tooth decay or breakdown, We may base Our benefit determination upon the filling which is the less costly service;
- when a filling and a crown are both professionally acceptable methods for treating tooth decay or breakdown, We may base Our benefit determination upon the filling which is the less costly service; and
- when a partial denture and fixed bridgework are both professionally acceptable methods for replacing multiple missing teeth in an arch, We may base Our benefit determination upon the partial denture which is the less costly service.

If We pay benefits based upon a less costly service in accordance with this subsection, the Dentist may charge You or Your Dependent for the difference between the service that was performed and the less costly service. This is the case even if the service is performed by an In-Network Dentist.

Certain comprehensive dental services have multiple steps associated with them. These steps can be completed at one time or during multiple sessions. For benefit purposes under this certificate, these separate steps of one service are considered to be part of the more comprehensive service. Even if the dentist

submits separate bills, the total benefit payable for all related charges will be limited by the maximum benefit payable for the more comprehensive service. For example, root canal therapy includes x-rays, opening of the pulp chamber, additional x-rays, and filling of the chamber. Although these services may be performed in multiple sessions, they all constitute root canal therapy. Therefore, We will only pay benefits for the root canal therapy.

Orthodontic Covered Services

Orthodontic treatment generally consists of initial placement of an appliance and periodic follow-up visits.

The benefit payable for the initial placement will not exceed 20% of the Maximum Benefit Amount for Orthodontia.

The benefit payable for the periodic follow-up visits will be payable on a quarterly basis during the course of the orthodontic treatment if:

- Dental Insurance is in effect for the person receiving the orthodontic treatment; and
- Proof is given to Us that the orthodontic treatment is continuing.

Benefits for Orthodontic Services Begun Prior to this Dental Insurance

If the initial placement was made prior to this Dental Insurance being in effect, the benefit payable will be reduced by the portion attributable to the initial placement.

If the periodic follow-up visits commenced prior to this Dental Insurance being in effect:

- the number of months for which benefits are payable will be reduced by the number of months of treatment performed before this Dental Insurance was in effect; and
- the total amount of the benefit payable for the periodic visits will be reduced proportionately.

Pretreatment Estimate of Benefits

If a planned dental service is expected to cost more than $300, You have the option of requesting a pretreatment estimate of benefits. The Dentist should submit a claim detailing the services to be performed and the amount to be charged. After We receive this information, We will provide You with an estimate of the Dental Insurance benefits available for the service. The estimate is not a guarantee of the amount We will pay. Under the Alternate Benefit provision, benefits may be based on the cost of a service other than the service that You choose. You are required to submit Proof on or after the date the dental service is completed in order for Us to pay a benefit for such service.

The pretreatment estimate of benefits is only an estimate of benefits available for proposed dental services. You are not required to obtain a pretreatment estimate of benefits. As always, You or Your Dependent and the Dentist are responsible for choosing the services to be performed.

DENTAL INSURANCE (continued)

Benefits We Will Pay After Insurance Ends

We will pay benefits for a 31 day period after Your insurance ends for the completion of installation of a prosthetic device if:

- the Dentist prepared the abutment teeth or made impressions before Your insurance ends; and
- the device is installed within 31 days after the date the insurance ends.

We will pay benefits for a 31 day period after Your insurance ends for the completion of installation of a Cast Restoration if:

- the Dentist prepared the tooth for the Cast Restoration before Your insurance ends; and
- the Cast Restoration is installed within 31 days after the date the insurance ends.

We will pay benefits for a 31 day period after Your insurance ends for completion of root canal therapy if:

- the Dentist opened into the pulp chamber before Your insurance ends; and
- the treatment is finished within 31 days after the date the insurance ends.

DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES

Type A Covered Services

1. Oral exams and problem-focused exams, but no more than twice every 12 months.
2. Screenings, including state or federally mandated screenings, to determine an individual's need to be seen by a dentist for diagnosis, but no more than twice every 12 months.
3. Patient assessments (limited clinical inspection that is performed to identify possible signs of oral or systemic disease, malformation, or injury, and the potential need for referral for diagnosis and treatment), but no more than twice every 12 months.
4. Full mouth or panoramic x-rays once every 60 months.
5. Bitewing x-rays 1 set every 6 months.
6. Intraoral-periapical x-rays.
7. X-rays, except as mentioned elsewhere.
8. Pulp vitality tests and bacteriological studies for determination of bacteriologic agents.
9. Genetic test for susceptibility to oral diseases.
10. Cleaning of teeth (oral prophylaxis), but no more than twice every 12 months..
11. Topical fluoride treatment for a Child under age 19 once in a 6 month period.
12. Space maintainers for a Child under age 14 once per lifetime per tooth area.
13. Sealants or sealant repairs for a Child under age 19 which are applied to non-restored, non-decayed first and second permanent molars, once per tooth.
14. Preventive resin restorations, which are applied to non-restored first and second permanent molars, once per tooth.
15. Periodontal maintenance, where periodontal treatment (including scaling, root planing, and periodontal surgery, such as osseous surgery) has been performed. Periodontal maintenance is limited to four times in any 12 months less the number of teeth cleanings received during such 12 month period.

