September 1, 2020

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 Ameritas
- 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 Director of Benefit Programs at (413) 345-2156 or uawdental@external.umass.edu The Trust Fund's website also has detailed information about all aspects of the Plans: https://www.uawumasstrustfund.org/

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

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ABOUT YOUR TRUST FUND

The UAW/UMass Health & Welfare Trust Fund is a self-administered, joint labor-management, employer-funded Taft-Hartley Trust Fund. Your coverage is provided as a result of a collective bargaining agreement between the University of Massachusetts Board of Trustees and the United Auto Workers, Local 2322 (GEO-UAW Local 2322 & PRO-UAW Local 2322).

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

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

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

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

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

YOUR EMPLOYER PAYS FOR YOUR BENEFITS

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

IMPORTANT PHONE NUMBERS

Trust Fund Director of Benefit Programs: (413) 345-2156

Ameritas: (800) 487-5553

EyeMed Vision Care: (866) 299-1358

Graduate Employee Organization: (413) 545-0705

UAW Local 2322: (413) 534-7600

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

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

WHAT IS A SUMMARY PLAN DESCRIPTION (SPD)?

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

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

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

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

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

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

OVERVIEW of GHWP

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

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

To complete the application, submit all of the information requested and make sure to complete the final step of the process, which is to electronically sign your benefits authorization form according to the online instructions. Without this e-signed form on file, we cannot verify your eligibility or complete the processing of your application. The online application requests a Social Security Number (SNN). You may bypass this step initially by checking the box indicating that you have not yet received an SSN. Ultimately, the insurance companies 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://www.studentinsurance.com/Client/941

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 24, 2020 and May 29, 2021 will be used to calculate eligibility for GHWP benefits for plan year 2020-21. For plan year 2020-21, the minimum earnings required in a GEO-eligible position is $5762.70* This amount must be earned between May 24, 2020 and May 29, 2021 to make you eligible for 12 months of Trust Fund benefits between September 1, 2020 and August 31, 2021.

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

University Without Walls Earning Equivalent

If you are teaching in the University Without Walls, teaching a 3-credit course for one semester/session is considered equivalent to earning $5762.70 and makes you eligible for benefits between September 1, 2020 and August 31, 2021.

Spring-Entering Graduate Employees

If you are a spring semester entering graduate student, and you earn at least $5762.70 between May 24, 2020 and May 29, 2021, you will be eligible as of the first official day of the spring 2021 semester, February 1, 2021 (as established by UMass) through the end of the plan year, August 31, 2021.

How Summer Earnings are Calculated

Summer earnings in a GEO-eligible position count "forward" toward your eligibility for the next plan year that starts in September. If your only earnings during an academic year occur in the summer, this will not make you eligible for coverage during the concurrent summer months. For example, if your only GEO-eligible earnings commence June 1, 2020, these will count toward your eligibility for benefits starting September 1, 2020.

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 2020-21, the yearly premium for single+1 or family dental coverage is $100 per year, due upon application. There is no premium due for single+1 or family vision coverage. Trustees reserve the right to terminate the family portion of any participant's coverage due to lack of payment of the applicable family premiums, retroactive to the start of coverage date or retroactive to the last month that was paid in full.

Eligibility for your children

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

They’re your biological children; or

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

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

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

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

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

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

After your Child Ages Out of Eligibility

Your child’s Ameritas coverage may be continued up to his or her 26th birthday

if: Your child is unmarried; and

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

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

Children with Disabilities

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

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

Your child is not married; and

Your child became handicapped before age 19; and

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

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

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

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

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

Be issued by a court or authorized state agency;

Clearly specify the alternate recipient;

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

Clearly state the period to which such order applies; and

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

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

BENEFITS OF GHWP

The benefit plan descriptions for the dental and vision plans can be found below. Our dental plan is the Ameritas Classic PPO & Plus Plan. The benefits follow a plan year of 9/1 to 8/31 of each year. Each 9/1, the dental plan year maximum amount renews. Our vision plan is the EyeMed Select Plan. The benefits follow a point of service plan year, meaning that your benefit renews 12 months after the last time you utilized it. Both of our plans have nationwide networks of providers. You can locate providers at https://www.uawumasstrustfund.org/

Appeals

Both insurers have internal appeals processes for claims. These processes are completely separate from the Trust Fund. If an Ameritas claim is denied, you can request an appeal by writing to Ameritas within 180 days of receiving MetLife's decision. Send appeals to Quality Control, P.O. Box 82657, Lincoln, NE 68501-2657. If your appeal is about urgent care, you may call Toll Free at 877-897-4328, and an Expedited Review will be conducted. To appeal an EyeMed decision, you should submit your request in writing to: Member Appeals Coordinator, EyeMed Vision Care, 4000 Luxottica Place, Mason, OH 45040. Your request for a review of the adverse benefit determination must be submitted within 180 days of the date of the Explanation of Benefits.

Subscriber Certificates/Member Guides

Subscriber certificates and member guides are available at https://www.uawumasstrustfund.org/

Pre-treatment estimates

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

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 Ameritas: Please contact Ameritas customer service at (800) 487-5553. For EyeMed: Submit a Second Opinion Request Form. Once completed, it should be sent to the Quality Assurance team for consideration at Vision Care Services (Fax: (513) 492-4999), or Attn: Quality Assurance, 4000 Luxottica Place, Mason, OH 45040

COVID-19 (Personal Protective Equipment) PPE Fee Reimbursement

For plan year 2020-21, the Trust Fund will maintain a fund to reimburse employees for PPE fees charged by dental and vision providers due to COVID-19 and not covered by insurance. The fund is limited and available on a first come first served basis. Reimbursement requests should be made using the online benefits application; documentation of the charge will be required. Final approval is per the decision of the Trustees. Due to the limited nature of the fund, reimbursement is not guaranteed.

UAW/UMass Health & Welfare Trust Fund

Policy # 010-53791 Dental Fusion Highlight Sheet

GRADUATE EMPLOYEES **Effective Date: 9/1/2020**

FUSION: THE ULTIMATE CHOICE[SM]

For the maximum:

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

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

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

Orthodontia Summary – Adult coverage and Child(ren) to age 19 coverage

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

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

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

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

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

In & Out of Network

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

UAW/UMass Health & Welfare Trust Fund

Policy # 010-53791 Dental Fusion Highlight Sheet

Ameritas Information

We're Here to Help

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

Dental Health Scorecard

How would you rate your dental health?

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

Rx Savings

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

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

Eyewear Savings

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

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

Preventive Plus℠

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

Dental Network Information

To find a provider, visit ameritas.com and select **FIND A PROVIDER,** then **DENTAL,** then select **choose a network provider**. Enter your criteria to search by location or for a specific dentist or practice. When prompted to select your network, choose the **Ameritas Classic (PPO) & Plus Network** or contact Customer Connections at 800-487-5553 to speak with an Ameritas representative.

Pretreatment

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

Open Enrollment

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

UAW/UMass Health & Welfare Trust Fund

Policy # 010-53791 Dental Fusion Highlight Sheet

Ameritas

Dental Cost Estimator

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

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

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

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

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

Worldwide Support

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

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

Language Services

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

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

UAW/UMass H&W Trust Fund

Grad Employee Unit, group #9794348

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.

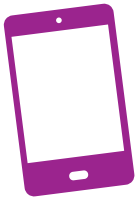
Benefits Snapshot	With EyeMed	Out-of-Network Reimbursement
Exam, with dilation as necessary (once every 12 months)	$10 Co-pay	Up to $50
Frames (once every 12 months)	$0 Co-pay, $150 Allowance; 20% off balance over $150	Up to $90
Single Vision Lenses (once every 12 months)	$10 Co-pay	Up to $42
or Contacts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

*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 September 1-August 31 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, 9/1 to 8/31 of each year. If you pay on a monthly basis, charges dated after 9/1 are eligible. If you purchase semester or yearly plans, the period of the receipt must include a majority of the plan year to be eligible (i.e. though dated in Sept, UMass Fall 2020 gym receipts are eligible; receipts for the previous summer are not).

Eligible Wellness Activities

Eligible activities promote fitness and stress reduction through physical exercise. Examples include gym memberships, yoga, dance, aerobics and martial arts classes, golf and ski fees, marathon, road race and endurance course fees, swim fees, intramural sport fees, court fees and ice rental fees for related sport. Weight loss programs with fitness components, workout program DVDs, personal coaching/fitness tracking devices (all brands are eligible, excludes accessories and only 1 per person per plan year), fitness and personal training apps, mental health apps and out-of-pocket mental health costs not covered by insurance, state & national park passes and camping fees. Certain equipment purchases supporting fitness and well-being are also eligible for reimbursement during plan year 2020-21, including weights and dumbbells, resistance bands, yoga mats and blocks, treadmills, ellipticals and rowing machines, sport equipment like balls and rackets, camping and backpacking equipment, skis and snowshoes, ergonomic desks and chairs, face masks, and headphones. Final approval of equipment purchases is per the decision of the Trustees.

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

Activities that aren't eligible include: massage, acupuncture, health costs, spa treatments, facials, and clothing and shoes. Receipts for family members or other individuals are not eligible.

Special Circumstances

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

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

For the 2020-21 plan year, the Trust Fund will not offer prepaid memberships with Central Rock Gym or The Healing Zone due to COVID-19.

Pre-Paid Daily Burn Subscriptions

For the 2020-21 plan year, The Trust Fund is offering prepaid 6-month & 12-month subscriptions to the online fitness platform, Daily Burn. These subscriptions are limited and are available on a first-come first-served basis. Six-month memberships will be considered in lieu of $95 of any wellness reimbursement you are otherwise eligible for; 12-month memberships are in lieu of the full $190 wellness reimbursement. Daily Burn subscriptions may be claimed in the wellness section of the regular Trust Fund benefits application.

Calm Subscriptions

Eligible Grad Employees can access ***Calm***, the world's #1 app for meditation, sleep and relaxation, for free. Each subscription is 12 months long and subscriptions may be claimed on the dashboard of your Trust Fund benefits account, where you will find a code to be used on the Calm website.

How & When You'll Receive Reimbursement

Personal check: You can alternatively opt for payment via personal check and the check will be mailed to the address we have on file for you. It generally takes 4-6 weeks to receive your reimbursement using this method.

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 2020-21 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 an eligible source of childcare. Trust Fund Trustees reserve the right to ultimately determine eligibility. Eligible childcare includes:

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

How we Distribute Funds

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

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

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

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

UAW/UMass Health & Welfare Trust Fund

Flat Fee Expected Parent CoPayment Chart

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

				.75 time or more 30-40 hrs/wk care			.5 time 20-30 hrs/wk care			.25 time or less less than 20 hrs/wk	
	MA EEC Weekly Rates for Parents										
Income Level	Infant/Toddler/PreS	School Age		Infant/Toddler/PreS	School Age		Infant/Toddler/PreS	School Age		Infant/Toddler/PreS	School Age
12	$75.00	$45.00		$562.50	$337.50		$375.00	$225.00		$187.50	$112.50
13	$82.50	$49.50		$618.75	$371.25		$412.50	$247.50		$206.25	$123.75
14	$87.50	$52.50		$656.25	$393.75		$437.50	$262.50		$218.75	$131.25
15	$95.00	$57.00		$712.50	$427.50		$475.00	$285.00		$237.50	$142.50
16	$102.50	$61.50		$768.75	$461.25		$512.50	$307.50		$256.25	$153.75
17	$110.00	$66.00		$825.00	$495.00		$550.00	$330.00		$275.00	$165.00
18	$115.00	$69.00		$862.50	$517.50		$575.00	$345.00		$287.50	$172.50
19	$120.00	$72.00		$900.00	$540.00		$600.00	$360.00		$300.00	$180.00
20	$125.00	$75.00		$937.50	$562.50		$625.00	$375.00		$312.50	$187.50
21	$130.00	$78.00		$975.00	$585.00		$650.00	$390.00		$325.00	$195.00
22	$135.00	$81.00		$1,012.50	$607.50		$675.00	$405.00		$337.50	$202.50
23	$140.00	$84.00		$1,050.00	$630.00		$700.00	$420.00		$350.00	$210.00
24	$145.00	$87.00		$1,087.50	$652.50		$725.00	$435.00		$362.50	$217.50
25	$160.00	$96.00		$1,200.00	$720.00		$800.00	$480.00		$400.00	$240.00
26	$175.00	$105.00		$1,312.50	$787.50		$875.00	$525.00		$437.50	$262.50
27	$190.00	$114.00		$1,425.00	$855.00		$950.00	$570.00		$475.00	$285.00
28	$205.00	$123.00		$1,537.50	$922.50		$1,025.00	$615.00		$512.50	$307.50

How to use this chart

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

The Trust Fund crosschecks receipts provided for care at the Center for Early Education and Care (CEEC) with CEEC records from the same period. In addition, the Trust Fund receives information from the Graduate Student Senate (GSS) and the CCAMPIS grant administrator for childcare awards families receive from GSS, Student Affairs or CCAMPIS for the same period and reduces reported costs accordingly.

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

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

Maximum Annual Reimbursement

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

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, log in to your existing application, following prompts for the childcare section only. If you are new to our system, you can start a new application.

Outschool Family Wallet

Starting mid plan year 2020-21, Trust Fund maintains a wallet of funds accessible to eligible employees with pre-school and school-aged children. The wallet can be used by parents to purchase Outschool content, is limited and available on a first come first served basis. Access to the wallet is capped at $75 per year per household. The wallet is shared across Graduate Employee Unit and Postdoctoral Unit families.

SHERRI KILLINS
COMMISSIONER

Commonwealth of Massachusetts

Department of Early Education and Care (EEC)

EEC FINANCIAL ASSISTANCE

PARENT CO-PAYMENT TABLE

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

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

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

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

Commonwealth of Massachusetts

Department of Early Education and Care (EEC)

SHERRI KILLINS
COMMISSIONER

PARENT CO-PAYMENT TABLE

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

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

This will show you the parent co-pay pertaining to that family size and income.

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

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

OPTIONAL METLAW PREPAID LEGAL BENEFIT

Eligible Postdocs 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
Use the regular online benefits application to apply, 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 them to the addressee, and forwarding and explaining any response to the participant.	Fully Covered	$75
Document Review This service covers the review of any personal legal document of the participant, such as letters, leases or purchase agreements.	Fully Covered	$100
Elder Law Matters This service covers counseling the participant over the phone or in the office on any personal issues relating to the participant's parents as they affect the participant. The service includes reviewing documents of the parents to advise the participant on the effect on the participant. The documents include Medicare or Medicaid materials, prescription plans, leases, nursing home agreements, powers of attorney, living wills and wills. The service also includes preparing deeds involving the parents when the participant is either the grantor or grantee; and preparing promissory notes involving the parents when the participant is the payor or payee.	Fully Covered	$140
Mortgages This service covers the preparation of any mortgage or deed of trust for which the participant is the mortgagor.	Fully Covered	$70
Promissory Notes This service covers the preparation of any promissory note for which the participant is the payor or payee.	Fully Covered	$70
ESTATE PLANNING DOCUMENTS	IN	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 maximum of $800 per day up to $100,000 total trial supplement maximum.

Exclusions: No service, including advice and consultations, will be provided for (1) employment-related matters, including Company or statutory benefits; (2) matters involving the 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 enrolled. The online application is available at https://hwtrust.geouaw.org/ If you have any difficulty with the online application, please contact the Director of Benefits at uawdental@external.umass.edu or (413) 345-2156.

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

Your name;

Your address;

Your Social Security Number;

Your birth date;

The names and birth dates of each member of your family you wish to enroll;

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

Notify the Trust Fund About Any Changes

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

You must notify the Trust Fund when:

You move;

Your email address changes;

You get married;

You are divorced or legally separated, or end your domestic partnership;

You have a new baby or legally adopt a child;

Your child reaches age 19;

A family member covered by the Benefit Fund dies;

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

Your Benefits Authorization Form

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

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

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

WHEN YOUR COVERAGE BEGINS

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

If you are a new employee

If you are an incoming graduate student employee for academic year 2020-21 the earliest start date for your benefits is September 1, 2020.

If you are an existing employee

If you were a graduate student employee during academic year 2019-20, and were otherwise eligible, you can still enroll in the 2019-20 plan up to June 30, 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 2020-21, open enrollment occurs according to the following schedule with the following applicable coverage start dates:

Aug 15-Sept 5, 2020, for a coverage start date of 9/1/20

Nov 1-Nov 15, 2020, for a coverage start date of 11/1/20

Feb 1-Feb 15, 2021, 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, 2019; for a coverage start date of 6/1/20

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. Ameritas does not issue hard-copy ID cards but you can download a digital ID by registering at www.ameritas.com

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

Ameritas Group #: 010-53791

EyeMed Group #: 9794348

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

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

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

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

including: You did not receive your card(s);

Your card is lost or stolen;

Your name is not spelled correctly

ID Cards for Dependents and Expired ID cards

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

WHEN YOUR ELIGIBILITY ENDS

You will lose your eligibility at the end of the plan year on 8/31 if you do not have GEO-qualified earnings meeting the minimum required for the next academic year. If you fail to enroll as a student, withdraw from student status, or fail to meet the minimum earnings requirement due to early termination of employment, your coverage ends 30 days after the date of the aforementioned event.

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 https://www.uawumasstrustfund.org/geo-cobra

Length of COBRA coverage

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

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

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

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

Extensions to the length of COBRA continuation coverage

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

-Disability

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

-Second Qualifying Event

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

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

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

Periodic payments for continuation coverage: After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The amount due for each coverage period for each qualified beneficiary is shown in this notice. The periodic payments can be made on a monthly basis. Under the Plan, each of these periodic payments for continuation coverage is due on the 1st day of the month for that coverage period. If

you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break. The Plan send periodic notices of payments due for these coverage periods.

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

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

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

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

PAYMENT POLICIES

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

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

NOTICE OF PRIVACY PRACTICES

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

Disclosure and Use of Protected Health Information

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

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

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

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

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

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

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

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

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

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

Authorization to Use or Disclose Protected Health Information

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

Your Rights With Respect to Your Protected Health Information

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

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

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

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

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

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

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

Duties of the Fund

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

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

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

Contact

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

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

By email: uawdental@external.umass.edu

By phone: (413) 345-2156

Ameritas Life Insurance Corp.

A STOCK COMPANY
LINCOLN, NEBRASKA

GROUP DENTAL INSURANCE POLICY

The Policyholder	**UAW/UMASS HEALTH & WELFARE TRUST FUND**		
		Policy Number	**10-53791**
State of Delivery	**Massachusetts**	**Plan Effective Date**	**July 1, 2020**
		Plan Change Effective Date	**September 1, 2020**
Premium Due Date 1st of each month.		**Renewal Date**	**September 1**

Ameritas Life Insurance Corp. agrees to pay, with respect to each Insured Person, the group insurance benefits provided in this policy.

This policy is issued to the Policyholder in consideration of the Policyholder's application and the payment of premiums, as provided herein.

This policy is delivered in and governed by the laws of the state of delivery.

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

AMERITAS LIFE INSURANCE CORP.

Corporate Secretary

President

Massachusetts Notice of Inquiry and Grievance Procedures

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

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

I. Definitions

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

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

II. Internal Grievance Process

1. Filing a Grievance

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

2. Written Decision

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

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

3. Reconsideration

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

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

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

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

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

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

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

ដែលអាចស្នើសុំ សេវាអ្នកបកប្រែភាសាផ្ទាល់មាត់ និងបកប្រែ អក្សរសម្រាប់នីតិវិធីរដ្ឋបាល នានាមានផ្តល់ជូន

若您提出要求，我們可以提供與行政程序有關的語言翻譯服務。

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

Κατόπιν αίτησης διαθέτονται ερμηνευτικές και μεταφραστικές
υπηρεσίες για διαχειριστικές υποθέσεις.

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

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

ເມື່ອໄດ້ມີການຮ້ອງຂໍ, ຈະມີບໍລິການບາຍພາສາແລະແປພາສາໄວ້ສຳຫລັບເລື່ອງຕ່າງໆ ທີ່ກ່ຽວຂ້ອງກັບ
ກະບວນການຕ່າງ ໆ ທາງດ້ານການບໍລິຫານ.

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

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

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

IMPORTANT INFORMATION

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

CONSUMER RIGHTS

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

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

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

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

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

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

OUR PRACTICES

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

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

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

The Quality Management Program addresses the following standards:

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

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

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

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

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

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

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

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

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

877-897-4328 (Toll-Free)

NOTICE

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

Information that can be accessed at this location includes:

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

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

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

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

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

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

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

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

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

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

1Creation of a user name and password required.

THIS DISCOUNT ACCESS IS NOT INSURANCE

Non-Insurance Products/Services

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

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

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

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

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

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

TABLE OF CONTENTS

SCHEDULE OF BENEFITS
OUTLINE OF COVERAGE

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

Benefit Class	Class Description
Class 1	Post Doctoral Researcher

DENTAL EXPENSE BENEFITS

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

Deductible Amount:

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

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

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

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

Eligible Dental Expense Benefits for Temporomandibular Joint Dysfunction may not exceed $500 per Lifetime.

ORTHODONTIC EXPENSE BENEFITS

Deductible Amount - Once per lifetime	$0
Coinsurance Percentage	50%
Maximum Benefit During Lifetime	$1,000

The Maximum Benefit shown above will be modified for:

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

    i. insured under the policy, and

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

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

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

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

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

COMBINED EXPENSE BENEFITS

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

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

PREMIUMS

TABLE OF MONTHLY PREMIUM RATES

Dental and Eye Care Insurance	$28.60 per Insured Person
	$28.61 One Dependent Only
	$65.03 Two or More Dependents
Orthodontic Insurance	$1.00 per Insured Person
	$1.08 One Dependent Only
	$7.12 Two or More Dependents

PAYMENT OF PREMIUMS. The first premium will be due on the Policy Effective Date to cover the period from that date to the first Premium Due Date. Other premiums will be due on or before each Premium Due Date. Premiums are payable at our Home Office or at some other location to which we and the Policyholder agree.

PREMIUM DUE DATE. The Premium Due Date will be the first day of the month that falls on or after the Policy Effective Date. If we agree with the Policyholder to the payment of premiums on a basis other than monthly, the Premium Due Date will be fixed to match the correct basis. If there is a change in the method of payment or Premium Due Date, a pro-rata charge in the premium due will be made.

PREMIUM STATEMENTS. The premium due as of any Premium Due Date is the number of units in force on such date for each type of insurance multiplied by the rate shown in the Table of Premium Rates. A premium statement will be made as of the Premium Due Date showing the premium payable. If premiums are payable on other than a monthly basis, each statement will show any pro-rata premium charges and credits in the last premium period due to changes in the number of Insureds and in the amount of insurance for which people are insured. This is subject to the rules below.

SIMPLIFIED ACCOUNTING. The premium will start on the Premium Due Date falling on or after the date the insurance or the increase in the insurance is effective for: a) a person becoming insured; or b) an increase in the amount of insurance on any person. The premium will stop on the Premium Due Date falling on or after the date of termination of insurance or through the date of service of the last paid claim. There will be no pro-rata charges or credits for a partial month. If premiums are payable other than monthly, charges and credits will be figured as though the Premium Due Date is monthly.

We will be liable for the return of unearned premiums (premium for the period which claims were not paid) to the Policyholder only for the 3 months before the date we receive evidence that a return is due.

ADJUSTMENTS IN PREMIUM RATES. We may change the rates shown in the Table of Premium Rates by giving the Policyholder at least 30 days advance written notice. We may change the rates at any time the Schedule of Benefits, or any other terms and conditions of the policy, are changed. We will not change the rates until the Renewal Date shown on the policy cover or more than once in any 12 month period thereafter, unless there is a change in the Schedule of Benefits or a change in any other terms and conditions in the policy.

Notwithstanding the above, We the Company reserve the right to change any one or more of the rates prior to the Renewal Date or more than once in any 12 month period thereafter upon the occurrence of any one or more of the following:

1. We determine that the average number of dependent children for each Insured with Dependent coverage exceeds 4.0; and/or

2. We determine that the number of Insureds is less than 80% of those Insureds initially enrolled under the Policy as of either (i) the Plan Effective Date, if during the period of time between the Plan Effective Date and the Renewal Date, or (ii) the most recent 12 month anniversary of the Renewal Date: and/or

3. We are required by either the federal government or by any state or local government or by any agency thereof to change benefits as a result of regulatory change or pay a new or increased tax, assessment, or monetary charge of any kind (other than a new or any increase to the amount of tax we pay based upon our net operating income). Such taxes, assessments or fees would include those that are charged or assessed in connection with the operation of a health care exchange authorized by federal or state law.

Should any of the above occur and should we elect to change rates as a result, we agree to notify the Policyholder of the corresponding rate changes at least 30 days in advance of the Premium Due Date for which the rate change shall be effective. The right to change rates as well as the timing of such changes in the above limited situations shall at all times be subject to applicable state laws and regulations.

RENEWAL DATE refers to the date each calendar year that the coverage issued under the group policy is considered for renewal. The Renewal Date(s) are shown on the policy cover.

DEFINITIONS

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

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

INSURED refers to a person:

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

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

c. for whom the insurance has become effective.

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

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

DEPENDENT refers to:

a. an Insured's spouse or Domestic Partner.

b. each unmarried child less than 26 years of age, for whom the Insured, the Insured's spouse, or the Insured's Domestic Partner is legally responsible, including natural born children, adopted children from the date of placement for adoption, and children covered under a Qualified Medical Child Support Order as defined by applicable Federal and State laws.

c. each unmarried child age 26 or older who is Totally Disabled and becomes Totally Disabled as defined below while insured as a dependent under b. above. Coverage of such child will not cease if proof of dependency and disability is given within 31 days of attaining the limiting age and subsequently as may be required by us but not more frequently than annually after the initial two-year period following the child's attaining the limiting age. Any costs for providing continuing proof will be at our expense.

TOTAL DISABILITY describes the Insured's Dependent as:

1. Continuously incapable of self-sustaining employment because of mental retardation or physical handicap; and

2. Chiefly dependent upon the Insured for support and maintenance.

DEPENDENT UNIT refers to all of the people who are insured as the dependents of any one Insured.

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

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

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

LATE ENTRANT refers to any person:

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

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

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

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

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

CONDITIONS FOR INSURANCE COVERAGE

ELIGIBILITY

ELIGIBLE CLASS FOR MEMBERS. The members of the eligible class(es) are shown on the Schedule of Benefits. Each member of the eligible class (referred to as "Member") will qualify for such insurance on the day he or she completes the required eligibility period, if any. Members choosing to elect coverage will hereinafter be referred to as "Insured."

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

If both spouses are Members, and if either of them insures their dependent children, then the spouse, whoever elects, will be considered the dependent of the other. As a dependent, the person will not be considered a Member of the Eligible Class, but will be eligible for insurance as a dependent.

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

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

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

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

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

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

Any spouse who elects to be a dependent rather than a member of the Eligible Class for Personal Insurance, as explained above, is not a member of the Eligible Class for Dependent Insurance.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

TERMINATION DATES

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

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

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

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

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

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

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

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

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

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

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

Federally Required Continuation
For Employees and/or Dependents

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

1. groups of less than 20 employees.

2. certain church plans.

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

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

Leave of Absence
For Employees Only

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

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

Separation or Divorce
For Dependents Only

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

a. become legally separated; or

b. dissolve the marriage;

unless the judgment of separation or divorce excludes such continuation.

For purposes of this continuation provision such spouse is called "former spouse."

The former spouse may also continue to insure his or her dependent children.

Coverage may be continued if the judgment of dissolution or separation was entered prior to the effective date of this plan.

Benefits

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

Termination

Such insurance will stop on the earliest of:

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

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

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

4. the date either party remarries*;

5. the date insurance terminates for the Insured;

6. the date the policy terminates.

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

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

Premium

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

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

Claims

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

Notice

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

DENTAL EXPENSE BENEFITS

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

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

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

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

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

COVERED EXPENSES. Covered Expenses include:

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

Covered Expenses are subject to "Limitations." See Limitations and Table of Dental Procedures.

Benefits payable for Covered Expenses also will be based on the lesser of:

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

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

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

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

EMERGENCY CARE. Services provided in or by a hospital emergency facility to a covered person after the development of a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity that the absence of prompt medical attention could reasonable be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the covered person's or another

person's health in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3. for appliances, restorations, or procedures to:

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

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

5. to replace lost or stolen appliances.

6. for any treatment which is for cosmetic purposes.

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

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

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

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

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

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

TABLE OF DENTAL PROCEDURES

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

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

- Your benefits are based on a Benefit Year. A Benefit Year runs from September 1 through August 31.
- Benefit Period means the period from September 1 of any year through August 31 of the next year. But during the first year a person is insured, a benefit period means the period from his or her effective date through August 31 of the next year.
- Covered procedures are subject to all plan provisions, procedure and frequency limitations, and/or consultant review.
- Reference to "traumatic injury" under this plan is defined as injury caused by external forces (ie. outside the mouth) and specifically excludes injury caused by internal forces such as bruxism (grinding of teeth).
- Benefits for replacement dental prosthesis or prosthetic crown will be based on the prior placement date. Frequencies which reference Benefit Period will be measured forward within the limits defined as the Benefit Period. All other frequencies will be measured forward from the last covered date of service.
- Radiographic images, periodontal charting and supporting diagnostic data may be requested for our review.
- We recommend that a pre-treatment estimate be submitted for all anticipated work that is considered to be expensive by our insured.
- A pre-treatment estimate is not a pre-authorization or guarantee of payment or eligibility; rather it is an indication of the estimated benefits available if the described procedures are performed.

TYPE 1 PROCEDURES

PAYMENT BASIS - NON PARTICIPATING PROVIDERS - Usual and Customary

BENEFIT PERIOD - Benefit Year

For Additional Limitations - See Limitations

ROUTINE ORAL EVALUATION

D0120 Periodic oral evaluation - established patient.

D0145 Oral evaluation for a patient under three years of age and counseling with primary caregiver.

D0150 Comprehensive oral evaluation - new or established patient.

D0180 Comprehensive periodontal evaluation - new or established patient.

COMPREHENSIVE EVALUATION: D0150, D0180

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

In addition, D0150, D0180 coverage is limited to 2 of any of these procedures per 12 month(s).

D0120, D0145, also contribute(s) to this limitation.

If frequency met, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency.

ROUTINE EVALUATION: D0120, D0145

Coverage is limited to 2 of any of these procedures per 12 month(s).

D0150, D0180, also contribute(s) to this limitation.

Procedure D0120 will be considered for individuals age 3 and over. Procedure D0145 will be considered for individuals age 2 and under.

COMPLETE SERIES OR PANORAMIC

D0210 Intraoral - complete series of radiographic images.

D0330 Panoramic radiographic image.

COMPLETE SERIES/PANORAMIC: D0210, D0330

Coverage is limited to 1 of any of these procedures per 5 year(s).

OTHER XRAYS

D0220 Intraoral - periapical first radiographic image.

D0230 Intraoral - periapical each additional radiographic image.

D0240 Intraoral - occlusal radiographic image.

D0250 Extra-oral - 2D projection radiographic image created using a stationary radiation source, and detector.

D0251 Extra-oral posterior dental radiographic image.

PERIAPICAL: D0220, D0230

The maximum amount considered for x-ray radiographic images taken on one day will be equivalent to an allowance of a D0210.

BITEWINGS

D0270 Bitewing - single radiographic image.

D0272 Bitewings - two radiographic images.

D0273 Bitewings - three radiographic images.

D0274 Bitewings - four radiographic images.

D0277 Vertical bitewings - 7 to 8 radiographic images.

BITEWINGS: D0270, D0272, D0273, D0274

Coverage is limited to 1 of any of these procedures per 6 month(s).

D0277, also contribute(s) to this limitation.

The maximum amount considered for x-ray radiographic images taken on one day will be equivalent to an allowance of a D0210.

VERTICAL BITEWINGS: D0277

Coverage is limited to 1 of any of these procedures per 5 year(s).

The maximum amount considered for x-ray radiographic images taken on one day will be equivalent to an allowance of a D0210.

PRE-DIAGNOSTIC TEST

D0431 Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures.

TESTS: D0431

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

PROPHYLAXIS (CLEANING) AND FLUORIDE

D1110 Prophylaxis - adult.
D1120 Prophylaxis - child.
D1206 Topical application of fluoride varnish.
D1208 Topical application of fluoride-excluding varnish.
D9932 Cleaning and inspection of removable complete denture, maxillary.
D9933 Cleaning and inspection of removable complete denture, mandibular.
D9934 Cleaning and inspection of removable partial denture, maxillary.
D9935 Cleaning and inspection of removable partial denture, mandibular.

FLUORIDE: D1206, D1208

Coverage is limited to 1 of any of these procedures per 6 month(s).
Benefits are considered for persons age 18 and under.

PROPHYLAXIS: D1110, D1120

Coverage is limited to 4 of any of these procedures per 12 month(s).
D4346, D4910, also contribute(s) to this limitation.
An adult prophylaxis (cleaning) is considered for individuals age 14 and over. A child prophylaxis (cleaning) is considered for individuals age 13 and under. Benefits for prophylaxis (cleaning) are not available when performed on the same date as periodontal procedures.

CLEANING AND INSPECTION OF REMOVABLE DENTURE: D9932, D9933, D9934, D9935

Coverage is limited to 4 of any of these procedures per 12 month(s).
Benefits are not available when performed on the same date as prophylaxis (cleaning) or periodontal maintenance.

SEALANT

D1351 Sealant - per tooth.
D1352 Preventive resin restoration in a moderate to high caries risk patient-permanent.
D1353 Sealant repair - per tooth.

SEALANT: D1351, D1352, D1353

Coverage is limited to 1 of any of these procedures per lifetime.
Benefits are considered for persons age 18 and under.
Benefits are considered on permanent molars only, excluding 3rd molars (wisdom teeth).
Coverage is allowed on the occlusal surface only.

SPACE MAINTAINERS

D1510 Space maintainer-fixed, unilateral-per quadrant.
D1516 Space maintainer - fixed - bilateral, maxillary.
D1517 Space maintainer - fixed - bilateral, mandibular.
D1520 Space maintainer-removable, unilateral-per quadrant.
D1526 Space maintainer - removable - bilateral, maxillary.
D1527 Space maintainer - removable - bilateral, mandibular.
D1551 Re-cement or re-bond bilateral space maintainer-maxillary.
D1552 Re-cement or re-bond bilateral space maintainer-mandibular.
D1553 Re-cement or re-bond unilateral space maintainer-per quadrant.
D1556 Removal of fixed unilateral space maintainer-per quadrant.
D1557 Removal of fixed bilateral space maintainer-maxillary.
D1558 Removal of fixed bilateral space maintainer-mandibular.
D1575 Distal shoe space maintainer - fixed, unilateral-per quadrant.

SPACE MAINTAINER: D1510, D1516, D1517, D1520, D1526, D1527, D1575

Benefits are considered for persons age 13 and under.
Coverage is limited to space maintenance for unerupted teeth, following extraction of primary teeth. Allowances include all adjustments within 6 months of placement date.

OTHER PERIODONTAL SERVICES

D4346 Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation.
D4910 Periodontal maintenance.

PERIODONTAL MAINTENANCE: D4346, D4910

Coverage is limited to 4 of any of these procedures per 12 month(s).
D1110, D1120, also contribute(s) to this limitation.
Benefits are not available if performed on the same date as any other periodontal service.
Procedure D4910 is contingent upon evidence of full mouth active periodontal therapy.
Procedure D4346 is limited to persons age 14 and over.

APPLIANCE THERAPY

D8210 Removable appliance therapy.
D8220 Fixed appliance therapy.

APPLIANCE THERAPY: D8210, D8220

Coverage is limited to the correction of thumb-sucking.

TYPE 2 PROCEDURES

PAYMENT BASIS - NON PARTICIPATING PROVIDERS - Usual and Customary

BENEFIT PERIOD - Benefit Year

For Additional Limitations - See Limitations

LIMITED ORAL EVALUATION

D0140 Limited oral evaluation - problem focused.

D0170 Re-evaluation - limited, problem focused (established patient; not post-operative visit).

LIMITED ORAL EVALUATION: D0140, D0170

Coverage is allowed for accidental injury only. If not due to an accident, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency.

ORAL PATHOLOGY/LABORATORY

D0472 Accession of tissue, gross examination, preparation and transmission of written report.

D0473 Accession of tissue, gross and microscopic examination, preparation and transmission of written report.

D0474 Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report.

ORAL PATHOLOGY LABORATORY: D0472, D0473, D0474

Coverage is limited to 1 of any of these procedures per 12 month(s).

Coverage is limited to 1 examination per biopsy/excision.

AMALGAM RESTORATIONS (FILLINGS)

D2140 Amalgam - one surface, primary or permanent.

D2150 Amalgam - two surfaces, primary or permanent.

D2160 Amalgam - three surfaces, primary or permanent.

D2161 Amalgam - four or more surfaces, primary or permanent.

AMALGAM RESTORATIONS: D2140, D2150, D2160, D2161

Coverage is limited to 1 of any of these procedures per 6 month(s).

D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2990, D9911, also contribute(s) to this limitation.

RESIN RESTORATIONS (FILLINGS)

D2330 Resin-based composite - one surface, anterior.

D2331 Resin-based composite - two surfaces, anterior.

D2332 Resin-based composite - three surfaces, anterior.

D2335 Resin-based composite - four or more surfaces or involving incisal angle (anterior).

D2391 Resin-based composite - one surface, posterior.

D2392 Resin-based composite - two surfaces, posterior.

D2393 Resin-based composite - three surfaces, posterior.

D2394 Resin-based composite - four or more surfaces, posterior.

D2410 Gold foil - one surface.

D2420 Gold foil - two surfaces.

D2430 Gold foil - three surfaces.

D2990 Resin infiltration of incipient smooth surface lesions.

COMPOSITE RESTORATIONS: D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2990

Coverage is limited to 1 of any of these procedures per 6 month(s).

D2140, D2150, D2160, D2161, D9911, also contribute(s) to this limitation.

Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

GOLD FOIL RESTORATIONS: D2410, D2420, D2430

Gold foils are considered at an alternate benefit of an amalgam/composite restoration.

STAINLESS STEEL CROWN (PREFABRICATED CROWN)

D2390 Resin-based composite crown, anterior.

D2929 Prefabricated porcelain/ceramic crown - primary tooth.

D2930 Prefabricated stainless steel crown - primary tooth.

D2931 Prefabricated stainless steel crown - permanent tooth.

D2932 Prefabricated resin crown.

D2933 Prefabricated stainless steel crown with resin window.

D2934 Prefabricated esthetic coated stainless steel crown - primary tooth.

STAINLESS STEEL CROWN: D2390, D2929, D2930, D2931, D2932, D2933, D2934

Replacement is limited to 1 of any of these procedures per 12 month(s).

Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

RECEMENT

D2910 Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration.
D2915 Re-cement or re-bond indirectly fabricated or prefabricated post and core.
D2920 Re-cement or re-bond crown.
D2921 Reattachment of tooth fragment, incisal edge or cusp.
D6092 Re-cement or re-bond implant/abutment supported crown.
D6093 Re-cement or re-bond implant/abutment supported fixed partial denture.
D6930 Re-cement or re-bond fixed partial denture.

SEDATIVE FILLING

D2940 Protective restoration.
D2941 Interim therapeutic restoration - primary dentition.

PULP CAP

D3110 Pulp cap - direct (excluding final restoration).

ENDODONTICS MISCELLANEOUS

D3220 Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament.
D3221 Pulpal debridement, primary and permanent teeth.
D3222 Partial Pulpotomy for apexogenesis - permanent tooth with incomplete root development.
D3230 Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration).
D3240 Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration).
D3333 Internal root repair of perforation defects.
D3351 Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.).
D3352 Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.).
D3353 Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.).
D3357 Pulpal regeneration - completion of treatment.
D3430 Retrograde filling - per root.
D3450 Root amputation - per root.
D3920 Hemisection (including any root removal), not including root canal therapy.

ENDODONTICS MISCELLANEOUS: D3333, D3430, D3450, D3920

Procedure D3333 is limited to permanent teeth only.

ENDODONTIC THERAPY (ROOT CANALS)

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

ROOT CANALS: D3310, D3320, D3330, D3332

Benefits are considered on permanent teeth only.

Allowances include intraoperative radiographic images and cultures but exclude final restoration.

RETREATMENT OF ROOT CANAL: D3346, D3347, D3348

Coverage is limited to 1 of any of these procedures per 12 month(s).

D3310, D3320, D3330, also contribute(s) to this limitation.

Benefits are considered on permanent teeth only.

Coverage is limited to service dates more than 12 months after root canal therapy. Allowances include intraoperative radiographic images and cultures but exclude final restoration.

TYPE 2 PROCEDURES

SURGICAL ENDODONTICS

D3355 Pulpal regeneration - initial visit.
D3356 Pulpal regeneration - interim medication replacement.
D3410 Apicoectomy - anterior.
D3421 Apicoectomy - premolar (first root).
D3425 Apicoectomy - molar (first root).
D3426 Apicoectomy (each additional root).
D3427 Periradicular surgery without apicoectomy.