Type B Covered Services

1. Emergency palliative treatment to relieve tooth pain.
2. Initial placement of amalgam fillings.
3. Replacement of an existing amalgam filling, but only if:
   - at least 24 months have passed since the existing filling was placed; or
   - a new surface of decay is identified on that tooth.
4. Initial placement of resin-based composite fillings.
5. Replacement of an existing resin-based composite filling, but only if:
   - at least 24 months have passed since the existing filling was placed; or
   - a new surface of decay is identified on that tooth.
6. Protective (sedative) fillings.
7. Oral surgery, except as mentioned elsewhere in this certificate.
8. Consultations for interpretation of diagnostic image by a Dentist not associated with the capture of the image, but not more than twice in a 12 month period.
9. Other consultations, but not more than twice in a 12 month period.
10. Root canal treatment, including bone grafts and tissue regeneration procedures in conjunction with periradicular surgery, but not more than once for the same tooth.
11. Other endodontic procedures, such as apicoectomy, retrograde fillings, root amputation, and hemisection.
12. Periodontal scaling and root planing, but no more than once per quadrant in any 24 month period.

DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES (continued)

13. Periodontal surgery, including gingivectomy, gingivoplasty and osseous surgery, but no more than one surgical procedure per quadrant in any 36 month period.
14. Simple extractions. Extractions of primary teeth or adult teeth solely for orthodontic purposes will be treated as orthodontic services.
15. Surgical extractions. Extractions of primary teeth or adult teeth solely for orthodontic purposes will be treated as orthodontic services.
16. Pulp capping (excluding final restoration).
17. Therapeutic pulpotomy (excluding final restoration).
18. Pulp therapy.
19. Apexification/recalcification.
20. Pulpal regeneration, but not more than once per lifetime.
21. General anesthesia or intravenous sedation in connection with oral surgery, extractions or other Covered Services, when We determine such anesthesia is necessary in accordance with generally accepted dental standards.
22. Relinings and rebasings of existing removable Dentures:
    - if at least 6 months have passed since the installation of the existing removable Denture; and
    - not more than once in any 36 month period.
23. Re-cementing of Cast Restorations or Dentures, but not more than once in a 12 month period.
24. Addition of teeth to a partial removable Denture.
25. Tissue conditioning, but not more than once in a 36 month period.
26. Simple repairs of Cast Restorations or Dentures other than recementing, but not more than once in a 12 month period.
27. Prefabricated crown, but no more than one replacement for the same tooth within 24 consecutive months.

Type C Covered Services

1. Initial installation of full or partial Dentures (other than implant supported prosthetics).
2. Replacement of a non-serviceable fixed Denture if such Denture was installed more than 60 months prior to replacement.
3. Replacement of a non-serviceable removable Denture if such Denture was installed more than 60 months prior to replacement.
4. Replacement of an immediate, temporary, full Denture with a permanent, full Denture, if the immediate, temporary, full Denture cannot be made permanent and such replacement is done within 12 months of the installation of the immediate, temporary, full Denture.
5. Adjustments of Dentures, if at least 6 months have passed since the installation of the Denture and not more than once in any 12 month period.
6. Initial installation of Cast Restorations (except implant supported Cast Restorations).
7. Replacement of any Cast Restoration (except an implant supported Cast Restoration) with the same or a different type of Cast Restoration, but no more than one replacement for the same tooth surface within 60 months of the initial installation or a prior replacement.
8. Core buildup, but no more than once per tooth in a period of 60 months.
9. Posts and cores, but no more than once per tooth in a period of 60 months.
10. Implant services (including sinus augmentation and bone replacement and graft for ridge preservation), but no more than once for the same tooth position in a 60 month period.
11. Repair of implants, but no more than once in a 12 month period.
12. Implant supported Cast Restorations, but no more than once for the same tooth position in a 60 month period.

DENTAL INSURANCE: DESCRIPTION OF COVERED SERVICES (continued)

13. Implant supported fixed Dentures, but no more than once for the same tooth position in a 60 month period.
14. Implant supported removable Dentures, but no more than once for the same tooth position in a 60 month period.
15. Occlusal adjustments, but not more than once in a 12 month period.
16. Non-surgical treatment of temporomandibular joint disorders. This includes cone beam imaging, but cone beam imaging for such treatment will not be covered more than once for the same tooth position in a 60 month period.

    The Lifetime Individual Maximum Benefit Amount for temporomandibular joint disorders is shown in the SCHEDULE OF BENEFITS.
17. Cleaning and inspection of a removable appliance, but no more than twice every 12 months.

Orthodontic Covered Services

Orthodontia for You, Your Spouse and Your Children up to age 19.

DENTAL INSURANCE: EXCLUSIONS

We will not pay Dental Insurance benefits for charges incurred for:

1. services which are not Dentally Necessary, or those which do not meet generally accepted standards of care for treating the particular dental condition;
2. services for which You would not be required to pay in the absence of Dental Insurance;
3. services or supplies received by You or Your Dependent before the Dental Insurance starts for that person;
4. services which are neither performed nor prescribed by a Dentist, except for those services of a licensed Dental Hygienist which are supervised and billed by a Dentist, and which are for:
    - scaling and polishing of teeth; or
    - fluoride treatments;
5. services which are primarily cosmetic;
6. services or appliances which restore or alter occlusion or vertical dimension;
7. restoration of tooth structure damaged by attrition, abrasion or erosion, unless caused by disease;
8. restorations or appliances used for the purpose of periodontal splinting;
9. counseling or instruction about oral hygiene, plaque control, nutrition and tobacco;
10. personal supplies or devices including, but not limited to: water piks, toothbrushes, or dental floss;
11. decoration or inscription of any tooth, device, appliance, crown or other dental work;
12. missed appointments;
13. services:
    - covered under any workers' compensation or occupational disease law;
    - covered under any employer liability law;
    - for which the Employer of the person receiving such services is required to pay; or
    - received at a facility maintained by the Policyholder, labor union, mutual benefit association, or VA hospital;
14. services covered under other coverage provided by the Policyholder;
15. biopsies of hard or soft oral tissue;
16. temporary or provisional restorations;
17. temporary or provisional appliances;
18. prescription drugs;
19. services for which the submitted documentation indicates a poor prognosis;
20. the following, when charged by the Dentist on a separate basis:
    - claim form completion;
    - infection control, such as gloves, masks, and sterilization of supplies; or
    - local anesthesia, non-intravenous conscious sedation or analgesia, such as nitrous oxide;
21. dental services arising out of accidental injury to the teeth and supporting structures, except for injuries to the teeth due to chewing or biting of food;
22. caries susceptibility tests;
23. labial veneers;
24. full mouth debridements;
25. local chemotherapeutic agents;
26. modification of removable prosthodontic and other removable prosthetic services;
27. injections of therapeutic drugs;
28. application of desensitizing agents;

DENTAL INSURANCE: EXCLUSIONS (continued)

29. fixed and removable appliances for correction of harmful habits;
30. appliances or treatment for bruxism (grinding teeth), including but not limited to occlusal guards and night guards;
31. precision attachments associated with fixed and removable prostheses, except when the precision attachment is related to implant prosthetics;
32. adjustment of a Denture made within 6 months after installation by the same Dentist who installed it;
33. duplicate prosthetic devices or appliances;
34. replacement of a lost or stolen appliance, Cast Restoration or Denture;
35. replacement of an orthodontic device;
36. diagnostic casts;
37. intra and extraoral photographic images.

DENTAL INSURANCE: COORDINATION OF BENEFITS

When You or a Dependent incur charges for Covered Services, there may be other Plans, as defined below, that also provide benefits for those same charges. In that case, We may reduce what We pay based on what the other Plans pay. This Coordination of Benefits section explains how and when We do this.

DEFINITIONS

In this section, the terms set forth below have the following meanings:

Allowable Expense means a necessary dental expense for which both of the following are true:

- a covered person must pay it; and
- it is at least partly covered by one or more of the Plans that provide benefits to the covered person.

If a Plan provides fixed benefits for specified events or conditions (instead of benefits based on expenses incurred), such benefits are Allowable Expenses.

If a Plan provides benefits in the form of services, We treat the reasonable cash value of each service performed as both an Allowable Expense and a benefit paid by that Plan.

The term does not include:

- expenses for services performed because of a Job-Related Injury or Sickness;
- any amount of expenses in excess of the higher reasonable and customary fee for a service, if two or more Plans compute their benefit payments on the basis of reasonable and customary fees;
- any amount of expenses in excess of the higher negotiated fee for a service, if two or more Plans compute their benefit payments on the basis of negotiated fees; and
- any amount of benefits that a Primary Plan does not pay because the covered person fails to comply with the Primary Plan's managed care or utilization review provisions, these include provisions requiring:
    - second surgical opinions;
    - pre-certification of services;
    - use of providers in a Plan's network of providers; or
    - any other similar provisions.

We won't use this provision to refuse to pay benefits because an HMO member has elected to have dental services provided by a non-HMO provider and the HMO's contract does not require the HMO to pay for providing those services.

Claim Determination Period means a period that starts on any October 1 and ends on the day before the next October 1. A Claim Determination Period for any covered person will not include periods of time during which that person is not covered under This Plan.

Custodial Parent means a Parent awarded custody, other than joint custody, by a court decree. In the absence of a court decree, it means the Parent with whom the child resides more than half of the Year without regard to any temporary visitation.