SURGICAL PERIODONTICS

D4210 Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant.
D4211 Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant.
D4240 Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant.
D4241 Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant.
D4260 Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant.
D4261 Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant.
D4263 Bone replacement graft - retained natural tooth - first site in quadrant.
D4264 Bone replacement graft - retained natural tooth - each additional site in quadrant.
D4265 Biologic materials to aid in soft and osseous tissue regeneration.
D4270 Pedicle soft tissue graft procedure.
D4273 Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft.
D4274 Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area).
D4275 Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant or edentulous tooth position in graft.
D4276 Combined connective tissue and double pedicle graft, per tooth.
D4277 Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft.
D4278 Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant or edentulous tooth position in same graft site.
D4283 Autogenous connective tissue graft procedure (including donor and recipient surgical sites) - each additional contiguous tooth, implant or edentulous tooth position in same graft site.
D4285 Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) - each additional contiguous tooth, implant or edentulous tooth position in same graft site.

BONE GRAFTS: D4263, D4264, D4265
Each quadrant is limited to 1 of each of these procedures per 3 year(s).
Coverage is limited to treatment of periodontal disease.

GINGIVECTOMY: D4210, D4211
Each quadrant is limited to 1 of each of these procedures per 3 year(s).
Coverage is limited to treatment of periodontal disease.

OSSEOUS SURGERY: D4240, D4241, D4260, D4261
Each quadrant is limited to 1 of each of these procedures per 3 year(s).
Coverage is limited to treatment of periodontal disease.

TISSUE GRAFTS: D4270, D4273, D4275, D4276, D4277, D4278, D4283, D4285
Each quadrant is limited to 2 of any of these procedures per 3 year(s).
Coverage is limited to treatment of periodontal disease.

NON-SURGICAL PERIODONTICS

D4341 Periodontal scaling and root planing - four or more teeth per quadrant.
D4342 Periodontal scaling and root planing - one to three teeth, per quadrant.

D4381 Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report.
ANTIMICROBIAL AGENTS: D4381
Each quadrant is limited to 2 of any of these procedures per 2 year(s).
PERIODONTAL SCALING & ROOT PLANING: D4341, D4342
Each quadrant is limited to 1 of each of these procedures per 2 year(s).

FULL MOUTH DEBRIDEMENT
D4355 Full mouth debridement to enable comprehensive oral evaluation and diagnosis on a subsequent visit.
FULL MOUTH DEBRIDEMENT: D4355
Coverage is limited to 1 of any of these procedures per 5 year(s).

DENTURE REPAIR
D5511 Repair broken complete denture base, mandibular.
D5512 Repair broken complete denture base, maxillary.
D5520 Replace missing or broken teeth - complete denture (each tooth).
D5611 Repair resin partial denture base, mandibular.
D5612 Repair resin partial denture base, maxillary.
D5621 Repair cast partial framework, mandibular.
D5622 Repair cast partial framework, maxillary.
D5630 Repair or replace broken retentive/clasping materials per tooth.
D5640 Replace broken teeth - per tooth.

DENTURE REBASES
D5710 Rebase complete maxillary denture.
D5711 Rebase complete mandibular denture.
D5720 Rebase maxillary partial denture.
D5721 Rebase mandibular partial denture.

DENTURE RELINES
D5730 Reline complete maxillary denture (direct).
D5731 Reline complete mandibular denture (direct).
D5740 Reline maxillary partial denture (direct).
D5741 Reline mandibular partial denture (direct).
D5750 Reline complete maxillary denture (indirect).
D5751 Reline complete mandibular denture (indirect).
D5760 Reline maxillary partial denture (indirect).
D5761 Reline mandibular partial denture (indirect).
DENTURE RELINE: D5730, D5731, D5740, D5741, D5750, D5751, D5760, D5761
Coverage is limited to service dates more than 6 months after placement date.

TISSUE CONDITIONING
D5850 Tissue conditioning, maxillary.
D5851 Tissue conditioning, mandibular.

NON-SURGICAL EXTRACTIONS
D7111 Extraction, coronal remnants - primary tooth.
D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal).

SURGICAL EXTRACTIONS
D7210 Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated.
D7220 Removal of impacted tooth - soft tissue.
D7230 Removal of impacted tooth - partially bony.
D7240 Removal of impacted tooth - completely bony.
D7241 Removal of impacted tooth - completely bony, with unusual surgical complications.
D7250 Removal of residual tooth roots (cutting procedure).
D7251 Coronectomy-intentional partial tooth removal.

TYPE 2 PROCEDURES

OTHER ORAL SURGERY

D7260 Oroantral fistula closure.
D7261 Primary closure of a sinus perforation.
D7270 Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.
D7272 Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization).
D7280 Exposure of an unerupted tooth.
D7282 Mobilization of erupted or malpositioned tooth to aid eruption.
D7283 Placement of device to facilitate eruption of impacted tooth.
D7310 Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.
D7311 Alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.
D7320 Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.
D7321 Alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.
D7340 Vestibuloplasty - ridge extension (secondary epithelialization).
D7350 Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue).
D7410 Excision of benign lesion up to 1.25 cm.
D7411 Excision of benign lesion greater than 1.25 cm.
D7412 Excision of benign lesion, complicated.
D7413 Excision of malignant lesion up to 1.25 cm.
D7414 Excision of malignant lesion greater than 1.25 cm.
D7415 Excision of malignant lesion, complicated.
D7440 Excision of malignant tumor - lesion diameter up to 1.25 cm.
D7441 Excision of malignant tumor - lesion diameter greater than 1.25 cm.
D7450 Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm.
D7451 Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm.
D7460 Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm.
D7461 Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm.
D7465 Destruction of lesion(s) by physical or chemical method, by report.
D7471 Removal of lateral exostosis (maxilla or mandible).
D7472 Removal of torus palatinus.
D7473 Removal of torus mandibularis.
D7485 Reduction of osseous tuberosity.
D7490 Radical resection of maxilla or mandible.
D7510 Incision and drainage of abscess - intraoral soft tissue.
D7520 Incision and drainage of abscess - extraoral soft tissue.
D7530 Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue.
D7540 Removal of reaction producing foreign bodies, musculoskeletal system.
D7550 Partial ostectomy/sequestrectomy for removal of non-vital bone.
D7560 Maxillary sinusotomy for removal of tooth fragment or foreign body.
D7910 Suture of recent small wounds up to 5 cm.
D7911 Complicated suture - up to 5 cm.
D7912 Complicated suture - greater than 5 cm.
D7960 Frenulectomy-also known as frenectomy or frenotomy-separate procedure not incidental to another procedure.
D7963 Frenuloplasty.
D7970 Excision of hyperplastic tissue - per arch.
D7972 Surgical reduction of fibrous tuberosity.
D7979 Non-surgical sialolithotomy.
D7980 Surgical sialolithotomy.
D7983 Closure of salivary fistula.

REMOVAL OF BONE TISSUE: D7471, D7472, D7473

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

BIOPSY OF ORAL TISSUE

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

D7288 Brush biopsy - transepithelial sample collection.

PALLIATIVE

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

PALLIATIVE TREATMENT: D9110

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

ANESTHESIA-GENERAL/IV

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

GENERAL ANESTHESIA: D9222, D9223, D9239, D9243

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

PROFESSIONAL CONSULT/VISIT/SERVICES

D9310 Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician.
D9430 Office visit for observation (during regularly scheduled hours) - no other services performed.
D9440 Office visit - after regularly scheduled hours.
D9930 Treatment of complications (post-surgical) - unusual circumstances, by report.

CONSULTATION: D9310

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

OFFICE VISIT: D9430, D9440

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

MISCELLANEOUS

D0486 Laboratory accession of transepithelial cytologic sample, microscopic examination, preparation and transmission of written report.
D2951 Pin retention - per tooth, in addition to restoration.
D9911 Application of desensitizing resin for cervical and/or root surfaces, per tooth.

DESENSITIZATION: D9911

Coverage is limited to 1 of any of these procedures per 6 month(s).

D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2990, also contribute(s) to this limitation.

Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

TYPE 3 PROCEDURES

PAYMENT BASIS - NON PARTICIPATING PROVIDERS - Usual and Customary

BENEFIT PERIOD - Benefit Year

For Additional Limitations - See Limitations

INLAY RESTORATIONS

D2510 Inlay - metallic - one surface.
D2520 Inlay - metallic - two surfaces.
D2530 Inlay - metallic - three or more surfaces.
D2610 Inlay - porcelain/ceramic - one surface.
D2620 Inlay - porcelain/ceramic - two surfaces.
D2630 Inlay - porcelain/ceramic - three or more surfaces.
D2650 Inlay - resin-based composite - one surface.
D2651 Inlay - resin-based composite - two surfaces.
D2652 Inlay - resin-based composite - three or more surfaces.

INLAY: D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652

Inlays will be considered at an alternate benefit of an amalgam/composite restoration and only when resulting from caries (tooth decay) or traumatic injury.

ONLAY RESTORATIONS

D2542 Onlay - metallic - two surfaces.
D2543 Onlay - metallic - three surfaces.
D2544 Onlay - metallic - four or more surfaces.
D2642 Onlay - porcelain/ceramic - two surfaces.
D2643 Onlay - porcelain/ceramic - three surfaces.
D2644 Onlay - porcelain/ceramic - four or more surfaces.
D2662 Onlay - resin-based composite - two surfaces.
D2663 Onlay - resin-based composite - three surfaces.
D2664 Onlay - resin-based composite - four or more surfaces.

ONLAY: D2542, D2543, D2544, D2642, D2643, D2644, D2662, D2663, D2664

Replacement is limited to 1 of any of these procedures per 5 year(s).

D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.

Frequency is waived for accidental injury.

Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.

Benefits will not be considered if procedure D2390, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

CROWNS SINGLE RESTORATIONS

D2710 Crown - resin-based composite (indirect).
D2712 Crown - 3/4 resin-based composite (indirect).
D2720 Crown - resin with high noble metal.
D2721 Crown - resin with predominantly base metal.
D2722 Crown - resin with noble metal.
D2740 Crown - porcelain/ceramic.
D2750 Crown - porcelain fused to high noble metal.
D2751 Crown - porcelain fused to predominantly base metal.
D2752 Crown - porcelain fused to noble metal.
D2753 Crown-porcelain fused to titanium and titanium alloys.
D2780 Crown - 3/4 cast high noble metal.
D2781 Crown - 3/4 cast predominantly base metal.
D2782 Crown - 3/4 cast noble metal.
D2783 Crown - 3/4 porcelain/ceramic.
D2790 Crown - full cast high noble metal.

D2791 Crown - full cast predominantly base metal.
D2792 Crown - full cast noble metal.
D2794 Crown - titanium and titanium alloys.

CROWN: D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794

Replacement is limited to 1 of any of these procedures per 5 year(s).

D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.

Frequency is waived for accidental injury.

Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.

Benefits will not be considered if procedure D2390, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

CORE BUILD-UP

D2950 Core buildup, including any pins when required.

CORE BUILDUP: D2950

A pretreatment is strongly suggested for D2950. This is reviewed by our dental consultants and benefits are allowed when diagnostic data indicates significant tooth structure loss.

POST AND CORE

D2952 Post and core in addition to crown, indirectly fabricated.
D2954 Prefabricated post and core in addition to crown.

FIXED CROWN AND PARTIAL DENTURE REPAIR

D2980 Crown repair necessitated by restorative material failure.
D2981 Inlay repair necessitated by restorative material failure.
D2982 Onlay repair necessitated by restorative material failure.
D2983 Veneer repair necessitated by restorative material failure.
D6980 Fixed partial denture repair necessitated by restorative material failure.
D9120 Fixed partial denture sectioning.

CROWN LENGTHENING

D4249 Clinical crown lengthening - hard tissue.

PROSTHODONTICS - FIXED/REMOVABLE (DENTURES)

D5110 Complete denture - maxillary.
D5120 Complete denture - mandibular.
D5130 Immediate denture - maxillary.
D5140 Immediate denture - mandibular.
D5211 Maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth).
D5212 Mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth).
D5213 Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth).
D5214 Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth).
D5221 Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth).
D5222 Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth).
D5223 Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth).

D5224 Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth).
D5225 Maxillary partial denture - flexible base (including retentive/clasping materials, rests, and teeth).
D5226 Mandibular partial denture - flexible base (including retentive/clasping materials, rests, and teeth).
D5282 Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary.
D5283 Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), mandibular.
D5284 Removable unilateral partial denture-one piece flexible base (including retentive/clasping materials, rests, and teeth) - per quadrant.
D5286 Removable unilateral partial denture-one piece resin (including retentive/clasping materials, rests, and teeth) - per quadrant.
D5670 Replace all teeth and acrylic on cast metal framework (maxillary).
D5671 Replace all teeth and acrylic on cast metal framework (mandibular).
D5810 Interim complete denture (maxillary).
D5811 Interim complete denture (mandibular).
D5820 Interim partial denture (including retentive/clasping materials, rests, and teeth), maxillary.
D5821 Interim partial denture (including retentive/clasping matierals, rests, and teeth), mandibular.
D5863 Overdenture - complete maxillary.
D5864 Overdenture - partial maxillary.
D5865 Overdenture - complete mandibular.
D5866 Overdenture - partial mandibular.
D5876 Add metal substructure to acrylic full denture (per arch).
D6110 Implant/abutment supported removable denture for edentulous arch - maxillary.
D6111 Implant/abutment supported removable denture for edentulous arch - mandibular.
D6112 Implant/abutment supported removable denture for partially edentulous arch - maxillary.
D6113 Implant/abutment supported removable denture for partially edentulous arch - mandibular.
D6114 Implant/abutment supported fixed denture for edentulous arch - maxillary.
D6115 Implant/abutment supported fixed denture for edentulous arch - mandibular.
D6116 Implant/abutment supported fixed denture for partially edentulous arch - maxillary.
D6117 Implant/abutment supported fixed denture for partially edentulous arch - mandibular.
D6118 Implant/abutment supported interim fixed denture for edentulous arch - mandibular.
D6119 Implant/abutment supported interim fixed denture for edentulous arch - maxillary.

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

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

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

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

DENTURE ADJUSTMENTS

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

DENTURE ADJUSTMENT: D5410, D5411, D5421, D5422

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

ADD TOOTH/CLASP TO EXISTING PARTIAL

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

IMPLANTS
D6010 Surgical placement of implant body: endosteal implant.
D6040 Surgical placement: eposteal implant.
D6050 Surgical placement: transosteal implant.
D6051 Interim abutment.
D6052 Semi-precision attachment abutment.
D6055 Connecting bar-implant supported or abutment supported.
D6056 Prefabricated abutment - includes placement.
D6057 Custom abutment - includes placement.
IMPLANT: D6010, D6040, D6050
Replacement is limited to 1 of any of these procedures per 5 year(s).
D5211, D5212, D5213, D5214, D5225, D5226, D5282, D5283, D5284, D5286, D6094, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.
Frequency is waived for accidental injury.
Benefits for procedures D6051, D6052, D6055, D6056 and D6057 will be contingent upon the implant being covered. Replacement for procedures D6052, D6056 and D6057 are limited to 1 of any of these procedures in 5 years.

IMPLANT SERVICES
D6080 Implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prostheses and abutments.
D6081 Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure.
D6090 Repair implant supported prosthesis, by report.
D6091 Replacement of replaceable part of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment.
D6095 Repair implant abutment, by report.
D6096 Remove broken implant retaining screw.
D6100 Implant removal, by report.
D6190 Radiographic/surgical implant index, by report.
IMPLANT SERVICES: D6080, D6081, D6090, D6091, D6095, D6096, D6100, D6190
Coverage for D6080 and D6081 is limited to 2 of any of these procedures in a 12 month period.
Coverage for D6090, D6091, D6095 and D6096 is limited to service dates more than 6 months after placement date. Coverage for D6190 is limited to 1 per arch in a 24 month period.

PROSTHODONTICS - FIXED
D6058 Abutment supported porcelain/ceramic crown.
D6059 Abutment supported porcelain fused to metal crown (high noble metal).
D6060 Abutment supported porcelain fused to metal crown (predominantly base metal).
D6061 Abutment supported porcelain fused to metal crown (noble metal).
D6062 Abutment supported cast metal crown (high noble metal).
D6063 Abutment supported cast metal crown (predominantly base metal).
D6064 Abutment supported cast metal crown (noble metal).
D6065 Implant supported porcelain/ceramic crown.
D6066 Implant supported crown - porcelain fused to high noble alloys.
D6067 Implant supported crown - high noble alloys.
D6068 Abutment supported retainer for porcelain/ceramic FPD.
D6069 Abutment supported retainer for porcelain fused to metal FPD (high noble metal).
D6070 Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal).
D6071 Abutment supported retainer for porcelain fused to metal FPD (noble metal).
D6072 Abutment supported retainer for cast metal FPD (high noble metal).
D6073 Abutment supported retainer for cast metal FPD (predominantly base metal).
D6074 Abutment supported retainer for cast metal FPD (noble metal).
D6075 Implant supported retainer for ceramic FPD.
D6076 Implant supported retainer for FPD - porcelain fused to high noble alloys.
D6077 Implant supported retainer for metal FPD - high noble alloy.

TYPE 3 PROCEDURES

D6082 Implant supported crown-porcelain fused to predominantly base alloys.
D6083 Implant supported crown-porcelain fused to noble alloys.
D6084 Implant supported crown-porcelain fused to titanium and titanium alloys.
D6086 Implant supported crown-predominantly base alloys.
D6087 Implant supported crown-noble alloys.
D6088 Implant supported crown-titanium and titanium alloys.
D6094 Abutment supported crown - titanium and titanium alloys.
D6097 Abutment supported crown-porcelain fused to titanium and titanium alloys.
D6098 Implant supported retainer-porcelain fused to predominantly base alloys.
D6099 Implant supported retainer for FPD-porcelain fused to noble alloys.
D6120 Implant supported retainer-porcelain fused to titanium and titanium alloys.
D6121 Implant supported retainer for metal FPD-predominantly base alloys.
D6122 Implant supported retainer for metal FPD-noble alloys.
D6123 Implant supported retainer for metal FPD-titanium and titanium alloys.
D6194 Abutment supported retainer crown for FPD - titanium and titanium alloys.
D6195 Abutment supported retainer-porcelain fused to titanium and titanium alloys.
D6205 Pontic - indirect resin based composite.
D6210 Pontic - cast high noble metal.
D6211 Pontic - cast predominantly base metal.
D6212 Pontic - cast noble metal.
D6214 Pontic - titanium and titanium alloys.
D6240 Pontic - porcelain fused to high noble metal.
D6241 Pontic - porcelain fused to predominantly base metal.
D6242 Pontic - porcelain fused to noble metal.
D6243 Pontic-porcelain fused to titanium and titanium alloys.
D6245 Pontic - porcelain/ceramic.
D6250 Pontic - resin with high noble metal.
D6251 Pontic - resin with predominantly base metal.
D6252 Pontic - resin with noble metal.
D6545 Retainer - cast metal for resin bonded fixed prosthesis.
D6548 Retainer - porcelain/ceramic for resin bonded fixed prosthesis.
D6549 Resin retainer - for resin bonded fixed prosthesis.
D6600 Retainer inlay - porcelain/ceramic, two surfaces.
D6601 Retainer inlay - porcelain/ceramic, three or more surfaces.
D6602 Retainer inlay - cast high noble metal, two surfaces.
D6603 Retainer inlay - cast high noble metal, three or more surfaces.
D6604 Retainer inlay - cast predominantly base metal, two surfaces.
D6605 Retainer inlay - cast predominantly base metal, three or more surfaces.
D6606 Retainer inlay - cast noble metal, two surfaces.
D6607 Retainer inlay - cast noble metal, three or more surfaces.
D6608 Retainer onlay - porcelain/ceramic, two surfaces.
D6609 Retainer onlay - porcelain/ceramic, three or more surfaces.
D6610 Retainer onlay - cast high noble metal, two surfaces.
D6611 Retainer onlay - cast high noble metal, three or more surfaces.
D6612 Retainer onlay - cast predominantly base metal, two surfaces.
D6613 Retainer onlay - cast predominantly base metal, three or more surfaces.
D6614 Retainer onlay - cast noble metal, two surfaces.
D6615 Retainer onlay - cast noble metal, three or more surfaces.
D6624 Retainer inlay - titanium.
D6634 Retainer onlay - titanium.
D6710 Retainer crown - indirect resin based composite.
D6720 Retainer crown - resin with high noble metal.
D6721 Retainer crown - resin with predominantly base metal.
D6722 Retainer crown - resin with noble metal.
D6740 Retainer crown - porcelain/ceramic.
D6750 Retainer crown - porcelain fused to high noble metal.
D6751 Retainer crown - porcelain fused to predominantly base metal.
D6752 Retainer crown - porcelain fused to noble metal.
D6753 Retainer crown-porcelain fused to titanium and titanium alloys.
D6780 Retainer crown - 3/4 cast high noble metal.
D6781 Retainer crown - 3/4 cast predominantly base metal.

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

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

Replacement is limited to 1 of any of these procedures per 5 year(s).

D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, also contribute(s) to this limitation.

Frequency is waived for accidental injury.

Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

Benefits will not be considered if procedure D2390, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

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

Replacement is limited to 1 of any of these procedures per 5 year(s).

D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.

Frequency is waived for accidental injury.

Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

Benefits will not be considered if procedure D2390, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

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

Replacement is limited to 1 of any of these procedures per 5 year(s).

D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.

Frequency is waived for accidental injury.

Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

Benefits will not be considered if procedure D2390, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

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

Replacement is limited to 1 of any of these procedures per 5 year(s).

D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5282, D5283, D5284, D5286, D6010, D6040, D6050, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6082, D6083, D6084, D6086, D6087, D6088, D6094, D6097, D6098, D6099, D6120, D6121, D6122, D6123, D6194, D6195, also contribute(s) to this limitation.

Frequency is waived for accidental injury.
Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

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

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

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

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

BONE AUGMENTATION

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

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

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

OCCLUSAL GUARD

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

OCCLUSAL GUARD: D9944, D9945, D9946

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

OCCLUSAL ADJUSTMENT

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

OCCLUSAL ADJUSTMENT: D9951, D9952

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

TYPE 4 PROCEDURES

PAYMENT BASIS - NON PARTICIPATING PROVIDERS - Usual and Customary

BENEFIT PERIOD - Benefit Year

For Additional Limitations - See Limitations

NON-SURGICAL MISCELLANEOUS

D0160	Detailed and extensive oral evaluation - problem focused, by report.
D0320	Temporomandibular joint arthrogram, including injection.
D0321	Other temporomandibular joint radiographic images, by report.
D0322	Tomographic survey.
D0340	2D Cephalometric radiographic image - acquisition, measurement and analysis.
D0368	Cone beam CT capture and interpretation for TMJ series including two or more exposures.
D0369	Maxillofacial MRI capture and interpretation.
D0384	Cone beam CT image capture for TMJ series including two or more exposures.
D0385	Maxillofacial MRI image capture.
D0391	Interpretation of diagnostic image by a practitioner not associated with capture of the image, including report.
D0470	Diagnostic casts.
D7880	Occlusal orthotic device, by report.
D7881	Occlusal orthotic device adjustment.
D9130	Temporomandibular joint dysfunction - non-invasive physical therapies.

TYPE 1 PROCEDURES

PAYMENT BASIS - PARTICIPATING PROVIDERS - Maximum Allowable Charge

BENEFIT PERIOD - Benefit Year

For Additional Limitations - See Limitations

ROUTINE ORAL EVALUATION

D0120 Periodic oral evaluation - established patient.

D0145 Oral evaluation for a patient under three years of age and counseling with primary caregiver.

D0150 Comprehensive oral evaluation - new or established patient.

D0180 Comprehensive periodontal evaluation - new or established patient.

COMPREHENSIVE EVALUATION: D0150, D0180

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

In addition, D0150, D0180 coverage is limited to 2 of any of these procedures per 12 month(s).

D0120, D0145, also contribute(s) to this limitation.

If frequency met, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency.

ROUTINE EVALUATION: D0120, D0145

Coverage is limited to 2 of any of these procedures per 12 month(s).

D0150, D0180, also contribute(s) to this limitation.

Procedure D0120 will be considered for individuals age 3 and over. Procedure D0145 will be considered for individuals age 2 and under.

COMPLETE SERIES OR PANORAMIC

D0210 Intraoral - complete series of radiographic images.

D0330 Panoramic radiographic image.

COMPLETE SERIES/PANORAMIC: D0210, D0330

Coverage is limited to 1 of any of these procedures per 5 year(s).

OTHER XRAYS

D0220 Intraoral - periapical first radiographic image.

D0230 Intraoral - periapical each additional radiographic image.

D0240 Intraoral - occlusal radiographic image.

D0250 Extra-oral - 2D projection radiographic image created using a stationary radiation source, and detector.

D0251 Extra-oral posterior dental radiographic image.

PERIAPICAL: D0220, D0230

The maximum amount considered for x-ray radiographic images taken on one day will be equivalent to an allowance of a D0210.

BITEWINGS

D0270 Bitewing - single radiographic image.

D0272 Bitewings - two radiographic images.

D0273 Bitewings - three radiographic images.

D0274 Bitewings - four radiographic images.

D0277 Vertical bitewings - 7 to 8 radiographic images.

BITEWINGS: D0270, D0272, D0273, D0274

Coverage is limited to 1 of any of these procedures per 6 month(s).

D0277, also contribute(s) to this limitation.

The maximum amount considered for x-ray radiographic images taken on one day will be equivalent to an allowance of a D0210.

VERTICAL BITEWINGS: D0277

Coverage is limited to 1 of any of these procedures per 5 year(s).

The maximum amount considered for x-ray radiographic images taken on one day will be equivalent to an allowance of a D0210.

PRE-DIAGNOSTIC TEST

D0431 Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures.

TESTS: D0431

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

PROPHYLAXIS (CLEANING) AND FLUORIDE
- D1110 Prophylaxis - adult.
- D1120 Prophylaxis - child.
- D1206 Topical application of fluoride varnish.
- D1208 Topical application of fluoride-excluding varnish.
- D9932 Cleaning and inspection of removable complete denture, maxillary.
- D9933 Cleaning and inspection of removable complete denture, mandibular.
- D9934 Cleaning and inspection of removable partial denture, maxillary.
- D9935 Cleaning and inspection of removable partial denture, mandibular.

FLUORIDE: D1206, D1208

Coverage is limited to 1 of any of these procedures per 6 month(s).
Benefits are considered for persons age 18 and under.

PROPHYLAXIS: D1110, D1120

Coverage is limited to 4 of any of these procedures per 12 month(s).
D4346, D4910, also contribute(s) to this limitation.
An adult prophylaxis (cleaning) is considered for individuals age 14 and over. A child prophylaxis (cleaning) is considered for individuals age 13 and under. Benefits for prophylaxis (cleaning) are not available when performed on the same date as periodontal procedures.

CLEANING AND INSPECTION OF REMOVABLE DENTURE: D9932, D9933, D9934, D9935

Coverage is limited to 4 of any of these procedures per 12 month(s).
Benefits are not available when performed on the same date as prophylaxis (cleaning) or periodontal maintenance.

SEALANT
- D1351 Sealant - per tooth.
- D1352 Preventive resin restoration in a moderate to high caries risk patient-permanent.
- D1353 Sealant repair - per tooth.

SEALANT: D1351, D1352, D1353

Coverage is limited to 1 of any of these procedures per lifetime.
Benefits are considered for persons age 18 and under.
Benefits are considered on permanent molars only, excluding 3rd molars (wisdom teeth).
Coverage is allowed on the occlusal surface only.

SPACE MAINTAINERS
- D1510 Space maintainer-fixed, unilateral-per quadrant.
- D1516 Space maintainer - fixed - bilateral, maxillary.
- D1517 Space maintainer - fixed - bilateral, mandibular.
- D1520 Space maintainer-removable, unilateral-per quadrant.
- D1526 Space maintainer - removable - bilateral, maxillary.
- D1527 Space maintainer - removable - bilateral, mandibular.
- D1551 Re-cement or re-bond bilateral space maintainer-maxillary.
- D1552 Re-cement or re-bond bilateral space maintainer-mandibular.
- D1553 Re-cement or re-bond unilateral space maintainer-per quadrant.
- D1556 Removal of fixed unilateral space maintainer-per quadrant.
- D1557 Removal of fixed bilateral space maintainer-maxillary.
- D1558 Removal of fixed bilateral space maintainer-mandibular.
- D1575 Distal shoe space maintainer - fixed, unilateral-per quadrant.

SPACE MAINTAINER: D1510, D1516, D1517, D1520, D1526, D1527, D1575

Benefits are considered for persons age 13 and under.
Coverage is limited to space maintenance for unerupted teeth, following extraction of primary teeth. Allowances include all adjustments within 6 months of placement date.

OTHER PERIODONTAL SERVICES
- D4346 Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation.
- D4910 Periodontal maintenance.

PERIODONTAL MAINTENANCE: D4346, D4910

Coverage is limited to 4 of any of these procedures per 12 month(s).
D1110, D1120, also contribute(s) to this limitation.
Benefits are not available if performed on the same date as any other periodontal service.
Procedure D4910 is contingent upon evidence of full mouth active periodontal therapy.
Procedure D4346 is limited to persons age 14 and over.

APPLIANCE THERAPY

D8210 Removable appliance therapy.
D8220 Fixed appliance therapy.

APPLIANCE THERAPY: D8210, D8220

Coverage is limited to the correction of thumb-sucking.

TYPE 2 PROCEDURES

PAYMENT BASIS - PARTICIPATING PROVIDERS - Maximum Allowable Charge

BENEFIT PERIOD - Benefit Year

For Additional Limitations - See Limitations

LIMITED ORAL EVALUATION

D0140 Limited oral evaluation - problem focused.

D0170 Re-evaluation - limited, problem focused (established patient; not post-operative visit).

LIMITED ORAL EVALUATION: D0140, D0170

Coverage is allowed for accidental injury only. If not due to an accident, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency.

ORAL PATHOLOGY/LABORATORY

D0472 Accession of tissue, gross examination, preparation and transmission of written report.

D0473 Accession of tissue, gross and microscopic examination, preparation and transmission of written report.

D0474 Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report.

ORAL PATHOLOGY LABORATORY: D0472, D0473, D0474

Coverage is limited to 1 of any of these procedures per 12 month(s).

Coverage is limited to 1 examination per biopsy/excision.

AMALGAM RESTORATIONS (FILLINGS)

D2140 Amalgam - one surface, primary or permanent.

D2150 Amalgam - two surfaces, primary or permanent.

D2160 Amalgam - three surfaces, primary or permanent.

D2161 Amalgam - four or more surfaces, primary or permanent.

AMALGAM RESTORATIONS: D2140, D2150, D2160, D2161

Coverage is limited to 1 of any of these procedures per 6 month(s).

D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2990, D9911, also contribute(s) to this limitation.

RESIN RESTORATIONS (FILLINGS)

D2330 Resin-based composite - one surface, anterior.

D2331 Resin-based composite - two surfaces, anterior.

D2332 Resin-based composite - three surfaces, anterior.

D2335 Resin-based composite - four or more surfaces or involving incisal angle (anterior).

D2391 Resin-based composite - one surface, posterior.

D2392 Resin-based composite - two surfaces, posterior.

D2393 Resin-based composite - three surfaces, posterior.

D2394 Resin-based composite - four or more surfaces, posterior.

D2410 Gold foil - one surface.

D2420 Gold foil - two surfaces.

D2430 Gold foil - three surfaces.

D2990 Resin infiltration of incipient smooth surface lesions.

COMPOSITE RESTORATIONS: D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2990

Coverage is limited to 1 of any of these procedures per 6 month(s).

D2140, D2150, D2160, D2161, D9911, also contribute(s) to this limitation.

Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

GOLD FOIL RESTORATIONS: D2410, D2420, D2430

Gold foils are considered at an alternate benefit of an amalgam/composite restoration.

STAINLESS STEEL CROWN (PREFABRICATED CROWN)

D2390 Resin-based composite crown, anterior.

D2929 Prefabricated porcelain/ceramic crown - primary tooth.

D2930 Prefabricated stainless steel crown - primary tooth.

D2931 Prefabricated stainless steel crown - permanent tooth.

D2932 Prefabricated resin crown.

D2933 Prefabricated stainless steel crown with resin window.

D2934 Prefabricated esthetic coated stainless steel crown - primary tooth.

STAINLESS STEEL CROWN: D2390, D2929, D2930, D2931, D2932, D2933, D2934

Replacement is limited to 1 of any of these procedures per 12 month(s).

Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

RECEMENT

D2910 Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration.
D2915 Re-cement or re-bond indirectly fabricated or prefabricated post and core.
D2920 Re-cement or re-bond crown.
D2921 Reattachment of tooth fragment, incisal edge or cusp.
D6092 Re-cement or re-bond implant/abutment supported crown.
D6093 Re-cement or re-bond implant/abutment supported fixed partial denture.
D6930 Re-cement or re-bond fixed partial denture.

SEDATIVE FILLING

D2940 Protective restoration.
D2941 Interim therapeutic restoration - primary dentition.

PULP CAP

D3110 Pulp cap - direct (excluding final restoration).

ENDODONTICS MISCELLANEOUS

D3220 Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament.
D3221 Pulpal debridement, primary and permanent teeth.
D3222 Partial Pulpotomy for apexogenesis - permanent tooth with incomplete root development.
D3230 Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration).
D3240 Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration).
D3333 Internal root repair of perforation defects.
D3351 Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.).
D3352 Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.).
D3353 Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.).
D3357 Pulpal regeneration - completion of treatment.
D3430 Retrograde filling - per root.
D3450 Root amputation - per root.
D3920 Hemisection (including any root removal), not including root canal therapy.

ENDODONTICS MISCELLANEOUS: D3333, D3430, D3450, D3920

Procedure D3333 is limited to permanent teeth only.

ENDODONTIC THERAPY (ROOT CANALS)

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

ROOT CANALS: D3310, D3320, D3330, D3332

Benefits are considered on permanent teeth only.

Allowances include intraoperative radiographic images and cultures but exclude final restoration.

RETREATMENT OF ROOT CANAL: D3346, D3347, D3348

Coverage is limited to 1 of any of these procedures per 12 month(s).

D3310, D3320, D3330, also contribute(s) to this limitation.

Benefits are considered on permanent teeth only.

Coverage is limited to service dates more than 12 months after root canal therapy. Allowances include intraoperative radiographic images and cultures but exclude final restoration.

TYPE 2 PROCEDURES

SURGICAL ENDODONTICS

D3355 Pulpal regeneration - initial visit.
D3356 Pulpal regeneration - interim medication replacement.
D3410 Apicoectomy - anterior.
D3421 Apicoectomy - premolar (first root).
D3425 Apicoectomy - molar (first root).
D3426 Apicoectomy (each additional root).
D3427 Periradicular surgery without apicoectomy.

SURGICAL PERIODONTICS

D4210 Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant.
D4211 Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant.
D4240 Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant.
D4241 Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant.
D4260 Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant.
D4261 Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant.
D4263 Bone replacement graft - retained natural tooth - first site in quadrant.
D4264 Bone replacement graft - retained natural tooth - each additional site in quadrant.
D4265 Biologic materials to aid in soft and osseous tissue regeneration.
D4270 Pedicle soft tissue graft procedure.
D4273 Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft.
D4274 Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area).
D4275 Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant or edentulous tooth position in graft.
D4276 Combined connective tissue and double pedicle graft, per tooth.
D4277 Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft.
D4278 Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant or edentulous tooth position in same graft site.
D4283 Autogenous connective tissue graft procedure (including donor and recipient surgical sites) - each additional contiguous tooth, implant or edentulous tooth position in same graft site.
D4285 Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) - each additional contiguous tooth, implant or edentulous tooth position in same graft site.

BONE GRAFTS: D4263, D4264, D4265
Each quadrant is limited to 1 of each of these procedures per 3 year(s).
Coverage is limited to treatment of periodontal disease.

GINGIVECTOMY: D4210, D4211
Each quadrant is limited to 1 of each of these procedures per 3 year(s).
Coverage is limited to treatment of periodontal disease.

OSSEOUS SURGERY: D4240, D4241, D4260, D4261
Each quadrant is limited to 1 of each of these procedures per 3 year(s).
Coverage is limited to treatment of periodontal disease.

TISSUE GRAFTS: D4270, D4273, D4275, D4276, D4277, D4278, D4283, D4285
Each quadrant is limited to 2 of any of these procedures per 3 year(s).
Coverage is limited to treatment of periodontal disease.

NON-SURGICAL PERIODONTICS

D4341 Periodontal scaling and root planing - four or more teeth per quadrant.
D4342 Periodontal scaling and root planing - one to three teeth, per quadrant.

D4381 Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report.
ANTIMICROBIAL AGENTS: D4381
Each quadrant is limited to 2 of any of these procedures per 2 year(s).
PERIODONTAL SCALING & ROOT PLANING: D4341, D4342
Each quadrant is limited to 1 of each of these procedures per 2 year(s).

FULL MOUTH DEBRIDEMENT
D4355 Full mouth debridement to enable comprehensive oral evaluation and diagnosis on a subsequent visit.
FULL MOUTH DEBRIDEMENT: D4355
Coverage is limited to 1 of any of these procedures per 5 year(s).

DENTURE REPAIR
D5511 Repair broken complete denture base, mandibular.
D5512 Repair broken complete denture base, maxillary.
D5520 Replace missing or broken teeth - complete denture (each tooth).
D5611 Repair resin partial denture base, mandibular.
D5612 Repair resin partial denture base, maxillary.
D5621 Repair cast partial framework, mandibular.
D5622 Repair cast partial framework, maxillary.
D5630 Repair or replace broken retentive/clasping materials per tooth.
D5640 Replace broken teeth - per tooth.

DENTURE REBASES
D5710 Rebase complete maxillary denture.
D5711 Rebase complete mandibular denture.
D5720 Rebase maxillary partial denture.
D5721 Rebase mandibular partial denture.

DENTURE RELINES
D5730 Reline complete maxillary denture (direct).
D5731 Reline complete mandibular denture (direct).
D5740 Reline maxillary partial denture (direct).
D5741 Reline mandibular partial denture (direct).
D5750 Reline complete maxillary denture (indirect).
D5751 Reline complete mandibular denture (indirect).
D5760 Reline maxillary partial denture (indirect).
D5761 Reline mandibular partial denture (indirect).
DENTURE RELINE: D5730, D5731, D5740, D5741, D5750, D5751, D5760, D5761
Coverage is limited to service dates more than 6 months after placement date.

TISSUE CONDITIONING
D5850 Tissue conditioning, maxillary.
D5851 Tissue conditioning, mandibular.

NON-SURGICAL EXTRACTIONS
D7111 Extraction, coronal remnants - primary tooth.
D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal).

SURGICAL EXTRACTIONS
D7210 Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated.
D7220 Removal of impacted tooth - soft tissue.
D7230 Removal of impacted tooth - partially bony.
D7240 Removal of impacted tooth - completely bony.
D7241 Removal of impacted tooth - completely bony, with unusual surgical complications.
D7250 Removal of residual tooth roots (cutting procedure).
D7251 Coronectomy-intentional partial tooth removal.

TYPE 2 PROCEDURES

OTHER ORAL SURGERY

D7260 Oroantral fistula closure.
D7261 Primary closure of a sinus perforation.
D7270 Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.
D7272 Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization).
D7280 Exposure of an unerupted tooth.
D7282 Mobilization of erupted or malpositioned tooth to aid eruption.
D7283 Placement of device to facilitate eruption of impacted tooth.
D7310 Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.
D7311 Alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.
D7320 Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.
D7321 Alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.
D7340 Vestibuloplasty - ridge extension (secondary epithelialization).
D7350 Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue).
D7410 Excision of benign lesion up to 1.25 cm.
D7411 Excision of benign lesion greater than 1.25 cm.
D7412 Excision of benign lesion, complicated.
D7413 Excision of malignant lesion up to 1.25 cm.
D7414 Excision of malignant lesion greater than 1.25 cm.
D7415 Excision of malignant lesion, complicated.
D7440 Excision of malignant tumor - lesion diameter up to 1.25 cm.
D7441 Excision of malignant tumor - lesion diameter greater than 1.25 cm.
D7450 Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm.
D7451 Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm.
D7460 Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm.
D7461 Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm.
D7465 Destruction of lesion(s) by physical or chemical method, by report.
D7471 Removal of lateral exostosis (maxilla or mandible).
D7472 Removal of torus palatinus.
D7473 Removal of torus mandibularis.
D7485 Reduction of osseous tuberosity.
D7490 Radical resection of maxilla or mandible.
D7510 Incision and drainage of abscess - intraoral soft tissue.
D7520 Incision and drainage of abscess - extraoral soft tissue.
D7530 Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue.
D7540 Removal of reaction producing foreign bodies, musculoskeletal system.
D7550 Partial ostectomy/sequestrectomy for removal of non-vital bone.
D7560 Maxillary sinusotomy for removal of tooth fragment or foreign body.
D7910 Suture of recent small wounds up to 5 cm.
D7911 Complicated suture - up to 5 cm.
D7912 Complicated suture - greater than 5 cm.
D7960 Frenulectomy-also known as frenectomy or frenotomy-separate procedure not incidental to another procedure.
D7963 Frenuloplasty.
D7970 Excision of hyperplastic tissue - per arch.
D7972 Surgical reduction of fibrous tuberosity.
D7979 Non-surgical sialolithotomy.
D7980 Surgical sialolithotomy.
D7983 Closure of salivary fistula.