HMO means a Health Maintenance Organization or Dental Health Maintenance Organization.

Job-Related Injury or **Sickness** means any injury or sickness:

- for which You are entitled to benefits under a workers' compensation or similar law, or any arrangement that provides for similar compensation; or
- arising out of employment for wage or profit.

Parent means a person who covers a child as a dependent under a Plan.

Plan means any of the following, if it provides benefits or services for an Allowable Expense:

- a group insurance plan;
- an HMO;
- a blanket plan;
- uninsured arrangements of group or group type coverage;
- a group practice plan;
- a group service plan;
- a group prepayment plan;
- any other plan that covers people as a group;
- motor vehicle No Fault coverage if the coverage is required by law; and
- any other coverage required or provided by any law or any governmental program, except Medicaid.

The term does not include any of the following:

- individual or family insurance or subscriber contracts;
- individual or family coverage through closed panel Plans or other prepayment, group practice or individual practice Plans;
- hospital indemnity coverage;
- a school blanket plan that only provides accident-type coverage on a 24 hour basis, or a "to and from school basis," to students in a grammar school, high school or college;
- disability income protection coverage;
- accident only coverage;
- specified disease or specified accident coverage;
- nursing home or long term care coverage; or
- any government program or coverage if, by state or Federal law, its benefits are excess to those of any private insurance plan or other non-government plan.

The provisions of This Plan, which limit benefits based on benefits or services provided under:

- Government Plans; or
- Plans which the Policyholder (or an affiliate) contributes to or sponsors;

will not be affected by these Coordination of Benefits provisions.

Each policy, contract or other arrangement for benefits is a separate Plan. If part of a Plan reserves the right to reduce what it pays based on benefits or services provided by other Plans, that part will be treated separately from any parts which do not. If two people are both insured under This Plan as Employees, each person's insurance will be treated as a separate Plan.

This Plan means the dental benefits described in this certificate, except for any provisions in this certificate that limit insurance based on benefits for services provided under government plans, or plans which the Policyholder (or an affiliate) contributes to or sponsors.

Primary Plan means a Plan that pays its benefits first under the "Rules to Decide Which Plan Is Primary" section. A Primary Plan pays benefits as if the Secondary Plans do not exist.

Secondary Plan means a Plan that is not a Primary Plan. A Secondary Plan may reduce its benefits by amounts payable by the Primary Plan. If there are more than two Plans that provide coverage, a Plan may be Primary to some plans, and Secondary to others.

RULES TO DECIDE WHICH PLAN IS PRIMARY

When more than one Plan covers the person for whom Allowable Expenses were incurred, We determine which plan is primary by applying the rules in this section.

When there is a basis for claim under This Plan and another Plan, This Plan is Secondary unless:

- the other Plan has rules coordinating its benefits with those of This Plan; and
- this Plan is primary under This Plan's rules.

The first rule below, which will allow Us to determine which Plan is Primary, is the rule that We will use.

Dependent or Non-Dependent: A Plan that covers a person other than as a dependent (for example, as an employee, member, subscriber, or retiree) is Primary and shall pay its benefits before a Plan that covers the person as a dependent; except that if the person is a Medicare beneficiary and, as a result of federal law or regulations, Medicare is:

- Secondary to the Plan covering the person as a dependent; and
- Primary to the Plan covering the person as other than a dependent (e.g., a retired employee);

then the order of benefits between the two Plans is reversed and the Plan that covers the person as a dependent is Primary.

Child Covered Under More Than One Plan – Court Decree: When This Plan and another Plan cover the same Child as the Dependent of two or more Parents, and the specific terms of a court decree state that one of the Parents must provide health coverage or pay for the Child's health care expenses, that Parent's Plan is Primary, if the Plan has actual knowledge of those terms. This rule applies to Claim Determination Periods that start after the Plan is given notice of the court decree.

Child Covered Under More Than One Plan – The Birthday Rule: When This Plan and another Plan cover the same Child as the Dependent of two or more Parents, the Primary Plan is the Plan of the Parent whose birthday falls earlier in the Year if:

- the Parents are married; or
- the Parents are not separated (whether or not they have ever married); or
- a court decree awards joint custody without specifying which Parent must provide health coverage.

If both Parents have the same birthday, the Plan that covered either of the Parents longer is the Primary Plan.

However, if the other Plan does not have this rule, but instead has a rule based on the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

Child Covered Under More than One Plan – Custodial Parent: When This Plan and another Plan cover the same Child as the Dependent of two or more Parents, if the Parents are not married, or are separated (whether or not they ever married), or are divorced, the Primary Plan is:

- the Plan of the Custodial Parent; then
- the Plan of the spouse of the Custodial Parent; then
- the Plan of the non-custodial Parent; and then
- the Plan of the spouse of the non-custodial Parent.

Active or Inactive Employee: A Plan that covers a person as an employee who is neither laid off nor retired is Primary to a Plan that covers the person as a laid-off or retired employee (or as that person'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 is ignored.

Continuation Coverage: The Plan that covers a person as an active employee, member or subscriber (or as that employee's Dependent) is Primary to a Plan that covers that person under a right of continuation pursuant to federal law (e.g., COBRA) or state law. If the Plan that covers the person has not adopted this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule shall not apply.

Longer/Shorter Time Covered: If none of the above rules determine which Plan is Primary, the Plan that has covered the person for the longer time shall be Primary to a Plan that has covered the person for a shorter time.

No Rules Apply: If none of the above rules determine which Plan is Primary, the Allowable Expenses shall be shared equally between all the Plans. In no event will This Plan pay more than it would if it were Primary.

EFFECT ON BENEFITS OF THIS PLAN

If This Plan is Secondary, when the total Allowable Expenses incurred by a covered person in any Claim Determination Period are less than the sum of:

- the benefits that would be payable under This Plan without applying this Coordination of Benefits provision; and
- the benefits that would be payable under all other Plans without applying Coordination of Benefits or similar provisions;

then We will reduce the benefits that would otherwise be payable under This Plan. The sum of these reduced benefits, plus all benefits payable for such Allowable Expenses under all other Plans, will not exceed the total of the Allowable Expenses. Benefits payable under all other Plans include all benefits that would be payable if the proper claims had been made on time.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

We need certain information to apply the Coordination of Benefits rules. We have the right to decide which facts We need. We may get facts from or give them to any other organization or person. We do not need to tell, or get the consent of, any person or organization to do this. To obtain all benefits available, a covered person who incurs Allowable Expenses should file a claim under each Plan which covers the person. Each person claiming benefits under This Plan must give Us any facts We need to pay the claim.

FACILITY OF PAYMENT

A payment made under another Plan may include an amount which should have been paid under This Plan. If it does, We may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again. The term “payment made” includes benefits provided in the form of services, in which case We may pay the reasonable cash value of the benefits provided in the form of services.

DENTAL INSURANCE: COORDINATION OF BENEFITS (continued)

RIGHT OF RECOVERY

If the amount We pay is more than We should have paid under this Coordination of Benefits provision, We may recover the excess from one or more of:

- the person We have paid or for whom We have paid;
- insurance companies; or
- other organizations.

The amount of the payment includes the reasonable cash value of any benefits provided in the form of services.

FILING A CLAIM

The Policyholder should have a supply of claim forms. Obtain a claim form from the Policyholder and fill it out carefully. Return the completed claim form with the required Proof to the Policyholder. The Policyholder will certify Your insurance under the Group Policy and send the certified claim form and Proof to Us.

For Dental Insurance, all claim forms needed to file for benefits under the group insurance program can be obtained by calling MetLife at 1-800-942-0854. Dental claim forms can also be downloaded from www.metlife.com/dental. The instructions on the claim form should be followed carefully. This will expedite the processing of the claim.

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 DENTAL INSURANCE BENEFITS

When a claimant files a claim for Dental 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.

Claim and Proof may also be given to Us by following the steps set forth below:

Step 1
A claimant can provide notice of claim and request a claim form by calling Us at 1-800-942-0854.

Step 2
We will send a claim form to the claimant within 15 days of the notice and request. The instructions on the claim form should be followed carefully. This will expedite the processing of the claim. If we do not provide payment within 45 days of Our receipt of the notice of claim, We will notify You in Writing specifying the reasons for the non-payment or whatever documentation is necessary for payment of the claim. If We do not comply with this provision, We shall pay, in addition to any benefits payable, interest on such benefits which will accrue beginning 45 days after our receipt of the notice of claim at the rate of one and one half percent a month, not to exceed 18 percent per year. The provisions of this paragraph will not apply to a claim that We are investigating because of suspected fraud.

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.

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.

DENTAL INSURANCE: PROCEDURES FOR DENTAL CLAIMS

Procedures for Presenting Claims for Dental Insurance Benefits

All claim forms needed to file for Dental Insurance benefits under the group insurance program can be obtained from the Employer who can also answer questions about the insurance benefits and to assist You or, if applicable, Your beneficiary in filing claims. Dental claim forms can also be downloaded from www.metlife.com/dental. 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.

Routine Questions on Dental Insurance Claims

If there is any question about a claim payment, an explanation may be requested from MetLife by dialing 1-800-942-0854.

Claim Submission

For claims for Dental Insurance benefits, the claimant must complete the appropriate claim form and submit the required Proof as described in the FILING A CLAIM section of the certificate.

Claim forms must be submitted in accordance with the instructions on the claim form.