REMOVAL OF BONE TISSUE: D7471, D7472, D7473

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

BIOPSY OF ORAL TISSUE

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

D7288 Brush biopsy - transepithelial sample collection.

PALLIATIVE

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

PALLIATIVE TREATMENT: D9110

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

ANESTHESIA-GENERAL/IV

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

GENERAL ANESTHESIA: D9222, D9223, D9239, D9243

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

PROFESSIONAL CONSULT/VISIT/SERVICES

D9310 Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician.
D9430 Office visit for observation (during regularly scheduled hours) - no other services performed.
D9440 Office visit - after regularly scheduled hours.
D9930 Treatment of complications (post-surgical) - unusual circumstances, by report.

CONSULTATION: D9310

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

OFFICE VISIT: D9430, D9440

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

MISCELLANEOUS

D0486 Laboratory accession of transepithelial cytologic sample, microscopic examination, preparation and transmission of written report.
D2951 Pin retention - per tooth, in addition to restoration.
D9911 Application of desensitizing resin for cervical and/or root surfaces, per tooth.

DESENSITIZATION: D9911

Coverage is limited to 1 of any of these procedures per 6 month(s).

D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2990, also contribute(s) to this limitation.

Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

TYPE 3 PROCEDURES

PAYMENT BASIS - PARTICIPATING PROVIDERS - Maximum Allowable Charge

BENEFIT PERIOD - Benefit Year

For Additional Limitations - See Limitations

INLAY RESTORATIONS

D2510 Inlay - metallic - one surface.
D2520 Inlay - metallic - two surfaces.
D2530 Inlay - metallic - three or more surfaces.
D2610 Inlay - porcelain/ceramic - one surface.
D2620 Inlay - porcelain/ceramic - two surfaces.
D2630 Inlay - porcelain/ceramic - three or more surfaces.
D2650 Inlay - resin-based composite - one surface.
D2651 Inlay - resin-based composite - two surfaces.
D2652 Inlay - resin-based composite - three or more surfaces.

INLAY: D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652

Inlays will be considered at an alternate benefit of an amalgam/composite restoration and only when resulting from caries (tooth decay) or traumatic injury.

ONLAY RESTORATIONS

D2542 Onlay - metallic - two surfaces.
D2543 Onlay - metallic - three surfaces.
D2544 Onlay - metallic - four or more surfaces.
D2642 Onlay - porcelain/ceramic - two surfaces.
D2643 Onlay - porcelain/ceramic - three surfaces.
D2644 Onlay - porcelain/ceramic - four or more surfaces.
D2662 Onlay - resin-based composite - two surfaces.
D2663 Onlay - resin-based composite - three surfaces.
D2664 Onlay - resin-based composite - four or more surfaces.

ONLAY: D2542, D2543, D2544, D2642, D2643, D2644, D2662, D2663, D2664

Replacement is limited to 1 of any of these procedures per 5 year(s).

D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.

Frequency is waived for accidental injury.

Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.

Benefits will not be considered if procedure D2390, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

CROWNS SINGLE RESTORATIONS

D2710 Crown - resin-based composite (indirect).
D2712 Crown - 3/4 resin-based composite (indirect).
D2720 Crown - resin with high noble metal.
D2721 Crown - resin with predominantly base metal.
D2722 Crown - resin with noble metal.
D2740 Crown - porcelain/ceramic.
D2750 Crown - porcelain fused to high noble metal.
D2751 Crown - porcelain fused to predominantly base metal.
D2752 Crown - porcelain fused to noble metal.
D2753 Crown-porcelain fused to titanium and titanium alloys.
D2780 Crown - 3/4 cast high noble metal.
D2781 Crown - 3/4 cast predominantly base metal.
D2782 Crown - 3/4 cast noble metal.
D2783 Crown - 3/4 porcelain/ceramic.
D2790 Crown - full cast high noble metal.

D2791 Crown - full cast predominantly base metal.
D2792 Crown - full cast noble metal.
D2794 Crown - titanium and titanium alloys.

CROWN: D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794

Replacement is limited to 1 of any of these procedures per 5 year(s).

D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.

Frequency is waived for accidental injury.

Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.

Benefits will not be considered if procedure D2390, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

CORE BUILD-UP

D2950 Core buildup, including any pins when required.

CORE BUILDUP: D2950

A pretreatment is strongly suggested for D2950. This is reviewed by our dental consultants and benefits are allowed when diagnostic data indicates significant tooth structure loss.

POST AND CORE

D2952 Post and core in addition to crown, indirectly fabricated.
D2954 Prefabricated post and core in addition to crown.

FIXED CROWN AND PARTIAL DENTURE REPAIR

D2980 Crown repair necessitated by restorative material failure.
D2981 Inlay repair necessitated by restorative material failure.
D2982 Onlay repair necessitated by restorative material failure.
D2983 Veneer repair necessitated by restorative material failure.
D6980 Fixed partial denture repair necessitated by restorative material failure.
D9120 Fixed partial denture sectioning.

CROWN LENGTHENING

D4249 Clinical crown lengthening - hard tissue.

PROSTHODONTICS - FIXED/REMOVABLE (DENTURES)

D5110 Complete denture - maxillary.
D5120 Complete denture - mandibular.
D5130 Immediate denture - maxillary.
D5140 Immediate denture - mandibular.
D5211 Maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth).
D5212 Mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth).
D5213 Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth).
D5214 Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth).
D5221 Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth).
D5222 Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth).
D5223 Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth).

D5224 Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth).
D5225 Maxillary partial denture - flexible base (including retentive/clasping materials, rests, and teeth).
D5226 Mandibular partial denture - flexible base (including retentive/clasping materials, rests, and teeth).
D5282 Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary.
D5283 Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), mandibular.
D5284 Removable unilateral partial denture-one piece flexible base (including retentive/clasping materials, rests, and teeth) - per quadrant.
D5286 Removable unilateral partial denture-one piece resin (including retentive/clasping materials, rests, and teeth) - per quadrant.
D5670 Replace all teeth and acrylic on cast metal framework (maxillary).
D5671 Replace all teeth and acrylic on cast metal framework (mandibular).
D5810 Interim complete denture (maxillary).
D5811 Interim complete denture (mandibular).
D5820 Interim partial denture (including retentive/clasping materials, rests, and teeth), maxillary.
D5821 Interim partial denture (including retentive/clasping matierals, rests, and teeth), mandibular.
D5863 Overdenture - complete maxillary.
D5864 Overdenture - partial maxillary.
D5865 Overdenture - complete mandibular.
D5866 Overdenture - partial mandibular.
D5876 Add metal substructure to acrylic full denture (per arch).
D6110 Implant/abutment supported removable denture for edentulous arch - maxillary.
D6111 Implant/abutment supported removable denture for edentulous arch - mandibular.
D6112 Implant/abutment supported removable denture for partially edentulous arch - maxillary.
D6113 Implant/abutment supported removable denture for partially edentulous arch - mandibular.
D6114 Implant/abutment supported fixed denture for edentulous arch - maxillary.
D6115 Implant/abutment supported fixed denture for edentulous arch - mandibular.
D6116 Implant/abutment supported fixed denture for partially edentulous arch - maxillary.
D6117 Implant/abutment supported fixed denture for partially edentulous arch - mandibular.
D6118 Implant/abutment supported interim fixed denture for edentulous arch - mandibular.
D6119 Implant/abutment supported interim fixed denture for edentulous arch - maxillary.

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

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

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

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

DENTURE ADJUSTMENTS

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

DENTURE ADJUSTMENT: D5410, D5411, D5421, D5422

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

ADD TOOTH/CLASP TO EXISTING PARTIAL

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

IMPLANTS
D6010 Surgical placement of implant body: endosteal implant.
D6040 Surgical placement: eposteal implant.
D6050 Surgical placement: transosteal implant.
D6051 Interim abutment.
D6052 Semi-precision attachment abutment.
D6055 Connecting bar-implant supported or abutment supported.
D6056 Prefabricated abutment - includes placement.
D6057 Custom abutment - includes placement.

IMPLANT: D6010, D6040, D6050

Replacement is limited to 1 of any of these procedures per 5 year(s).
D5211, D5212, D5213, D5214, D5225, D5226, D5282, D5283, D5284, D5286, D6094, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.
Frequency is waived for accidental injury.
Benefits for procedures D6051, D6052, D6055, D6056 and D6057 will be contingent upon the implant being covered. Replacement for procedures D6052, D6056 and D6057 are limited to 1 of any of these procedures in 5 years.

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

IMPLANT SERVICES: D6080, D6081, D6090, D6091, D6095, D6096, D6100, D6190

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

PROSTHODONTICS - FIXED
D6058 Abutment supported porcelain/ceramic crown.
D6059 Abutment supported porcelain fused to metal crown (high noble metal).
D6060 Abutment supported porcelain fused to metal crown (predominantly base metal).
D6061 Abutment supported porcelain fused to metal crown (noble metal).
D6062 Abutment supported cast metal crown (high noble metal).
D6063 Abutment supported cast metal crown (predominantly base metal).
D6064 Abutment supported cast metal crown (noble metal).
D6065 Implant supported porcelain/ceramic crown.
D6066 Implant supported crown - porcelain fused to high noble alloys.
D6067 Implant supported crown - high noble alloys.
D6068 Abutment supported retainer for porcelain/ceramic FPD.
D6069 Abutment supported retainer for porcelain fused to metal FPD (high noble metal).
D6070 Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal).
D6071 Abutment supported retainer for porcelain fused to metal FPD (noble metal).
D6072 Abutment supported retainer for cast metal FPD (high noble metal).
D6073 Abutment supported retainer for cast metal FPD (predominantly base metal).
D6074 Abutment supported retainer for cast metal FPD (noble metal).
D6075 Implant supported retainer for ceramic FPD.
D6076 Implant supported retainer for FPD - porcelain fused to high noble alloys.
D6077 Implant supported retainer for metal FPD - high noble alloy.

TYPE 3 PROCEDURES

D6082 Implant supported crown-porcelain fused to predominantly base alloys.
D6083 Implant supported crown-porcelain fused to noble alloys.
D6084 Implant supported crown-porcelain fused to titanium and titanium alloys.
D6086 Implant supported crown-predominantly base alloys.
D6087 Implant supported crown-noble alloys.
D6088 Implant supported crown-titanium and titanium alloys.
D6094 Abutment supported crown - titanium and titanium alloys.
D6097 Abutment supported crown-porcelain fused to titanium and titanium alloys.
D6098 Implant supported retainer-porcelain fused to predominantly base alloys.
D6099 Implant supported retainer for FPD-porcelain fused to noble alloys.
D6120 Implant supported retainer-porcelain fused to titanium and titanium alloys.
D6121 Implant supported retainer for metal FPD-predominantly base alloys.
D6122 Implant supported retainer for metal FPD-noble alloys.
D6123 Implant supported retainer for metal FPD-titanium and titanium alloys.
D6194 Abutment supported retainer crown for FPD - titanium and titanium alloys.
D6195 Abutment supported retainer-porcelain fused to titanium and titanium alloys.
D6205 Pontic - indirect resin based composite.
D6210 Pontic - cast high noble metal.
D6211 Pontic - cast predominantly base metal.
D6212 Pontic - cast noble metal.
D6214 Pontic - titanium and titanium alloys.
D6240 Pontic - porcelain fused to high noble metal.
D6241 Pontic - porcelain fused to predominantly base metal.
D6242 Pontic - porcelain fused to noble metal.
D6243 Pontic-porcelain fused to titanium and titanium alloys.
D6245 Pontic - porcelain/ceramic.
D6250 Pontic - resin with high noble metal.
D6251 Pontic - resin with predominantly base metal.
D6252 Pontic - resin with noble metal.
D6545 Retainer - cast metal for resin bonded fixed prosthesis.
D6548 Retainer - porcelain/ceramic for resin bonded fixed prosthesis.
D6549 Resin retainer - for resin bonded fixed prosthesis.
D6600 Retainer inlay - porcelain/ceramic, two surfaces.
D6601 Retainer inlay - porcelain/ceramic, three or more surfaces.
D6602 Retainer inlay - cast high noble metal, two surfaces.
D6603 Retainer inlay - cast high noble metal, three or more surfaces.
D6604 Retainer inlay - cast predominantly base metal, two surfaces.
D6605 Retainer inlay - cast predominantly base metal, three or more surfaces.
D6606 Retainer inlay - cast noble metal, two surfaces.
D6607 Retainer inlay - cast noble metal, three or more surfaces.
D6608 Retainer onlay - porcelain/ceramic, two surfaces.
D6609 Retainer onlay - porcelain/ceramic, three or more surfaces.
D6610 Retainer onlay - cast high noble metal, two surfaces.
D6611 Retainer onlay - cast high noble metal, three or more surfaces.
D6612 Retainer onlay - cast predominantly base metal, two surfaces.
D6613 Retainer onlay - cast predominantly base metal, three or more surfaces.
D6614 Retainer onlay - cast noble metal, two surfaces.
D6615 Retainer onlay - cast noble metal, three or more surfaces.
D6624 Retainer inlay - titanium.
D6634 Retainer onlay - titanium.
D6710 Retainer crown - indirect resin based composite.
D6720 Retainer crown - resin with high noble metal.
D6721 Retainer crown - resin with predominantly base metal.
D6722 Retainer crown - resin with noble metal.
D6740 Retainer crown - porcelain/ceramic.
D6750 Retainer crown - porcelain fused to high noble metal.
D6751 Retainer crown - porcelain fused to predominantly base metal.
D6752 Retainer crown - porcelain fused to noble metal.
D6753 Retainer crown-porcelain fused to titanium and titanium alloys.
D6780 Retainer crown - 3/4 cast high noble metal.
D6781 Retainer crown - 3/4 cast predominantly base metal.

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

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

Replacement is limited to 1 of any of these procedures per 5 year(s).

D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, also contribute(s) to this limitation.

Frequency is waived for accidental injury.

Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

Benefits will not be considered if procedure D2390, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

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

Replacement is limited to 1 of any of these procedures per 5 year(s).

D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.

Frequency is waived for accidental injury.

Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

Benefits will not be considered if procedure D2390, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

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

Replacement is limited to 1 of any of these procedures per 5 year(s).

D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.

Frequency is waived for accidental injury.

Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

Benefits will not be considered if procedure D2390, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

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

Replacement is limited to 1 of any of these procedures per 5 year(s).

D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5282, D5283, D5284, D5286, D6010, D6040, D6050, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6082, D6083, D6084, D6086, D6087, D6088, D6094, D6097, D6098, D6099, D6120, D6121, D6122, D6123, D6194, D6195, also contribute(s) to this limitation.

Frequency is waived for accidental injury.
Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

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

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

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

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

BONE AUGMENTATION

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

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

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

OCCLUSAL GUARD

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

OCCLUSAL GUARD: D9944, D9945, D9946

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

OCCLUSAL ADJUSTMENT

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

OCCLUSAL ADJUSTMENT: D9951, D9952

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

TYPE 4 PROCEDURES

PAYMENT BASIS - PARTICIPATING PROVIDERS - Maximum Allowable Charge

BENEFIT PERIOD - Benefit Year

For Additional Limitations - See Limitations

NON-SURGICAL MISCELLANEOUS

D0160	Detailed and extensive oral evaluation - problem focused, by report.
D0320	Temporomandibular joint arthrogram, including injection.
D0321	Other temporomandibular joint radiographic images, by report.
D0322	Tomographic survey.
D0340	2D Cephalometric radiographic image - acquisition, measurement and analysis.
D0368	Cone beam CT capture and interpretation for TMJ series including two or more exposures.
D0369	Maxillofacial MRI capture and interpretation.
D0384	Cone beam CT image capture for TMJ series including two or more exposures.
D0385	Maxillofacial MRI image capture.
D0391	Interpretation of diagnostic image by a practitioner not associated with capture of the image, including report.
D0470	Diagnostic casts.
D7880	Occlusal orthotic device, by report.
D7881	Occlusal orthotic device adjustment.
D9130	Temporomandibular joint dysfunction - non-invasive physical therapies.

ORTHODONTIC EXPENSE BENEFITS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

COORDINATION OF BENEFITS

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

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

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

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

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

   a. Any group or blanket insurance policy.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

        i. the parents are married;

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

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

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

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

        i. the Plan of the Custodial Parent;

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

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

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

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

    d. The benefits of a Plan that cover a person as an employee who is neither laid-off nor retired (or as that employee's dependent) are determined before those of a Plan that covers that person as a laid-off or retired employee (or as that employee's dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule will be ignored.

    e. If a person whose coverage is provided under a right of continuation provided by a federal or state law also is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule will be ignored.

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

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

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

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

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

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

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

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

GENERAL PROVISIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CONFORMITY WITH LAW. Any policy provision that conflicts with the laws of the state in which the policy is issued, when the policy is issued, is automatically changed to meet the minimum requirements of those laws.

ENTIRE CONTRACT. The policy and the application of the Policyholder constitute the entire contract between the parties. A copy of the Policyholder's application is attached to the policy when issued. All statements made by the Policyholder or an Insured will, in the absence of fraud, be considered representations and not warranties. No statement made to obtain insurance will be used to void the insurance or reduce the benefits of this policy unless it is in a written application signed by the Policyholder or Insured. A copy of this must have been given to the Policyholder or Insured.

No change in this policy will be valid unless approved in writing by one of our officers and given to the Policyholder for attachment to the policy. No agent has the authority to change this policy or waive any of its provisions. Any change in this policy will be valid even though an Insured may not have agreed to it.

INSURANCE DATA. The Policyholder will furnish, at our request, data necessary to administer this policy. The data will include, but not be limited to data:

i. necessary to calculate premiums;

ii. necessary to determine a person's effective date or termination date of insurance;

iii. necessary to determine the proper coverage level of insurance.

We shall have the right to inspect any of the Policyholder's records we find necessary to properly administer this policy. Any inspections will be at a time and place convenient to the Policyholder.

We will not refuse to insure a person who is eligible to be insured just because the Policyholder fails or errs in giving us the data necessary to include that person for coverage. An Insured's insurance will not stay in force nor an amount of insurance be continued after the termination date, according to the Conditions for Insurance, because the Policyholder fails or errors in giving us the necessary data concerning an Insured's termination.

CERTIFICATES. We will issue certificates to the Policyholder showing the coverage under the policy. The Policyholder will distribute a certificate to each insured Member. If the terms of the certificate differ from the policy, the terms stated in the policy will govern.

PARTICIPATION REQUIREMENTS. There are two requirements that must be met in order for the policy to be placed in force, and to remain in force:

a. a certain percentage of all Members qualified for insurance must be insured at all times; and

b. a certain number of Members must be insured at all times.

The Participation Requirements are as follows:

Percentage of Members-	100% Participation in another dental plan will be considered as participation in this policy.
Number of Members-	79

TERMINATION OF THE POLICY. The Policyholder may terminate this policy as of any Premium Due Date by giving us written notice before that date.

We may terminate this policy on the earlier of:

1. any Premium Due Date if the participation of Insureds and/or Dependents does not meet the requirements in "Conditions For Insurance." Written notice of termination of insurance must be given to the Policyholder at least 45 days before the date of termination.

2. any Premium Due Date on or after the first policy year, for reasons other than lack of participation. Written notice of termination of insurance must be given to the Policyholder at least 60 days before the date of termination.

If any premium is not paid when due, this policy will automatically be terminated as of the Premium Due Date, except as stated below.

GRACE PERIOD. This policy has a 31 day grace period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following 31 days. During the grace period, the policy will stay in force. If the Policyholder has not sent us a written request to terminate the policy and a premium is not paid by the end of the grace period, the policy will terminate at the end of the grace period. If the Policyholder gives us written notice of termination before the Premium Due Date, the policy will be terminated as of the date requested. The Policyholder will be liable for any unpaid premium for the time this policy was in force, including the grace period.

CONSIDERATION. This policy is issued to the Policyholder in consideration of the application and the payment of premiums specified in this policy.

TERMS AND CONDITIONS. Payment of any benefit under this policy is subject to the definitions and all other terms of this policy pertinent to the benefit.

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

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

CLAIMS FOR BENEFITS

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

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

NOTICE OF DECISION OF CLAIM

We will evaluate your claim promptly after we receive it.

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

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

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

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

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

APPEAL PROCEDURE

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

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

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

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

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

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

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

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

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

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

Any request for appeal should be directed to:

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

Application is Hereby Made to

AMERITAS LIFE INSURANCE CORP.

by: UAW/UMASS HEALTH & WELFARE TRUST FUND

whose main office address is: 6 UNIVERSITY DR STE 206-226
AMHERST, MA 01002-2360

for Group Policy No. 10-53791

This group policy is hereby approved. Its terms are hereby accepted.

This Acceptance Application is made in duplicate. One is attached to the policy. The other part has been returned to the Company.

It is agreed that this application supersedes any previous application for the group policy.

UAW/UMASS HEALTH & WELFARE TRUST FUND

(Full or Corporate Name of Applicant)

Dated at_____ By _____
(Signature and Title)

On _____, 20___ Witness_____
(To be signed by Resident Agent where required by law)

This copy is to remain Attached to the Policy

Ameritas Life Insurance Corp.

A STOCK COMPANY
LINCOLN, NEBRASKA

CERTIFICATE
GROUP DENTAL INSURANCE

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

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

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

Class Number 2

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

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

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

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

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

President

Massachusetts Notice of Inquiry and Grievance Procedures

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

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

I. Definitions

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

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

II. Internal Grievance Process

1. Filing a Grievance

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

2. Written Decision

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

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

3. Reconsideration

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

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

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

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

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

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

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

ដែលអាចស្នើសុំ សេវាអ្នកបកប្រែភាសាផ្ទាល់មាត់ និងបកប្រែអក្សរ ទាក់ទងនឹងនីតិវិធីរដ្ឋបាល មានផ្តល់ជូន

若您提出要求，我們可以提供與行政程序有關的語言翻譯服務。

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

Κατόπιν αίτησης διαθέτονται ερμηνευτικές και μεταφραστικές
υπηρεσίες για διαχειριστικές υποθέσεις.

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

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

ເມື່ອໄດ້ມີການຮ້ອງຂໍ, ຈະມີບໍລິການບາຍພາສາແລະແປພາສາໄວ້ສຳຫລັບເລື່ອງຕ່າງໆ ທີ່ກ່ຽວຂ້ອງກັບ
ກະບວນການຕ່າງ ໆ ທາງດ້ານການບໍລິຫານ.

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

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

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

IMPORTANT INFORMATION

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

CONSUMER RIGHTS

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

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

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

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

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

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

OUR PRACTICES

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

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

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

The Quality Management Program addresses the following standards:

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

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

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

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

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

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

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

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

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

877-897-4328 (Toll-Free)

NOTICE

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

Information that can be accessed at this location includes:

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

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

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

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

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

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

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

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

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

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

1Creation of a user name and password required.

THIS DISCOUNT ACCESS IS NOT INSURANCE

Non-Insurance Products/Services

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

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

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

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

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

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

Ameritas Life Insurance Corp.

A STOCK COMPANY
LINCOLN, NEBRASKA

GROUP EYE CARE INSURANCE POLICY

The Policyholder	**UAW/UMASS HEALTH & WELFARE TRUST FUND**		
		Policy Number	**10-53791**
State of Delivery	**Massachusetts**	**Plan Effective Date**	**July 1, 2020**
		Plan Change Effective Date	**September 1, 2020**
Premium Due Date 1st of each month.		**Renewal Date**	**September 1**

Ameritas Life Insurance Corp. agrees to pay, with respect to each Insured Person, the group insurance benefits provided in this policy.

This policy is issued to the Policyholder in consideration of the Policyholder's application and the payment of premiums, as provided herein.

This policy is delivered in and governed by the laws of the state of delivery.

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

AMERITAS LIFE INSURANCE CORP.

Corporate Secretary

President

Massachusetts Notice of Inquiry and Grievance Procedures

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

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

I. Definitions

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

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

II. Internal Grievance Process

1. Filing a Grievance

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

2. Written Decision

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

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

3. Reconsideration

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

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

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

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

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

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

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

[illegible]

若您提出要求，我們可以提供與行政程序有關的語言翻譯服務。

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administrasyon an, la pou ou depi ou mande-l.

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THIS DISCOUNT ACCESS IS NOT INSURANCE

Non-Insurance Products/Services

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

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

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

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

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

TABLE OF CONTENTS

SCHEDULE OF BENEFITS
OUTLINE OF COVERAGE

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

Benefit Class	Class Description
Class 1	Post Doctoral Researcher

EYE CARE EXPENSE BENEFITS

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

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

COMBINED EXPENSE BENEFITS

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

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

PREMIUMS

TABLE OF MONTHLY PREMIUM RATES

Dental and Eye Care Insurance	$28.60 per Insured Person
	$28.61 One Dependent Only
	$65.03 Two or More Dependents

PAYMENT OF PREMIUMS. The first premium will be due on the Policy Effective Date to cover the period from that date to the first Premium Due Date. Other premiums will be due on or before each Premium Due Date. Premiums are payable at our Home Office or at some other location to which we and the Policyholder agree.

PREMIUM DUE DATE. The Premium Due Date will be the first day of the month that falls on or after the Policy Effective Date. If we agree with the Policyholder to the payment of premiums on a basis other than monthly, the Premium Due Date will be fixed to match the correct basis. If there is a change in the method of payment or Premium Due Date, a pro-rata charge in the premium due will be made.

PREMIUM STATEMENTS. The premium due as of any Premium Due Date is the number of units in force on such date for each type of insurance multiplied by the rate shown in the Table of Premium Rates. A premium statement will be made as of the Premium Due Date showing the premium payable. If premiums are payable on other than a monthly basis, each statement will show any pro-rata premium charges and credits in the last premium period due to changes in the number of Insureds and in the amount of insurance for which people are insured. This is subject to the rules below.

SIMPLIFIED ACCOUNTING. The premium will start on the Premium Due Date falling on or after the date the insurance or the increase in the insurance is effective for: a) a person becoming insured; or b) an increase in the amount of insurance on any person. The premium will stop on the Premium Due Date falling on or after the date of termination of insurance or through the date of service of the last paid claim. There will be no pro-rata charges or credits for a partial month. If premiums are payable other than monthly, charges and credits will be figured as though the Premium Due Date is monthly.

We will be liable for the return of unearned premiums (premium for the period which claims were not paid) to the Policyholder only for the 3 months before the date we receive evidence that a return is due.

ADJUSTMENTS IN PREMIUM RATES. We may change the rates shown in the Table of Premium Rates by giving the Policyholder at least 30 days advance written notice. We may change the rates at any time the Schedule of Benefits, or any other terms and conditions of the policy, are changed. We will not change the rates until the Renewal Date shown on the policy cover or more than once in any 12 month period thereafter, unless there is a change in the Schedule of Benefits or a change in any other terms and conditions in the policy.

Notwithstanding the above, We the Company reserve the right to change any one or more of the rates prior to the Renewal Date or more than once in any 12 month period thereafter upon the occurrence of any one or more of the following:

1. We determine that the average number of dependent children for each Insured with Dependent coverage exceeds 4.0; and/or

Ameritas Life Insurance Corp.

A STOCK COMPANY
LINCOLN, NEBRASKA

CERTIFICATE
GROUP EYE CARE INSURANCE

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

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

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

Class Number 2

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

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

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

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

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

President

Massachusetts Notice of Inquiry and Grievance Procedures

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

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

I. Definitions

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

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

II. Internal Grievance Process

1. Filing a Grievance

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

2. Written Decision

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

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

3. Reconsideration

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

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

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

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

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

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

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

ដែលអាចស្នើសុំ សេវាអ្នកបកប្រែភាសា និងបកប្រែអក្សរ ទាក់ទងនឹងនីតិវិធីរដ្ឋបាល មានផ្តល់ជូន

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

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

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

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Benefit Class	Class Description
Class 2	Graduate Employee

EYE CARE EXPENSE BENEFITS

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

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

COMBINED EXPENSE BENEFITS

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

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

DEFINITIONS

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

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

INSURED refers to a person:

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

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

c. for whom the insurance has become effective.

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

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

DEPENDENT refers to:

a. an Insured's spouse or Domestic Partner.

b. each unmarried child less than 26 years of age, for whom the Insured, the Insured's spouse, or the Insured's Domestic Partner is legally responsible, including natural born children, adopted children from the date of placement for adoption, and children covered under a Qualified Medical Child Support Order as defined by applicable Federal and State laws.

c. each unmarried child age 26 or older who is Totally Disabled and becomes Totally Disabled as defined below while insured as a dependent under b. above. Coverage of such child will not cease if proof of dependency and disability is given within 31 days of attaining the limiting age and subsequently as may be required by us but not more frequently than annually after the initial two-year period following the child's attaining the limiting age. Any costs for providing continuing proof will be at our expense.

TOTAL DISABILITY describes the Insured's Dependent as:

1. Continuously incapable of self-sustaining employment because of mental retardation or physical handicap; and

2. Chiefly dependent upon the Insured for support and maintenance.

DEPENDENT UNIT refers to all of the people who are insured as the dependents of any one Insured.

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

LATE ENTRANT refers to any person:

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

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

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

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

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

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

CONDITIONS FOR INSURANCE COVERAGE

ELIGIBILITY

ELIGIBLE CLASS FOR MEMBERS. The members of the eligible class(es) are shown on the Schedule of Benefits. Each member of the eligible class (referred to as "Member") will qualify for such insurance on the day he or she completes the required eligibility period, if any. Members choosing to elect coverage will hereinafter be referred to as "Insured."

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

If both spouses are Members, and if either of them insures their dependent children, then the spouse, whoever elects, will be considered the dependent of the other. As a dependent, the person will not be considered a Member of the Eligible Class, but will be eligible for insurance as a dependent.

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

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

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

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

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

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

Any spouse who elects to be a dependent rather than a member of the Eligible Class for Personal Insurance, as explained above, is not a member of the Eligible Class for Dependent Insurance.

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

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

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

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

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

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

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

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

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

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

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

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

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

TERMINATION DATES

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

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

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

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

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

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

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

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

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

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

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

Federally Required Continuation
For Employees and/or Dependents

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

1. groups of less than 20 employees.

2. certain church plans.

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

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

Leave of Absence
For Employees Only

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

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

Separation or Divorce
For Dependents Only

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

a. become legally separated; or

b. dissolve the marriage;

unless the judgment of separation or divorce excludes such continuation.

For purposes of this continuation provision such spouse is called "former spouse."

The former spouse may also continue to insure his or her dependent children.

Coverage may be continued if the judgment of dissolution or separation was entered prior to the effective date of this plan.

Benefits

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

Termination

Such insurance will stop on the earliest of:

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

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

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

4. the date either party remarries*;

5. the date insurance terminates for the Insured;

6. the date the policy terminates.

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

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

Premium

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

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

Claims

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

Notice

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

EYE CARE INSURANCE

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

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

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

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

Benefit Period means the period from September 1 of any year through August 31 of the next year. But during the first year a person is insured, a benefit period means the period from his or her effective date through August 31 of the next year.

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

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

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

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

SCHEDULE OF EYE CARE SERVICES

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

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

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

Materials

Frame

Lenses

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

GENERAL PROVISIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ERISA INFORMATION AND NOTICE OF YOUR RIGHTS

A. General Plan Information

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

B. Notice of Legal Process

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

C. Eligibility and Benefits Provided Under the Group Policy

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

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

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

E. Termination Of The Group Policy

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

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

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

F. Claims For Benefits

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

G. Continuation of Coverage Provisions (COBRA)

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

i. Definitions For This Section

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

A Qualifying Event occurs when:

1. The Member dies (hereinafter referred to as Qualifying Event 1);

2. The Member's employment terminates for reasons other than gross misconduct as determined by the Employer (hereinafter referred to as Qualifying Event 2);

3. The Member's work hours fall below the minimum number required to be a Member (hereinafter referred to as Qualifying Event 3);

4. The Member becomes divorced or legally separated from a Spouse (hereinafter referred to as Qualifying Event 4);

5. The Member becomes entitled to receive Medicare benefits under Title XVII of the Social Security Act (hereinafter referred to as Qualifying Event 5);

6. The Child of a Member ceases to be a Dependent (hereinafter referred to as Qualifying Event 6);

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

ii. Electing COBRA Continuation

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

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

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

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

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

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

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

iii. Notice Requirements

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

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

a. The date of the Qualifying Event; or

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

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

a. The date of the disability determination;

b. The date of the Qualifying Event; or

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

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

   a. The date of the Qualifying Event; or

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

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

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

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

iv. COBRA Continuation Period

1. 18-month COBRA Continuation

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

2. 29-month COBRA Continuation

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

3. 36-Month COBRA Continuation

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

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

4. COBRA Continuation For Certain Bankruptcy Proceedings

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

v. Premium Requirements

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

18 month continuation - 102%

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

36 month continuation - 102%

vi. When COBRA Continuation Ends

COBRA continuation ends on the earliest of:

1. The date the Group Policy terminates;

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

3. The last day of the COBRA continuation period.

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

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

H. Your Rights under ERISA

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

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

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

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

Continue Group Health Plan Coverage

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

Assistance with Your Rights

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

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

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

CLAIMS FOR BENEFITS

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

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

NOTICE OF DECISION OF CLAIM

We will evaluate your claim promptly after we receive it.

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

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

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

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

APPEAL PROCEDURE

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

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

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

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

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

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

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

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

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

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

Any request for appeal should be directed to:
Quality Control, P.O. Box 82657, Lincoln, NE 68501-2657.

Your Information. Your Rights. Our Responsibilities.

Ameritas

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

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

how we use or disclose information

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

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

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

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

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

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

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

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

our responsibilities

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

your rights

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

exercising your rights

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

This revised notice is effective 9/30/17.

2. We determine that the number of Insureds is less than 80% of those Insureds initially enrolled under the Policy as of either (i) the Plan Effective Date, if during the period of time between the Plan Effective Date and the Renewal Date, or (ii) the most recent 12 month anniversary of the Renewal Date: and/or

3. We are required by either the federal government or by any state or local government or by any agency thereof to change benefits as a result of regulatory change or pay a new or increased tax, assessment, or monetary charge of any kind (other than a new or any increase to the amount of tax we pay based upon our net operating income). Such taxes, assessments or fees would include those that are charged or assessed in connection with the operation of a health care exchange authorized by federal or state law.

Should any of the above occur and should we elect to change rates as a result, we agree to notify the Policyholder of the corresponding rate changes at least 30 days in advance of the Premium Due Date for which the rate change shall be effective. The right to change rates as well as the timing of such changes in the above limited situations shall at all times be subject to applicable state laws and regulations.

RENEWAL DATE refers to the date each calendar year that the coverage issued under the group policy is considered for renewal. The Renewal Date(s) are shown on the policy cover.

DEFINITIONS

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

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

INSURED refers to a person:

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

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

c. for whom the insurance has become effective.

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

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

DEPENDENT refers to:

a. an Insured's spouse or Domestic Partner.

b. each unmarried child less than 26 years of age, for whom the Insured, the Insured's spouse, or the Insured's Domestic Partner is legally responsible, including natural born children, adopted children from the date of placement for adoption, and children covered under a Qualified Medical Child Support Order as defined by applicable Federal and State laws.

c. each unmarried child age 26 or older who is Totally Disabled and becomes Totally Disabled as defined below while insured as a dependent under b. above. Coverage of such child will not cease if proof of dependency and disability is given within 31 days of attaining the limiting age and subsequently as may be required by us but not more frequently than annually after the initial two-year period following the child's attaining the limiting age. Any costs for providing continuing proof will be at our expense.

TOTAL DISABILITY describes the Insured's Dependent as:

1. Continuously incapable of self-sustaining employment because of mental retardation or physical handicap; and

2. Chiefly dependent upon the Insured for support and maintenance.

DEPENDENT UNIT refers to all of the people who are insured as the dependents of any one Insured.

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

LATE ENTRANT refers to any person:

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

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

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

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

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

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

CONDITIONS FOR INSURANCE COVERAGE

ELIGIBILITY

ELIGIBLE CLASS FOR MEMBERS. The members of the eligible class(es) are shown on the Schedule of Benefits. Each member of the eligible class (referred to as "Member") will qualify for such insurance on the day he or she completes the required eligibility period, if any. Members choosing to elect coverage will hereinafter be referred to as "Insured."

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

If both spouses are Members, and if either of them insures their dependent children, then the spouse, whoever elects, will be considered the dependent of the other. As a dependent, the person will not be considered a Member of the Eligible Class, but will be eligible for insurance as a dependent.

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

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

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

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

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

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

Any spouse who elects to be a dependent rather than a member of the Eligible Class for Personal Insurance, as explained above, is not a member of the Eligible Class for Dependent Insurance.

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

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

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

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

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

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

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

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

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

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

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

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

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

TERMINATION DATES

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

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

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

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

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

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

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

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

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

If an employee leaves his/her job for any reason (quit, terminated, laid off, plant closing, etc.) or if a child ceases to be a dependent under this policy, group coverages provided under this policy will be extended for 31 days in accordance with Massachusetts Law, chapter 175, section 110D. The employer/employee contributions will remain the same for the 31-day period as during employment. The 31-day continuation period begins the date the employee actually terminates employment or the date the child ceases to be considered a dependent under the policy.

This continuation of coverage is in addition to any other continuation periods applicable under Massachusetts law as defined below. This benefit does not extinguish eligibility for benefits available under the Federal Consolidated Omnibus budget Reconciliation Act. (COBRA).

Federally Required Continuation
For Employees and/or Dependents

Through the Consolidated Omnibus Budget Reconciliation Act (COBRA) the federal government requires the Policyholder to provide continuation of coverages to employees and/or dependents who would otherwise lose their coverages. There are some groups which are not subject to the law. They are:

1. groups of less than 20 employees.

2. certain church plans.

When a person is eligible for both state benefits and federal COBRA benefits, certain state and federal benefits overlap and run concurrently. Please note the election of continued coverage under certain state laws may extinguish eligibility for benefits under federal law.

For details the employee and/or dependent(s) must contact the person who handles the Policyholder's insurance matters.

Leave of Absence
For Employees Only

If membership is because of employment and an Insured's active service terminates because of a leave of absence, the insurance will stay in force for two months only if the Policyholder pays his or her premiums and does not cancel the insurance.

If the Policyholder is subject to COBRA, the rules applicable to COBRA will supersede the continuation due to a leave of absence.

Separation or Divorce
For Dependents Only

The Insured's spouse may continue coverage without additional premium (unless the divorce or separation judgment specifies otherwise) if the Insured and the spouse:

a. become legally separated; or

b. dissolve the marriage;

unless the judgment of separation or divorce excludes such continuation.

For purposes of this continuation provision such spouse is called "former spouse."

The former spouse may also continue to insure his or her dependent children.

Coverage may be continued if the judgment of dissolution or separation was entered prior to the effective date of this plan.

Benefits

This continuation applies to all benefits provided under this policy covering the former spouse.

Termination

Such insurance will stop on the earliest of:

1. the last day of the period for which the premium is paid;

2. the date coverage would normally stop under the terms of the policy;

3. the date specified in the judgment of separation or dissolution;

4. the date either party remarries*;

5. the date insurance terminates for the Insured;

6. the date the policy terminates.

*In the event of the remarriage of the Insured, the former spouse shall have the right, if so provided in said judgment, to continue to be covered as a member of the group.

We will send notice of termination of continuation coverage, and any right to reinstate coverage to the former spouse at the last known address.

Premium

We may charge the full premium, i.e., the employee and employer's portion, during the continuation period.

We may change the premium rate at any time the Insured's group plan premium rate is changed. Any part of the premium to be paid by the former spouse should be paid to the employer. The employer may stop coverage if any premium is not received within 30 days following the due date.

Claims

Claims incurred by the former spouse will be paid to the former spouse or the provider. Claims incurred by dependent children not living with the Insured will be paid to the provider or the parent with custody.

Notice

We are required to send notice of name, address and policy numbers of persons electing this continuation to the Massachusetts Department of Public Welfare. We must send the notice within 30 days of the date continuation coverage starts.

EYE CARE INSURANCE

If an Insured under this section incurs Covered Expenses, we will pay benefits as stated below.

COVERED EXPENSES. Covered Expenses include the charge for the covered procedure furnished up to the maximum amount.

COVERED EXPENSES. Covered Expenses means the Eye Care expenses incurred by an Insured for the procedures shown in the Schedule of Eye Care Services, up to the Maximum Covered Expense shown for each procedure and the Eye Care Maximum as shown in the Schedule of Benefits, if applicable. Such expenses will be Covered Expenses only to the extent that they are incurred for procedures done by a physician, optometrist, or optician. These expenses are subject to the "Limitations" below.

DEDUCTIBLE AMOUNT. The Deductible Amount shown in the Schedule of Benefits is an amount of Covered Expenses for which no benefits are payable. It applies separately to the Covered Expenses incurred by each Insured. Benefits will be paid only for those Covered Expenses that are over the deductible amount.

Benefit Period means the period from September 1 of any year through August 31 of the next year. But during the first year a person is insured, a benefit period means the period from his or her effective date through August 31 of the next year.

EXPENSES INCURRED. An expense is incurred at the time a service is rendered or a supply furnished.

EXTENSION OF BENEFITS. Should an Insured's coverage under this section terminate, we will pay Covered Expenses for frames or lenses which were ordered while coverage was in force, provided such frames or lenses are delivered within 30 days from the date the Insured's coverage ceases.