Initial Determination

After You submit a claim for Dental Insurance benefits to MetLife, 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 30 day period from the date You submitted Your claim; except for situations requiring an extension of time of up to 15 days because of matters beyond the control of MetLife. If MetLife needs such an extension, MetLife will notify You prior to the expiration of the initial 30 day period, 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 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. Further, if an internal rule, protocol, guideline or other criterion was relied upon in making the denial, the claims decision will state the rule, protocol, guideline or other criteria or indicate that such rule, protocol, guideline or other criteria was relied upon and that You may request a copy free of charge.

Appealing the Initial Determination

If MetLife denies Your claim, You may take two appeals of the initial determination. 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
- Whether the appeal is the first or second appeal of the initial determination
- An explanation why You are appealing the initial determination.

DENTAL INSURANCE: PROCEDURES FOR DENTAL CLAIMS (continued)

As part of each 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 or determination on the first appeal, MetLife will conduct a full and fair review of Your claim. Deference will not be given to initial denials, 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 dentistry involved in the 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 30 days after MetLife's receipt of Your written request for review, except that under special circumstances MetLife may have up to an additional 30 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 30 day period, state the reason(s) why such an extension is needed, and state when it will make its determination.

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 and references any specific Plan provision(s) on which the denial is based. If an internal rule, protocol, guideline or other criterion was relied upon in denying the claim on appeal, the final written decision will state the rule, protocol, guideline or other criteria or indicate that such rule, protocol, guideline or other criteria was relied upon and that You may request a copy free of charge. Upon written request, MetLife will provide You free of charge with copies of documents, records and other information relevant to Your claim.

GENERAL PROVISIONS

Assignment

The rights and benefits under the Group Policy are not assignable prior to a claim for benefits, except as required by law. We are not responsible for the validity of an assignment.

Upon receipt of a Covered Service, You may assign Dental Insurance benefits to the Dentist providing such service.

Dental Insurance: Who We Will Pay

If You assign payment of Dental Insurance benefits to Your or Your Dependent's Dentist, We will pay benefits directly to the Dentist. Otherwise, We will pay Dental Insurance benefits to You.

Entire Contract

Your insurance is provided under a contract of group insurance with the Policyholder. The entire contract with the Policyholder is made up of the following:

1. the Group Policy and its Exhibits, which include the certificate(s);
2. the Policyholder's application; and
3. any amendments and/or endorsements to the Group Policy.

Incontestability: Statements Made by You

Any statement made by You will be considered a representation and not a warranty.

Evidence of insurability will not be required nor will any statement made by You, which relates to insurability, be used:

1. to contest the validity of the insurance benefits; or
2. to reduce the insurance benefits.

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.

Overpayments

Recovery of Dental Insurance Overpayments

We have the right to recover any amount that We determine to be an overpayment, whether for services received by You or Your Dependents.

An overpayment occurs if We determine that:

- the total amount paid by Us on a claim for Dental Insurance is more than the total of the benefits due to You under this certificate; or
- payment We made should have been made by another group plan.

If such overpayment occurs, You have an obligation to reimburse Us.

GENERAL PROVISIONS (continued)

How We Recover Overpayments

We may recover the overpayment from You by:

- stopping or reducing any future benefits payable for Dental Insurance;
- demanding an immediate refund of the overpayment from You; and
- taking legal action.

If the overpayment results from Our having made a payment to You that should have been made under another group plan, We may recover such overpayment from one or more of the following:

- any other insurance company;
- any other organization; or
- any person to or for whom payment was made.

PLAN PRIVACY INFORMATION

Notwithstanding any other Plan provision in this or other sections of this Plan, the Plan will operate in accordance with the HIPAA privacy laws and regulations as set forth in 45 CFR Parts 160 and 164, and as they may be amended ("HIPAA"), with respect to protected health information ("PHI") as that term is defined therein. The Plan Administrator and/or his or her designee retains full discretion in interpreting these rules and applying them to specific situations. All such decisions shall be given full deference unless the decision is determined to be arbitrary and capricious.

The term "Plan Sponsor" means UAW UMass Health and Welfare Trust Fund.

The term "Plan Administrator" means UAW UMass Health and Welfare Trust Fund.

I. Permitted Uses and Disclosures of PHI by the Plan and the Plan Sponsor

The Plan and the Plan Sponsor are permitted to use and disclose PHI for the following purposes, to the extent they are not inconsistent with HIPAA:

- For general plan administration, including policyholder service functions, enrollment and eligibility functions, reporting functions, auditing functions, financial and billing functions, to assist in the administration of a consumer dispute or inquiry, and any other authorized insurance or benefit function.

- As required for computer programming, consulting or other work done in respect to the computer programs or systems utilized by the Plan.

- Other uses relating to plan administration which are approved in writing by the Plan Administrator or Plan Privacy Officer.

- At the request of an individual, to assist in resolving claims the individual may have with respect to benefits under the Plan.

II. Uses and Disclosures of PHI by the Plan and the Plan Sponsor for Required Purposes

The Plan and Plan Sponsor may use or disclose PHI for the following required purposes:

- Judicial and administrative proceedings, in response to lawfully executed process, such as a court order or subpoena.

- For public health and health oversight activities, and other governmental activities accompanied by lawfully executed process.

- As otherwise may be required by law.

III. Sharing of PHI With the Plan Sponsor

As a condition of the Plan Sponsor receiving PHI from the Plan, the Plan Documents have been amended to incorporate the following provisions, under which the Plan Sponsor agrees to:

- Not use or further disclose PHI other than as permitted or required by the plan documents in Sections I and II above;

- Ensure that any agents to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor;

- Not use or disclose PHI for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;

- Report to the Plan any use or disclosure of the information that is inconsistent with the permitted uses or disclosures of which it becomes aware;

- Make PHI available to Plan participants for the purposes of the rights of access and inspection, amendment, and accounting of disclosures as required by HIPAA;

- Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with HIPAA;

- If feasible, return or destroy all PHI received from the Plan that the sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible;

- Ensure that adequate separation between the Plan and Plan Sponsor is established in accordance with the following requirements:

  (A) Employees to be Given Access to PHI: The following employees (or class of employees) of the Plan Sponsor are the only individuals that may access PHI provided by the Plan:

  Senior Benefits Specialist

  (B) Restriction to Plan Administration Functions: The access to and use of PHI by the employees of the Plan Sponsor designated above will be limited to plan administration functions that the Plan Sponsor performs for the Plan.

  (C) Mechanism for Resolving issues of Noncompliance: If the Plan Administrator or Privacy Officer determines that an employee of the Plan Sponsor designated above has acted in noncompliance with the plan document provisions outlined above, then the Plan Administrator or Privacy Officer shall take or seek to have taken appropriate disciplinary action with respect to that employee, up to and including termination of employment as appropriate. The Plan Administrator or Privacy Officer shall also document the facts of the violation, actions that have been taken to discipline the offending party and the steps taken to prevent future violations.

- Certify to the Plan, prior to the Plan permitting disclosure of PHI to the Plan Sponsor, that the Plan Documents have been amended to incorporate the provisions in this Section III.

IV. Participants Rights

Participants and their covered dependents will have the rights set forth in the Plan's or its dental insurer's HIPAA Notice of Privacy Practices for Protected Health Information and any other rights and protections required under the HIPAA. The Notice may periodically be revised by the Plan or its dental insurer.

V. Privacy Complaints/Issues

All complaints or issues raised by Plan participants or their covered dependents in respect to the use of their PHI must be submitted in writing to the Plan Administrator or the Plan's appointed Privacy Officer. A response will be made within 30 days of the receipt of the written complaint. In the event more time is required to resolve any issues this period can be extended to 90 days. The affected participant must receive written notice of the extension and the resolution of their complaint. The Plan Administrator or Privacy Officer shall have full discretion in resolving the complaint and making any required interpretations and factual determinations. The decision of the Plan Administrator or Privacy Officer shall be final and be given full deference by all parties.

VI. Security

As a condition of the Plan Sponsor receiving electronic PHI ("ePHI") from the Plan, the Plan Documents have been amended to incorporate the following provisions, under which the Plan Sponsor agrees to:

- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that it creates, receives, maintains, or transmits on behalf of the Plan;

- Ensure that the adequate separation between the Plan and the Plan Sponsor, which is required by the applicable section(s) of the Plan relating to the sharing of PHI with the Plan Sponsor, is supported by reasonable and appropriate security measures;

- Ensure that any agent to whom it provides ePHI agrees to implement reasonable and appropriate security measures to protect the information; and

- Report to the Plan any security incident of which it becomes aware. In this context, the term "security incident" means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in information systems such as hardware, software, information, data, applications, communications, and people.

FUTURE OF THE PLAN

It is hoped that the Plan will be continued indefinitely, but UAW UMass Health and 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.

The Board of Directors of UAW UMass Health and Welfare Trust Fund shall be empowered to amend or terminate the Plan or any benefit under the Plan at any time.

Uniformed Services Employment And Reemployment Rights Act

This section describes the right that you may have to continue coverage for yourself and your covered dependents under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

Continuation of Group Dental Insurance:

If you take a leave from employment for "service in the uniformed services," as that term is defined in USERRA, and as a consequence your dental insurance coverage under your employer's group dental insurance policy ends, you may elect to continue dental insurance for yourself and your covered dependents, for a limited period of time, as described below.

The law requires that your employer notify you of your rights, benefits and obligations under USERRA including instructions on how to elect to continue insurance, the amount and procedure for payment of premium. If permitted by USERRA, your employer may require that you elect to continue coverage within a period of time specified by your employer.

You may be responsible for payment of the required premium to continue insurance. If your leave from employment for service in the uniformed services lasts less than 31 days, your required premium will be no more than the amount you were required to pay for dental insurance before the leave began; for a leave lasting 31 or more days, you may be required to pay up to 102% of the total dental insurance premium, including any amount that your employer was paying before the leave began.