LIMITATIONS: Covered Expenses will not include and no benefits will be payable for expenses incurred for:

1. vision examinations.
2. frames or lenses ordered before the Insured was covered under this section.
3. subject to Extension of Benefits, frame or lens ordered after the Insured's coverage under this section ceases.
4. sub-normal vision aids; orthoptic or vision training or any associated testing.
5. non-prescription lenses.
6. replacement or repair of lost or broken lenses or frames except at normal intervals.
7. any corrective eyewear required by an employer as a condition of employment.
8. medical or surgical treatment of the eyes.
9. any service or supply not shown on the Schedule of Eye Care Services.
10. coated lenses; oversize lenses (exceeding 71 mm); photo-gray lenses; polished edges; UV-400 coating and facets, and tints other than solid.

SCHEDULE OF EYE CARE SERVICES

The following is a complete list of eye care services for which benefits are payable. No benefits are payable for a service which is not listed.

SERVICE	MAXIMUM COVERED EXPENSE
Maximum Amount -- Each Benefit Period	$150*

The Maximum Amount is the most the plan will provide for all services subject to any plan frequencies, limitations, and/or deductible.

Materials

Frame

Lenses

- Single Vision
- Bifocal
- Trifocal
- No line bifocal or progressive power
- Lenticular
- Contact Lenses

GENERAL PROVISIONS

NOTICE OF CLAIM. Written notice of a claim must be given to us within 90 days after the incurred date of the services provided for which benefits are payable.

Notice must be given to us at our Home Office, or to one of our agents. Notice should include the Policyholder's name, Insured's name, and policy number. If it was not reasonably possible to give written notice within the 90 day period stated above, we will not reduce or deny a claim for this reason if notice is filed as soon as is reasonably possible.

CLAIM FORMS. When we receive the notice of a claim, we will send the claimant forms for filing proof of loss. If these forms are not furnished within 15 days after the giving of such notice, the claimant will meet our proof of loss requirements by giving us a written statement of the nature and extent of loss within the time limit for filing proofs of loss.

PROOF OF LOSS. Written proof of loss must be given to us within 90 days after the incurred date of the services provided for which benefits are payable. If it is impossible to give written proof within the 90 day period, we will not reduce or deny a claim for this reason if the proof is filed as soon as is reasonably possible.

TIME OF PAYMENT. We will pay all benefits within 45 days of when we receive all information necessary to pay the claim. If a claim cannot be paid within 45 days of receipt, we will notify you within that 45-day period providing you with a list of information necessary for us to pay the claim. If payment is not made within the required time frame, we will pay interest at the rate of eighteen percent per year on benefits for valid claims. Interest will begin to accrue 45 days after we receive notice of the claim and will accrue until the claim is settled.

PAYMENT OF BENEFITS. Participating Providers have agreed to accept assignment of benefits for services and supplies performed or furnished by them. When a Non-Participating Provider performs services, all benefits will be paid to the Insured unless otherwise indicated by the Insured's authorization to pay the Non-Participating Provider directly.

FACILITY OF PAYMENT. If an Insured or beneficiary is not capable of giving us a valid receipt for any payment or if benefits are payable to the estate of the Insured, then we may, at our option, pay the benefit up to an amount not to exceed $1,000, to any relative by blood or connection by marriage of the Insured who is considered by us to be equitably entitled to the benefit.

Any equitable payment made in good faith will release us from liability to the extent of payment.

PROVIDER-PATIENT RELATIONSHIP. The Insured may choose any Provider who is licensed by the law of the state in which treatment is provided within the scope of their license. We will in no way disturb the provider-patient relationship.

LEGAL PROCEEDINGS. No legal action can be brought against us until 60 days after the Insured sends us the required proof of loss. No legal action against us can start more than five years after proof of loss is required.

INCONTESTABILITY. Any statement made by the Policyholder to obtain the Policy is a representation and not a warranty. No misrepresentation by the Policyholder will be used to deny a claim or to deny the validity of the Policy unless:

1. The Policy would not have been issued if we had known the truth; and

2. We have given the Policyholder a copy of a written instrument signed by the Policyholder that contains the misrepresentation.

The validity of the Policy will not be contested after it has been in force for one year, except for nonpayment of premiums or fraudulent misrepresentations.

WORKER'S COMPENSATION. The coverage provided under the Policy is not a substitute for coverage under a workmen's compensation or state disability income benefit law and does not relieve the Policyholder of any obligation to provide such coverage.

As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at 1-877-MA-ENROLL or visit the Connector website (www.mahealthconnector.org). This plan is not intended to provide comprehensive health care coverage and does not meet Minimum Creditable Coverage standards, even if it does include services that are not available in the insured's other health plans.

If you have questions about this notice, you may contact the Division of Insurance by calling (617) 521-7794 or visiting its website at www.mass.gov/doi.

CONFORMITY WITH LAW. Any policy provision that conflicts with the laws of the state in which the policy is issued, when the policy is issued, is automatically changed to meet the minimum requirements of those laws.

ENTIRE CONTRACT. The policy and the application of the Policyholder constitute the entire contract between the parties. A copy of the Policyholder's application is attached to the policy when issued. All statements made by the Policyholder or an Insured will, in the absence of fraud, be considered representations and not warranties. No statement made to obtain insurance will be used to void the insurance or reduce the benefits of this policy unless it is in a written application signed by the Policyholder or Insured. A copy of this must have been given to the Policyholder or Insured.

No change in this policy will be valid unless approved in writing by one of our officers and given to the Policyholder for attachment to the policy. No agent has the authority to change this policy or waive any of its provisions. Any change in this policy will be valid even though an Insured may not have agreed to it.

INSURANCE DATA. The Policyholder will furnish, at our request, data necessary to administer this policy. The data will include, but not be limited to data:

i. necessary to calculate premiums;

ii. necessary to determine a person's effective date or termination date of insurance;

iii. necessary to determine the proper coverage level of insurance.

We shall have the right to inspect any of the Policyholder's records we find necessary to properly administer this policy. Any inspections will be at a time and place convenient to the Policyholder.

We will not refuse to insure a person who is eligible to be insured just because the Policyholder fails or errs in giving us the data necessary to include that person for coverage. An Insured's insurance will not stay in force nor an amount of insurance be continued after the termination date, according to the Conditions for Insurance, because the Policyholder fails or errors in giving us the necessary data concerning an Insured's termination.

CERTIFICATES. We will issue certificates to the Policyholder showing the coverage under the policy. The Policyholder will distribute a certificate to each insured Member. If the terms of the certificate differ from the policy, the terms stated in the policy will govern.

PARTICIPATION REQUIREMENTS. There are two requirements that must be met in order for the policy to be placed in force, and to remain in force:

a. a certain percentage of all Members qualified for insurance must be insured at all times; and

b. a certain number of Members must be insured at all times.

The Participation Requirements are as follows:

Percentage of Members-	100%
Number of Members-	79

TERMINATION OF THE POLICY. The Policyholder may terminate this policy as of any Premium Due Date by giving us written notice before that date.

We may terminate this policy on the earlier of:

1. any Premium Due Date if the participation of Insureds and/or Dependents does not meet the requirements in "Conditions For Insurance." Written notice of termination of insurance must be given to the Policyholder at least 45 days before the date of termination.

2. any Premium Due Date on or after the first policy year, for reasons other than lack of participation. Written notice of termination of insurance must be given to the Policyholder at least 60 days before the date of termination.

If any premium is not paid when due, this policy will automatically be terminated as of the Premium Due Date, except as stated below.

GRACE PERIOD. This policy has a 31 day grace period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following 31 days. During the grace period, the policy will stay in force. If the Policyholder has not sent us a written request to terminate the policy and a premium is not paid by the end of the grace period, the policy will terminate at the end of the grace period. If the Policyholder gives us written notice of termination before the Premium Due Date, the policy will be terminated as of the date requested. The Policyholder will be liable for any unpaid premium for the time this policy was in force, including the grace period.

CONSIDERATION. This policy is issued to the Policyholder in consideration of the application and the payment of premiums specified in this policy.

TERMS AND CONDITIONS. Payment of any benefit under this policy is subject to the definitions and all other terms of this policy pertinent to the benefit.

CLAIMS REVIEW PROCEDURES
AS REQUIRED UNDER
EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

The following provides information regarding the claims review process and your rights to request a review of any part of a claim that is denied. Please note that certain state laws may also require specified claims payment procedures as well as internal appeal procedures and/or independent external review processes. Therefore, in addition to the review procedures defined below, you may also have additional rights provided to you under state law. If your state has specific grievance procedures, an additional notice specific to your state will also be included within the group policy and your certificate.

CLAIMS FOR BENEFITS

Claims may be submitted by mailing the completed claim form along with any requested information to:

Ameritas Life Insurance Corp.
PO Box 82520
Lincoln, NE 68501

NOTICE OF DECISION OF CLAIM

We will evaluate your claim promptly after we receive it.

We will provide you written notice regarding the payment under the claim within 30 calendar days following receipt of the claim. This period may be extended for an additional 15 days, provided that we have determined that an extension is necessary due to matters beyond our control, and notify you, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which we expect to render a decision. If the extension is due to your failure to provide information necessary to decide the claim, the notice of extension shall specifically describe the required information we need to decide the claim.

If we request additional information, you will have 45 days to provide the information. If you do not provide the requested information within 45 days, we may decide your claim based on the information we have received.

If we deny any part of your claim, you will receive a written notice of denial containing:

a. The reasons for our decision.
b. Reference to the parts of the Group Policy on which our decision is based.
c. Reference to any internal rule or guideline relied upon in making our decision, along with your right to receive a copy of these guidelines, free of charge, upon request.
d. A statement that you may request an explanation of the scientific or clinical judgment we relied upon to exclude expenses that are experimental or investigational, or are not necessary or accepted according to generally accepted standards of Eye Care practice.
e. A description of any additional information needed to support your claim and why such information is necessary.
f. Information concerning your right to a review of our decision.
g. Information concerning your right to bring a civil action for benefits under section 502(a) of ERISA following an adverse benefit determination on review.

APPEAL PROCEDURE

If all or part of a claim is denied, you may request a review in writing within 180 days after receiving notice of the benefit denial.

You may send us written comments or other items to support your claim. You may review and receive copies of any non-privileged information that is relevant to your appeal. There will be no charge for such copies. You may request the names of the experts we consulted who provided advice to us about your claim.

The appeal review will be conducted by the Plan's named fiduciary and will be someone other than the person who denied the initial claim and will not be subordinate to that person. The person conducting the review will not give deference to the initial denial decision. If the denial was based in whole or in part on a medical judgment, including determinations with regard to whether a service was considered experimental, investigational, and/or not medically necessary, the person conducting the review will consult with a qualified health care professional. This health care professional will be someone other than the person who made the original judgment and will not be subordinate to that person. Our review will include any written comments or other items you submit to support your claim.

We will review your claim promptly after we receive your request.

If your appeal is about urgent care, you may call Toll Free at 877-897-4328, and an Expedited Review will be conducted. Verbal notification of our decision will be made within 72 hours, followed by written notice within 3 calendar days after that.

If your appeal is about benefit decisions related to clinical or medical necessity, a Standard Consultant Review will be conducted. A written decision will be provided within 30 calendar days of the receipt of the request for appeal.

If your appeal is about benefit decisions related to coverage, a Standard Administrative Review will be conducted. A written decision will be provided within 60 calendar days of the receipt of the request for appeal.

If we deny any part of your claim on review, you will receive a written notice of denial containing:

a. The reasons for our decision.
b. Reference to the parts of the Group Policy on which our decision is based.
c. Reference to any internal rule or guideline relied upon in making our decision along with your right to receive a copy of these guidelines, free of charge, upon request.
d. Information concerning your right to receive, free of charge, copies of non-privileged documents and records relevant to your claim.
e. A statement that you may request an explanation of the scientific or clinical judgment we relied upon to exclude expenses that are experimental or investigational, or are not necessary or accepted according to generally accepted standards of Eye Care practice.
f. Information concerning your right to bring a civil action for benefits under section 502(a) of ERISA.

Certain state laws also require specified internal appeal procedures and/or external review processes. In addition to the review procedures defined above, you may also have additional rights provided to you under state law. Please review your certificate for such information, call us, or contact your state insurance regulatory agency for assistance. In any event, you need not exhaust such state law procedures prior to bringing civil action under Section 502(a) of ERISA.

Any request for appeal should be directed to:
Quality Control, P.O. Box 82657, Lincoln, NE 68501-2657.

Application is Hereby Made to

AMERITAS LIFE INSURANCE CORP.

by: UAW/UMASS HEALTH & WELFARE TRUST FUND

whose main office address is: 6 UNIVERSITY DR STE 206-226
AMHERST, MA 01002-2360

for Group Policy No. 10-53791

This group policy is hereby approved. Its terms are hereby accepted.

This Acceptance Application is made in duplicate. One is attached to the policy. The other part has been returned to the Company.

It is agreed that this application supersedes any previous application for the group policy.

UAW/UMASS HEALTH & WELFARE TRUST FUND

(Full or Corporate Name of Applicant)

Dated at_____ By _____
(Signature and Title)

On _____, 20___ Witness_____
(To be signed by Resident Agent where required by law)

This copy is to remain Attached to the Policy

TABLE OF CONTENTS

SCHEDULE OF BENEFITS
OUTLINE OF COVERAGE

The Insurance for each Insured and each Insured Dependent will be based on the Insured's class shown in this Schedule of Benefits.

Benefit Class	Class Description
Class 2	Graduate Employee

DENTAL EXPENSE BENEFITS

When you select a Participating Provider, a discounted fee schedule is used which is intended to provide you, the Insured, reduced out of pocket costs.

Deductible Amount:

When a Participating Provider is used:	
Type 1, Type 2, Type 3, and Type 4 Procedures	$0
When a Non-Participating Provider is used:	
Type 1 and Type 4 Procedures	$0
Combined Type 2 and Type 3 Procedures - Each Benefit Period	$75

On the date that three members of one family have satisfied their own Deductible Amounts for that Benefit Period, no Covered Expenses incurred after that date by any other family member will be applied toward the satisfaction of any Deductible Amount for the rest of that Benefit Period. No Covered Expense that was incurred prior to such date, which was used to satisfy any part of a Deductible Amount, will be eligible for reimbursement.

	Participating Provider	Non-Participating Provider
Coinsurance Percentage:		
Type 1 Procedures	100%	100%
Type 2 Procedures	80%	80%
Type 3 Procedures	65%	65%
Type 4 Procedures	65%	65%
When a Non-Participating Provider is used:		
Maximum Amount - Each Benefit Period		$2,250*
When a Participating Provider is used:		
Maximum Amount - Each Benefit Period		$2,250*

In no event will expenses incurred for Type 1 Procedures count toward the Maximum Benefit.

Eligible Dental Expense Benefits for Temporomandibular Joint Dysfunction may not exceed $500 per Lifetime.

ORTHODONTIC EXPENSE BENEFITS

Deductible Amount - Once per lifetime	$0
Coinsurance Percentage	50%
Maximum Benefit During Lifetime	$1,000

The Maximum Benefit shown above will be modified for:

a. any person who was insured for an Orthodontic Expense Benefit under the prior carrier on August 31, 2020, and
b. on September 1, 2020 is both:

    i. insured under the policy, and

    ii. currently undergoing a Treatment Program which would have been a covered Treatment Program under the prior carrier had the prior carrier's coverage remained in force.

The modification will result in a reduction of the Maximum Benefit based on:

a. the normal benefit payable under the policy for the current Treatment Program, minus

b. any amounts to which the person is entitled from the prior carrier for such Treatment Program.

Nothing stated above, however, will act to provide coverage or increase benefits, when the Treatment Program is subject to any limitation shown on 9260.

COMBINED EXPENSE BENEFITS

*Combined Dental and Eye Care Maximum - Each Benefit Period	$2,250

The maximums listed with the (*) above are subject to the maximum amount listed here.

DEFINITIONS

COMPANY refers to Ameritas Life Insurance Corp. The words "we", "us" and "our" refer to Company. Our Home Office address is 5900 "O" Street, Lincoln, Nebraska 68510.

POLICYHOLDER refers to the Policyholder stated on the face page of the policy.

INSURED refers to a person:

a. who is a Member of the eligible class; and

b. who has qualified for insurance by completing the eligibility period, if any; and

c. for whom the insurance has become effective.

DOMESTIC PARTNER: Refers to two unrelated individuals who share the necessities of life, live together, and have an emotional and financial commitment to one another, similar to that of a spouse.

CHILD. Child refers to the child of the Insured , a child of the Insured's spouse or a child of the Insured's Domestic Partner, if they otherwise meet the definition of Dependent.

DEPENDENT refers to:

a. an Insured's spouse or Domestic Partner.

b. each unmarried child less than 26 years of age, for whom the Insured, the Insured's spouse, or the Insured's Domestic Partner is legally responsible, including natural born children, adopted children from the date of placement for adoption, and children covered under a Qualified Medical Child Support Order as defined by applicable Federal and State laws.

c. each unmarried child age 26 or older who is Totally Disabled and becomes Totally Disabled as defined below while insured as a dependent under b. above. Coverage of such child will not cease if proof of dependency and disability is given within 31 days of attaining the limiting age and subsequently as may be required by us but not more frequently than annually after the initial two-year period following the child's attaining the limiting age. Any costs for providing continuing proof will be at our expense.

TOTAL DISABILITY describes the Insured's Dependent as:

1. Continuously incapable of self-sustaining employment because of mental retardation or physical handicap; and

2. Chiefly dependent upon the Insured for support and maintenance.

DEPENDENT UNIT refers to all of the people who are insured as the dependents of any one Insured.

PROVIDER refers to any person who is licensed by the law of the state in which treatment is provided within the scope of the license.

PARTICIPATING AND NON-PARTICIPATING PROVIDERS. A Participating Provider is a Provider who has a contract with Us to provide services to Insureds at a discount. A Participating Provider is also referred to as a "Network Provider". The terms and conditions of the agreement with our network providers are available upon request. Members are required to pay the difference between the plan payment and the Participating Provider's contracted fees for covered services. A Non-Participating Provider is any other provider and may also be referred

to as an “Out-of-Network Provider.” Members are required to pay the difference between the plan payment and the provider’s actual fee for covered services. Therefore, the out-of-pocket expenses may be lower if services are provided by a Participating Provider.

LATE ENTRANT refers to any person:

a. whose Effective Date of insurance is more than 31 days from the date the person becomes eligible for insurance; or

b. who has elected to become insured again after canceling a premium contribution agreement.

PLAN EFFECTIVE DATE refers to the date coverage under the policy becomes effective. The Plan Effective Date for the Policyholder is shown on the policy cover. The effective date of coverage for an Insured is shown in the Policyholder's records.

All insurance will begin at 12:01 A.M. on the Effective Date. It will end after 11:59 P.M. on the Termination Date. All times are stated as Standard Time of the residence of the Insured.

PLAN CHANGE EFFECTIVE DATE refers to the date that the policy provisions originally issued to the Policyholder change as requested by the Policyholder. The Plan Change Effective date for the Policyholder will be shown on the policy cover, if the Policyholder has requested a change. The plan change effective date for an Insured is shown in the Policyholder’s records or on the cover of the certificate.

CONDITIONS FOR INSURANCE COVERAGE

ELIGIBILITY

ELIGIBLE CLASS FOR MEMBERS. The members of the eligible class(es) are shown on the Schedule of Benefits. Each member of the eligible class (referred to as "Member") will qualify for such insurance on the day he or she completes the required eligibility period, if any. Members choosing to elect coverage will hereinafter be referred to as "Insured."

If employment is the basis for membership, a member of the Eligible Class for Insurance is any graduate employee working at least 20 hours per week. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

If both spouses are Members, and if either of them insures their dependent children, then the spouse, whoever elects, will be considered the dependent of the other. As a dependent, the person will not be considered a Member of the Eligible Class, but will be eligible for insurance as a dependent.

ELIGIBLE CLASS FOR DEPENDENT INSURANCE. Each Member of the eligible class(es) for dependent coverage is eligible for the Dependent Insurance under the policy and will qualify for this Dependent Insurance on the latest of:

1. the day he or she qualifies for coverage as a Member;

2. the day he or she first becomes a Member; or

3. the day he or she first has a dependent. For dependent children, a newborn child will be considered an eligible dependent upon reaching their 2nd birthday. The child may be added at birth or within 31 days of the 2nd birthday.

A Member must be an Insured to also insure his or her dependents.

If employment is the basis for membership, a member of the Eligible Class for Dependent Insurance is any graduate employee working at least 20 hours per week and has eligible dependents. If membership is by reason other than employment, then a member of the Eligible Class for Insurance is as defined by the Policyholder.

Any spouse who elects to be a dependent rather than a member of the Eligible Class for Personal Insurance, as explained above, is not a member of the Eligible Class for Dependent Insurance.

When a member of the Eligible Class for Dependent Insurance dies and, if at the date of death, has dependents insured, the Policyholder has the option of offering the dependents of the deceased employee continued coverage. If elected by the Policyholder and the affected dependents, the name of such deceased member will continue to be listed as a member of the Eligible Class for Dependent Insurance.

CONTRIBUTION REQUIREMENTS. Member Insurance: An Insured is not required to contribute to the payment of his or her insurance premiums. An insured may or may not be required to contribute to the payment of insurance premiums if he or she is both covered under this policy and also covered under another plan.

Dependent Insurance: An Insured is required to contribute to the payment of insurance premiums for his or her dependents.

ELIGIBILITY PERIOD. For Members on the Plan Effective Date of the policy, qualification will occur after an eligibility period defined by the Policyholder is satisfied. The same eligibility period will be applied to all members.

For persons who become Members after the Plan Effective Date of the policy, qualification will occur after an eligibility period defined by the Policyholder is satisfied. The same eligibility period will be applied to all members.

If employment is the basis for membership in the Eligible Class for Members, an Insured whose eligibility terminates and is established again, may or may not have to complete a new eligibility period before he or she can again qualify for insurance.

ELIMINATION PERIOD. Certain covered expenses may be subject to a elimination period, the period between the effective date of the policy and the effective date of coverage of benefits. Please refer to the TABLE OF DENTAL PROCEDURES, DENTAL EXPENSE BENEFITS and if applicable, the ORTHODONTIC EXPENSE BENEFITS pages for details.

EFFECTIVE DATE. Each Member has the option of being insured and insuring his or her Dependents. To elect coverage, he or she must agree in writing to contribute to the payment of the insurance premiums. The Effective Date for each Member and his or her Dependents, will be:

1. the date on which the Member qualifies for insurance, if the Member agrees to contribute on or before that date.

2. the date on which the Member agrees to contribute, if that date is within 31 days after the date he or she qualifies for insurance.

3. the date we accept the Member and/or Dependent for insurance when the Member and/or Dependent is a Late Entrant. The Member and/or Dependent will be subject to any limitation concerning Late Entrants.

EXCEPTIONS. If employment is the basis for membership, a Member must be in active service on the date the insurance, or any increase in insurance, is to take effect. If not, the insurance will not take effect until the day he or she returns to active service. Active service refers to the performance in the customary manner by an employee of all the regular duties of his or her employment with his or her employer on a full time basis at one of the employer's business establishments or at some location to which the employer's business requires the employee to travel.

A Member will be in active service on any regular non-working day if he or she is not totally disabled on that day and if he or she was in active service on the regular working day before that day.

If membership is by reason other than employment, a Member must not be totally disabled on the date the insurance, or any increase in insurance, is to take effect. The insurance will not take effect until the day after he or she ceases to be totally disabled.

TERMINATION DATES

INSUREDS. The insurance for any Insured, will automatically terminate on the **earliest of:**

1. the date the Insured ceases to be a Member;
2. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
3. the date the policy is terminated.

DEPENDENTS. The insurance for all of an Insured's dependents will automatically terminate on the **earliest of:**

1. the date on which the Insured's coverage terminates;
2. the date on which the Insured ceases to be a Member;
3. the last day of the period for which the Insured has contributed, if required, to the payment of insurance premiums; or
4. the date all Dependent Insurance under the policy is terminated.

The insurance for any Dependent will automatically terminate on the day before the date on which the dependent no longer meets the definition of a dependent. See "Definitions."

NOTICE REQUIREMENTS. If an Insured's coverage terminates due to non-payment of premiums, then each Insured will be provided a notice of such termination. The notice will be mailed to the last known address of the Insured. Any claims for services will be paid in accordance with the terms of the contract for any health care service received by the Insured prior to the date of notification.

CONTINUATION OF COVERAGE. If coverage ceases according to TERMINATION DATE, some or all of the insurance coverages may be continued. Contact your plan administrator for details.

An employee or dependent whose insurance has stopped may be able to continue some or all of the insurance coverages. The sections below explain when and how insurance may be continued. If insurance is continued, it must be according to a plan which does not allow individual selection.

Thirty-One Day Continuation of Coverage in accordance with M.G.L. c.175, s. 110D

If an employee leaves his/her job for any reason (quit, terminated, laid off, plant closing, etc.) or if a child ceases to be a dependent under this policy, group coverages provided under this policy will be extended for 31 days in accordance with Massachusetts Law, chapter 175, section 110D. The employer/employee contributions will remain the same for the 31-day period as during employment. The 31-day continuation period begins the date the employee actually terminates employment or the date the child ceases to be considered a dependent under the policy.

This continuation of coverage is in addition to any other continuation periods applicable under Massachusetts law as defined below. This benefit does not extinguish eligibility for benefits available under the Federal Consolidated Omnibus budget Reconciliation Act. (COBRA).

Federally Required Continuation
For Employees and/or Dependents

Through the Consolidated Omnibus Budget Reconciliation Act (COBRA) the federal government requires the Policyholder to provide continuation of coverages to employees and/or dependents who would otherwise lose their coverages. There are some groups which are not subject to the law. They are:

1. groups of less than 20 employees.

2. certain church plans.

When a person is eligible for both state benefits and federal COBRA benefits, certain state and federal benefits overlap and run concurrently. Please note the election of continued coverage under certain state laws may extinguish eligibility for benefits under federal law.

For details the employee and/or dependent(s) must contact the person who handles the Policyholder's insurance matters.

Leave of Absence
For Employees Only

If membership is because of employment and an Insured's active service terminates because of a leave of absence, the insurance will stay in force for two months only if the Policyholder pays his or her premiums and does not cancel the insurance.

If the Policyholder is subject to COBRA, the rules applicable to COBRA will supersede the continuation due to a leave of absence.

Separation or Divorce
For Dependents Only

The Insured's spouse may continue coverage without additional premium (unless the divorce or separation judgment specifies otherwise) if the Insured and the spouse:

a. become legally separated; or

b. dissolve the marriage;

unless the judgment of separation or divorce excludes such continuation.

For purposes of this continuation provision such spouse is called "former spouse."

The former spouse may also continue to insure his or her dependent children.

Coverage may be continued if the judgment of dissolution or separation was entered prior to the effective date of this plan.

Benefits

This continuation applies to all benefits provided under this policy covering the former spouse.

Termination

Such insurance will stop on the earliest of:

1. the last day of the period for which the premium is paid;

2. the date coverage would normally stop under the terms of the policy;

3. the date specified in the judgment of separation or dissolution;

4. the date either party remarries*;

5. the date insurance terminates for the Insured;

6. the date the policy terminates.

*In the event of the remarriage of the Insured, the former spouse shall have the right, if so provided in said judgment, to continue to be covered as a member of the group.

We will send notice of termination of continuation coverage, and any right to reinstate coverage to the former spouse at the last known address.

Premium

We may charge the full premium, i.e., the employee and employer's portion, during the continuation period.

We may change the premium rate at any time the Insured's group plan premium rate is changed. Any part of the premium to be paid by the former spouse should be paid to the employer. The employer may stop coverage if any premium is not received within 30 days following the due date.

Claims

Claims incurred by the former spouse will be paid to the former spouse or the provider. Claims incurred by dependent children not living with the Insured will be paid to the provider or the parent with custody.

Notice

We are required to send notice of name, address and policy numbers of persons electing this continuation to the Massachusetts Department of Public Welfare. We must send the notice within 30 days of the date continuation coverage starts.

DENTAL EXPENSE BENEFITS

We will determine dental expense benefits according to the terms of the group policy for dental expenses incurred by an Insured. An Insured person has the freedom of choice to receive treatment from any Provider.

DETERMINING BENEFITS. The benefits payable will be determined by totaling all of the Covered Expenses submitted into each benefit type as shown in the Table of Dental Procedures. This amount is reduced by the Deductible, if any. The result is then multiplied by the Coinsurance Percentage(s) shown in the Schedule of Benefits. Benefits are subject to the Maximum Amount, if any, shown in the Schedule of Benefits.

BENEFIT PERIOD. Benefit Period refers to the period shown in the Table of Dental Procedures.

DEDUCTIBLE. The Deductible is shown on the Schedule of Benefits and is a specified amount of Covered Expenses that must be incurred and paid by each Insured person prior to any benefits being paid.

MAXIMUM AMOUNT. The Maximum Amount shown in the Schedule of Benefits is the maximum amount that may be paid for the Covered Expenses incurred by an Insured.

COVERED EXPENSES. Covered Expenses include:

1. only those expenses for dental procedures performed by a Provider; and
2. only those expenses for dental procedures listed and outlined on the Table of Dental Procedures.

Covered Expenses are subject to "Limitations." See Limitations and Table of Dental Procedures.

Benefits payable for Covered Expenses also will be based on the lesser of:

1. the actual charge of the Provider.
2. the usual and customary ("U&C") as covered under your plan, if services are provided by a Non Participating Provider.
3. the Maximum Allowable Charge ("MAC") as covered under your plan.

Usual and Customary (“U&C”) describes those dental charges that we have determined to be the usual and customary charge for a given dental procedure within a particular ZIP code area. The U&C is based upon a combination of dental charge information taken from our own database as well as from data received from nationally recognized industry databases. From the array of charges ranked by amount, your Policyholder (in most cases your employer) has selected a percentile that will be used to determine the maximum U&C for your plan. The U&C is reviewed and updated periodically. The U&C can differ from the actual fee charged by the provider and is not indicative of the appropriateness of the provider’s fee. Instead, the U&C is simply a plan provision used to determine the extent of benefit coverage purchased by your Policyholder.

MAC - The Maximum Allowable Charge is derived from the array of provider charges within a particular ZIP code area. These allowances are the charges accepted by dentists who are Participating Providers. The MAC is reviewed and updated periodically to reflect increasing provider fees within the ZIP code area.

In no event will Covered Persons be held liable for payment denials by us for improper utilization of covered services caused by Participating Providers.

EMERGENCY CARE. Services provided in or by a hospital emergency facility to a covered person after the development of a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity that the absence of prompt medical attention could reasonable be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the covered person's or another

person's health in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part.

If a covered person receives Emergency Care and cannot reasonably reach a Participating Provider, payment for care related to the emergency shall be made at the same level and in the same manner as if the covered person had been treated by a Participating Provider.

ALTERNATIVE PROCEDURES. If two or more procedures are considered adequate and appropriate treatment to correct a certain condition under generally accepted standards of dental care, the amount of the Covered Expense will be equal to the charge for the least expensive procedure. This provision is NOT intended to dictate a course of treatment. Instead, this provision is designed to determine the amount of the plan allowance for a submitted treatment when an adequate and appropriate alternative procedure is available. Accordingly, you may choose to apply the alternate benefit amount determined under this provision toward payment of the submitted treatment.

We may request pre-operative dental radiographic images, periodontal charting and/or additional diagnostic data to determine the plan allowance for the procedures submitted. We strongly encourage pre-treatment estimates so you understand your benefits before any treatment begins. Ask your provider to submit a claim form for this purpose.

EXPENSES INCURRED. An expense is incurred at the time the impression is made for an appliance or change to an appliance. An expense is incurred at the time the tooth or teeth are prepared for a dental prosthesis or prosthetic crown. For root canal therapy, an expense is incurred at the time the pulp chamber is opened. All other expenses are incurred at the time the service is rendered or a supply furnished.

PRE-EXISTING CONDITION. A medical condition for which a Covered Person received medical advice or treatment or displayed symptoms which would have led an ordinarily prudent person to seek medical advice or treatment for that medical conditions during a specific period prior to the effective date of coverage.

This coverage does not restrict or limit coverage for any pre-existing conditions as defined above. Contract limitations are listed below.

LIMITATIONS. Covered Expenses will not include and benefits will not be payable for expenses incurred:

1. in the first 12 months that a person is insured if the person is a Late Entrant; except for evaluations, prophylaxis (cleanings), and fluoride application.

2. a. for initial placement of any dental prosthesis or prosthetic crown unless such placement is needed because of the extraction of one or more teeth while the insured person is covered under this contract. But the extraction of a third molar (wisdom tooth) will not qualify under the above. Any such dental prosthesis or prosthetic crown must include the replacement of the extracted tooth or teeth unless the insured person is covered on September 1, 2020. For those Insureds covered on September 1, 2020, see b.

    b. Limitation a. will be waived for those Insureds whose coverage was effective on September 1, 2020 and

        i. the person has the tooth extracted while insured under the prior contract: and

        ii. has a dental prosthesis or prosthetic crown installed to replace the extracted tooth while insured under our contract;

but such extraction and installation must take place within a twelve-month period; and

iii. the dental prosthesis or prosthetic crown noted above must be an initial placement.

3. for appliances, restorations, or procedures to:

a. alter vertical dimension;
b. restore or maintain occlusion; or
c. splint or replace tooth structure lost as a result of abrasion or attrition.

4. for any procedure begun after the insured person's insurance under this contract terminates; or for any prosthetic dental appliances installed or delivered more than 90 days after the Insured's insurance under this contract terminates.

5. to replace lost or stolen appliances.

6. for any treatment which is for cosmetic purposes.

7. for any procedure not shown in the Table of Dental Procedures. (There may be additional frequencies and limitations that apply, please see the Table of Dental Procedures for details.)

8. for orthodontic treatment under this benefit provision. (If orthodontic expense benefits have been included in this policy, please refer to the Schedule of Benefits and Orthodontic Expense Benefits provision found on 9260).

9. for which the Insured person is entitled to benefits under any workmen's compensation or similar law, or charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.

10. for charges which the Insured person is not liable or which would not have been made had no insurance been in force.

11. for services that are not required for necessary care and treatment or are not within the generally accepted parameters of care.

12. because of war or any act of war, declared or not.

TABLE OF DENTAL PROCEDURES

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY FOR YOUR PROCEDURE FREQUENCIES AND PROVISIONS.

The attached is a list of dental procedures for which benefits are payable under this section; and is based upon the Current Dental Terminology © American Dental Association. **No benefits are payable for a procedure that is not listed.**

- Your benefits are based on a Benefit Year. A Benefit Year runs from September 1 through August 31.
- Benefit Period means the period from September 1 of any year through August 31 of the next year. But during the first year a person is insured, a benefit period means the period from his or her effective date through August 31 of the next year.
- Covered procedures are subject to all plan provisions, procedure and frequency limitations, and/or consultant review.
- Reference to "traumatic injury" under this plan is defined as injury caused by external forces (ie. outside the mouth) and specifically excludes injury caused by internal forces such as bruxism (grinding of teeth).
- Benefits for replacement dental prosthesis or prosthetic crown will be based on the prior placement date. Frequencies which reference Benefit Period will be measured forward within the limits defined as the Benefit Period. All other frequencies will be measured forward from the last covered date of service.
- Radiographic images, periodontal charting and supporting diagnostic data may be requested for our review.
- We recommend that a pre-treatment estimate be submitted for all anticipated work that is considered to be expensive by our insured.
- A pre-treatment estimate is not a pre-authorization or guarantee of payment or eligibility; rather it is an indication of the estimated benefits available if the described procedures are performed.

TYPE 1 PROCEDURES

PAYMENT BASIS - NON PARTICIPATING PROVIDERS - Usual and Customary

BENEFIT PERIOD - Benefit Year

For Additional Limitations - See Limitations

ROUTINE ORAL EVALUATION

D0120 Periodic oral evaluation - established patient.

D0145 Oral evaluation for a patient under three years of age and counseling with primary caregiver.

D0150 Comprehensive oral evaluation - new or established patient.

D0180 Comprehensive periodontal evaluation - new or established patient.

COMPREHENSIVE EVALUATION: D0150, D0180

Coverage is limited to 1 of each of these procedures per provider.

In addition, D0150, D0180 coverage is limited to 2 of any of these procedures per 12 month(s).

D0120, D0145, also contribute(s) to this limitation.

If frequency met, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency.

ROUTINE EVALUATION: D0120, D0145

Coverage is limited to 2 of any of these procedures per 12 month(s).

D0150, D0180, also contribute(s) to this limitation.

Procedure D0120 will be considered for individuals age 3 and over. Procedure D0145 will be considered for individuals age 2 and under.

COMPLETE SERIES OR PANORAMIC

D0210 Intraoral - complete series of radiographic images.

D0330 Panoramic radiographic image.

COMPLETE SERIES/PANORAMIC: D0210, D0330

Coverage is limited to 1 of any of these procedures per 5 year(s).

OTHER XRAYS

D0220 Intraoral - periapical first radiographic image.

D0230 Intraoral - periapical each additional radiographic image.

D0240 Intraoral - occlusal radiographic image.

D0250 Extra-oral - 2D projection radiographic image created using a stationary radiation source, and detector.

D0251 Extra-oral posterior dental radiographic image.

PERIAPICAL: D0220, D0230

The maximum amount considered for x-ray radiographic images taken on one day will be equivalent to an allowance of a D0210.

BITEWINGS

D0270 Bitewing - single radiographic image.

D0272 Bitewings - two radiographic images.

D0273 Bitewings - three radiographic images.

D0274 Bitewings - four radiographic images.

D0277 Vertical bitewings - 7 to 8 radiographic images.

BITEWINGS: D0270, D0272, D0273, D0274

Coverage is limited to 1 of any of these procedures per 6 month(s).

D0277, also contribute(s) to this limitation.

The maximum amount considered for x-ray radiographic images taken on one day will be equivalent to an allowance of a D0210.

VERTICAL BITEWINGS: D0277

Coverage is limited to 1 of any of these procedures per 5 year(s).

The maximum amount considered for x-ray radiographic images taken on one day will be equivalent to an allowance of a D0210.

PRE-DIAGNOSTIC TEST

D0431 Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures.

TESTS: D0431

Coverage is limited to 1 of any of these procedures per 2 year(s).
Benefits are considered for persons from age 35 and over.

PROPHYLAXIS (CLEANING) AND FLUORIDE
- D1110 Prophylaxis - adult.
- D1120 Prophylaxis - child.
- D1206 Topical application of fluoride varnish.
- D1208 Topical application of fluoride-excluding varnish.
- D9932 Cleaning and inspection of removable complete denture, maxillary.
- D9933 Cleaning and inspection of removable complete denture, mandibular.
- D9934 Cleaning and inspection of removable partial denture, maxillary.
- D9935 Cleaning and inspection of removable partial denture, mandibular.

FLUORIDE: D1206, D1208

Coverage is limited to 1 of any of these procedures per 6 month(s).
Benefits are considered for persons age 18 and under.

PROPHYLAXIS: D1110, D1120

Coverage is limited to 4 of any of these procedures per 12 month(s).
D4346, D4910, also contribute(s) to this limitation.
An adult prophylaxis (cleaning) is considered for individuals age 14 and over. A child prophylaxis (cleaning) is considered for individuals age 13 and under. Benefits for prophylaxis (cleaning) are not available when performed on the same date as periodontal procedures.

CLEANING AND INSPECTION OF REMOVABLE DENTURE: D9932, D9933, D9934, D9935

Coverage is limited to 4 of any of these procedures per 12 month(s).
Benefits are not available when performed on the same date as prophylaxis (cleaning) or periodontal maintenance.

SEALANT
- D1351 Sealant - per tooth.
- D1352 Preventive resin restoration in a moderate to high caries risk patient-permanent.
- D1353 Sealant repair - per tooth.

SEALANT: D1351, D1352, D1353

Coverage is limited to 1 of any of these procedures per lifetime.
Benefits are considered for persons age 18 and under.
Benefits are considered on permanent molars only, excluding 3rd molars (wisdom teeth).
Coverage is allowed on the occlusal surface only.

SPACE MAINTAINERS
- D1510 Space maintainer-fixed, unilateral-per quadrant.
- D1516 Space maintainer - fixed - bilateral, maxillary.
- D1517 Space maintainer - fixed - bilateral, mandibular.
- D1520 Space maintainer-removable, unilateral-per quadrant.
- D1526 Space maintainer - removable - bilateral, maxillary.
- D1527 Space maintainer - removable - bilateral, mandibular.
- D1551 Re-cement or re-bond bilateral space maintainer-maxillary.
- D1552 Re-cement or re-bond bilateral space maintainer-mandibular.
- D1553 Re-cement or re-bond unilateral space maintainer-per quadrant.
- D1556 Removal of fixed unilateral space maintainer-per quadrant.
- D1557 Removal of fixed bilateral space maintainer-maxillary.
- D1558 Removal of fixed bilateral space maintainer-mandibular.
- D1575 Distal shoe space maintainer - fixed, unilateral-per quadrant.

SPACE MAINTAINER: D1510, D1516, D1517, D1520, D1526, D1527, D1575

Benefits are considered for persons age 13 and under.
Coverage is limited to space maintenance for unerupted teeth, following extraction of primary teeth. Allowances include all adjustments within 6 months of placement date.

OTHER PERIODONTAL SERVICES
- D4346 Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation.
- D4910 Periodontal maintenance.

PERIODONTAL MAINTENANCE: D4346, D4910

Coverage is limited to 4 of any of these procedures per 12 month(s).
D1110, D1120, also contribute(s) to this limitation.
Benefits are not available if performed on the same date as any other periodontal service.
Procedure D4910 is contingent upon evidence of full mouth active periodontal therapy.
Procedure D4346 is limited to persons age 14 and over.

APPLIANCE THERAPY

D8210 Removable appliance therapy.
D8220 Fixed appliance therapy.

APPLIANCE THERAPY: D8210, D8220

Coverage is limited to the correction of thumb-sucking.

TYPE 2 PROCEDURES

PAYMENT BASIS - NON PARTICIPATING PROVIDERS - Usual and Customary

BENEFIT PERIOD - Benefit Year

For Additional Limitations - See Limitations

LIMITED ORAL EVALUATION

D0140 Limited oral evaluation - problem focused.

D0170 Re-evaluation - limited, problem focused (established patient; not post-operative visit).

LIMITED ORAL EVALUATION: D0140, D0170

Coverage is allowed for accidental injury only. If not due to an accident, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency.

ORAL PATHOLOGY/LABORATORY

D0472 Accession of tissue, gross examination, preparation and transmission of written report.

D0473 Accession of tissue, gross and microscopic examination, preparation and transmission of written report.

D0474 Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report.

ORAL PATHOLOGY LABORATORY: D0472, D0473, D0474

Coverage is limited to 1 of any of these procedures per 12 month(s).

Coverage is limited to 1 examination per biopsy/excision.

AMALGAM RESTORATIONS (FILLINGS)

D2140 Amalgam - one surface, primary or permanent.

D2150 Amalgam - two surfaces, primary or permanent.

D2160 Amalgam - three surfaces, primary or permanent.

D2161 Amalgam - four or more surfaces, primary or permanent.

AMALGAM RESTORATIONS: D2140, D2150, D2160, D2161

Coverage is limited to 1 of any of these procedures per 6 month(s).

D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2990, D9911, also contribute(s) to this limitation.

RESIN RESTORATIONS (FILLINGS)

D2330 Resin-based composite - one surface, anterior.

D2331 Resin-based composite - two surfaces, anterior.

D2332 Resin-based composite - three surfaces, anterior.

D2335 Resin-based composite - four or more surfaces or involving incisal angle (anterior).

D2391 Resin-based composite - one surface, posterior.

D2392 Resin-based composite - two surfaces, posterior.

D2393 Resin-based composite - three surfaces, posterior.

D2394 Resin-based composite - four or more surfaces, posterior.

D2410 Gold foil - one surface.

D2420 Gold foil - two surfaces.

D2430 Gold foil - three surfaces.

D2990 Resin infiltration of incipient smooth surface lesions.

COMPOSITE RESTORATIONS: D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2990

Coverage is limited to 1 of any of these procedures per 6 month(s).

D2140, D2150, D2160, D2161, D9911, also contribute(s) to this limitation.

Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

GOLD FOIL RESTORATIONS: D2410, D2420, D2430

Gold foils are considered at an alternate benefit of an amalgam/composite restoration.

STAINLESS STEEL CROWN (PREFABRICATED CROWN)

D2390 Resin-based composite crown, anterior.

D2929 Prefabricated porcelain/ceramic crown - primary tooth.

D2930 Prefabricated stainless steel crown - primary tooth.

D2931 Prefabricated stainless steel crown - permanent tooth.

D2932 Prefabricated resin crown.

D2933 Prefabricated stainless steel crown with resin window.

D2934 Prefabricated esthetic coated stainless steel crown - primary tooth.

STAINLESS STEEL CROWN: D2390, D2929, D2930, D2931, D2932, D2933, D2934

Replacement is limited to 1 of any of these procedures per 12 month(s).

Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

RECEMENT

D2910 Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration.
D2915 Re-cement or re-bond indirectly fabricated or prefabricated post and core.
D2920 Re-cement or re-bond crown.
D2921 Reattachment of tooth fragment, incisal edge or cusp.
D6092 Re-cement or re-bond implant/abutment supported crown.
D6093 Re-cement or re-bond implant/abutment supported fixed partial denture.
D6930 Re-cement or re-bond fixed partial denture.

SEDATIVE FILLING

D2940 Protective restoration.
D2941 Interim therapeutic restoration - primary dentition.

PULP CAP

D3110 Pulp cap - direct (excluding final restoration).

ENDODONTICS MISCELLANEOUS

D3220 Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament.
D3221 Pulpal debridement, primary and permanent teeth.
D3222 Partial Pulpotomy for apexogenesis - permanent tooth with incomplete root development.
D3230 Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration).
D3240 Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration).
D3333 Internal root repair of perforation defects.
D3351 Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.).
D3352 Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.).
D3353 Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.).
D3357 Pulpal regeneration - completion of treatment.
D3430 Retrograde filling - per root.
D3450 Root amputation - per root.
D3920 Hemisection (including any root removal), not including root canal therapy.

ENDODONTICS MISCELLANEOUS: D3333, D3430, D3450, D3920

Procedure D3333 is limited to permanent teeth only.

ENDODONTIC THERAPY (ROOT CANALS)

D3310 Endodontic therapy, anterior tooth.
D3320 Endodontic therapy, premolar tooth (excluding final restorations).
D3330 Endodontic therapy, molar tooth (excluding final restorations).
D3332 Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth.
D3346 Retreatment of previous root canal therapy - anterior.
D3347 Retreatment of previous root canal therapy - premolar.
D3348 Retreatment of previous root canal therapy - molar.

ROOT CANALS: D3310, D3320, D3330, D3332

Benefits are considered on permanent teeth only.

Allowances include intraoperative radiographic images and cultures but exclude final restoration.

RETREATMENT OF ROOT CANAL: D3346, D3347, D3348

Coverage is limited to 1 of any of these procedures per 12 month(s).

D3310, D3320, D3330, also contribute(s) to this limitation.

Benefits are considered on permanent teeth only.

Coverage is limited to service dates more than 12 months after root canal therapy. Allowances include intraoperative radiographic images and cultures but exclude final restoration.

TYPE 2 PROCEDURES

SURGICAL ENDODONTICS

D3355 Pulpal regeneration - initial visit.
D3356 Pulpal regeneration - interim medication replacement.
D3410 Apicoectomy - anterior.
D3421 Apicoectomy - premolar (first root).
D3425 Apicoectomy - molar (first root).
D3426 Apicoectomy (each additional root).
D3427 Periradicular surgery without apicoectomy.

SURGICAL PERIODONTICS

D4210 Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant.
D4211 Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant.
D4240 Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant.
D4241 Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant.
D4260 Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant.
D4261 Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant.
D4263 Bone replacement graft - retained natural tooth - first site in quadrant.
D4264 Bone replacement graft - retained natural tooth - each additional site in quadrant.
D4265 Biologic materials to aid in soft and osseous tissue regeneration.
D4270 Pedicle soft tissue graft procedure.
D4273 Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft.
D4274 Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area).
D4275 Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant or edentulous tooth position in graft.
D4276 Combined connective tissue and double pedicle graft, per tooth.
D4277 Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft.
D4278 Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant or edentulous tooth position in same graft site.
D4283 Autogenous connective tissue graft procedure (including donor and recipient surgical sites) - each additional contiguous tooth, implant or edentulous tooth position in same graft site.
D4285 Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) - each additional contiguous tooth, implant or edentulous tooth position in same graft site.

BONE GRAFTS: D4263, D4264, D4265
Each quadrant is limited to 1 of each of these procedures per 3 year(s).
Coverage is limited to treatment of periodontal disease.

GINGIVECTOMY: D4210, D4211
Each quadrant is limited to 1 of each of these procedures per 3 year(s).
Coverage is limited to treatment of periodontal disease.

OSSEOUS SURGERY: D4240, D4241, D4260, D4261
Each quadrant is limited to 1 of each of these procedures per 3 year(s).
Coverage is limited to treatment of periodontal disease.

TISSUE GRAFTS: D4270, D4273, D4275, D4276, D4277, D4278, D4283, D4285
Each quadrant is limited to 2 of any of these procedures per 3 year(s).
Coverage is limited to treatment of periodontal disease.

NON-SURGICAL PERIODONTICS

D4341 Periodontal scaling and root planing - four or more teeth per quadrant.
D4342 Periodontal scaling and root planing - one to three teeth, per quadrant.

D4381 Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report.
ANTIMICROBIAL AGENTS: D4381
Each quadrant is limited to 2 of any of these procedures per 2 year(s).
PERIODONTAL SCALING & ROOT PLANING: D4341, D4342
Each quadrant is limited to 1 of each of these procedures per 2 year(s).

FULL MOUTH DEBRIDEMENT
D4355 Full mouth debridement to enable comprehensive oral evaluation and diagnosis on a subsequent visit.
FULL MOUTH DEBRIDEMENT: D4355
Coverage is limited to 1 of any of these procedures per 5 year(s).

DENTURE REPAIR
D5511 Repair broken complete denture base, mandibular.
D5512 Repair broken complete denture base, maxillary.
D5520 Replace missing or broken teeth - complete denture (each tooth).
D5611 Repair resin partial denture base, mandibular.
D5612 Repair resin partial denture base, maxillary.
D5621 Repair cast partial framework, mandibular.
D5622 Repair cast partial framework, maxillary.
D5630 Repair or replace broken retentive/clasping materials per tooth.
D5640 Replace broken teeth - per tooth.

DENTURE REBASES
D5710 Rebase complete maxillary denture.
D5711 Rebase complete mandibular denture.
D5720 Rebase maxillary partial denture.
D5721 Rebase mandibular partial denture.

DENTURE RELINES
D5730 Reline complete maxillary denture (direct).
D5731 Reline complete mandibular denture (direct).
D5740 Reline maxillary partial denture (direct).
D5741 Reline mandibular partial denture (direct).
D5750 Reline complete maxillary denture (indirect).
D5751 Reline complete mandibular denture (indirect).
D5760 Reline maxillary partial denture (indirect).
D5761 Reline mandibular partial denture (indirect).
DENTURE RELINE: D5730, D5731, D5740, D5741, D5750, D5751, D5760, D5761
Coverage is limited to service dates more than 6 months after placement date.

TISSUE CONDITIONING
D5850 Tissue conditioning, maxillary.
D5851 Tissue conditioning, mandibular.

NON-SURGICAL EXTRACTIONS
D7111 Extraction, coronal remnants - primary tooth.
D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal).

SURGICAL EXTRACTIONS
D7210 Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated.
D7220 Removal of impacted tooth - soft tissue.
D7230 Removal of impacted tooth - partially bony.
D7240 Removal of impacted tooth - completely bony.
D7241 Removal of impacted tooth - completely bony, with unusual surgical complications.
D7250 Removal of residual tooth roots (cutting procedure).
D7251 Coronectomy-intentional partial tooth removal.

TYPE 2 PROCEDURES

OTHER ORAL SURGERY

D7260 Oroantral fistula closure.
D7261 Primary closure of a sinus perforation.
D7270 Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.
D7272 Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization).
D7280 Exposure of an unerupted tooth.
D7282 Mobilization of erupted or malpositioned tooth to aid eruption.
D7283 Placement of device to facilitate eruption of impacted tooth.
D7310 Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.
D7311 Alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.
D7320 Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.
D7321 Alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.
D7340 Vestibuloplasty - ridge extension (secondary epithelialization).
D7350 Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue).
D7410 Excision of benign lesion up to 1.25 cm.
D7411 Excision of benign lesion greater than 1.25 cm.
D7412 Excision of benign lesion, complicated.
D7413 Excision of malignant lesion up to 1.25 cm.
D7414 Excision of malignant lesion greater than 1.25 cm.
D7415 Excision of malignant lesion, complicated.
D7440 Excision of malignant tumor - lesion diameter up to 1.25 cm.
D7441 Excision of malignant tumor - lesion diameter greater than 1.25 cm.
D7450 Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm.
D7451 Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm.
D7460 Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm.
D7461 Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm.
D7465 Destruction of lesion(s) by physical or chemical method, by report.
D7471 Removal of lateral exostosis (maxilla or mandible).
D7472 Removal of torus palatinus.
D7473 Removal of torus mandibularis.
D7485 Reduction of osseous tuberosity.
D7490 Radical resection of maxilla or mandible.
D7510 Incision and drainage of abscess - intraoral soft tissue.
D7520 Incision and drainage of abscess - extraoral soft tissue.
D7530 Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue.
D7540 Removal of reaction producing foreign bodies, musculoskeletal system.
D7550 Partial ostectomy/sequestrectomy for removal of non-vital bone.
D7560 Maxillary sinusotomy for removal of tooth fragment or foreign body.
D7910 Suture of recent small wounds up to 5 cm.
D7911 Complicated suture - up to 5 cm.
D7912 Complicated suture - greater than 5 cm.
D7960 Frenulectomy-also known as frenectomy or frenotomy-separate procedure not incidental to another procedure.
D7963 Frenuloplasty.
D7970 Excision of hyperplastic tissue - per arch.
D7972 Surgical reduction of fibrous tuberosity.
D7979 Non-surgical sialolithotomy.
D7980 Surgical sialolithotomy.
D7983 Closure of salivary fistula.

REMOVAL OF BONE TISSUE: D7471, D7472, D7473

Coverage is limited to 5 of any of these procedures per lifetime.

BIOPSY OF ORAL TISSUE

D7285 Incisional biopsy of oral tissue - hard (bone, tooth).
D7286 Incisional biopsy of oral tissue - soft.
D7287 Exfoliative cytological sample collection.

D7288 Brush biopsy - transepithelial sample collection.

PALLIATIVE

D9110 Palliative (emergency) treatment of dental pain - minor procedure.

PALLIATIVE TREATMENT: D9110

Not covered in conjunction with other procedures, except diagnostic x-ray radiographic images.

ANESTHESIA-GENERAL/IV

D9219 Evaluation for moderate sedation, deep sedation or general anesthesia.
D9222 Deep sedation/general anesthesia - first 15 minutes.
D9223 Deep sedation/general anesthesia - each subsequent 15 minute increment.
D9239 Intravenous moderate (conscious) sedation/analgesia - first 15 minutes.
D9243 Intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment.

GENERAL ANESTHESIA: D9222, D9223, D9239, D9243

Coverage is only available with a cutting procedure. A maximum of four (D9222, D9223, D9239 or D9243) will be considered.

PROFESSIONAL CONSULT/VISIT/SERVICES

D9310 Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician.
D9430 Office visit for observation (during regularly scheduled hours) - no other services performed.
D9440 Office visit - after regularly scheduled hours.
D9930 Treatment of complications (post-surgical) - unusual circumstances, by report.

CONSULTATION: D9310

Coverage is limited to 1 of any of these procedures per provider.

OFFICE VISIT: D9430, D9440

Procedure D9430 is allowed for accidental injury only. Procedure D9440 will be allowed on the basis of services rendered or visit, whichever is greater.

MISCELLANEOUS

D0486 Laboratory accession of transepithelial cytologic sample, microscopic examination, preparation and transmission of written report.
D2951 Pin retention - per tooth, in addition to restoration.
D9911 Application of desensitizing resin for cervical and/or root surfaces, per tooth.

DESENSITIZATION: D9911

Coverage is limited to 1 of any of these procedures per 6 month(s).

D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2990, also contribute(s) to this limitation.

Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

TYPE 3 PROCEDURES

PAYMENT BASIS - NON PARTICIPATING PROVIDERS - Usual and Customary

BENEFIT PERIOD - Benefit Year

For Additional Limitations - See Limitations

INLAY RESTORATIONS

D2510 Inlay - metallic - one surface.
D2520 Inlay - metallic - two surfaces.
D2530 Inlay - metallic - three or more surfaces.
D2610 Inlay - porcelain/ceramic - one surface.
D2620 Inlay - porcelain/ceramic - two surfaces.
D2630 Inlay - porcelain/ceramic - three or more surfaces.
D2650 Inlay - resin-based composite - one surface.
D2651 Inlay - resin-based composite - two surfaces.
D2652 Inlay - resin-based composite - three or more surfaces.

INLAY: D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652

Inlays will be considered at an alternate benefit of an amalgam/composite restoration and only when resulting from caries (tooth decay) or traumatic injury.

ONLAY RESTORATIONS

D2542 Onlay - metallic - two surfaces.
D2543 Onlay - metallic - three surfaces.
D2544 Onlay - metallic - four or more surfaces.
D2642 Onlay - porcelain/ceramic - two surfaces.
D2643 Onlay - porcelain/ceramic - three surfaces.
D2644 Onlay - porcelain/ceramic - four or more surfaces.
D2662 Onlay - resin-based composite - two surfaces.
D2663 Onlay - resin-based composite - three surfaces.
D2664 Onlay - resin-based composite - four or more surfaces.

ONLAY: D2542, D2543, D2544, D2642, D2643, D2644, D2662, D2663, D2664

Replacement is limited to 1 of any of these procedures per 5 year(s).

D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.

Frequency is waived for accidental injury.

Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.

Benefits will not be considered if procedure D2390, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

CROWNS SINGLE RESTORATIONS

D2710 Crown - resin-based composite (indirect).
D2712 Crown - 3/4 resin-based composite (indirect).
D2720 Crown - resin with high noble metal.
D2721 Crown - resin with predominantly base metal.
D2722 Crown - resin with noble metal.
D2740 Crown - porcelain/ceramic.
D2750 Crown - porcelain fused to high noble metal.
D2751 Crown - porcelain fused to predominantly base metal.
D2752 Crown - porcelain fused to noble metal.
D2753 Crown-porcelain fused to titanium and titanium alloys.
D2780 Crown - 3/4 cast high noble metal.
D2781 Crown - 3/4 cast predominantly base metal.
D2782 Crown - 3/4 cast noble metal.
D2783 Crown - 3/4 porcelain/ceramic.
D2790 Crown - full cast high noble metal.

D2791 Crown - full cast predominantly base metal.
D2792 Crown - full cast noble metal.
D2794 Crown - titanium and titanium alloys.

CROWN: D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794

Replacement is limited to 1 of any of these procedures per 5 year(s).

D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.

Frequency is waived for accidental injury.

Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.

Benefits will not be considered if procedure D2390, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

CORE BUILD-UP

D2950 Core buildup, including any pins when required.

CORE BUILDUP: D2950

A pretreatment is strongly suggested for D2950. This is reviewed by our dental consultants and benefits are allowed when diagnostic data indicates significant tooth structure loss.

POST AND CORE

D2952 Post and core in addition to crown, indirectly fabricated.
D2954 Prefabricated post and core in addition to crown.

FIXED CROWN AND PARTIAL DENTURE REPAIR

D2980 Crown repair necessitated by restorative material failure.
D2981 Inlay repair necessitated by restorative material failure.
D2982 Onlay repair necessitated by restorative material failure.
D2983 Veneer repair necessitated by restorative material failure.
D6980 Fixed partial denture repair necessitated by restorative material failure.
D9120 Fixed partial denture sectioning.

CROWN LENGTHENING

D4249 Clinical crown lengthening - hard tissue.

PROSTHODONTICS - FIXED/REMOVABLE (DENTURES)

D5110 Complete denture - maxillary.
D5120 Complete denture - mandibular.
D5130 Immediate denture - maxillary.
D5140 Immediate denture - mandibular.
D5211 Maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth).
D5212 Mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth).
D5213 Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth).
D5214 Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth).
D5221 Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth).
D5222 Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth).
D5223 Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth).

D5224 Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth).
D5225 Maxillary partial denture - flexible base (including retentive/clasping materials, rests, and teeth).
D5226 Mandibular partial denture - flexible base (including retentive/clasping materials, rests, and teeth).
D5282 Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary.
D5283 Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), mandibular.
D5284 Removable unilateral partial denture-one piece flexible base (including retentive/clasping materials, rests, and teeth) - per quadrant.
D5286 Removable unilateral partial denture-one piece resin (including retentive/clasping materials, rests, and teeth) - per quadrant.
D5670 Replace all teeth and acrylic on cast metal framework (maxillary).
D5671 Replace all teeth and acrylic on cast metal framework (mandibular).
D5810 Interim complete denture (maxillary).
D5811 Interim complete denture (mandibular).
D5820 Interim partial denture (including retentive/clasping materials, rests, and teeth), maxillary.
D5821 Interim partial denture (including retentive/clasping matierals, rests, and teeth), mandibular.
D5863 Overdenture - complete maxillary.
D5864 Overdenture - partial maxillary.
D5865 Overdenture - complete mandibular.
D5866 Overdenture - partial mandibular.
D5876 Add metal substructure to acrylic full denture (per arch).
D6110 Implant/abutment supported removable denture for edentulous arch - maxillary.
D6111 Implant/abutment supported removable denture for edentulous arch - mandibular.
D6112 Implant/abutment supported removable denture for partially edentulous arch - maxillary.
D6113 Implant/abutment supported removable denture for partially edentulous arch - mandibular.
D6114 Implant/abutment supported fixed denture for edentulous arch - maxillary.
D6115 Implant/abutment supported fixed denture for edentulous arch - mandibular.
D6116 Implant/abutment supported fixed denture for partially edentulous arch - maxillary.
D6117 Implant/abutment supported fixed denture for partially edentulous arch - mandibular.
D6118 Implant/abutment supported interim fixed denture for edentulous arch - mandibular.
D6119 Implant/abutment supported interim fixed denture for edentulous arch - maxillary.

COMPLETE DENTURE: D5110, D5120, D5130, D5140, D5863, D5865, D5876, D6110, D6111, D6114, D6115

Replacement is limited to 1 of any of these procedures per 5 year(s).
Frequency is waived for accidental injury.
Allowances include adjustments within 6 months after placement date. Procedures D5863, D5865, D6110, D6111, D6114 and D6115 are considered at an alternate benefit of a D5110/D5120. Benefits for procedure D5876 is contingent upon the related denture being covered.

PARTIAL DENTURE: D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5282, D5283, D5284, D5286, D5670, D5671, D5864, D5866, D6112, D6113, D6116, D6117

Replacement is limited to 1 of any of these procedures per 5 year(s).
D6010, D6040, D6050, also contribute(s) to this limitation.
Frequency is waived for accidental injury.
Allowances include adjustments within 6 months of placement date. Procedures D5864, D5866, D6112, D6113, D6116 and D6117 are considered at an alternate benefit of a D5213/D5214.

DENTURE ADJUSTMENTS

D5410 Adjust complete denture - maxillary.
D5411 Adjust complete denture - mandibular.
D5421 Adjust partial denture - maxillary.
D5422 Adjust partial denture - mandibular.

DENTURE ADJUSTMENT: D5410, D5411, D5421, D5422

Coverage is limited to dates of service more than 6 months after placement date.

ADD TOOTH/CLASP TO EXISTING PARTIAL

D5650 Add tooth to existing partial denture.
D5660 Add clasp to existing partial denture-per tooth.

IMPLANTS
D6010 Surgical placement of implant body: endosteal implant.
D6040 Surgical placement: eposteal implant.
D6050 Surgical placement: transosteal implant.
D6051 Interim abutment.
D6052 Semi-precision attachment abutment.
D6055 Connecting bar-implant supported or abutment supported.
D6056 Prefabricated abutment - includes placement.
D6057 Custom abutment - includes placement.
IMPLANT: D6010, D6040, D6050
Replacement is limited to 1 of any of these procedures per 5 year(s).
D5211, D5212, D5213, D5214, D5225, D5226, D5282, D5283, D5284, D5286, D6094, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.
Frequency is waived for accidental injury.
Benefits for procedures D6051, D6052, D6055, D6056 and D6057 will be contingent upon the implant being covered. Replacement for procedures D6052, D6056 and D6057 are limited to 1 of any of these procedures in 5 years.

IMPLANT SERVICES
D6080 Implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prostheses and abutments.
D6081 Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure.
D6090 Repair implant supported prosthesis, by report.
D6091 Replacement of replaceable part of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment.
D6095 Repair implant abutment, by report.
D6096 Remove broken implant retaining screw.
D6100 Implant removal, by report.
D6190 Radiographic/surgical implant index, by report.
IMPLANT SERVICES: D6080, D6081, D6090, D6091, D6095, D6096, D6100, D6190
Coverage for D6080 and D6081 is limited to 2 of any of these procedures in a 12 month period.
Coverage for D6090, D6091, D6095 and D6096 is limited to service dates more than 6 months after placement date. Coverage for D6190 is limited to 1 per arch in a 24 month period.

PROSTHODONTICS - FIXED
D6058 Abutment supported porcelain/ceramic crown.
D6059 Abutment supported porcelain fused to metal crown (high noble metal).
D6060 Abutment supported porcelain fused to metal crown (predominantly base metal).
D6061 Abutment supported porcelain fused to metal crown (noble metal).
D6062 Abutment supported cast metal crown (high noble metal).
D6063 Abutment supported cast metal crown (predominantly base metal).
D6064 Abutment supported cast metal crown (noble metal).
D6065 Implant supported porcelain/ceramic crown.
D6066 Implant supported crown - porcelain fused to high noble alloys.
D6067 Implant supported crown - high noble alloys.
D6068 Abutment supported retainer for porcelain/ceramic FPD.
D6069 Abutment supported retainer for porcelain fused to metal FPD (high noble metal).
D6070 Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal).
D6071 Abutment supported retainer for porcelain fused to metal FPD (noble metal).
D6072 Abutment supported retainer for cast metal FPD (high noble metal).
D6073 Abutment supported retainer for cast metal FPD (predominantly base metal).
D6074 Abutment supported retainer for cast metal FPD (noble metal).
D6075 Implant supported retainer for ceramic FPD.
D6076 Implant supported retainer for FPD - porcelain fused to high noble alloys.
D6077 Implant supported retainer for metal FPD - high noble alloy.

TYPE 3 PROCEDURES

D6082 Implant supported crown-porcelain fused to predominantly base alloys.
D6083 Implant supported crown-porcelain fused to noble alloys.
D6084 Implant supported crown-porcelain fused to titanium and titanium alloys.
D6086 Implant supported crown-predominantly base alloys.
D6087 Implant supported crown-noble alloys.
D6088 Implant supported crown-titanium and titanium alloys.
D6094 Abutment supported crown - titanium and titanium alloys.
D6097 Abutment supported crown-porcelain fused to titanium and titanium alloys.
D6098 Implant supported retainer-porcelain fused to predominantly base alloys.
D6099 Implant supported retainer for FPD-porcelain fused to noble alloys.
D6120 Implant supported retainer-porcelain fused to titanium and titanium alloys.
D6121 Implant supported retainer for metal FPD-predominantly base alloys.
D6122 Implant supported retainer for metal FPD-noble alloys.
D6123 Implant supported retainer for metal FPD-titanium and titanium alloys.
D6194 Abutment supported retainer crown for FPD - titanium and titanium alloys.
D6195 Abutment supported retainer-porcelain fused to titanium and titanium alloys.
D6205 Pontic - indirect resin based composite.
D6210 Pontic - cast high noble metal.
D6211 Pontic - cast predominantly base metal.
D6212 Pontic - cast noble metal.
D6214 Pontic - titanium and titanium alloys.
D6240 Pontic - porcelain fused to high noble metal.
D6241 Pontic - porcelain fused to predominantly base metal.
D6242 Pontic - porcelain fused to noble metal.
D6243 Pontic-porcelain fused to titanium and titanium alloys.
D6245 Pontic - porcelain/ceramic.
D6250 Pontic - resin with high noble metal.
D6251 Pontic - resin with predominantly base metal.
D6252 Pontic - resin with noble metal.
D6545 Retainer - cast metal for resin bonded fixed prosthesis.
D6548 Retainer - porcelain/ceramic for resin bonded fixed prosthesis.
D6549 Resin retainer - for resin bonded fixed prosthesis.
D6600 Retainer inlay - porcelain/ceramic, two surfaces.
D6601 Retainer inlay - porcelain/ceramic, three or more surfaces.
D6602 Retainer inlay - cast high noble metal, two surfaces.
D6603 Retainer inlay - cast high noble metal, three or more surfaces.
D6604 Retainer inlay - cast predominantly base metal, two surfaces.
D6605 Retainer inlay - cast predominantly base metal, three or more surfaces.
D6606 Retainer inlay - cast noble metal, two surfaces.
D6607 Retainer inlay - cast noble metal, three or more surfaces.
D6608 Retainer onlay - porcelain/ceramic, two surfaces.
D6609 Retainer onlay - porcelain/ceramic, three or more surfaces.
D6610 Retainer onlay - cast high noble metal, two surfaces.
D6611 Retainer onlay - cast high noble metal, three or more surfaces.
D6612 Retainer onlay - cast predominantly base metal, two surfaces.
D6613 Retainer onlay - cast predominantly base metal, three or more surfaces.
D6614 Retainer onlay - cast noble metal, two surfaces.
D6615 Retainer onlay - cast noble metal, three or more surfaces.
D6624 Retainer inlay - titanium.
D6634 Retainer onlay - titanium.
D6710 Retainer crown - indirect resin based composite.
D6720 Retainer crown - resin with high noble metal.
D6721 Retainer crown - resin with predominantly base metal.
D6722 Retainer crown - resin with noble metal.
D6740 Retainer crown - porcelain/ceramic.
D6750 Retainer crown - porcelain fused to high noble metal.
D6751 Retainer crown - porcelain fused to predominantly base metal.
D6752 Retainer crown - porcelain fused to noble metal.
D6753 Retainer crown-porcelain fused to titanium and titanium alloys.
D6780 Retainer crown - 3/4 cast high noble metal.
D6781 Retainer crown - 3/4 cast predominantly base metal.

D6782 Retainer crown - 3/4 cast noble metal.
D6783 Retainer crown - 3/4 porcelain/ceramic.
D6784 Retainer crown 3/4-titanium and titanium alloys.
D6790 Retainer crown - full cast high noble metal.
D6791 Retainer crown - full cast predominantly base metal.
D6792 Retainer crown - full cast noble metal.
D6794 Retainer crown - titanium and titanium alloys.
D6940 Stress breaker.

FIXED PARTIAL CROWN: D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794

Replacement is limited to 1 of any of these procedures per 5 year(s).

D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, also contribute(s) to this limitation.

Frequency is waived for accidental injury.

Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

Benefits will not be considered if procedure D2390, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL INLAY: D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624

Replacement is limited to 1 of any of these procedures per 5 year(s).

D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.

Frequency is waived for accidental injury.

Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

Benefits will not be considered if procedure D2390, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL ONLAY: D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634

Replacement is limited to 1 of any of these procedures per 5 year(s).

D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.

Frequency is waived for accidental injury.

Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

Benefits will not be considered if procedure D2390, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL PONTIC: D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252

Replacement is limited to 1 of any of these procedures per 5 year(s).

D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5282, D5283, D5284, D5286, D6010, D6040, D6050, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6082, D6083, D6084, D6086, D6087, D6088, D6094, D6097, D6098, D6099, D6120, D6121, D6122, D6123, D6194, D6195, also contribute(s) to this limitation.

Frequency is waived for accidental injury.
Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

IMPLANT SUPPORTED CROWN: D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6082, D6083, D6084, D6086, D6087, D6088, D6094, D6097

Replacement is limited to 1 of any of these procedures per 5 year(s).
D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5282, D5283, D5284, D5286, D6194, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.
Frequency is waived for accidental injury.
Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

IMPLANT SUPPORTED RETAINER: D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6098, D6099, D6120, D6121, D6122, D6123, D6194, D6195

Replacement is limited to 1 of any of these procedures per 5 year(s).
D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5282, D5283, D5284, D5286, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6082, D6083, D6084, D6086, D6087, D6088, D6094, D6097, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.
Frequency is waived for accidental injury.
Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

BONE AUGMENTATION

D6104 Bone graft at time of implant placement.
D7950 Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla - autogenous or nonautogenous, by report.
D7951 Sinus augmentation with bone or bone substitutes via a lateral open approach.
D7952 Sinus augmentation via a vertical approach.
D7953 Bone replacement graft for ridge preservation - per site.

BONE AUGMENTATION: D6104, D7950, D7951, D7952, D7953

Each quadrant is limited to 1 of any of these procedures per 5 year(s).
Coverage of D6104, D7950, D7951, D7952 and D7953 is limited to the treatment and placement of endosteal implant D6010, D6040 eposteal implant or D6050 transosteal implant.

OCCLUSAL GUARD

D9944 Occlusal guard - hard appliance, full arch.
D9945 Occlusal guard - soft appliance, full arch.
D9946 Occlusal guard - hard appliance, partial arch.

OCCLUSAL GUARD: D9944, D9945, D9946

Coverage is limited to 1 of any of these procedures per 3 year(s).
Benefits will not be available if performed for athletic purposes.

OCCLUSAL ADJUSTMENT

D9951 Occlusal adjustment - limited.
D9952 Occlusal adjustment - complete.

OCCLUSAL ADJUSTMENT: D9951, D9952

Coverage is considered only when performed in conjunction with periodontal procedures for the treatment of periodontal disease.

TYPE 4 PROCEDURES

PAYMENT BASIS - NON PARTICIPATING PROVIDERS - Usual and Customary

BENEFIT PERIOD - Benefit Year

For Additional Limitations - See Limitations

NON-SURGICAL MISCELLANEOUS

D0160	Detailed and extensive oral evaluation - problem focused, by report.
D0320	Temporomandibular joint arthrogram, including injection.
D0321	Other temporomandibular joint radiographic images, by report.
D0322	Tomographic survey.
D0340	2D Cephalometric radiographic image - acquisition, measurement and analysis.
D0368	Cone beam CT capture and interpretation for TMJ series including two or more exposures.
D0369	Maxillofacial MRI capture and interpretation.
D0384	Cone beam CT image capture for TMJ series including two or more exposures.
D0385	Maxillofacial MRI image capture.
D0391	Interpretation of diagnostic image by a practitioner not associated with capture of the image, including report.
D0470	Diagnostic casts.
D7880	Occlusal orthotic device, by report.
D7881	Occlusal orthotic device adjustment.
D9130	Temporomandibular joint dysfunction - non-invasive physical therapies.

TYPE 1 PROCEDURES

PAYMENT BASIS - PARTICIPATING PROVIDERS - Maximum Allowable Charge

BENEFIT PERIOD - Benefit Year

For Additional Limitations - See Limitations

ROUTINE ORAL EVALUATION

D0120 Periodic oral evaluation - established patient.
D0145 Oral evaluation for a patient under three years of age and counseling with primary caregiver.
D0150 Comprehensive oral evaluation - new or established patient.
D0180 Comprehensive periodontal evaluation - new or established patient.

COMPREHENSIVE EVALUATION: D0150, D0180

Coverage is limited to 1 of each of these procedures per provider.
In addition, D0150, D0180 coverage is limited to 2 of any of these procedures per 12 month(s).
D0120, D0145, also contribute(s) to this limitation.
If frequency met, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency.

ROUTINE EVALUATION: D0120, D0145

Coverage is limited to 2 of any of these procedures per 12 month(s).
D0150, D0180, also contribute(s) to this limitation.
Procedure D0120 will be considered for individuals age 3 and over. Procedure D0145 will be considered for individuals age 2 and under.

COMPLETE SERIES OR PANORAMIC

D0210 Intraoral - complete series of radiographic images.
D0330 Panoramic radiographic image.

COMPLETE SERIES/PANORAMIC: D0210, D0330

Coverage is limited to 1 of any of these procedures per 5 year(s).

OTHER XRAYS

D0220 Intraoral - periapical first radiographic image.
D0230 Intraoral - periapical each additional radiographic image.
D0240 Intraoral - occlusal radiographic image.
D0250 Extra-oral - 2D projection radiographic image created using a stationary radiation source, and detector.
D0251 Extra-oral posterior dental radiographic image.

PERIAPICAL: D0220, D0230

The maximum amount considered for x-ray radiographic images taken on one day will be equivalent to an allowance of a D0210.

BITEWINGS

D0270 Bitewing - single radiographic image.
D0272 Bitewings - two radiographic images.
D0273 Bitewings - three radiographic images.
D0274 Bitewings - four radiographic images.
D0277 Vertical bitewings - 7 to 8 radiographic images.

BITEWINGS: D0270, D0272, D0273, D0274

Coverage is limited to 1 of any of these procedures per 6 month(s).
D0277, also contribute(s) to this limitation.
The maximum amount considered for x-ray radiographic images taken on one day will be equivalent to an allowance of a D0210.

VERTICAL BITEWINGS: D0277

Coverage is limited to 1 of any of these procedures per 5 year(s).
The maximum amount considered for x-ray radiographic images taken on one day will be equivalent to an allowance of a D0210.

PRE-DIAGNOSTIC TEST

D0431 Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures.

TESTS: D0431

Coverage is limited to 1 of any of these procedures per 2 year(s).
Benefits are considered for persons from age 35 and over.

PROPHYLAXIS (CLEANING) AND FLUORIDE
- D1110 Prophylaxis - adult.
- D1120 Prophylaxis - child.
- D1206 Topical application of fluoride varnish.
- D1208 Topical application of fluoride-excluding varnish.
- D9932 Cleaning and inspection of removable complete denture, maxillary.
- D9933 Cleaning and inspection of removable complete denture, mandibular.
- D9934 Cleaning and inspection of removable partial denture, maxillary.
- D9935 Cleaning and inspection of removable partial denture, mandibular.

FLUORIDE: D1206, D1208

Coverage is limited to 1 of any of these procedures per 6 month(s).
Benefits are considered for persons age 18 and under.

PROPHYLAXIS: D1110, D1120

Coverage is limited to 4 of any of these procedures per 12 month(s).
D4346, D4910, also contribute(s) to this limitation.
An adult prophylaxis (cleaning) is considered for individuals age 14 and over. A child prophylaxis (cleaning) is considered for individuals age 13 and under. Benefits for prophylaxis (cleaning) are not available when performed on the same date as periodontal procedures.

CLEANING AND INSPECTION OF REMOVABLE DENTURE: D9932, D9933, D9934, D9935

Coverage is limited to 4 of any of these procedures per 12 month(s).
Benefits are not available when performed on the same date as prophylaxis (cleaning) or periodontal maintenance.

SEALANT
- D1351 Sealant - per tooth.
- D1352 Preventive resin restoration in a moderate to high caries risk patient-permanent.
- D1353 Sealant repair - per tooth.

SEALANT: D1351, D1352, D1353

Coverage is limited to 1 of any of these procedures per lifetime.
Benefits are considered for persons age 18 and under.
Benefits are considered on permanent molars only, excluding 3rd molars (wisdom teeth).
Coverage is allowed on the occlusal surface only.

SPACE MAINTAINERS
- D1510 Space maintainer-fixed, unilateral-per quadrant.
- D1516 Space maintainer - fixed - bilateral, maxillary.
- D1517 Space maintainer - fixed - bilateral, mandibular.
- D1520 Space maintainer-removable, unilateral-per quadrant.
- D1526 Space maintainer - removable - bilateral, maxillary.
- D1527 Space maintainer - removable - bilateral, mandibular.
- D1551 Re-cement or re-bond bilateral space maintainer-maxillary.
- D1552 Re-cement or re-bond bilateral space maintainer-mandibular.
- D1553 Re-cement or re-bond unilateral space maintainer-per quadrant.
- D1556 Removal of fixed unilateral space maintainer-per quadrant.
- D1557 Removal of fixed bilateral space maintainer-maxillary.
- D1558 Removal of fixed bilateral space maintainer-mandibular.
- D1575 Distal shoe space maintainer - fixed, unilateral-per quadrant.

SPACE MAINTAINER: D1510, D1516, D1517, D1520, D1526, D1527, D1575

Benefits are considered for persons age 13 and under.
Coverage is limited to space maintenance for unerupted teeth, following extraction of primary teeth. Allowances include all adjustments within 6 months of placement date.

OTHER PERIODONTAL SERVICES
- D4346 Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation.
- D4910 Periodontal maintenance.

PERIODONTAL MAINTENANCE: D4346, D4910

Coverage is limited to 4 of any of these procedures per 12 month(s).
D1110, D1120, also contribute(s) to this limitation.
Benefits are not available if performed on the same date as any other periodontal service.
Procedure D4910 is contingent upon evidence of full mouth active periodontal therapy.
Procedure D4346 is limited to persons age 14 and over.

APPLIANCE THERAPY

D8210 Removable appliance therapy.
D8220 Fixed appliance therapy.

APPLIANCE THERAPY: D8210, D8220

Coverage is limited to the correction of thumb-sucking.

TYPE 2 PROCEDURES

PAYMENT BASIS - PARTICIPATING PROVIDERS - Maximum Allowable Charge

BENEFIT PERIOD - Benefit Year

For Additional Limitations - See Limitations

LIMITED ORAL EVALUATION

D0140 Limited oral evaluation - problem focused.

D0170 Re-evaluation - limited, problem focused (established patient; not post-operative visit).

LIMITED ORAL EVALUATION: D0140, D0170

Coverage is allowed for accidental injury only. If not due to an accident, will be considered at an alternate benefit of a D0120/D0145 and count towards this frequency.

ORAL PATHOLOGY/LABORATORY

D0472 Accession of tissue, gross examination, preparation and transmission of written report.

D0473 Accession of tissue, gross and microscopic examination, preparation and transmission of written report.

D0474 Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report.

ORAL PATHOLOGY LABORATORY: D0472, D0473, D0474

Coverage is limited to 1 of any of these procedures per 12 month(s).