Your and your covered dependents' insurance that is continued pursuant to USERRA will end on the earliest of the following:

- the end of 24 consecutive months from the date your leave from employment for service in the uniformed services begins; or
- the day after the date on which you fail to apply for, or return to employment, in accordance with USERRA.

You and your covered dependent may become entitled to continuation of coverage under the Consolidated Omnibus Budget Reconciliation Act ("COBRA") while you have dental insurance coverage under your employer's group dental insurance policy pursuant to USERRA. Contact your employer for more information.

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. Potenza

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 $65	$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	$68	$66
Standard Plastic Lenses			
Single Vision	$10 Copay	$25	$42
Bifocal	$10 Copay	$45	$78
Trifocal	$10 Copay	$80	$130
Standard Progressive Lens**	$65	$95	$78
Premium Progressive Lens**	$25, 80% of Charge less $120 Allowance	$95	$78
Lens Options:			
UV Treatment	$15	$0	N/A
Tint (Solid and Gradient)	$15	$0	N/A
Standard Plastic Scratch Coating	$15	$0	N/A
Standard Polycarbonate - Adults	$40	$0	N/A
Standard Polycarbonate - Kids under 19	$40	$0	N/A
Standard Anti-Reflective Coating	$45	$0	N/A
Polarized	20% off Retail Price	$0	N/A
Other Add-Ons	20% off Retail Price	$0	N/A
Contact Lenses (Contact lens allowance includes materials only)			
Conventional	$0 Copay; $135 allowance, 15% off balance over $135	$114.75	$108
Disposable	$0 Copay; $135 allowance, plus balance over $135	$135	$108
Medically Necessary	$0 Copay, Paid-in-Full	Retail less 5%	$200
Laser Vision Correction: Lasik or PRK from U.S. Laser Network	15% off retail price or 5% off promotional price	N/A	N/A
Additional Pairs Benefit:	Members also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used.	N/A	N/A
Frequency:			
Examination	Once every 12 months		
Lenses	Once every 12 months		
Contact Lenses	Once every 12 months		
Frame	Once every 12 months		
Monthly Administrative Fee: Per Subscriber Per Month (Composite)	$0.93		

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

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

Additional Discounts:
Member receives a 25% discount on items not covered by the plan at network Providers, which cannot be combined with any other discounts or promotional offers. Discount does not apply to Eyemed Provider's professional services, or contact lenses.
Members also receive 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 80% or more -OR- Bundled With Group Medical or Dental
Option 1

Version 7

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 $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% of 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 see EyeMed's online provider locator to determine which participating providers have agreed to the discounted rate

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

Additional Discounts:
Member receives a 20% discount on items not covered by the plan at network Providers. Discount does not apply to EyeMed Provider's professional services, or contact lenses. Plan discounts cannot be combined with any other discounts or promotional offers. Services or materials provided by any other group benefit plan providing vision care may not be covered.
Members also receive 15% off retail price or 5% off promotional price for 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

TC9

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

Version 7

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 $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	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 H&W 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.
The contact lens benefit allowance is not applicable to this service.
Benefit Allowances provide no remaining balance for future use within the same Benefit Frequency.
Certain brand name Vision Materials in which the manufacturer imposes a no-discount practice.
Rates are valid only when the quoted plan is the sole stand-alone vision plan offered by the group
Rates are valid for groups domiciled in the State of MA.
Fees quoted will be valid until the 7/1/2018 plan implementation date. Date quoted: 6/27/2018.
Rates assume greater than 80% Employer contribution for employees and dependents or that the vision program is bundled with medical/dental benefit.

Plan Exclusions:
1) Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Anisekonic lenses; 2) Medical and/or surgical treatment of the eye, eyes or supporting structures;
3) Any eye or Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; Safety eyewear
4) Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof;
5) Plano (non-prescription) lenses and/or contact lenses; 6) Non-prescription sunglasses; 7) Two pair of glasses in lieu of bifocals;
8) Services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered,
and the services rendered to the Insured Person are within 31 days from the date of such order; 9) Services or materials provided by any other group benefit plan providing vision care;
10) Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available.

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

Signature

8/21/2018
Date

TC0

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

UAW Health & Welfare Trust
EyeMed Select Plan H, Fee For Service
Employer pays 80% or more -OR- Bundled With Group Medical or Dental
Option 1

Version 7

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If UAW Health & Welfare Trust has chosen this benefit design, sign here:

Signature

8/21/18
Date

Leslie Edwards Davis, Director of Benefit Programs

TC0

UAW Health & Welfare Trust

Supplement

Option 1

Progressive Price List*	Member Cost In-Network (Includes Lens Copay)
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For a current listing of brands by tier, go to:
http://www.eyemedvisioncare.com/theme/pdf/microsite-template/eyemedlenslist.pdf