Coverage is limited to 1 examination per biopsy/excision.

AMALGAM RESTORATIONS (FILLINGS)

D2140 Amalgam - one surface, primary or permanent.

D2150 Amalgam - two surfaces, primary or permanent.

D2160 Amalgam - three surfaces, primary or permanent.

D2161 Amalgam - four or more surfaces, primary or permanent.

AMALGAM RESTORATIONS: D2140, D2150, D2160, D2161

Coverage is limited to 1 of any of these procedures per 6 month(s).

D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2990, D9911, also contribute(s) to this limitation.

RESIN RESTORATIONS (FILLINGS)

D2330 Resin-based composite - one surface, anterior.

D2331 Resin-based composite - two surfaces, anterior.

D2332 Resin-based composite - three surfaces, anterior.

D2335 Resin-based composite - four or more surfaces or involving incisal angle (anterior).

D2391 Resin-based composite - one surface, posterior.

D2392 Resin-based composite - two surfaces, posterior.

D2393 Resin-based composite - three surfaces, posterior.

D2394 Resin-based composite - four or more surfaces, posterior.

D2410 Gold foil - one surface.

D2420 Gold foil - two surfaces.

D2430 Gold foil - three surfaces.

D2990 Resin infiltration of incipient smooth surface lesions.

COMPOSITE RESTORATIONS: D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2990

Coverage is limited to 1 of any of these procedures per 6 month(s).

D2140, D2150, D2160, D2161, D9911, also contribute(s) to this limitation.

Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

GOLD FOIL RESTORATIONS: D2410, D2420, D2430

Gold foils are considered at an alternate benefit of an amalgam/composite restoration.

STAINLESS STEEL CROWN (PREFABRICATED CROWN)

D2390 Resin-based composite crown, anterior.

D2929 Prefabricated porcelain/ceramic crown - primary tooth.

D2930 Prefabricated stainless steel crown - primary tooth.

D2931 Prefabricated stainless steel crown - permanent tooth.

D2932 Prefabricated resin crown.

D2933 Prefabricated stainless steel crown with resin window.

D2934 Prefabricated esthetic coated stainless steel crown - primary tooth.

STAINLESS STEEL CROWN: D2390, D2929, D2930, D2931, D2932, D2933, D2934

Replacement is limited to 1 of any of these procedures per 12 month(s).

Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

RECEMENT

D2910 Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration.
D2915 Re-cement or re-bond indirectly fabricated or prefabricated post and core.
D2920 Re-cement or re-bond crown.
D2921 Reattachment of tooth fragment, incisal edge or cusp.
D6092 Re-cement or re-bond implant/abutment supported crown.
D6093 Re-cement or re-bond implant/abutment supported fixed partial denture.
D6930 Re-cement or re-bond fixed partial denture.

SEDATIVE FILLING

D2940 Protective restoration.
D2941 Interim therapeutic restoration - primary dentition.

PULP CAP

D3110 Pulp cap - direct (excluding final restoration).

ENDODONTICS MISCELLANEOUS

D3220 Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament.
D3221 Pulpal debridement, primary and permanent teeth.
D3222 Partial Pulpotomy for apexogenesis - permanent tooth with incomplete root development.
D3230 Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration).
D3240 Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration).
D3333 Internal root repair of perforation defects.
D3351 Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.).
D3352 Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.).
D3353 Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.).
D3357 Pulpal regeneration - completion of treatment.
D3430 Retrograde filling - per root.
D3450 Root amputation - per root.
D3920 Hemisection (including any root removal), not including root canal therapy.

ENDODONTICS MISCELLANEOUS: D3333, D3430, D3450, D3920

Procedure D3333 is limited to permanent teeth only.

ENDODONTIC THERAPY (ROOT CANALS)

D3310 Endodontic therapy, anterior tooth.
D3320 Endodontic therapy, premolar tooth (excluding final restorations).
D3330 Endodontic therapy, molar tooth (excluding final restorations).
D3332 Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth.
D3346 Retreatment of previous root canal therapy - anterior.
D3347 Retreatment of previous root canal therapy - premolar.
D3348 Retreatment of previous root canal therapy - molar.

ROOT CANALS: D3310, D3320, D3330, D3332

Benefits are considered on permanent teeth only.

Allowances include intraoperative radiographic images and cultures but exclude final restoration.

RETREATMENT OF ROOT CANAL: D3346, D3347, D3348

Coverage is limited to 1 of any of these procedures per 12 month(s).

D3310, D3320, D3330, also contribute(s) to this limitation.

Benefits are considered on permanent teeth only.

Coverage is limited to service dates more than 12 months after root canal therapy. Allowances include intraoperative radiographic images and cultures but exclude final restoration.

TYPE 2 PROCEDURES

SURGICAL ENDODONTICS

D3355 Pulpal regeneration - initial visit.
D3356 Pulpal regeneration - interim medication replacement.
D3410 Apicoectomy - anterior.
D3421 Apicoectomy - premolar (first root).
D3425 Apicoectomy - molar (first root).
D3426 Apicoectomy (each additional root).
D3427 Periradicular surgery without apicoectomy.

SURGICAL PERIODONTICS

D4210 Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant.
D4211 Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant.
D4240 Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant.
D4241 Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant.
D4260 Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant.
D4261 Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant.
D4263 Bone replacement graft - retained natural tooth - first site in quadrant.
D4264 Bone replacement graft - retained natural tooth - each additional site in quadrant.
D4265 Biologic materials to aid in soft and osseous tissue regeneration.
D4270 Pedicle soft tissue graft procedure.
D4273 Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft.
D4274 Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area).
D4275 Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant or edentulous tooth position in graft.
D4276 Combined connective tissue and double pedicle graft, per tooth.
D4277 Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft.
D4278 Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant or edentulous tooth position in same graft site.
D4283 Autogenous connective tissue graft procedure (including donor and recipient surgical sites) - each additional contiguous tooth, implant or edentulous tooth position in same graft site.
D4285 Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) - each additional contiguous tooth, implant or edentulous tooth position in same graft site.

BONE GRAFTS: D4263, D4264, D4265
Each quadrant is limited to 1 of each of these procedures per 3 year(s).
Coverage is limited to treatment of periodontal disease.

GINGIVECTOMY: D4210, D4211
Each quadrant is limited to 1 of each of these procedures per 3 year(s).
Coverage is limited to treatment of periodontal disease.

OSSEOUS SURGERY: D4240, D4241, D4260, D4261
Each quadrant is limited to 1 of each of these procedures per 3 year(s).
Coverage is limited to treatment of periodontal disease.

TISSUE GRAFTS: D4270, D4273, D4275, D4276, D4277, D4278, D4283, D4285
Each quadrant is limited to 2 of any of these procedures per 3 year(s).
Coverage is limited to treatment of periodontal disease.

NON-SURGICAL PERIODONTICS

D4341 Periodontal scaling and root planing - four or more teeth per quadrant.
D4342 Periodontal scaling and root planing - one to three teeth, per quadrant.

D4381 Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report.

ANTIMICROBIAL AGENTS: D4381

Each quadrant is limited to 2 of any of these procedures per 2 year(s).

PERIODONTAL SCALING & ROOT PLANING: D4341, D4342

Each quadrant is limited to 1 of each of these procedures per 2 year(s).

FULL MOUTH DEBRIDEMENT

D4355 Full mouth debridement to enable comprehensive oral evaluation and diagnosis on a subsequent visit.

FULL MOUTH DEBRIDEMENT: D4355

Coverage is limited to 1 of any of these procedures per 5 year(s).

DENTURE REPAIR

D5511 Repair broken complete denture base, mandibular.
D5512 Repair broken complete denture base, maxillary.
D5520 Replace missing or broken teeth - complete denture (each tooth).
D5611 Repair resin partial denture base, mandibular.
D5612 Repair resin partial denture base, maxillary.
D5621 Repair cast partial framework, mandibular.
D5622 Repair cast partial framework, maxillary.
D5630 Repair or replace broken retentive/clasping materials per tooth.
D5640 Replace broken teeth - per tooth.

DENTURE REBASES

D5710 Rebase complete maxillary denture.
D5711 Rebase complete mandibular denture.
D5720 Rebase maxillary partial denture.
D5721 Rebase mandibular partial denture.

DENTURE RELINES

D5730 Reline complete maxillary denture (direct).
D5731 Reline complete mandibular denture (direct).
D5740 Reline maxillary partial denture (direct).
D5741 Reline mandibular partial denture (direct).
D5750 Reline complete maxillary denture (indirect).
D5751 Reline complete mandibular denture (indirect).
D5760 Reline maxillary partial denture (indirect).
D5761 Reline mandibular partial denture (indirect).

DENTURE RELINE: D5730, D5731, D5740, D5741, D5750, D5751, D5760, D5761

Coverage is limited to service dates more than 6 months after placement date.

TISSUE CONDITIONING

D5850 Tissue conditioning, maxillary.
D5851 Tissue conditioning, mandibular.

NON-SURGICAL EXTRACTIONS

D7111 Extraction, coronal remnants - primary tooth.
D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal).

SURGICAL EXTRACTIONS

D7210 Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated.
D7220 Removal of impacted tooth - soft tissue.
D7230 Removal of impacted tooth - partially bony.
D7240 Removal of impacted tooth - completely bony.
D7241 Removal of impacted tooth - completely bony, with unusual surgical complications.
D7250 Removal of residual tooth roots (cutting procedure).
D7251 Coronectomy-intentional partial tooth removal.

TYPE 2 PROCEDURES

OTHER ORAL SURGERY

D7260 Oroantral fistula closure.
D7261 Primary closure of a sinus perforation.
D7270 Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth.
D7272 Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization).
D7280 Exposure of an unerupted tooth.
D7282 Mobilization of erupted or malpositioned tooth to aid eruption.
D7283 Placement of device to facilitate eruption of impacted tooth.
D7310 Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.
D7311 Alveoplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.
D7320 Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant.
D7321 Alveoplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant.
D7340 Vestibuloplasty - ridge extension (secondary epithelialization).
D7350 Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue).
D7410 Excision of benign lesion up to 1.25 cm.
D7411 Excision of benign lesion greater than 1.25 cm.
D7412 Excision of benign lesion, complicated.
D7413 Excision of malignant lesion up to 1.25 cm.
D7414 Excision of malignant lesion greater than 1.25 cm.
D7415 Excision of malignant lesion, complicated.
D7440 Excision of malignant tumor - lesion diameter up to 1.25 cm.
D7441 Excision of malignant tumor - lesion diameter greater than 1.25 cm.
D7450 Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm.
D7451 Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm.
D7460 Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm.
D7461 Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm.
D7465 Destruction of lesion(s) by physical or chemical method, by report.
D7471 Removal of lateral exostosis (maxilla or mandible).
D7472 Removal of torus palatinus.
D7473 Removal of torus mandibularis.
D7485 Reduction of osseous tuberosity.
D7490 Radical resection of maxilla or mandible.
D7510 Incision and drainage of abscess - intraoral soft tissue.
D7520 Incision and drainage of abscess - extraoral soft tissue.
D7530 Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue.
D7540 Removal of reaction producing foreign bodies, musculoskeletal system.
D7550 Partial ostectomy/sequestrectomy for removal of non-vital bone.
D7560 Maxillary sinusotomy for removal of tooth fragment or foreign body.
D7910 Suture of recent small wounds up to 5 cm.
D7911 Complicated suture - up to 5 cm.
D7912 Complicated suture - greater than 5 cm.
D7960 Frenulectomy-also known as frenectomy or frenotomy-separate procedure not incidental to another procedure.
D7963 Frenuloplasty.
D7970 Excision of hyperplastic tissue - per arch.
D7972 Surgical reduction of fibrous tuberosity.
D7979 Non-surgical sialolithotomy.
D7980 Surgical sialolithotomy.
D7983 Closure of salivary fistula.

REMOVAL OF BONE TISSUE: D7471, D7472, D7473

Coverage is limited to 5 of any of these procedures per lifetime.

BIOPSY OF ORAL TISSUE

D7285 Incisional biopsy of oral tissue - hard (bone, tooth).
D7286 Incisional biopsy of oral tissue - soft.
D7287 Exfoliative cytological sample collection.

D7288 Brush biopsy - transepithelial sample collection.

PALLIATIVE

D9110 Palliative (emergency) treatment of dental pain - minor procedure.

PALLIATIVE TREATMENT: D9110

Not covered in conjunction with other procedures, except diagnostic x-ray radiographic images.

ANESTHESIA-GENERAL/IV

D9219 Evaluation for moderate sedation, deep sedation or general anesthesia.
D9222 Deep sedation/general anesthesia - first 15 minutes.
D9223 Deep sedation/general anesthesia - each subsequent 15 minute increment.
D9239 Intravenous moderate (conscious) sedation/analgesia - first 15 minutes.
D9243 Intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment.

GENERAL ANESTHESIA: D9222, D9223, D9239, D9243

Coverage is only available with a cutting procedure. A maximum of four (D9222, D9223, D9239 or D9243) will be considered.

PROFESSIONAL CONSULT/VISIT/SERVICES

D9310 Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician.
D9430 Office visit for observation (during regularly scheduled hours) - no other services performed.
D9440 Office visit - after regularly scheduled hours.
D9930 Treatment of complications (post-surgical) - unusual circumstances, by report.

CONSULTATION: D9310

Coverage is limited to 1 of any of these procedures per provider.

OFFICE VISIT: D9430, D9440

Procedure D9430 is allowed for accidental injury only. Procedure D9440 will be allowed on the basis of services rendered or visit, whichever is greater.

MISCELLANEOUS

D0486 Laboratory accession of transepithelial cytologic sample, microscopic examination, preparation and transmission of written report.
D2951 Pin retention - per tooth, in addition to restoration.
D9911 Application of desensitizing resin for cervical and/or root surfaces, per tooth.

DESENSITIZATION: D9911

Coverage is limited to 1 of any of these procedures per 6 month(s).

D2140, D2150, D2160, D2161, D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394, D2990, also contribute(s) to this limitation.

Coverage is limited to necessary placement resulting from decay or replacement due to existing unserviceable restorations.

TYPE 3 PROCEDURES

PAYMENT BASIS - PARTICIPATING PROVIDERS - Maximum Allowable Charge

BENEFIT PERIOD - Benefit Year

For Additional Limitations - See Limitations

INLAY RESTORATIONS

D2510 Inlay - metallic - one surface.
D2520 Inlay - metallic - two surfaces.
D2530 Inlay - metallic - three or more surfaces.
D2610 Inlay - porcelain/ceramic - one surface.
D2620 Inlay - porcelain/ceramic - two surfaces.
D2630 Inlay - porcelain/ceramic - three or more surfaces.
D2650 Inlay - resin-based composite - one surface.
D2651 Inlay - resin-based composite - two surfaces.
D2652 Inlay - resin-based composite - three or more surfaces.

INLAY: D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652

Inlays will be considered at an alternate benefit of an amalgam/composite restoration and only when resulting from caries (tooth decay) or traumatic injury.

ONLAY RESTORATIONS

D2542 Onlay - metallic - two surfaces.
D2543 Onlay - metallic - three surfaces.
D2544 Onlay - metallic - four or more surfaces.
D2642 Onlay - porcelain/ceramic - two surfaces.
D2643 Onlay - porcelain/ceramic - three surfaces.
D2644 Onlay - porcelain/ceramic - four or more surfaces.
D2662 Onlay - resin-based composite - two surfaces.
D2663 Onlay - resin-based composite - three surfaces.
D2664 Onlay - resin-based composite - four or more surfaces.

ONLAY: D2542, D2543, D2544, D2642, D2643, D2644, D2662, D2663, D2664

Replacement is limited to 1 of any of these procedures per 5 year(s).

D2510, D2520, D2530, D2610, D2620, D2630, D2650, D2651, D2652, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.

Frequency is waived for accidental injury.

Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.

Benefits will not be considered if procedure D2390, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

CROWNS SINGLE RESTORATIONS

D2710 Crown - resin-based composite (indirect).
D2712 Crown - 3/4 resin-based composite (indirect).
D2720 Crown - resin with high noble metal.
D2721 Crown - resin with predominantly base metal.
D2722 Crown - resin with noble metal.
D2740 Crown - porcelain/ceramic.
D2750 Crown - porcelain fused to high noble metal.
D2751 Crown - porcelain fused to predominantly base metal.
D2752 Crown - porcelain fused to noble metal.
D2753 Crown-porcelain fused to titanium and titanium alloys.
D2780 Crown - 3/4 cast high noble metal.
D2781 Crown - 3/4 cast predominantly base metal.
D2782 Crown - 3/4 cast noble metal.
D2783 Crown - 3/4 porcelain/ceramic.
D2790 Crown - full cast high noble metal.

D2791 Crown - full cast predominantly base metal.
D2792 Crown - full cast noble metal.
D2794 Crown - titanium and titanium alloys.

CROWN: D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794

Replacement is limited to 1 of any of these procedures per 5 year(s).

D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.

Frequency is waived for accidental injury.

Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

Coverage is limited to necessary placement resulting from caries (tooth decay) or traumatic injury.

Benefits will not be considered if procedure D2390, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

CORE BUILD-UP

D2950 Core buildup, including any pins when required.

CORE BUILDUP: D2950

A pretreatment is strongly suggested for D2950. This is reviewed by our dental consultants and benefits are allowed when diagnostic data indicates significant tooth structure loss.

POST AND CORE

D2952 Post and core in addition to crown, indirectly fabricated.
D2954 Prefabricated post and core in addition to crown.

FIXED CROWN AND PARTIAL DENTURE REPAIR

D2980 Crown repair necessitated by restorative material failure.
D2981 Inlay repair necessitated by restorative material failure.
D2982 Onlay repair necessitated by restorative material failure.
D2983 Veneer repair necessitated by restorative material failure.
D6980 Fixed partial denture repair necessitated by restorative material failure.
D9120 Fixed partial denture sectioning.

CROWN LENGTHENING

D4249 Clinical crown lengthening - hard tissue.

PROSTHODONTICS - FIXED/REMOVABLE (DENTURES)

D5110 Complete denture - maxillary.
D5120 Complete denture - mandibular.
D5130 Immediate denture - maxillary.
D5140 Immediate denture - mandibular.
D5211 Maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth).
D5212 Mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth).
D5213 Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth).
D5214 Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth).
D5221 Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth).
D5222 Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth).
D5223 Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth).

D5224 Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth).
D5225 Maxillary partial denture - flexible base (including retentive/clasping materials, rests, and teeth).
D5226 Mandibular partial denture - flexible base (including retentive/clasping materials, rests, and teeth).
D5282 Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary.
D5283 Removable unilateral partial denture - one piece cast metal (including retentive/clasping materials, rests, and teeth), mandibular.
D5284 Removable unilateral partial denture-one piece flexible base (including retentive/clasping materials, rests, and teeth) - per quadrant.
D5286 Removable unilateral partial denture-one piece resin (including retentive/clasping materials, rests, and teeth) - per quadrant.
D5670 Replace all teeth and acrylic on cast metal framework (maxillary).
D5671 Replace all teeth and acrylic on cast metal framework (mandibular).
D5810 Interim complete denture (maxillary).
D5811 Interim complete denture (mandibular).
D5820 Interim partial denture (including retentive/clasping materials, rests, and teeth), maxillary.
D5821 Interim partial denture (including retentive/clasping matierals, rests, and teeth), mandibular.
D5863 Overdenture - complete maxillary.
D5864 Overdenture - partial maxillary.
D5865 Overdenture - complete mandibular.
D5866 Overdenture - partial mandibular.
D5876 Add metal substructure to acrylic full denture (per arch).
D6110 Implant/abutment supported removable denture for edentulous arch - maxillary.
D6111 Implant/abutment supported removable denture for edentulous arch - mandibular.
D6112 Implant/abutment supported removable denture for partially edentulous arch - maxillary.
D6113 Implant/abutment supported removable denture for partially edentulous arch - mandibular.
D6114 Implant/abutment supported fixed denture for edentulous arch - maxillary.
D6115 Implant/abutment supported fixed denture for edentulous arch - mandibular.
D6116 Implant/abutment supported fixed denture for partially edentulous arch - maxillary.
D6117 Implant/abutment supported fixed denture for partially edentulous arch - mandibular.
D6118 Implant/abutment supported interim fixed denture for edentulous arch - mandibular.
D6119 Implant/abutment supported interim fixed denture for edentulous arch - maxillary.

COMPLETE DENTURE: D5110, D5120, D5130, D5140, D5863, D5865, D5876, D6110, D6111, D6114, D6115

Replacement is limited to 1 of any of these procedures per 5 year(s).
Frequency is waived for accidental injury.
Allowances include adjustments within 6 months after placement date. Procedures D5863, D5865, D6110, D6111, D6114 and D6115 are considered at an alternate benefit of a D5110/D5120. Benefits for procedure D5876 is contingent upon the related denture being covered.

PARTIAL DENTURE: D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5282, D5283, D5284, D5286, D5670, D5671, D5864, D5866, D6112, D6113, D6116, D6117

Replacement is limited to 1 of any of these procedures per 5 year(s).
D6010, D6040, D6050, also contribute(s) to this limitation.
Frequency is waived for accidental injury.
Allowances include adjustments within 6 months of placement date. Procedures D5864, D5866, D6112, D6113, D6116 and D6117 are considered at an alternate benefit of a D5213/D5214.

DENTURE ADJUSTMENTS

D5410 Adjust complete denture - maxillary.
D5411 Adjust complete denture - mandibular.
D5421 Adjust partial denture - maxillary.
D5422 Adjust partial denture - mandibular.

DENTURE ADJUSTMENT: D5410, D5411, D5421, D5422

Coverage is limited to dates of service more than 6 months after placement date.

ADD TOOTH/CLASP TO EXISTING PARTIAL

D5650 Add tooth to existing partial denture.
D5660 Add clasp to existing partial denture-per tooth.

IMPLANTS
D6010 Surgical placement of implant body: endosteal implant.
D6040 Surgical placement: eposteal implant.
D6050 Surgical placement: transosteal implant.
D6051 Interim abutment.
D6052 Semi-precision attachment abutment.
D6055 Connecting bar-implant supported or abutment supported.
D6056 Prefabricated abutment - includes placement.
D6057 Custom abutment - includes placement.
IMPLANT: D6010, D6040, D6050
Replacement is limited to 1 of any of these procedures per 5 year(s).
D5211, D5212, D5213, D5214, D5225, D5226, D5282, D5283, D5284, D5286, D6094, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.
Frequency is waived for accidental injury.
Benefits for procedures D6051, D6052, D6055, D6056 and D6057 will be contingent upon the implant being covered. Replacement for procedures D6052, D6056 and D6057 are limited to 1 of any of these procedures in 5 years.

IMPLANT SERVICES
D6080 Implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prostheses and abutments.
D6081 Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure.
D6090 Repair implant supported prosthesis, by report.
D6091 Replacement of replaceable part of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment.
D6095 Repair implant abutment, by report.
D6096 Remove broken implant retaining screw.
D6100 Implant removal, by report.
D6190 Radiographic/surgical implant index, by report.
IMPLANT SERVICES: D6080, D6081, D6090, D6091, D6095, D6096, D6100, D6190
Coverage for D6080 and D6081 is limited to 2 of any of these procedures in a 12 month period.
Coverage for D6090, D6091, D6095 and D6096 is limited to service dates more than 6 months after placement date. Coverage for D6190 is limited to 1 per arch in a 24 month period.

PROSTHODONTICS - FIXED
D6058 Abutment supported porcelain/ceramic crown.
D6059 Abutment supported porcelain fused to metal crown (high noble metal).
D6060 Abutment supported porcelain fused to metal crown (predominantly base metal).
D6061 Abutment supported porcelain fused to metal crown (noble metal).
D6062 Abutment supported cast metal crown (high noble metal).
D6063 Abutment supported cast metal crown (predominantly base metal).
D6064 Abutment supported cast metal crown (noble metal).
D6065 Implant supported porcelain/ceramic crown.
D6066 Implant supported crown - porcelain fused to high noble alloys.
D6067 Implant supported crown - high noble alloys.
D6068 Abutment supported retainer for porcelain/ceramic FPD.
D6069 Abutment supported retainer for porcelain fused to metal FPD (high noble metal).
D6070 Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal).
D6071 Abutment supported retainer for porcelain fused to metal FPD (noble metal).
D6072 Abutment supported retainer for cast metal FPD (high noble metal).
D6073 Abutment supported retainer for cast metal FPD (predominantly base metal).
D6074 Abutment supported retainer for cast metal FPD (noble metal).
D6075 Implant supported retainer for ceramic FPD.
D6076 Implant supported retainer for FPD - porcelain fused to high noble alloys.
D6077 Implant supported retainer for metal FPD - high noble alloy.

D6082 Implant supported crown-porcelain fused to predominantly base alloys.
D6083 Implant supported crown-porcelain fused to noble alloys.
D6084 Implant supported crown-porcelain fused to titanium and titanium alloys.
D6086 Implant supported crown-predominantly base alloys.
D6087 Implant supported crown-noble alloys.
D6088 Implant supported crown-titanium and titanium alloys.
D6094 Abutment supported crown - titanium and titanium alloys.
D6097 Abutment supported crown-porcelain fused to titanium and titanium alloys.
D6098 Implant supported retainer-porcelain fused to predominantly base alloys.
D6099 Implant supported retainer for FPD-porcelain fused to noble alloys.
D6120 Implant supported retainer-porcelain fused to titanium and titanium alloys.
D6121 Implant supported retainer for metal FPD-predominantly base alloys.
D6122 Implant supported retainer for metal FPD-noble alloys.
D6123 Implant supported retainer for metal FPD-titanium and titanium alloys.
D6194 Abutment supported retainer crown for FPD - titanium and titanium alloys.
D6195 Abutment supported retainer-porcelain fused to titanium and titanium alloys.
D6205 Pontic - indirect resin based composite.
D6210 Pontic - cast high noble metal.
D6211 Pontic - cast predominantly base metal.
D6212 Pontic - cast noble metal.
D6214 Pontic - titanium and titanium alloys.
D6240 Pontic - porcelain fused to high noble metal.
D6241 Pontic - porcelain fused to predominantly base metal.
D6242 Pontic - porcelain fused to noble metal.
D6243 Pontic-porcelain fused to titanium and titanium alloys.
D6245 Pontic - porcelain/ceramic.
D6250 Pontic - resin with high noble metal.
D6251 Pontic - resin with predominantly base metal.
D6252 Pontic - resin with noble metal.
D6545 Retainer - cast metal for resin bonded fixed prosthesis.
D6548 Retainer - porcelain/ceramic for resin bonded fixed prosthesis.
D6549 Resin retainer - for resin bonded fixed prosthesis.
D6600 Retainer inlay - porcelain/ceramic, two surfaces.
D6601 Retainer inlay - porcelain/ceramic, three or more surfaces.
D6602 Retainer inlay - cast high noble metal, two surfaces.
D6603 Retainer inlay - cast high noble metal, three or more surfaces.
D6604 Retainer inlay - cast predominantly base metal, two surfaces.
D6605 Retainer inlay - cast predominantly base metal, three or more surfaces.
D6606 Retainer inlay - cast noble metal, two surfaces.
D6607 Retainer inlay - cast noble metal, three or more surfaces.
D6608 Retainer onlay - porcelain/ceramic, two surfaces.
D6609 Retainer onlay - porcelain/ceramic, three or more surfaces.
D6610 Retainer onlay - cast high noble metal, two surfaces.
D6611 Retainer onlay - cast high noble metal, three or more surfaces.
D6612 Retainer onlay - cast predominantly base metal, two surfaces.
D6613 Retainer onlay - cast predominantly base metal, three or more surfaces.
D6614 Retainer onlay - cast noble metal, two surfaces.
D6615 Retainer onlay - cast noble metal, three or more surfaces.
D6624 Retainer inlay - titanium.
D6634 Retainer onlay - titanium.
D6710 Retainer crown - indirect resin based composite.
D6720 Retainer crown - resin with high noble metal.
D6721 Retainer crown - resin with predominantly base metal.
D6722 Retainer crown - resin with noble metal.
D6740 Retainer crown - porcelain/ceramic.
D6750 Retainer crown - porcelain fused to high noble metal.
D6751 Retainer crown - porcelain fused to predominantly base metal.
D6752 Retainer crown - porcelain fused to noble metal.
D6753 Retainer crown-porcelain fused to titanium and titanium alloys.
D6780 Retainer crown - 3/4 cast high noble metal.
D6781 Retainer crown - 3/4 cast predominantly base metal.

D6782 Retainer crown - 3/4 cast noble metal.
D6783 Retainer crown - 3/4 porcelain/ceramic.
D6784 Retainer crown 3/4-titanium and titanium alloys.
D6790 Retainer crown - full cast high noble metal.
D6791 Retainer crown - full cast predominantly base metal.
D6792 Retainer crown - full cast noble metal.
D6794 Retainer crown - titanium and titanium alloys.
D6940 Stress breaker.

FIXED PARTIAL CROWN: D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794

Replacement is limited to 1 of any of these procedures per 5 year(s).

D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6624, D6634, also contribute(s) to this limitation.

Frequency is waived for accidental injury.

Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

Benefits will not be considered if procedure D2390, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL INLAY: D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624

Replacement is limited to 1 of any of these procedures per 5 year(s).

D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.

Frequency is waived for accidental injury.

Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

Benefits will not be considered if procedure D2390, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL ONLAY: D6608, D6609, D6610, D6611, D6612, D6613, D6614, D6615, D6634

Replacement is limited to 1 of any of these procedures per 5 year(s).

D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2753, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794, D6600, D6601, D6602, D6603, D6604, D6605, D6606, D6607, D6624, D6710, D6720, D6721, D6722, D6740, D6750, D6751, D6752, D6753, D6780, D6781, D6782, D6783, D6784, D6790, D6791, D6792, D6794, also contribute(s) to this limitation.

Frequency is waived for accidental injury.

Porcelain and resin benefits are considered for anterior and bicuspid teeth only.

Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

Benefits will not be considered if procedure D2390, D2929, D2930, D2931, D2932, D2933 or D2934 has been performed within 12 months.

FIXED PARTIAL PONTIC: D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252

Replacement is limited to 1 of any of these procedures per 5 year(s).

D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5282, D5283, D5284, D5286, D6010, D6040, D6050, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6082, D6083, D6084, D6086, D6087, D6088, D6094, D6097, D6098, D6099, D6120, D6121, D6122, D6123, D6194, D6195, also contribute(s) to this limitation.

Frequency is waived for accidental injury.
Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

IMPLANT SUPPORTED CROWN: D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6082, D6083, D6084, D6086, D6087, D6088, D6094, D6097
Replacement is limited to 1 of any of these procedures per 5 year(s).
D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5282, D5283, D5284, D5286, D6194, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.
Frequency is waived for accidental injury.
Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

IMPLANT SUPPORTED RETAINER: D6068, D6069, D6070, D6071, D6072, D6073, D6074, D6075, D6076, D6077, D6098, D6099, D6120, D6121, D6122, D6123, D6194, D6195
Replacement is limited to 1 of any of these procedures per 5 year(s).
D5211, D5212, D5213, D5214, D5221, D5222, D5223, D5224, D5225, D5226, D5282, D5283, D5284, D5286, D6058, D6059, D6060, D6061, D6062, D6063, D6064, D6065, D6066, D6067, D6082, D6083, D6084, D6086, D6087, D6088, D6094, D6097, D6205, D6210, D6211, D6212, D6214, D6240, D6241, D6242, D6243, D6245, D6250, D6251, D6252, also contribute(s) to this limitation.
Frequency is waived for accidental injury.
Porcelain and resin benefits are considered for anterior and bicuspid teeth only.
Procedures that contain titanium or high noble metal will be considered at the corresponding noble metal allowance.

BONE AUGMENTATION
D6104 Bone graft at time of implant placement.
D7950 Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla - autogenous or nonautogenous, by report.
D7951 Sinus augmentation with bone or bone substitutes via a lateral open approach.
D7952 Sinus augmentation via a vertical approach.
D7953 Bone replacement graft for ridge preservation - per site.

BONE AUGMENTATION: D6104, D7950, D7951, D7952, D7953
Each quadrant is limited to 1 of any of these procedures per 5 year(s).
Coverage of D6104, D7950, D7951, D7952 and D7953 is limited to the treatment and placement of endosteal implant D6010, D6040 eposteal implant or D6050 transosteal implant.

OCCLUSAL GUARD
D9944 Occlusal guard - hard appliance, full arch.
D9945 Occlusal guard - soft appliance, full arch.
D9946 Occlusal guard - hard appliance, partial arch.

OCCLUSAL GUARD: D9944, D9945, D9946
Coverage is limited to 1 of any of these procedures per 3 year(s).
Benefits will not be available if performed for athletic purposes.

OCCLUSAL ADJUSTMENT
D9951 Occlusal adjustment - limited.
D9952 Occlusal adjustment - complete.

OCCLUSAL ADJUSTMENT: D9951, D9952
Coverage is considered only when performed in conjunction with periodontal procedures for the treatment of periodontal disease.

TYPE 4 PROCEDURES

PAYMENT BASIS - PARTICIPATING PROVIDERS - Maximum Allowable Charge

BENEFIT PERIOD - Benefit Year

For Additional Limitations - See Limitations

NON-SURGICAL MISCELLANEOUS

D0160	Detailed and extensive oral evaluation - problem focused, by report.
D0320	Temporomandibular joint arthrogram, including injection.
D0321	Other temporomandibular joint radiographic images, by report.
D0322	Tomographic survey.
D0340	2D Cephalometric radiographic image - acquisition, measurement and analysis.
D0368	Cone beam CT capture and interpretation for TMJ series including two or more exposures.
D0369	Maxillofacial MRI capture and interpretation.
D0384	Cone beam CT image capture for TMJ series including two or more exposures.
D0385	Maxillofacial MRI image capture.
D0391	Interpretation of diagnostic image by a practitioner not associated with capture of the image, including report.
D0470	Diagnostic casts.
D7880	Occlusal orthotic device, by report.
D7881	Occlusal orthotic device adjustment.
D9130	Temporomandibular joint dysfunction - non-invasive physical therapies.

ORTHODONTIC EXPENSE BENEFITS

Orthodontic expense benefits will be determined according to the terms of the policy for orthodontic expenses incurred by an Insured.

DETERMINING BENEFITS. The benefits payable will be determined by totaling all of the Covered Expenses submitted. This amount is reduced by the Deductible, if any. The result is then multiplied by the Coinsurance Percentage shown in the Schedule of Benefits. Benefits are subject to the Maximum Amount shown in the Schedule of Benefits.

DEDUCTIBLE. The Deductible is shown on the Schedule of Benefits and is a specified amount of Covered Expenses that must be incurred and paid by each Insured person prior to any benefits being paid.

MAXIMUM AMOUNT. The Maximum Benefit During Lifetime shown in the Schedule of Benefits is the maximum amount that may be paid for the Covered Expenses incurred by an Insured during his or her lifetime.

COVERED EXPENSES. Covered Expenses refer to the usual and customary charges made by a provider for necessary orthodontic treatment rendered while the person is insured under this section. Expenses are limited to the Maximum Amount shown in the Schedule of Benefits and Limitations. All benefits are subject to the definitions, limitations and exclusions and are payable only when we determine they are necessary for prevention, diagnosis, care or treatment of a covered condition and meet generally accepted dental protocols.

Usual and Customary ("U&C") describes those dental charges that we have determined to be the usual and customary charge for a given dental procedure within a particular ZIP code area. The U&C is based upon a combination of dental charge information taken from our own database as well as from data received from nationally recognized industry databases. From the array of charges ranked by amount, your Policyholder (in most cases your employer) has selected a percentile that will be used to determine the maximum U&C for your plan. The U&C is reviewed and updated periodically. The U&C can differ from the actual fee charged by the provider and is not indicative of the appropriateness of the provider's fee. Instead, the U&C is simply a plan provision used to determine the extent of benefit coverage purchased by your Policyholder.

ORTHODONTIC TREATMENT. Orthodontic Treatment refers to the movement of teeth by means of active appliances to correct the position of maloccluded or malpositioned teeth.

TREATMENT PROGRAM. Treatment Program ("Program") means an interdependent series of orthodontic services prescribed by a provider to correct a specific dental condition. A Program will start when the bands, brackets or appliances are placed. A Program will end when the services are done, or after eight calendar quarters starting with the day the appliances were inserted, whichever is earlier.

EXPENSES INCURRED. Benefits will be payable when a Covered Expense is incurred:

a. at the end of every quarter (three-month period) of a Program for an Insured who pursues a Program, but not beyond the date the Program ends; or

b. at the time the service is rendered for an Insured who incurs Covered Expenses but does not pursue a Program.

The Covered Expenses for a Program are based on the estimated cost of the Insured's Program. They are pro-rated by quarter (three-month periods) over the estimated length of the Program, up to a maximum of eight quarters. The last quarterly payment for a Program may be changed if the estimated and actual cost of the Program differ.

LIMITATIONS. Covered Expenses will not include and benefits will not be payable for expenses incurred:

1. for a Program begun before the Insured became covered under this section, unless the Insured was covered for Orthodontic Expense Benefits under the prior carrier on August 31, 2020 and are both:

    a. insured under this policy; and
    b. currently undergoing a Treatment Program on September 1, 2020.

2. in the first 12 months that a person is insured if the person is a Late Entrant.

3. in any quarter of a Program if the Insured was not covered under this section for the entire quarter.

4. if the Insured's insurance under this section terminates.

5. for which the Insured is entitled to benefits under any workmen's compensation or similar law, or for charges for services or supplies received as a result of any dental condition caused or contributed to by an injury or sickness arising out of or in the course of any employment for wage or profit.

6. for charges the Insured is not legally required to pay or would not have been made had no insurance been in force.

7. for services not required for necessary care and treatment or not within the generally accepted parameters of care.

8. because of war or any act of war, declared or not.

9. To replace lost, missing or stolen orthodontic appliances.

COORDINATION OF BENEFITS

This section applies if an Insured person has dental coverage under more than one Plan definition below. All benefits provided under this policy are subject to this section.

EFFECT ON BENEFITS. The Order of Benefit Determination rules below determine which Plan will pay as the primary Plan. If all or any part of an Allowable Expense under this Plan is an Allowable Expense under any other Plan, then benefits will be reduced so that, when they are added to benefits payable under any other Plan for the same service or supply, the total does not exceed 100% of the total Allowable Expense.

If another Plan is primary and this Plan is considered secondary, the amount by which benefits have been reduced during the Claim Determination Period will be used by us to pay the Allowable Expenses not otherwise paid which were incurred by you in the same Claim Determination Period. We will determine our obligation to pay for Allowable Expenses as each claim is submitted, based on all claims submitted in the current Claim Determination Period.

DEFINITIONS. The following apply only to this provision of the policy.

1. "Plan" refers to the group policy and any of the following plans, whether insured or uninsured, providing benefits for dental services or supplies:

   a. Any group or blanket insurance policy.

   b. Any group Blue Cross, group Blue Shield, or group prepayment arrangement.

   c. Any labor/management, trusteed plan, labor organization, employer organization, or employee organization plan, whether on an insured or uninsured basis.

   d. Any coverage under a governmental plan that allows coordination of benefits, or any coverage required or provided by law. This does not include a state plan under Medicaid (TitleXVIII and XIX of the Social Security Act as enacted or amended). It also does not include any plan whose benefits by law are excess to those of any private insurance program or other non-governmental program.

2. "Plan" does **not** include the following:

   a. Individual or family benefits provided through insurance contracts, subscriber contracts, coverage through individual HMOs or other prepayment arrangements.

   b. Coverages for school type accidents only, including athletic injuries.

3. "Allowable Expense" refers to any necessary, reasonable and customary item of expense at least a portion of which is covered under at least one of the Plans covering the Insured person for whom that claim is made. When a Plan provides services rather than cash payments, the reasonable cash value of each service will be both an Allowable Expense and a benefit paid. Benefits payable under another Plan include benefits that would have been payable had a claim been made for them.

4. "Claim Determination Period" refers to a Benefit Period, but does not include any time during which a person has no coverage under this Plan.

5. "Custodial Parent" refers to a parent awarded custody of a minor child by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than half of the calendar year without regard to any temporary visitation.

ORDER OF BENEFIT DETERMINATION. When two or more Plans pay benefits, the rules for determining the order of payment are as follows:

1. A Plan that does not have a coordination of benefits provision is always considered primary and will pay benefits first.

2. If a Plan also has a coordination of benefits provision, the first of the following rules that describe which Plan pays its benefits before another Plan is the rule to use:

    a. The benefits of a Plan that covers a person as an employee, member or subscriber are determined before those of a Plan that covers the person as a dependent.

    b. If a Dependent child is covered by more than one Plan, then the primary Plan is the Plan of the parent whose birthday is earlier in the year if:

        i. the parents are married;

        ii. the parents are not separated (whether or not they ever have been married); or

        iii. a court decree awards joint custody without specifying that one party has the responsibility to provide Dental coverage.

        If both parents have the same birthday, the Plan that covered either of the parents longer is primary.

    c. If the Dependent child is covered by divorced or separated parents under two or more Plans, benefits for that Dependent child will be determined in the following order:

        i. the Plan of the Custodial Parent;

        ii. the Plan of the spouse of the Custodial Parent;

        iii. the Plan of the non-Custodial Parent; and then

        iv. the Plan of the spouse of the non-Custodial Parent.

        However, if the specific terms of a court decree establish a parent's responsibility for the child's Dental expenses and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to Claim Determination Periods or Benefit Periods commencing after the Plan is given notice of the court decree.

    d. The benefits of a Plan that cover a person as an employee who is neither laid-off nor retired (or as that employee's dependent) are determined before those of a Plan that covers that person as a laid-off or retired employee (or as that employee's dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule will be ignored.

    e. If a person whose coverage is provided under a right of continuation provided by a federal or state law also is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule will be ignored.

    f. The benefits of a Plan that has covered a person for a longer period will be determined first.

If the preceding rules do not determine the primary Plan, the allowable expenses shall be shared equally between the Plans meeting the definition of Plan under this provision. In addition, this Plan will not pay more than what it would have paid had it been primary.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION. We may without your consent and notice to you:

1. Release any information with respect to your coverage and benefits under the policy; and

2. Obtain from any other insurance company, organization or person any information with respect to your coverage and benefits under another Plan.

You must provide us with any information necessary to coordinate benefits.

FACILITY OF PAYMENT. When other Plans make payments that should have been made under this Plan according to the above terms, we will, at our discretion, pay to any organizations making these payments any amounts that we decide will satisfy the intent of the above terms. Amounts paid in this way will be benefits paid under this Plan. We will not be liable to the extent of these payments.

RIGHT OF RECOVERY. When we make payments for Allowable Expenses in excess of the amount that will satisfy the intent of the above terms, we will recover these payments, to the extent of the excess, from any persons or organizations to or for whom these payments were made. The amount of the payments made includes the reasonable cash value of any benefits provided in the form of services.

GENERAL PROVISIONS

NOTICE OF CLAIM. Written notice of a claim must be given to us within 90 days after the incurred date of the services provided for which benefits are payable.

Notice must be given to us at our Home Office, or to one of our agents. Notice should include the Policyholder's name, Insured's name, and policy number. If it was not reasonably possible to give written notice within the 90 day period stated above, we will not reduce or deny a claim for this reason if notice is filed as soon as is reasonably possible.

CLAIM FORMS. When we receive the notice of a claim, we will send the claimant forms for filing proof of loss. If these forms are not furnished within 15 days after the giving of such notice, the claimant will meet our proof of loss requirements by giving us a written statement of the nature and extent of loss within the time limit for filing proofs of loss.

PROOF OF LOSS. Written proof of loss must be given to us within 90 days after the incurred date of the services provided for which benefits are payable. If it is impossible to give written proof within the 90 day period, we will not reduce or deny a claim for this reason if the proof is filed as soon as is reasonably possible.

TIME OF PAYMENT. We will pay all benefits within 45 days of when we receive all information necessary to pay the claim. If a claim cannot be paid within 45 days of receipt, we will notify you within that 45-day period providing you with a list of information necessary for us to pay the claim. If payment is not made within the required time frame, we will pay interest at the rate of eighteen percent per year on benefits for valid claims. Interest will begin to accrue 45 days after we receive notice of the claim and will accrue until the claim is settled.

PAYMENT OF BENEFITS. Participating Providers have agreed to accept assignment of benefits for services and supplies performed or furnished by them. When a Non-Participating Provider performs services, all benefits will be paid to the Insured unless otherwise indicated by the Insured's authorization to pay the Non-Participating Provider directly.

FACILITY OF PAYMENT. If an Insured or beneficiary is not capable of giving us a valid receipt for any payment or if benefits are payable to the estate of the Insured, then we may, at our option, pay the benefit up to an amount not to exceed $1,000, to any relative by blood or connection by marriage of the Insured who is considered by us to be equitably entitled to the benefit.

Any equitable payment made in good faith will release us from liability to the extent of payment.

PROVIDER-PATIENT RELATIONSHIP. The Insured may choose any Provider who is licensed by the law of the state in which treatment is provided within the scope of their license. We will in no way disturb the provider-patient relationship.

LEGAL PROCEEDINGS. No legal action can be brought against us until 60 days after the Insured sends us the required proof of loss. No legal action against us can start more than five years after proof of loss is required.

INCONTESTABILITY. Any statement made by the Policyholder to obtain the Policy is a representation and not a warranty. No misrepresentation by the Policyholder will be used to deny a claim or to deny the validity of the Policy unless:

1. The Policy would not have been issued if we had known the truth; and

2. We have given the Policyholder a copy of a written instrument signed by the Policyholder that contains the misrepresentation.

The validity of the Policy will not be contested after it has been in force for one year, except for nonpayment of premiums or fraudulent misrepresentations.

WORKER'S COMPENSATION. The coverage provided under the Policy is not a substitute for coverage under a workmen's compensation or state disability income benefit law and does not relieve the Policyholder of any obligation to provide such coverage.

As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum Creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at 1-877-MA-ENROLL or visit the Connector website (www.mahealthconnector.org). This plan is not intended to provide comprehensive health care coverage and does not meet Minimum Creditable Coverage standards, even if it does include services that are not available in the insured's other health plans.

If you have questions about this notice, you may contact the Division of Insurance by calling (617) 521-7794 or visiting its website at www.mass.gov/doi.

ERISA INFORMATION AND NOTICE OF YOUR RIGHTS

A. General Plan Information

Name of Plan:	Dental Insurance
Name, Address of Plan Sponsor:	UAW/UMASS HEALTH & WELFARE TRUST FUND 6 UNIVERSITY DR STE 206-226 AMHERST, MA 01002
Plan Sponsor Tax Id Number:	04-3538613
Plan Number:	501
Type of Plan:	Group Insurance Plan
Name, Address, Phone Number of Plan Administrator:	LESLIE EDWARDS DAVIS UAW/UMASS HEALTH & WELFARE TRUST FUND 6 UNIVERSITY DR STE 206-226 AMHERST, MA 01002 413-345-2156
Name, Address of Registered Agent for Service of Legal Process:	Plan Sponsor
If Legal Process Involves Claims For Benefits Under The Group Policy, Additional Notification of Legal Process Must Be Sent To:	Ameritas Life Insurance Corp. P.O. Box 82595 Lincoln, NE 68501
Sources of Contributions:	Employer/Member
Funding Method:	Ameritas Life Insurance Corp.--Fully Insured
Plan Fiscal Year End:	September 30
Type of Administration:	
General Administration	Plan Sponsor
Contract & Claim Administration	Ameritas Life Insurance Corp.

B. Notice of Legal Process

Service of legal process may be made upon the plan administrator at the address listed above.

C. Eligibility and Benefits Provided Under the Group Policy

Please refer to the **Conditions for Insurance** within the Group Policy and Certificate of Coverage for a detailed description of the eligibility for participation under the plan as well as the benefits provided. If this plan includes a participating provider (PPO) option, provider lists are furnished without charge, as a separate document.

If you have any questions about your benefits or concerns about our services related to this Group Policy, you may call Customer Service Toll Free at 1-800-487-5553.

D. **Qualified Medical Child Support Order ("QMCSO")**

QMCSO Determinations. A Plan participant or beneficiary can obtain, without charge, a copy of the Plan's procedures governing Qualified Medical Child Support Order determinations from the Plan Administrator.

E. Termination Of The Group Policy

The Group Policy which provides benefits for this plan may be terminated by the Policyholder at any time with prior written notice to Ameritas Life Insurance Corp. It will terminate automatically if the Policyholder fails to pay the required premium. Ameritas Life Insurance Corp. may terminate the Group Policy on any Premium Due Date if the number of persons insured is less than the required minimum, or if Ameritas Life Insurance Corp. believes the Policyholder has failed to perform its obligations relating to the Group Policy.

After the first policy year, Ameritas Life Insurance Corp. may also terminate the Group Policy on any Premium Due Date for any reason by providing a 60-day advance written notice to the Policyholder.

The Group Policy may be changed in whole or in part. No change or amendment will be valid unless it is approved in writing by a Ameritas Life Insurance Corp. executive officer.

F. Claims For Benefits

Claims procedures are furnished automatically, without charge, as a separate document.

G. Continuation of Coverage Provisions (COBRA)

COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) gives Qualified Beneficiaries the right to elect COBRA continuation after insurance ends because of a Qualifying Event. The law generally covers group health plans maintained by employers with 20 or more employees in the prior year. The law does not, however, apply to plans sponsored by the Federal government and certain church-related organizations.

i. Definitions For This Section

Qualified Beneficiary means an Insured Person who is covered by the plan on the day before a qualifying event. Any child born to or placed for adoption with a covered employee during the period of COBRA coverage is considered a qualified beneficiary.

A Qualifying Event occurs when:

1. The Member dies (hereinafter referred to as Qualifying Event 1);

2. The Member's employment terminates for reasons other than gross misconduct as determined by the Employer (hereinafter referred to as Qualifying Event 2);

3. The Member's work hours fall below the minimum number required to be a Member (hereinafter referred to as Qualifying Event 3);

4. The Member becomes divorced or legally separated from a Spouse (hereinafter referred to as Qualifying Event 4);

5. The Member becomes entitled to receive Medicare benefits under Title XVII of the Social Security Act (hereinafter referred to as Qualifying Event 5);

6. The Child of a Member ceases to be a Dependent (hereinafter referred to as Qualifying Event 6);

7. The Employer files a petition for reorganization under Title 11 of the U.S. Bankruptcy Code, provided the Member is retired from the Employer and is insured on the date the petition is filed (hereinafter referred to as Qualifying Event 7).

ii. Electing COBRA Continuation

A. Each Qualified Beneficiary has the right to elect to continue coverage that was in effect on the day before the Qualifying Event. The Qualified Beneficiary must apply in writing within 60 days of the later of:

1. The date on which Insurance would otherwise end; and

2. The date on which the Employer or Plan Administrator gave the Qualified Beneficiary notice of the right to COBRA continuation.

B. A Qualified Beneficiary who does not elect COBRA Continuation coverage during their original election period may be entitled to a second election period if the following requirements are satisfied:

1. The Member's Insurance ended because of a trade related termination of their employment, which resulted in being certified eligible for trade adjustment assistance;

2. The Member is certified eligible for trade adjustment assistance (as determined by the appropriate governmental agency) within 6 months of the date Insurance ended due to the trade related termination of their employment; and

3. The Qualified Beneficiary must apply in writing within 60 days after the first day of the month in which they are certified eligible for trade adjustment assistance.

iii. Notice Requirements

1. When the Member becomes insured, the Plan Administrator must inform the Member and Spouse in writing of the right to COBRA continuation.

2. The Qualified Beneficiary must notify the Plan Administrator in writing of Qualifying Event 4 or 6 above within 60 days of the later of:

a. The date of the Qualifying Event; or

b. The date the Qualified Beneficiary loses coverage due to the Qualifying Event.

3. A Qualified Beneficiary, who is entitled to COBRA continuation due to the occurrence of Qualifying Event 2 or 3 and who is disabled at any time during the first 60 days of continuation coverage as determined by the Social Security Administration pursuant to Title II or XVI of the Social Security Act, must notify the Plan Administrator of the disability in writing within 60 days of the later of:

a. The date of the disability determination;

b. The date of the Qualifying Event; or

c. The date on which the Qualified Beneficiary loses coverage due to the Qualifying Event.

4. Each Qualified Beneficiary who has become entitled to COBRA continuation with a maximum duration of 18 or 29 months must notify the Plan Administrator of the occurrence of a second Qualifying Event within 60 days of the later of:

   a. The date of the Qualifying Event; or

   b. The date the Qualified Beneficiary loses coverage due to the Qualifying Event.

5. The Employer must give the Plan Administrator written notice within 30 days of the occurrence of Qualifying Event 1, 2, 3, 5, or 7.

6. Within 14 days of receipt of the Employer's notice, the Plan Administrator must notify each Qualified Beneficiary in writing of the right to elect COBRA continuation.

In order to protect your rights, Members and Qualified Beneficiaries should inform the Plan Administrator in writing of any change of address.

iv. COBRA Continuation Period

1. 18-month COBRA Continuation

   Each Qualified Beneficiary may continue Insurance for up to 18 months after the date of Qualifying Event 2 or 3.

2. 29-month COBRA Continuation

   Each Qualified Beneficiary, who is entitled to COBRA continuation due to the occurrence of Qualifying Event 2 or 3 and who is disabled at any time during the first 60 days of continuation coverage as determined by the Social Security Administration pursuant to Title II or XVI of the Social Security Act, may continue coverage for up to 29 months after the date of the Qualifying Event. All Insured Persons in the Qualified Beneficiary's family may also continue coverage for up to 29 months.

3. 36-Month COBRA Continuation

   If you are a Dependent, you may continue Coverage for up to 36 months after the date of Qualifying Event 1, 4, 5, or 6. Each Qualified Beneficiary who is entitled to continue Insurance for 18 or 29 months may be eligible to continue coverage for up to 36 months after the date of their original Qualifying Event if a second Qualifying Event occurs while they are on continuation coverage.

Note: The total period of COBRA continuation available in 1 through 3 will not exceed 36 months.

4. COBRA Continuation For Certain Bankruptcy Proceedings

   If the Qualifying Event is 7, the COBRA continuation period for a retiree or retiree's Spouse is the lifetime of the retiree. Upon the retiree's death, the COBRA continuation period for the surviving Dependents is 36 months from the date of the retiree's death.

v. Premium Requirements

Insurance continued under this provision will be retroactive to the date insurance would have ended because of a Qualifying Event. The Qualified Beneficiary must pay the initial required premium not later than 45 days after electing COBRA continuation, and monthly premium on or before the Premium Due Date thereafter. The monthly premium is a percentage of the total premium (both the portion paid by the employee and any portion paid by the employer) currently in effect on each Premium Due Date. The premium rate may change after you cease to be Actively at Work. The percentage is as follows:

18 month continuation - 102%

29 month continuation - 102% during the first 18 months, 150% during the next 11 months

36 month continuation - 102%

vi. When COBRA Continuation Ends

COBRA continuation ends on the earliest of:

1. The date the Group Policy terminates;

2. 31 days after the date the last period ends for which a required premium payment was made;

3. The last day of the COBRA continuation period.

4. The date the Qualified Beneficiary first becomes entitled to Medicare coverage under Title XVII of the Social Security Act;

5. The first date on which the Qualified Beneficiary is: (a) covered under another group Dental policy and (b) not subject to any preexisting condition limitation in that policy.

H. Your Rights under ERISA

As a participant in this Plan, you are entitled to certain rights and protections under the Employment Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits
Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work-sites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to operate and administer this plan prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Rights

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling those publications hotline of the Employee Benefits Security Administration

CLAIMS REVIEW PROCEDURES
AS REQUIRED UNDER
EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

The following provides information regarding the claims review process and your rights to request a review of any part of a claim that is denied. Please note that certain state laws may also require specified claims payment procedures as well as internal appeal procedures and/or independent external review processes. Therefore, in addition to the review procedures defined below, you may also have additional rights provided to you under state law. If your state has specific grievance procedures, an additional notice specific to your state will also be included within the group policy and your certificate.

CLAIMS FOR BENEFITS

Claims may be submitted by mailing the completed claim form along with any requested information to:

Ameritas Life Insurance Corp.
PO Box 82520
Lincoln, NE 68501

NOTICE OF DECISION OF CLAIM

We will evaluate your claim promptly after we receive it.

Dental Utilization Review Program. Generally, utilization review means a set of criteria designed to monitor the use of, or evaluate the medical necessity, appropriateness, or efficiency of health care services. We have established a utilization review program to ensure that any guidelines and criteria used to evaluate the medical necessity of a health care service are clearly documented and include procedures for applying such criteria based on the needs of the individual patients. The program was developed in conjunction with licensed dentists and is reviewed at least annually to ensure that criteria are applied consistently and are current with dental technology, evidence-based research and any dental trends.

We will provide you written notice regarding the payment under the claim within 30 calendar days following receipt of the claim. This period may be extended for an additional 15 days, provided that we have determined that an extension is necessary due to matters beyond our control, and notify you, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which we expect to render a decision. If the extension is due to your failure to provide information necessary to decide the claim, the notice of extension shall specifically describe the required information we need to decide the claim.

If we request additional information, you will have 45 days to provide the information. If you do not provide the requested information within 45 days, we may decide your claim based on the information we have received.

If we deny any part of your claim, you will receive a written notice of denial containing:

a. The reasons for our decision.
b. Reference to the parts of the Group Policy on which our decision is based.
c. Reference to any internal rule or guideline relied upon in making our decision, along with your right to receive a copy of these guidelines, free of charge, upon request.
d. A statement that you may request an explanation of the scientific or clinical judgment we relied upon to exclude expenses that are experimental or investigational, or are not necessary or accepted according to generally accepted standards of Dental practice.
e. A description of any additional information needed to support your claim and why such information is necessary.
f. Information concerning your right to a review of our decision.
g. Information concerning your right to bring a civil action for benefits under section 502(a) of ERISA following an adverse benefit determination on review.

APPEAL PROCEDURE

If all or part of a claim is denied, you may request a review in writing within 180 days after receiving notice of the benefit denial.

You may send us written comments or other items to support your claim. You may review and receive copies of any non-privileged information that is relevant to your appeal. There will be no charge for such copies. You may request the names of the experts we consulted who provided advice to us about your claim.

The appeal review will be conducted by the Plan's named fiduciary and will be someone other than the person who denied the initial claim and will not be subordinate to that person. The person conducting the review will not give deference to the initial denial decision. If the denial was based in whole or in part on a medical judgment, including determinations with regard to whether a service was considered experimental, investigational, and/or not medically necessary, the person conducting the review will consult with a qualified health care professional. This health care professional will be someone other than the person who made the original judgment and will not be subordinate to that person. Our review will include any written comments or other items you submit to support your claim.

We will review your claim promptly after we receive your request.

If your appeal is about urgent care, you may call Toll Free at 877-897-4328, and an Expedited Review will be conducted. Verbal notification of our decision will be made within 72 hours, followed by written notice within 3 calendar days after that.

If your appeal is about benefit decisions related to clinical or medical necessity, a Standard Consultant Review will be conducted. A written decision will be provided within 30 calendar days of the receipt of the request for appeal.

If your appeal is about benefit decisions related to coverage, a Standard Administrative Review will be conducted. A written decision will be provided within 60 calendar days of the receipt of the request for appeal.

If we deny any part of your claim on review, you will receive a written notice of denial containing:

a. The reasons for our decision.
b. Reference to the parts of the Group Policy on which our decision is based.
c. Reference to any internal rule or guideline relied upon in making our decision along with your right to receive a copy of these guidelines, free of charge, upon request.
d. Information concerning your right to receive, free of charge, copies of non-privileged documents and records relevant to your claim.
e. A statement that you may request an explanation of the scientific or clinical judgment we relied upon to exclude expenses that are experimental or investigational, or are not necessary or accepted according to generally accepted standards of Dental practice.
f. Information concerning your right to bring a civil action for benefits under section 502(a) of ERISA.

Certain state laws also require specified internal appeal procedures and/or external review processes. In addition to the review procedures defined above, you may also have additional rights provided to you under state law. Please review your certificate for such information, call us, or contact your state insurance regulatory agency for assistance. In any event, you need not exhaust such state law procedures prior to bringing civil action under Section 502(a) of ERISA.

Any request for appeal should be directed to:

Quality Control, P.O. Box 82657, Lincoln, NE 68501-2657.

Your Information. Your Rights. Our Responsibilities.

THIS NOTICE OF PRIVACY PRACTICES ("NOTICE") DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice describes how the Group Divisions of Ameritas Life Insurance Corp. and Ameritas Life Insurance Corp. of New York use and disclose your protected health information, and how we guard that information. We are required to abide by the terms of this notice as long as it remains in effect. We reserve the right to change the terms of this Notice as necessary, and to make a new Notice effective for all protected health information maintained by us. If we do make changes to this Notice, a copy of the new Notice will be placed on our web site at www.ameritas.com and/or sent to you if the changes are material. If you reside in a state whose law provides stricter privacy protections than those provided by HIPAA, we will maintain the privacy of your health information as required by your stricter state law.

how we use or disclose information

We must use and disclose your health information to provide that information:

- To you, or someone who has the legal right to act for you (your personal representative), in order to administer your rights as described in this notice; and
- To the Secretary of the Department of Health and Human Services, if necessary, to see that we are complying with federal privacy law and administrative simplification provisions of HIPAA.

We have the right to use and disclose your health information for your treatment, to pay for your health care, and to operate our business. For example, we typically use your information in the following ways:

- **For Payment.** We may use or disclose health information to collect premiums due to us, to determine your coverage, or to process claims for health care services you receive. For example, we may tell a provider whether you are eligible for coverage and what percentage of the bill may be covered.
- **For Treatment.** We may use or disclose health information to aid in your treatment or the coordination of your care. For example, we may disclose information to your provider to help them provide health care services to you.
- **For Health Care Operations.** We may use or disclose health information as necessary to operate and manage our business activities related to providing and managing your health care coverage. For example, we may use health information for operational activities such as quality assessment and improvement.
- **For Plan Sponsors.** If your coverage is through an employer sponsored group health plan, we may share summary health information and enrollment and disenrollment information with the plan sponsor. In addition, we may share other health information with the plan sponsor for plan administration purposes if the plan sponsor agrees to special restrictions on the use and disclosure of the information in accordance with federal law.

We may use or disclose your health information for the following purposes under limited circumstances:

- **As Required by Law.** We may disclose information about you if state or federal laws require it.
- **To Persons Involved With Your Care.** We may use or disclose your health information a person involved in your care or who helps you pay for your care, such as a family member or close personal friend, when you are incapacitated, emergency situations, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object, we will use our best judgment to decide if the disclosure is in your best interests.
- **To Law Enforcement.** We may disclose your health information to a law enforcement official to provide limited information to locate a missing person or report a crime.
- **To Correctional Institutions or Law Enforcement Officials.** We may disclose your health information if you are an inmate of a correctional institution or under the custody of law enforcement, but only if necessary for the institution to provide you with health care; to protect your health and safety, or the health and safety of others; or for the safety and security of the correctional institution.
- **To Avoid a Serious Threat to Health or Safety** to you, another person, or the public. For example, we may disclose information to a public health agency or law enforcement in the event of a natural disaster.
- **For Public Health Activities** such as reporting disease outbreaks to a valid public health authority.
- **For Reporting Victims of Abuse, Neglect, or Domestic Violence** to government authorities that are authorized by law to receive such information, including a social services or protective service agencies.
- **For Health Oversight Activities** to a health oversight agency for activities authorized by law, such as licensure, governmental audits, and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings** to respond to a court order, search warrant, or subpoena.
- **For Specialized Government Functions** such as national security and intelligence activities, the protective services for the President and others, or if you are a member of the military, as required by the armed forces.
- **To Business Associates** that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates are required, under contract with us and federal law, to protect the privacy of your information and are not allowed to use or disclose any information other than allowed by the contract and federal law.
- **For Workers' Compensation** as authorized by, or to the extent necessary to comply with, state workers' compensation laws that govern job-related injuries or illness.

- **To Provide Information Regarding Decedents.** We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties.
- **For Cadaveric Organ, Eye, or Tissue Donation.** We may disclose information to entities that handle procurement, banking, or transplantation of organs, eyes, or tissue to facilitate donation and transplantation.

Except for uses and disclosures described and limited as explained in this notice, we will use and disclose your health information only with written permission from you. We will not share your personal information for marketing purposes or sell your personal information unless you give us written permission to do so.

our responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this Notice, and give you a copy of it.
- We will not use or share your information other than as described in this Notice, unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing at the contact information below if you change your mind.

your rights

- **Right to Inspect and Copy.** You have the right to inspect and copy certain protected health information that may be used to make decisions about your plan benefits. Your request must be in writing and submitted to the Ameritas Privacy Office at the contact information below. We will usually provide access to your protected health information within 30 days of receiving the request. We reserve the right to charge a fee for the costs of copying, mailing, or other supplies associated with your request. You may also ask your providers for access to your records. We may deny your request in very limited circumstances. If we deny your request to inspect or obtain a copy of your protected health information, we will inform you in writing of the reason(s) within 30 days.
- **Right to Amend.** You have the right to request that we amend, correct, or delete your protected health information in our records if you believe that it is inaccurate or incomplete. Your request must be in writing and sent to the Ameritas Privacy Office at the contact information below. In addition, you must provide a reason that supports your request. We will respond to your request in writing within 30 days. We may deny your request for an amendment if it is not in writing, or does not include a reason to support the request. If we deny your request, we will communicate the reason(s) for denial. If we deny your request, you have the right to file a written statement of disagreement and any future disclosures of the disputed information will include your statement.
- **Right to Request Confidential Communication.** You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. Your request must be in writing and submitted to the Ameritas Privacy Office at the contact information below. We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.
- **Right to an Accounting of Disclosures of Your Protected Health Information.** You have the right to receive a list of the times we've shared your health information for up to six years prior to the date you ask, who we share it with, and why. Your request must be in writing and submitted to the Ameritas Privacy Office at the contact information below. We will include all the disclosures, except those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We will provide one accounting a year for free, but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
- **Know the Reasons for an Unfavorable Underwriting Decision.** You have the right to know the reason(s) for an unfavorable underwriting decision. Your request must be in writing, and must be asked for within 90 days from when the adverse underwriting decision is sent. We will respond within 21 days. Previous unfavorable underwriting decisions may not be used as a basis for future underwriting decisions unless we make an independent evaluation of basic facts. Your genetic information cannot be used for underwriting purposes.
- **Ask Us to Limit the Information We Share.** You can send us a written request at the contact information below to not use or share certain health information for treatment, payment, or health care operations. We are not required to agree to these requests.
- **Get a Copy of this Privacy Notice.** You can ask us for a paper copy of this Notice at any time, even if you have agreed to receive the Notice electronically. We will provide you with a paper copy promptly.

exercising your rights

- Submitting a Written Request. If you have any questions about this Notice, want more information about exercising your rights, or want to obtain an authorization form please contact us at: The Privacy Office, Attn. HIPAA Privacy, P.O. Box 82520, Lincoln, NE 68501-2520, e-mail us at privacy@ameritas.com, or call 1-800-487-5553
- Filing a Complaint. If you believe your privacy rights have been violated, you may file a complaint with us at the contact information listed above. You may also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C., 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

This revised notice is effective 9/30/17.

EyeMed VISION CARE®

FEE FOR SERVICE AGREEMENT

A wholly owned subsidiary of EyeMed Vision Care

UAW/UMass Health & Welfare Trust Fund

This Agreement is entered into by and between EyeMed Vision Care, L.L.C. ("EyeMed") and First American Administrators ("FAA"), with their principal place of business at 4000 Luxottica Place, Mason, OH 45040 and UAW/UMass Health & Welfare Trust Fund, with its principal place of business at 329 Middlesex House, 111 County Circle, Amherst, MA 01003-9255, as Plan Sponsor and Plan Administrator, on behalf of itself and its ERISA plan ("Plan Sponsor").

RECITALS

Plan Sponsor is an employer that provides benefits for its employees and their qualified dependents and now intends to offer vision benefits to such Participants (as defined herein);

Plan Sponsor has elected to pay for these vision benefits by self-funding vision benefits under its ERISA plan (the "ERISA Plan") and contracting out claims administration and Vision Network administration services;

Plan Sponsor wishes to engage the services of EyeMed to provide a vision benefit, claims administration, and Vision Network administration to assist employer in their responsibilities as Plan Sponsor and Plan Administrators for self-funded vision benefits;

EyeMed makes its Vision Network of Participating Providers available to Plan Sponsor's Members who have vision care coverage;

First American Administrators, Inc. ("FAA"), is a wholly owned subsidiary of EyeMed and a duly licensed third-party administrator in required states to provide certain administrative services available to Plan Sponsor's Members who have vision care coverage contained in their Plans.

NOW, THEREFORE, in accordance with the terms and conditions contained herein, the parties agree as follows:

I. EFFECTIVE DATE, TERM AND RENEWAL

A. Effective Date

This Agreement is effective November 1, 2010 ("Effective Date") and shall continue until terminated pursuant to this Agreement. For purposes of this Agreement: (i) all references to "Business Days" shall mean a day when both EyeMed and/or FAA and Plan Sponsor are open for business, excluding Saturday and Sunday; and (ii) any references to a particular time of the day shall be considered Eastern Time.

B. Term

The Agreement shall commence on the Effective Date have an initial term of forty-eight (48) months and shall renew for two 1 year renewals unless (i) Plan Sponsor gives written notice to EyeMed at least ninety (90) days prior to the expiration of the initial term or any twelve (12) month renewal term; (ii) EyeMed gives written notice to Plan Sponsor at least one hundred eighty (180) days prior to the expiration of the initial term or any twelve (12) month renewal term; or (iii) the Agreement is otherwise terminated in accordance with Section XIII.

C. Renewal

At least one hundred twenty (120) calendar days prior to the end of the current term, EyeMed shall provide Plan Sponsor with written notice of the Vision Benefits revised rates for the renewal period. If Plan Sponsor does not agree to the revised rates, this Agreement shall terminate at the end of the current term.

D. Definitions

Capitalized terms and otherwise defined terms within the section are defined on Exhibit A.

II. RESPONSIBILITIES OF EYEMED

A. Services

EyeMed shall provide the following:

1. Vision Benefit

EyeMed shall make available to Members the Vision Benefit as set forth on Exhibit B at Participating Provider locations. EyeMed shall also provide additional services, including but not limited to, responding to questions from Members, Providers and Plan Sponsor regarding Vision Benefits.

2. Enrollment Information for Participants

EyeMed shall maintain Participant enrollment records based on and in reliance upon data furnished to it by Plan Sponsor or its agent.

3. Identification Cards/Member Materials/SPD Review

EyeMed shall design, produce and distribute identification cards. In addition, upon request, EyeMed shall make available open enrollment materials and other communication materials. EyeMed agrees to review and advise concerning the description of Vision Benefits within Plan documents, including the Summary Plan Description and other materials intended for distribution to Participants.

4. Customer Service

EyeMed shall train and maintain adequate levels of staff as determined by EyeMed and provide a toll-free telephone number to respond to inquiries from Plan Sponsor's administrative staff, Members and Participating Providers concerning the Vision Benefit.

5. Web Access

EyeMed will maintain web access to the Vision Benefit and Member's eligibility information.

6. Usage Reporting

EyeMed shall provide standard usage reports quarterly, as defined by EyeMed, at no charge. All other requested reports shall be produced upon the mutual agreement of the parties, including but not limited to any associated cost(s) for such report(s).

7. Reporting Assistance for Plan Sponsor

EyeMed shall provide to Plan Sponsor reports regarding the financial and claims experience of the Plan, and other information the Plan Sponsor reasonably requires that assists Plan Sponsor in its compliance with income tax, ERISA reporting and disclosure requirements.

B. Provider Network Services and Provider Locator Service

1. Participating Provider Network

EyeMed shall provide a Vision Network of ophthalmologists, optometrists, opticians, and retail optical locations that are contracted with EyeMed to deliver services consisting of vision exams, materials, and contact lenses, at negotiated prices ("Participating Providers"). Any additions or deletions to the Vision Network shall be in EyeMed's sole discretion; provided, however, that EyeMed will make reasonable efforts to provide Plan Sponsor with reasonable advance notice of significant changes in the Vision Network, which would materially affect the nature or extent of services provided to Participants. EyeMed shall reimburse the Participating Provider at the rate contracted between EyeMed and the Participating Provider, which may be an amount different than what is set forth on Exhibit B.

2. Participating Provider Independent Contractor

EyeMed does not employ Participating Providers and such providers are not EyeMed's agents or partners. Participating Providers participate in the Vision Network only as independent contractors. Participating Providers are solely responsible for exercising professional judgment related to a Participant's care.

3. Participating Provider Locator

EyeMed shall maintain a provider locator service of Participating Providers that the Member may access through a toll-free telephone number or via the EyeMed website.

4. Credentialing

EyeMed shall credential, contract with, and re-credential each ophthalmologist and optometrist in accordance with EyeMed's credentialing procedures, which meet NCQA standards. EyeMed may contract with a NCQA accredited credentials verification organization of their choice to perform verifications of the credentials.

5. Nondiscrimination

EyeMed's Participating Providers Agreement requires Participating Providers make its services available to Members on the same basis as those services are provided to all other patients, and that Participating Provider shall not discriminate on the basis of age, sex, race, religion, or color.

6. Balance Billing

EyeMed's Participating Provider Agreement requires providers to not balance bill Members for Vision Benefits; provided, however, a Participating Provider shall collect from Members any copayment or coinsurance amounts for which Members are financially obligated under the ERISA Plan and any non-covered service(s).

C. Claims Processing Services

1. Claims Submission

FAA shall process in-network and out-of-network claims for Vision Benefits. In-network claims will be submitted directly to FAA by the Participating Provider. Out-of-network claims must initially be paid by the Member in full; the Member may then submit the out-of-network claim directly to FAA on the appropriate claim form. EyeMed shall make the out-of-network claim form available to Members through a toll-free telephone number or on the EyeMed website.

2 Claims Delegation

Plan Sponsor delegates to FAA the discretionary authority to determine the validity of claims and appeals under the ERISA Plan.

3. Claims Processing Services

FAA shall: (a) determine the amount of Vision Benefits payable, if any, for each claim; (b) notify the Member its decision concerning the claim; (c) disburse payments to the Participating Provider (per the Participating Provider Agreement) or the Member (per the out-of-network information on Exhibit B), as applicable. FAA's services under this paragraph shall comply with the provisions of ERISA Section 503 and its implementing regulations, to the extent that they address initial claims for benefits.

4. Claims Review Services

FAA shall provide for a review of denied claims upon request by the Member. FAA shall notify the Member of its decision on review. FAA's services under this paragraph shall comply with the provisions of ERISA Section 503 and its implementing regulations, to the extent that they address decisions on review.

5. Run-Out Claims Services

After the termination of this Agreement, FAA shall continue to provide claims processing services and claims review services, but only for those claims incurred prior to the date of termination of the Agreement. FAA shall provide such services for a period of 12 calendar months (the "Run-Out Period") following termination. During the Run-Out Period, FAA will continue to invoice the Plan Sponsor for the claims cost, and will additionally invoice the Plan Sponsor for an administrative fee equal to 6% of the claims cost. Plan Sponsor will be responsible for payment of such invoices. Invoicing and payment procedures applicable during the term of this Agreement shall continue to be applicable during the Run-Out Period. This clause shall survive the termination of this Agreement.

III. RESPONSIBILITIES OF PLAN SPONSOR

A. Responsibility for the ERISA Plan

1. Plan Administrator

Plan Sponsor is the Plan Administrator (as that term is defined in Section 3 (16) of the Employee Retirement Income Security Act of 1974 ("ERISA")) of the Plan. Plan Sponsor may name another entity or individual as Plan Administrator, provided that such Plan Administrator is not EyeMed or FAA and is not an EyeMed or FAA employee. EyeMed or FAA expressly decline to accept responsibility for being Plan Administrator.

2. Final Authority for the Plan

Plan Sponsor retains all final authority and responsibility for the Plan and its operations. Both parties shall be responsible for compliance with any and all applicable laws and regulations.

3. Plan Amendment and Certification from Plan Sponsor

Plan Sponsor represents and warrants that: (a) its ERISA Plan documents have been amended, in accordance with 45 CFR §164.504(f), so as to allow Plan Sponsor to receive Protected Heath Information; (b) the Plan Sponsor has received a certification from the ERISA Plan in accordance with 45 CFR §164.504(f)(2)(ii), and will provide a copy of such certification to EyeMed prior to the Effective Date; (c) the ERISA Plan document amendments permit Plan Sponsor to receive detailed invoices from FAA; and (d) Plan Sponsor has determined, through its own policies and procedures, that the detailed invoice from FAA contains the minimum information necessary for Plan Sponsor to carry out its payment and health care operations.

B. Enrollment Services

1. Participant Enrollment Information

Plan Sponsor will determine Participants eligibility in the Plan and provide EyeMed with data sufficient to enable EyeMed to maintain accurate Participant enrollment records. In the event benefits under the Plan are made available to an individual who is no longer eligible to receive such benefits resulting from Plan Sponsor's failure to timely notify FAA of the ineligibility of such individual, Plan Sponsor shall be liable to FAA for the payment of all benefits provided to such individual.

2. Membership File.

Plan Sponsor shall be responsible for determining and identifying those individuals that the Plan Sponsor determines is eligible to receive vision benefits under the ERISA Plan.

(a) Data Format. Plan Sponsor will provide EyeMed with electronic Member enrollment in either (i) the EyeMed standard data layout format; or (ii) the format required by the HIPAA rule governing the enrollment and disenrollment in a health plan transaction, as outlined in 42 CFR 162.1502, as it may be amended from time to time.

(b) Data Transmission Method. The electronic Member enrollment information shall be sent to EyeMed utilizing either (i) a secure FTP transmission or (ii) secure email.

(c) Data Updates. Plan Sponsor agrees to provide full electronic file updates no more frequently than two (2) times per calendar month in the agreed to format. Plan Sponsor may also utilize the EyeMed Group Portal for interim additions, changes or deletions related to Members and Plan Sponsor agrees to include all such interim modifications on the next full electronic file update.

(d) Changes to Data Format. Plan Sponsor and EyeMed must mutually agree in advance to changes to the electronic data format. Plan Sponsor must contact the EyeMed Account Service Manager to submit a request to change the current data format.

(e) Data Accuracy and Reliance. Plan Sponsor represents and warrants that, to the best of its ability, the electronic Member enrollment will be accurate and that EyeMed may rely on such information to authorize services for such enrolled Members.

IV. INVOICING ARRANGEMENTS

A. Invoice for Vision Benefits

FAA shall invoice Plan Sponsor on a monthly basis for eligible claims processed and paid during the previous month ("Claims Invoice"). In addition, FAA shall invoice Plan Sponsor a monthly administration fee as set forth on Exhibit B ("Administrative Invoice"). The monthly Administrative Invoice shall be determined by multiplying the number of Members identified by Plan Sponsor's electronic Member enrollment by the applicable rate set forth on Exhibit B. For purposes of the Administrative Invoice, FAA will count the Members who are active and eligible for the applicable billing month as of the 15th day of each month prior to the billing month in which the invoice is issued to Plan Sponsor. For example, FAA will determine the active and eligible Members for the July invoice as of June 15th.

B. Payment of Invoice

Plan Sponsor shall pay the entire amount of both the Claims Invoice and Administrative Invoice (excluding only "Disputed Amounts", as defined below) within thirty (30) calendar days from the date of each invoice. If any non-Disputed Amount owed by Plan Sponsor to EyeMed and/or FAA is not paid within sixty (60) calendar days of the date of such invoice, EyeMed may apply interest equal to one and one-half percent (1.5%) per month. In addition, if any Disputed Amount agreed or

determined to be owed by Plan Sponsor to EyeMed is not paid within fifteen (15) business days from the date of such agreement or determination, EyeMed may apply interest equal to one and one-half percent (1.5%) per month. Payment shall be considered credited to the account of Plan Sponsor when received by EyeMed. As used herein, "Disputed Amounts" shall mean invoice amounts that are subject to a bona fide dispute raised by Plan Sponsor in a writing received by EyeMed within fifteen (15) calendar days of the date of an invoice therefore and with respect to which the parties are making reasonable, diligent and good faith efforts to resolve.

V. RECORDS MAINTENANCE AND AUDIT

A. Records Maintenance

EyeMed owns and shall keep all books and records necessary to reflect accurately the business it transacts with respect to Plan Sponsor and to determine the respective rights of the parties under this Agreement. Such books and records shall be kept at the principal place of business of EyeMed or at such other location as EyeMed determines in its sole discretion. All records will be maintained for a period of at least seven (7) years after the date they are first prepared or for such longer period as may be required by law.

B. Audit

During the term of the Agreement, and at any time within twelve (12) months following its termination, Plan Sponsor or a mutually agreeable entity or a regulatory authority with jurisdiction over Plan Sponsor may audit or inspect the records of EyeMed and/or FAA to determine whether EyeMed and/or FAA is fulfilling the terms of this Agreement. Plan Sponsor must advise EyeMed and/or FAA at least thirty (30) calendar days in advance of Plan Sponsor's intent to audit. The place, time, type, duration, and frequency of all audits must be agreed to in writing by EyeMed and/or FAA in advance of the audit, which approval shall not be unreasonably withheld, excluding any information, including but not limited to, reports that EyeMed considers to be proprietary.

1. All audits shall be on a regular business day, during normal business hours and conducted in such manner as to avoid, to the extent reasonably possible, interference with the normal business functions of EyeMed and/or FAA. Plan Sponsor shall be solely responsible for all costs of the audit, except for any EyeMed and/or FAA employee time and office space. In addition, Plan Sponsor shall have the right to make copies, at Plan Sponsor's expense, of applicable files, records or other information maintained by EyeMed and/or FAA related to Plan Sponsor.

2. All audits shall be limited to information relating to the calendar year in which the audit is conducted and/or the immediately preceding calendar year. With respect to EyeMed's and/or FAA's transaction processing services, the audit scope and methodology shall be consistent with generally acceptable auditing standards, including a statistically valid random sample or other acceptable audit technique as approved in writing.

3. Plan Sponsor will provide EyeMed and/or FAA with a copy of any audit reports.

VI. INDEMNIFICATION

A. EyeMed and/or FAA Indemnification to Plan Sponsor

EyeMed and/or FAA will indemnify, defend and hold Plan Sponsor harmless from and against any loss, cost, damage, expense or other liability, including, without limitation, reasonable costs and reasonable attorney fees ("Costs") incurred in connection with any third party claims, suits, investigations or enforcement actions, including claims of infringement of any intellectual property rights ("Claims") which may be asserted against, imposed upon or incurred by Plan Sponsor and arising as a result of (i) EyeMed's and/or FAA's negligent acts or omissions or willful misconduct, or (ii) EyeMed's and/or FAA's breach of its obligations under this Agreement. EyeMed and/or FAA shall not be liable to Plan Sponsor for any third party claims, suits, investigations or enforcement actions, arising directly or indirectly from the acts or omissions of a Participating Provider.

B. Plan Sponsor Indemnification to EyeMed and/or FAA

Plan Sponsor will indemnify, defend and hold EyeMed and/or FAA harmless from and against any loss, cost, damage, expense or other liability, including, without limitation, reasonable costs and reasonable attorney fees ("Costs") incurred in connection with any third party claims, suits, investigations or enforcement actions, including claims of infringement of any intellectual property rights ("Claims") which may be asserted against, imposed upon or incurred by EyeMed and/or FAA and arising as a result of (i) Plan Sponsor's negligent acts or omissions or willful misconduct, or (ii) Plan Sponsor's breach of its obligations under this Agreement.

C. Notification of Claim

The party seeking indemnification shall notify the indemnifying party in writing within thirty (30) calendar days of receipt of any Claim for which indemnification may be sought hereunder, and shall tender the defense of such claim to the indemnifying party thereafter.

D. Survival

This clause shall survive the termination of this Agreement.

VII. INSURANCE

A. Commercial General Liability Insurance

EyeMed shall maintain Commercial General Liability Insurance, including coverage for contractual liability, public liability, property damage, products-completed operations, cross liability and severability of interest claims, personal injury and advertising injury, with limits of at least:

$3,000,000 per occurrence
$6,000,000 general aggregate

B. Workers' Compensation Insurance

EyeMed shall maintain Workers' Compensation Insurance with benefits afforded under the laws of any state in which the services are to be performed and Employer's Liability insurance with limits of at least:

$1,000,000 for Bodily Injury – each accident
$1,000,000 for Bodily Injury by disease – policy limits
$1,000,000 for Bodily Injury by disease – each employee

In states where Workers' Compensation Insurance is a monopolistic state-run system, EyeMed shall maintain Stop Gap Employer's Liability insurance with limits not less than One Million Dollars ($1,000,000) each accident or disease.

C. Business Automobile Insurance

EyeMed shall maintain Business Automobile Insurance with limits of at least One Million Dollars ($1,000,000) each accident for bodily injury and property damage, extending to all owned, hired and non-owned vehicles.

D. Commercial Crime Insurance

EyeMed shall maintain Commercial Crime Insurance with a limit of not less than Three Million Dollars ($3,000,000). The policy shall provide Employee Theft, Premises, Transit, Depositor's Forgery and Computer Theft and Funds Transfer coverages. The Commercial Crime policy shall include a third party customer property coverage endorsement with limits of at least One Million Dollars ($1,000,000).

E. Managed Care Error and Omissions Insurance

EyeMed shall maintain Managed Care Organization Errors and Omissions Insurance with a policy limit of not less than Three Million Dollars ($3,000,000) each claim and in the aggregate.

F. Policies of Insurance--Financial Rating

All policies of insurance required of EyeMed herein shall be issued by insurance companies having and maintaining a Financial Strength Rating of "A minus" or better and a Financial Size Category of "VII" or better in the A.M. Best Key Rating Guide for Property and Casualty Insurance Companies, except that, in the case of Workers' Compensation insurance, EyeMed may procure insurance from the stated fund of the state where services are to be provided.

G. Proof of Insurance

Upon Plan Sponsor's written request, certificates of insurance shall be delivered to Plan Sponsor upon execution of the Agreement. All policies of insurance will provide for at least thirty (30) days prior written notice to Plan Sponsor of the cancellation or substantial modification thereof. All policies required of EyeMed herein shall be endorsed to read that such policies are primary policies and any insurance carried by Plan Sponsor shall be noncontributing with such policies

VIII. LICENSE TO USE NAME AND TRADEMARKS

A. Plan Sponsor's Use of EyeMed's Name

Plan Sponsor may use the EyeMed name, as provided by EyeMed (the "Licensed Marks") solely in connection with communicating the Vision Benefit to its Members, and shall not use the Licensed Marks or any other trademarks, services marks or trade names of EyeMed (the "Trademarks") for any other purpose. Plan Sponsor shall not use EyeMed's logo without prior written consent or inconsistent with the attached Link and Logo Terms and Conditions related to website linking. Plan Sponsor shall not question, contest or challenge EyeMed's rights in and to the Trademarks, nor seek to register the same. Plan Sponsor expressly recognizes and acknowledges that the use of the Licensed Marks shall not

confer upon Plan Sponsor any proprietary rights to such marks. Upon termination of this Agreement, Plan Sponsor shall immediately stop using the Licensed Marks.

B. EyeMed's Use of Plan Sponsor's Name

EyeMed may use Plan Sponsor's name and logo(s) as provided by Plan Sponsor (the "Licensed Marks") solely in connection with communicating the Vision Benefit, and shall not use the Licensed Marks or any other trademarks, service marks or trade names of Plan Sponsor ("Trademarks") for any other purpose. EyeMed shall not question, contest or challenge Plan Sponsor's rights in and to the Trademarks, nor seek to register the same. EyeMed expressly recognizes and acknowledges that the Licensed Marks shall not confer upon EyeMed any proprietary rights to such marks. Upon termination of this Agreement, EyeMed shall immediately stop using the Licensed Marks.

C. Remedies

The parties expressly agree and understand that the remedy at law for any breach by it of the terms of this section would be inadequate and the damages flowing from such breach are not readily susceptible to being measured in monetary terms. Accordingly, it is acknowledged by each party that upon its breach of any provision of this section, the non-breaching party shall be entitled to seek immediate injunctive relief and may seek to obtain a temporary order restraining any threatened or further breach without the necessity of proof of actual damage. Nothing contained herein shall be deemed to limit the non-breaching party's remedy at law or in equity for any breach by the breaching party of the provisions of this section which may be pursued or availed of by the non-breaching party.

X. WEBSITE LINKING BY PLAN SPONSOR

EyeMed is the owner or operator of a web site located at www.eyemedvisioncare.com (the "EyeMed Site"). Plan Sponsor is the owner or operator of a web site (the "Plan Sponsor Site"). EyeMed and Plan Sponsor desire to allow users of the Plan Sponsor Site to link to the EyeMed Site landing on EyeMed's home page.

In the event Plan Sponsor establishes a hyperlink from Plan Sponsor's Site to EyeMed's site the parties hereby agree to the terms and conditions as set forth in the attached Link and Logo Terms and Conditions, Exhibit C.

X. PROTECTION OF CONFIDENTIAL INFORMATION

Plan Sponsor and EyeMed shall not disclose to any other person, firm or corporation, or use for its own benefit except as provided herein, the terms of this Agreement, or any information that it receives from the other party that is marked either "Confidential" or "Proprietary" or "Strictly Private" or "Internal Data," or that is any unmarked information in the form of financial information or trade secrets (collectively referred to as "Confidential Information"), without the express written authorization of the other party. Both parties shall take all necessary steps to protect the other party's trade secrets and confidential business information and records. Upon the termination of this Agreement, both parties agree to return any and all materials containing such Confidential Information, plus any and all copies, written or machine made, in whatever medium, that it may have, within ten (10) days of a request from the other party.

Confidential Information shall not include information that:

A. Was, at the time of receipt, otherwise known to the recipient without restrictions as to use or disclosure;

B. Was in the public domain at the time of disclosure or thereafter enters into the public domain through no breach of this Agreement by the recipient;

C. Becomes known to the recipient from a source other than the disclosing party, which source has no duty of confidentiality with respect to the information;

D. Is independently developed by the recipient without reliance on or access to any of the disclosing party's Confidential Information; or

E. Is required to be disclosed by a government agency or bureau, by a court of law or equity with competent jurisdiction over the recipient or by a recognized body engaged in professional self-regulation (such as national accounting or auditing associations), provided that the recipient will first have provided the disclosing party with prompt written notice of such required disclosure and will take reasonable steps to allow the disclosing party to seek a protective order with respect to the Confidential Information required to be disclosed. The recipient will promptly cooperate with and assist the disclosing party, at the disclosing party's expense, in connection with obtaining such protective order.

XI. BUSINESS ASSOCIATE AGREEMENT/HIPAA PRIVACY

In order to comply with the Administrative Simplification Provisions of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et. seq., and regulations promulgated thereunder, as amended from time to time (statute and regulations hereafter collectively referred to as "HIPAA"), the parties hereby agree to the terms and conditions described in the attached Business Associate Agreement-HIPAA Privacy, Exhibit D. Terms used, but not otherwise defined, shall have the same meaning as those terms in HIPAA.

XII. TERMINATION

A. Voluntary Termination

This Agreement may be terminated, without cause: (i) by mutual written agreement of the parties; or (ii) by either party providing sixty (60) days prior written notice without cause to the other party at any time during the term of the Agreement or any renewal term.

B. Termination for Cause or Default

Either party may terminate this Agreement if the other party is in material breach of this Agreement and fails to cure such breach within thirty (30) calendar days after receiving written notice reasonably detailing such breach. In the event that the breach is not cured within the thirty (30) day cure period, this Agreement shall terminate in accordance with the initial notice of breach. Additionally, either party shall be deemed to have materially breached this Agreement upon the occurrence of any of the following events, which list is not intended to be inclusive of what constitutes a material breach:

1. Either party shall become insolvent or otherwise admit in writing its inability to pay its debts when they become due, becomes bankrupt, seeks protection under any law for the protection of insolvents, or have a receiver or conservator appointed under any law pertaining to such party's insolvency.

2. Either party fails to remit any amounts due (excluding Disputed Amounts") under this Agreement within thirty (30) calendar days of the date such amount is due and payable.

3. Either party shall knowingly commit a material violation of the laws or regulations of any state where this Agreement is performed.

4. Any misrepresentation or falsification of any information supplied by Plan Sponsor or EyeMed for consideration by the other, except that EyeMed will not be responsible for any misrepresentation or falsification of information provided to it by a Participating Provider.

5. EyeMed or Plan Sponsor ceases to engage in all business activities.

6. EyeMed substantially fails to perform its obligations under this Agreement, including but not limited to maintaining an adequate Vision Network of Participating Providers, maintaining a Participating Provider locator service for Members to be able to locate Participating Providers, and maintaining sufficient customer service representatives to answer Member and Participating Provider calls.

7. FAA is in default of its payment obligations to any Participating Provider or Members with respect to the services rendered under this Agreement to the Member and fails to cure such default within ten (10) business days of written notice from Plan Sponsor, so long as FAA does not dispute in good faith the amount that is owed to the Participating Provider or Member. If FAA disputes in good faith that any money is owed or the amount which is owed, FAA is not in default under this Agreement.

XIII. GENERAL PROVISIONS

A. Requirements Imposed by Law

Each party agrees to adhere to legal requirements imposed by federal, state or other law as of the date such law becomes effective and applicable to this Agreement.

B. Independent Contractor

In the performance of the work, duties and obligations of the parties pursuant to this Agreement, each of the parties shall at all times be acting and performing as an independent contractor, and nothing in this Agreement shall be construed or deemed to create a relationship of employer and employee or partner or principal and agent.

C. Governing Law

This Agreement shall be governed by and construed in accordance with ERISA, federal law, and to the extent not preempted, by the laws of the State of Ohio.

D. Entire Contract

This Agreement together with all attachments contains all the terms and conditions agreed upon by the parties, and supersedes all other agreements, express or implied regarding the subject matter.

E. Waiver

The waiver of any party of any breach of this Agreement shall not be construed as a continuing waiver or a waiver of any other breach of this Agreement.

F. Attorney Fees

If EyeMed or Plan Sponsor find it necessary to enforce any part of this Agreement through legal proceedings, resulting in final judgment by a court of competent jurisdiction, Plan Sponsor and EyeMed agree that each party shall pay all of their own costs and attorneys' fees incurred for such purpose.

G. Severability

In the event that any clause, term, or condition of this Agreement shall be held invalid or contrary to law, this Agreement shall remain in full force and effect as to all other clauses, terms, and conditions.

H. Force Majeure

No party to this Agreement shall be liable for failure to perform any duty or obligation that such party may have under this Agreement where such failure has been caused by an act of God, fire, flood, strike, unavoidable accident, war or any cause outside the reasonable control of the party who had the duty to perform.

I. Heading

The section headings used herein are for reference and convenience only, and shall not enter into the interpretation hereof.

J. Counterparts

This Agreement may be executed in several counterparts, each of which shall be deemed an original, but all of which shall constitute one Agreement.

K. Assignment

This Agreement may not be assigned by a party, in whole or in part, without the prior written consent of the other, except that a party may, without the consent of the other, assign this Agreement to an affiliate.

L. Successor/Survival

All terms of this Agreement shall be binding upon, inure to the benefit of, and be enforceable by the parties hereto and their respective successors and assigns. All rights and obligations of the parties arising out of this Agreement prior to termination which by their nature are designed or intended to continue shall survive the termination of this Agreement.

M. Amendments

This Agreement may be amended from time to time by mutual agreement between Plan Sponsor and EyeMed, which amendment shall be in writing signed by the parties. Notwithstanding any provision contained herein to the contrary, each party shall have the right, for the purpose of complying with the provisions of any law or lawful order of a court or regulatory authority, to amend this Agreement including any Exhibits hereto, to increase, reduce or eliminate any of the Vision Benefits provided under this Agreement. If the parties cannot agree to an amendment, notwithstanding any provision of this Agreement to the contrary, Plan Sponsor or EyeMed may terminate this Agreement as of the end of any month by the giving of ninety (90) days prior written notice.

N. No Third Party Beneficiaries. Nothing express or implied in this Agreement is intended or shall be construed to confer upon or give any person, other than Plan Sponsor and EyeMed, any right or remedies under or by reason of this Agreement.

O. Notice

All notices, requests and demands under this Agreement shall be in writing. They shall be deemed to have been given upon delivery if (i) delivered in person, (ii) mailed by certified mail, postage pre-paid and return receipt requested, and (iii) deposited with an overnight delivery service by a nationally recognized overnight courier service. Notice shall be effective upon receipt and shall be directed to the individuals below and at the address in the first paragraph.

If to Plan Sponsor:	Ms. Leslie Edwards Benefits Administerator
If to EyeMed or FAA	Ms. Liz DiGiandomenico President CC: EyeMed Legal

IN WITNESS WHEREOF, the undersigned have executed this Agreement.

EyeMed Vision Care, LLC

By: _____
Kevin Thilst

Title: VP-Client Services

Date: 11-5-10

First American Administrators, Inc.

By: _____
Kevin Thilst

Title: VP Client Services

Date: 11-5-10

UAW/UMass Health & Welfare Trust Fund

By: Susan Chinman

Name: Susan Chinman

Title: University Trustee

Date: 10/22/10

Ronald R. Potwora

President UAW 2322

10/22/10

EXHIBIT A- DEFINITIONS

I. DEFINITIONS

The following terms used in this Agreement shall have the meaning as set forth hereafter:

A. "Agreement" shall mean the Fee for Service Agreement between EyeMed and/or FAA and Plan Sponsor

B. "Business Days" shall mean a day when both EyeMed and/or FAA and Plan Sponsor are open for business, excluding Saturday and Sunday.

C. "ERISA" shall mean the Employee Retirement Income Security Act of 1974.

D. "HIPAA" shall mean Health Insurance Portability and Accountability Act of 1996.

E. "Members" shall mean the Participant and eligible dependents who have health benefits under the ERISA Plan.

F. "PHI" shall mean Protected Health Information.

G. "Participants " shall mean the individual who has an employment arrangement, contractual arrangement, or affiliation with Plan Sponsor.

H. "Participating Provider" shall mean the ophthalmologists, optometrists, opticians, and retail optical locations who are contracted with EyeMed to deliver services consisting of vision exams, materials, and contact lenses, at negotiated prices.

I. "Plan" or "ERISA Plan" shall mean the plan established by the employer or other entity for self-funding vision benefits.

J. "Plan Administrator" shall mean the employer name in the plan document as responsible for day-to-day operations. Also known as the Plan Sponsor.

K. "Plan Sponsor" shall mean the entity that sponsor the vision plan.

L. "Vision Benefit" " shall mean the vision benefit as set forth on Exhibit B available to Members from Participating Providers.

M. "Vision Network" shall mean the collection of Participating Providers; the specific network as identified on Exhibit B.

EXHIBIT B – BENEFIT SCHEDULE

EyeMed Vision Care

UMASS/UAW - GEO Vision
EyeMed Select Plan H, Fee For Service
100% Employer Paid -OR- Bundled With Group Medical or Dental
Option 1

Version 4

Vision Care Services	Member Cost	Group Cost per Service	Out-of-Network
Exam with Dilation as Necessary	$10 Copay	Up to $35	$50
Exam Options:			
Standard Contact Lens Fit and Follow-Up:	Up to $40	N/A	N/A
Premium Contact Lens Fit and Follow-Up:	10% off Retail	N/A	N/A
Frames:			
Any available frame at provider location	$0 Copay; $120 Allowance, 20% off balance over $120	$65	$66
Standard Plastic Lenses			
Single Vision	$10 Copay	$25	$42
Bifocal	$10 Copay	$45	$78
Trifocal	$10 Copay	$80	$130
Standard Progressive Lens**	$25	$95	$78
Premium Progressive Lens**	$25, 80% of Charge less $120 Allowance	$95	$78
Lens Options:			
UV Treatment	$15	$0	N/A
Tint (Solid and Gradient)	$15	$0	N/A
Standard Plastic Scratch Coating	$15	$0	N/A
Standard Polycarbonate - Adults	$40	$0	N/A
Standard Polycarbonate - Kids under 19	$40	$0	N/A
Standard Anti-Reflective Coating	$45	$0	N/A
Polarized	20% off Retail Price	$0	N/A
Other Add-Ons	20% off Retail Price	$0	N/A
Contact Lenses			
(Contact lens allowance includes materials only)			
Conventional	$0 Copay; $135 allowance, 15% off balance over $135	$114.75	$108
Disposable	$0 Copay; $135 allowance, plus balance over $135	$135	$108
Medically Necessary	$0 Copay, Paid-in-Full	Retail less 5%	$200
Laser Vision Correction			
Lasik or PRK from U.S. Laser Network	15% off retail price or 5% off promotional price	N/A	N/A
Additional Pairs Benefit:	Members also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used.	N/A	N/A
Frequency:			
Examination	Once every 12 months		
Lenses	Once every 12 months		
Contact Lenses	Once every 12 months		
Frame	Once every 12 months		
Monthly Administrative Fee			
Per Subscriber Per Month (Composite)	$0.93		

All plans are based on a 48-month contract term and 48-month rate guarantee

** Standard/Premium Progressive lenses not covered - Rated as a Bifocal Lens

Additional Discounts:
Member receives a 20% discount on items not covered by the plan at network Providers, which cannot be combined with any other discounts or promotional offers. Discount does not apply to Eyefitad Provider's professional services, or contact lenses.
Members also receive 15% off retail price or 5% off promotional price for Lasik or PRK from the US Laser Network, owned and operated by LCA Vision.
After initial purchase, replacement contact lenses may be obtained via the Internet at substantial savings and mailed directly to the member. Details are available at www.eyemedvisioncare.com.
The contact lens benefit allowance is not applicable to this service.
Benefit Allowances provide no remaining balance for future use within the same Benefit Frequency.
Certain brand name Vision Materials in which the manufacturer imposes a no-discount practice.

Rates are valid for groups domiciled in the State of MA.
Fees quoted will be valid until the 11/1/2010 plan implementation date. Date quoted: 8/21/2010.
Rates assume 100% employer contribution for employees and dependents or that the vision program is bundled with medical/dental benefit.

Plan Exclusions:
1) Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; 2) Medical and/or surgical treatment of the eye, eyes or supporting structures;
3) Any eye or Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; Safety eyewear
4) Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof;
5) Plano (non-prescription) lenses and/or contact lenses; 6) Non-prescription sunglasses; 7) Two pair of glasses in lieu of bifocals;
8) Services or materials provided by any other group benefit plan providing vision care;
9) Services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order.
10) Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available.

If UMASS/UAW - GEO Vision has chosen this benefit design, attach this document to the group application and sign here:

Signature _____ Date 8/17/10 TCo

EXHIBIT C - LINK AND LOGO TERMS AND CONDITIONS

I. LINKING RIGHTS

A. Use of EyeMed Marks. EyeMed hereby grants Plan Sponsor the limited right to use the EyeMed Marks on the Plan Sponsor Site as a hyperlink to the EyeMed Site (the "Hyperlink"). "EyeMed Marks" means the trademarks, service marks, domain names, logos, and identifiers of EyeMed listed in Attachment A to this Agreement, which is incorporated herein.

B. Hyperlink. The Hyperlink will only be accessible to those Plan Sponsor Members users who are valid and existing Plan Sponsor Members. Plan Sponsor agrees to provide EyeMed upon request all information and data necessary to authenticate such users access to the EyeMed Site.

C. Ownership of Materials. Each Party retains all rights, title and interest in and to their respective web sites, including all intellectual property rights therein. All rights, title and interest in and to the EyeMed Marks, including all intellectual property rights therein, are owned and retained exclusively by EyeMed and its affiliates.

II. REPRESENTATIONS AND WARRANTIES.

A. EyeMed Marks. Plan Sponsor represents and warrants that: Plan Sponsor will not (i) use, register or attempt to register any EyeMed Mark as its own, (ii) use, register, or attempt to register any name, logo, mark, domain name, or other identifier which is likely to lead to confusion with the EyeMed Marks, (iii) use the EyeMed Marks in a manner likely to disparage or misrepresent EyeMed, or (iv) use the EyeMed Marks in a manner not expressly permitted by this Agreement or approved in writing by EyeMed. EyeMed represents and warrants that it owns the EyeMed Marks or otherwise has the right to grant the licenses granted herein.

B. The Sites. Each Party represents and warrants to the other with regard to its respective Site that (i) it is the owner or otherwise has the right to use and provide the Site; (ii) the Site is not and will not be obscene, defamatory, libelous, or otherwise offensive to a reasonable person; (iii) they employ customary security measures standard in the industry to protect access to the Sites and (iv) the Site will not be fraudulent, misleading, or in violation of any applicable law.

C. DISCLAIMER OF WARRANTY. EYMED EXPRESSLY DISCLAIMS, AND PLAN SPONSOR HEREBY EXPRESSLY WAIVES, ALL WARRANTIES, EXPRESS OR IMPLIED, INCLUDING, WITHOUT LIMITATION, WARRANTIES OF MERCHANTABILITY, NONINFRINGEMENT, AND FITNESS FOR A PARTICULAR PURPOSE WITH REGARD TO THE EYEMED MARKS.

III. INDEMNIFICATION

Plan Sponsor shall indemnify, defend, and hold harmless EyeMed with respect to any third party claim, including reasonable attorneys' fees (collectively, "Claims"), to the extent that any such Claim is based upon improper access to the EyeMed Site via the Plan Sponsor Site, Breach of any of Plan Sponsor's representations or warranties under this Agreement or obligations under applicable law; or arises out of Plan Sponsor's negligence or willful misconduct.

Attachment A
EYEMED MARKS

Logo. The EyeMed logo most recently provided by EyeMed and described in this Attachment A (or in any such revised logo display standards) is the only logo that may be used by Plan Sponsor.

EyeMed Vision Care

Attachment B
EYEMED INTERNET USE GUIDELINES

Upon execution of the Fee for Services Agreement with EyeMed you will be granted the limited right to use the EyeMed name, trademarks and logos ("marks") in accordance with these Guidelines.

Requirements for Internet/Web Site Use and Hot Linking

Use of the EyeMed name and logo on your web site is permitted for the purpose of providing a link to the EyeMed web site (www.eyemedvisioncare.com), so long as the link satisfies all six (6) of the following requirements:

a. Delivers users to the EyeMed homepage at www.eyemedvisioncare.com.
b. Provides users with a "point and click" feature clearly indicating the link will lead to the EyeMed homepage at www.eyemedvisioncare.com
c. Does not represent or suggest any relationship between the linking site and EyeMed Vision Care (in suggestions of affiliation, endorsement, or sponsorship).
d. Maintains the integrity of the EyeMed layout, content, and look and feel.
e. Delivers users to the EyeMed web site, unaltered, unmodified, unadulterated in any way.
f. Delivers the EyeMed content in its own browser and does not frame the EyeMed content in any way or through any action, including, but not limited to referencing EyeMed or EyeMed Vision Care as a metatag, which may create a misimpression or confusion among users with respect to sponsorship or affiliation.

Eligibility

Any deviation from these Guidelines require prior written approval from EyeMed. Questions regarding use of the EyeMed marks should be addressed to eyemedmarketing@eyemedvisioncare.com.

EXHIBIT D - BUSINESS ASSOCIATE ADDENDUM

I. DEFINITIONS

A. In General. Terms used, but not otherwise defined, in this Addendum shall have the same meaning as those terms in the Applicable Law.

B. Specific Definitions

1. "Applicable Law" shall mean any of the following items, including any amendments to any such item as such may become effective:

   a. the Health Insurance Portability and Accountability Act of 1996 ("HIPAA");

   b. the federal regulations regarding privacy and promulgated with respect to HIPAA, found at Title 45 CFR Parts 160 and 164 (the "Privacy Rule");

   c. the federal regulations regarding electronic data interchange and promulgated with respect to HIPAA, found at Title 45 CFR Parts 160 and 162 (the "Transaction Rule");

   d. the federal regulations regarding security and promulgated with respect to HIPAA, found at Title 45 CFR Parts 160 and 164 (the "Security Rule"); and

   e. the American Recovery and Reinvestment Act of 2009 ("ARRA"), §§ 13400-24.

2. "Business Associate" shall mean EyeMed Vision Care, LLC and First American Administrators, Inc.

3. "Covered Entity" shall mean the Plan Administrator and Plan Sponsor, on behalf of itself and the ERISA Plan.

4. "ePHI" shall mean electronic protected health information within the meaning of 45 CFR § 160.103, limited to the information created, received, maintained, or transmitted by Business Associate from or on behalf of Covered Entity.

5. "HIPAA Breach" shall have the same meaning as the term "breach" in 45 CFR § 164.402.

6. "Protected Health Information" or "PHI" shall have the same meaning as the term "protected health information" in 45 CFR § 160.103, limited to the information created, received, maintained, or transmitted by Business Associate from or on behalf of Covered Entity.

7. "Service Agreement" shall mean the Fee For Service Agreement.

8. "Unsecured PHI" shall have the same meaning as the term "unsecured protected health information" in 45 CFR § 164.402, limited to the information created, received, maintained, or transmitted by Business Associate from or on behalf of Covered Entity.

II. RIGHTS AND OBLIGATIONS OF BUSINESS ASSOCIATE

A. General Obligations

1. **Compliance with Privacy Rule**

   a. Business Associate shall not use or further disclose PHI other than as permitted or required by HIPAA, the Privacy Rule, and this Addendum.

   b. Business Associate shall use appropriate safeguards to prevent use or disclosure of the PHI other than as provided for by this Addendum.

   c. Business Associate shall report to Covered Entity any use or disclosure of PHI, known to Business Associate, that is not permitted by this Addendum.

2. **Compliance with Security Rule.**

   a. Business Associate shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of ePHI.

b. Business Associate shall report to Covered Entity any Security Incident of which Business Associate becomes aware.

3. **Compliance with ARRA.**

a. Business Associate shall comply with the security breach notice requirements provided in Section II.A.4 of the Addendum below.

b. Business Associate shall not receive remuneration, either directly or indirectly, in exchange for PHI, except as may be permitted by ARRA § 13405(d). This paragraph shall be effective 180 days after issuance of final regulations implementing ARRA § 13405.

c. Pursuant to the Privacy Rule, made applicable to Business Associate by ARRA, Business Associate shall adopt, implement, and follow privacy policies and procedures in the same manner and to the same extent as if it were a Covered Entity. This paragraph shall be effective on and after February 17, 2010.

d. Pursuant to the Security Rule, made applicable to Business Associate by ARRA, Business Associate shall adopt, implement, and follow security policies and procedures in the same manner and to the same extent as if it were a Covered Entity. This paragraph shall be effective on and after February 17, 2010.

4. **Notice of Security Breach.**

a. **Notice to the Covered Entity.** Business Associate shall notify the Covered Entity without unreasonable delay and within thirty (30) calendar days of Business Associate's discovery of a HIPAA Breach of Unsecured PHI. The notice to the Covered Entity shall include the identity of each Individual whose Unsecured PHI was involved in the HIPAA Breach, a brief description of the HIPAA Breach and any mitigation efforts. To the extent that the Business Associate does not know the identities of all affected Individuals when it is required to notify the Covered Entity, the Business Associate shall provide such additional information as soon as administratively practicable after such information becomes available. For purposes of this paragraph, a HIPAA Breach shall be treated as discovered as of the first day on which the HIPAA Breach is known or should reasonably have been known to Business Associate (including any person, other than the one committing the HIPAA Breach, which is an employee, officer, or other agent of the Business Associate).

b. **Notice to Individuals**. Business Associate will provide written notice of the HIPAA Breach of Unsecured PHI, on behalf of the Covered Entity, without unreasonable delay but no later than sixty (60) calendar days following the date the HIPAA Breach of Unsecured PHI is discovered or such later date as is authorized under 45 CFR § 164.412 to each Individual whose Unsecured PHI has been, or is reasonably believed by Business Associate to have been, accessed, used, or disclosed as a result of the HIPAA Breach. For purposes of this paragraph, a HIPAA Breach shall be treated as discovered as of the first day on which the HIPAA Breach is known or should reasonably have been known to Business Associate (including any person, other than the one committing the HIPAA Breach, which is an employee, officer, or other agent of the Business Associate).

The content, form, and delivery of such written notice shall comply in all respects with 45 CFR § 164.404(c)-(d).

Business Associate and Covered Entity shall cooperate in all respects regarding the drafting and the content of the notice. To that end, before sending any notice to any Individual, the Business Associate shall first provide a draft of the notice to the Covered Entity. Covered Entity shall have five (5) business days (plus any reasonable extensions) to provide comments on the Business Associate's draft of the notice.

c. **Notice to Media.** Business Associate will provide written notice of the HIPAA Breach of Unsecured PHI, on behalf of the Covered Entity, to the media to the extent required under 45 CFR § 164.406. Business Associate and the Covered Entity shall cooperate in all respects regarding the drafting and the content of the notice. To that end, before sending any notice to the media, Business Associate shall first provide a draft of the notice to the Covered Entity. Covered Entity shall have five (5) business days (plus any reasonable extensions) to provide comments on the Business Associate's draft of the notice.

d. **Notice to Secretary.** Business Associate will provide written notice of the HIPAA Breach of Unsecured PHI, on behalf of the Covered Entity, to the Secretary to the extent required under 45 CFR § 164.408. Business Associate and Covered Entity shall cooperate in all respects regarding the drafting and the content of the notice. To that end, before sending any notice to the Secretary, Business Associate shall first provide a draft of the notice to the Covered Entity. Covered Entity shall have five business days (plus any reasonable extensions) to provide comments on Business Associate's draft of the notice.

If the HIPAA Breach of Unsecured PHI involves less than five hundred (500) individuals, Business Associate will maintain a log or other documentation of the HIPAA Breach of Unsecured PHI which contains such information as would be required to be included if the log were maintained by the Covered Entity pursuant to 45 CFR § 164.408, and provide such log to the Covered Entity within five (5) business days of the Covered Entity's written request.

5. **Subcontractors and Agents.** Business Associate shall ensure that any agent, including a subcontractor, to whom it provides PHI agrees to the same restrictions and conditions that apply through this Addendum to Business Associate with respect to such PHI.

6. **Access to Books and Records by Secretary.** Business Associate shall make its internal practices, books, and records relating to the use, disclosure, and security of PHI available to the Secretary for purposes of the Secretary determining Covered Entity's compliance with HIPAA. Effective February 17, 2010, Business Associate shall make its internal practices, books, and records relating to the use, disclosure, and security of PHI available to the Secretary for purposes of the Secretary determining Business Associate's compliance with HIPAA.

7. **Mitigation.** Business Associate shall mitigate, to the extent practicable, any harmful effect that is known to Business Associate of (a) a use or disclosure of PHI by Business Associate in violation of the requirements of this Addendum, or (b) a Security Incident.

B. **Obligations Relating to Individual Rights**

1. **Restrictions on Disclosures.** Upon request by an Individual, Covered Entity shall determine whether an Individual shall be granted a restriction on disclosure of the PHI pursuant to 45 CFR § 164.522. Covered Entity will not agree to any such restriction, if such restriction would affect Business Associate's use or disclosure of PHI, without the prior consent of Business Associate, provided, however, that effective February 17, 2010, Business Associate's consent is not required for requests that must be granted under ARRA § 13405(a). Covered Entity will communicate any grant of a request, made consistent with the foregoing, to Business Associate. Business Associate will restrict its disclosures of the Individual's PHI in the same manner as would be required for Covered Entity. If Business Associate receives an Individual's request for restrictions, Business Associate shall forward such request to Covered Entity within five (5) business days.

2. **Access to PHI.** Upon request by an Individual, Covered Entity shall determine whether an Individual is entitled to access his or her PHI pursuant to 45 CFR § 164.524. If Covered Entity determines that an Individual is entitled to such access, and that such PHI is under the control of Business Associate, Covered Entity will communicate the decision to Business Associate. Business Associate shall provide access to the PHI in the same manner as would be required for Covered Entity. If Business Associate receives an Individual's request to access his or her PHI, Business Associate shall forward such request to Covered Entity within five (5) business days.

3. **Amendment of PHI.** Upon request by an Individual, Covered Entity shall determine whether any Individual is entitled to amend his or her PHI pursuant to 45 CFR § 164.526. If Covered Entity determines that an Individual is entitled to such an amendment, and that such PHI is both in a designated record set and under the control of Business Associate, Covered Entity will communicate the decision to Business Associate. Business Associate shall provide an opportunity to amend the PHI in the same manner as would be required for Covered Entity. If Business Associate receives an Individual's request to amend his or her PHI, Business Associate shall forward such request to Covered Entity within five (5) business days.

4. **Accounting of Disclosures.** Upon request by an Individual, Covered Entity shall determine whether any Individual is entitled to an accounting pursuant to 45 CFR § 164.528. If Covered Entity determines that an Individual is entitled to an accounting, Covered Entity will communicate the decision to Business Associate. Business Associate will provide information to Covered Entity that will enable Covered Entity to meet its accounting obligations. If Business

Associate receives an Individual's request for an accounting, Business Associate shall forward such request to Covered Entity within five (5) business days.

C. Permitted Uses and Disclosures by Business Associate

Except as otherwise limited in this Addendum or by Applicable Law, Business Associate may:

1. Use or disclose PHI to perform functions, activities, or services for or on behalf of Covered Entity, as specified in the Service Agreement between the Parties and in this Addendum, provided that such use or disclosure (i) is consistent with Covered Entity's Notice of Privacy Practices and (ii) would not violate HIPAA or the Privacy Rule if done by Covered Entity;

2. Use PHI for the proper management and administration of Business Associate or to carry out the legal responsibilities of Business Associate;

3. Disclose PHI for the proper management and administration of Business Associate, provided that (i) Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached or (ii) the disclosures are Required By Law; and

4. Use PHI to provide Data Aggregation services to Covered Entity as permitted by 42 CFR § 164.504(e)(2)(i)(B).

III. RIGHTS AND OBLIGATIONS OF COVERED ENTITY

A. Privacy Practices and Restrictions

1. Upon request, Covered Entity shall provide Business Associate with the notice of privacy practices that Covered Entity produces in accordance with 45 CFR § 164.520. If Covered Entity subsequently revises the notice, Covered Entity shall provide a copy of the revised notice to Business Associate.

2. Covered Entity shall notify Business Associate of any restriction to the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 CFR § 164.522. Covered Entity shall provide Business Associate with any changes in, or revocation of, permission by an Individual to use or disclose PHI, if such changes affect Business Associate's permitted or required uses and disclosures.

B. Permissible Requests by Covered Entity

Covered Entity shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under the Privacy Rule if done by Covered Entity.

IV. TERM AND TERMINATION

A. Term. The term of this Addendum shall begin on the Effective Date, and shall end upon the termination of the Services Agreement or upon termination for cause as set forth in the following Section IV.B, whichever is earlier.

B. Termination for Cause. Upon any Party's knowledge of a material breach of this Addendum by another Party, the nonbreaching Party shall have the following rights:

1. If the breach is curable, the nonbreaching party may provide an opportunity for the other Party to cure the breach or end the violation. Alternatively, or if the other Party fails to cure the breach or end the violation, the nonbreaching Party may terminate this Addendum and the Services Agreement.

2. If the breach is not curable, the nonbreaching Party may immediately terminate this Addendum and the Services Agreement.

3. If termination is not feasible, the nonbreaching Party may report the problem to the Secretary.

C. Effect of Termination.

1. Except as provided in the following paragraph, upon termination of this Addendum, for any reason, Business Associate shall return or destroy all PHI within its possession or control, and

all PHI that is in the possession or control of Business Associate's subcontractors or agents. Business Associate shall retain no copies of the PHI.

2. If Business Associate determines that returning or destroying the PHI is infeasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction infeasible. Business Associate shall extend the protections of this Addendum to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such PHI.

V. Miscellaneous

A. Electronic Health Records. The Parties agree that Business Associate shall not maintain any "electronic health record" or "personal health record," as those terms are defined in ARRA, for or on behalf of Covered Entity. As such, Business Associate has no obligation to document disclosures that are exempt from the accounting requirement under 45 CFR § 164.528(1)(i)-(ix), and Covered Entity agrees not to include Business Associate on any list Covered Entity produces pursuant to ARRA § 13405(c)(3).

B. Regulatory References. A reference in this Addendum to a section in any Applicable Law means the section in effect or as amended, and for which compliance is required.

C. Amendment. The Parties agree to take such action as is necessary to amend this Addendum from time to time as is necessary for Covered Entity to comply with the requirements of Applicable Law. All amendments to this Addendum, except those occurring by operation of law, shall be in writing and signed by both Parties.

D. Survival. The respective rights and obligations of Business Associate under Section IV.C. of this Addendum shall survive the term and termination of this Addendum.

E. Interpretation. Any ambiguity in this Addendum shall be resolved in favor of a meaning that permits Covered Entity to comply with Applicable Law.

F. No Third Party Beneficiaries. Nothing express or implied in this Addendum is intended to confer, nor shall anything herein confer upon any person, other than Covered Entity, Business Associate and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.

G. Assignment. No assignment of rights or obligations under this Addendum shall be made by either Party without the prior written consent of the other Party; provided however, that Business Associate may assign this Addendum to an affiliate.

H. Effect on Addendum. Except as specifically required to implement the purposes of this Addendum, or to the extent inconsistent with this Addendum, all other terms of the underlying Services Agreement shall remain in force and effect.

EyeMed Vision Care – UAW/UMass Health & Welfare Trust Fund
First Amendment to the Fee for Service Agreement

This First Amendment to the Fee for Service Agreement ("Agreement") is effective July 1, 2016, (the "Effective Date") and is entered into by and between EyeMed Vision Care, L.L.C. ("EyeMed") and First American Administrators ("FAA"), with their principal place of business at 4000 Luxottica Place, Mason, OH 45040 and UAW/UMass Health & Welfare Trust Fund with its principal place of business at 6 University Dr. Suite 206-229, Amherst, MA 01002, as Plan Sponsor and Plan Administrator ("Plan Sponsor").

WHEREAS, effective November 1, 2010, the parties entered into a Fee for Service Agreement; and

WHEREAS, pursuant to III.M of the Fee for Service Agreement the parties reserve the right to modify the Fee for Service Agreement in a writing signed by both parties; and

WHEREAS, the parties now agree to amend the Fee for Service Agreement.

NOW, THEREFORE, in consideration of the foregoing and the mutual covenants and agreements set forth herein, it is agreed as follows:

I. Section I.B Term shall be revised in its entirety as attached hereto:

B. TERM

The Agreement shall commence on the July 1, 2016 for a term of thirty (30) months and shall renew for two 1 year renewals unless (i) Plan Sponsor gives written notice to EyeMed at least ninety (90) days prior to the expiration of the initial term or any twelve (12) month renewal term; (ii) EyeMed gives written notice to Plan Sponsor at least one hundred eighty (180) days prior to the expiration of the initial term or any twelve (12) month renewal term; or (iii) the Agreement is otherwise terminated in accordance with Section XII.

II. Exhibit B-Benefit Schedule shall be revised in its entirety as attached hereto.

III. The parties agree that in all other respects the Fee for Service Agreement shall remain unchanged and in full force and effect.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement effective July 1, 2016.

EyeMed Vision Care, L.L.C.		**First American Administrators, Inc.**
By:		By:
Name: Jason M. Rom		Name: Jason M. Rom
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
LyeMed 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	$120
Standard Progressive Lens	$10 Copay	$78
Premium Progressive Lens	$10 Copay, 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; 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 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