Postdoctoral Research Organization

PRO/UAW Local 2322

BENEFITS GUIDE

2019-20

My benefit info:

Blue Cross Blue Shield

Group Name: UMass Post Doctoral Researchers

Plan Type: Blue Care Elect PPO

Member ID: _____

MetLife Dental

Group Name: UMass Post Doctoral Unit

Group #: 5993054

Employee ID: (your SSN)

Network: PDP Plus

EyeMed Vision

Group Name: UAW/UMass HW Plan-Post Doc Unit

Group #: 9878760

Member ID: (your SSN)

Network: Select

*** please note that this guide is edited for readability and length. For comprehensive information about your benefits, please consult your Summary Plan Description available at https://www.uawumasstrustfund.org/pd-forms-and-documents**

Table of Contents

We've made exciting enhancements to Postdoc benefits this year

Free subscription to Calm!
The world's #1 app for medication, sleep and relaxation is now the newest benefit available to all eligible Postdocs.

Childcare Reimbursement Fund
Funding for this benefit is increasing more than 20%, to $51,000 annually.

How to Enroll

Online Enrollment

The Trust Fund benefit application is entirely online at http://www.uawumasstrustfund.org The application takes 10 minutes to complete. The final step requires you to electronically sign a benefits authorization form—make sure not to skip this step!

Other than basic personal information, you'll need the following to complete the application:

⇒ Your Social Security Number

⇒ Date of birth for any dependents you wish to enroll

Eligibility

You're eligible if you're working in a PRO Unit position that is at least a 50% FTE.

Choosing Plans

Your choices regarding dental and vision plans (whether to enroll, opting for single versus family coverage) don't have to be the same—and you do not have to enroll in one benefit to enroll in the other. Likewise, your health plan is completely separate and your decision about that plan doesn't impact your decisions about dental and vision. We offer single, single+1 dependent and family options for both dental and vision insurance.

Coverage Options

Premiums

Single dental and vision coverage for you as the eligible employee are FREE. The monthly employee premiums for enrolling your family in the dental and/or vision plan are:

Dental	Vision
Single + 1 dependent: $15/month	Single + 1 dependent: FREE
Family: $30/month	Family: FREE

Qualified family members are: same or opposite sex domestic partners, spouses and children. When you commit to single+1 or family dental, *you commit to pay your premiums in a timely manner*. Should your premium payments lapse, you risk retroactive termination of your dependents' coverage. Once you enroll your dependent, they can only be removed or added back on your plan due to a qualifying event or during an open enrollment period.

Deadlines

New employees should enroll within 30 days of their employment start date to enroll to avoid possible waiting periods. If you missed this window, contact us—we can usually still enroll you. When you enroll, you enroll for your entire term of employment and *do not need to re-enroll each year*. If you need to make changes to your plans, you can do so during the annual open enrollment period which occurs each June (check our website for dates).

Benefits

MetLife Dental

Our dental plan is provided by MetLife and accesses the PDP Plus network. Plan highlights include:

⇒ Preventative procedures covered at 100% (ex: cleanings, exams)

⇒ Basic restorative procedures covered at 80% (ex: fillings, oral surgery)

⇒ Major restorative procedures covered at 65% (ex: crowns)

⇒ Orthodontia for adults and for children to age 26 covered at 50%**

⇒ TMJ benefit

⇒ $2250 annual maximum benefit per calendar year per individual

* coverages are subject to complete plan details on the following pages

**separate lifetime maximum of $1000

Important to Note

Pretreatment Estimates: If you're having anything other than routine services, ask your dentist to *submit a pretreatment estimate request to MetLife*. MetLife will respond in writing, detailing how much will be covered and how much you'll be responsible for paying.

Plan Year: Dental benefits renew on a calendar year basis. Each January 1, your $2250 maximum is restored and your deductible must be reached again.

Network: Our plan has a nationwide network. You can see a dentist while away from home. Just use an in-network provider to minimize costs.

Dental Benefits

Metropolitan Life Insurance Company

Overview of Benefits for: UMASS POST DOCTORAL UNIT Group #5993054 **Date Prepared: 08-18-2019**

The Preferred Dentist Program was designed to help you get the dental care you need and help lower your costs. You get benefits for a wide range of covered services — both in and out of the network. The goal is to deliver affordable protection for a healthier smile and a healthier you. **For complete plan benefits and exclusions go to https:/www.uawumasstrustfund.org/pd-dental**

Coverage Type	**In-Network:** % of Negotiated Fee	**Out-of-Network:** % of R&C Fee[1]
Type A	100%	100%
Type B	80%	80%
Type C	65%	65%
Orthodontia	50%	50%
Deductible: Individual/Family*	No Deductible	$75 (Type B & C)
Annual Maximum Benefit: Per Individual	$2250	$2250
Orthodontia Lifetime Maximum: Per Individual	$1000	$1000
	Ortho applies to Adult and Child (Up to dependent age limit)	

Understanding Your Dental Benefits Plan

With the MetLife Preferred Dentist Program you can visit the dentist of your choice – an “in-network” dentist (a participating MetLife dentist) or an “out-of-network” dentist.

- Plan benefits for in-network services are based on the percentage of the Negotiated fee –the fee that in-network dentists have agreed to accept as payment in full for covered services, subject to any co-payments, deductibles, cost sharing and benefit maximums. Negotiated fees are subject to change.
- Plan benefits for out-of-network services are based on a percentage of the Reasonable and Customary (R&C) charge. If you choose a dentist who does not participate in the network, your out-of-pocket expenses may be higher, since you will be responsible for paying any difference between the dentist's fee and your plan's payment for the approved service. Please refer to the Selected Covered Services and Frequency Limitations page of this document for details regarding how R&C charges are defined under this plan.

Take advantage of online self-service capabilities with MyBenefits.

- Check the status of your claims
- Locate a participating dentist
- Access MetLife’s Oral Health Library
- Elect to view your Explanation of Benefits online

If you are not already registered, just go to **www.metlife.com/mybenefits** and follow the easy registration instructions.

Certain plan benefits are based on a percentage of the negotiated fee. This is the amount that participating dentists have agreed to accept as payment in full. If your plan benefits are based on a percentage of the Reasonable and Customary (R&C) charges, your out-of-pocket expenses may be more, since you will be responsible for paying any difference between the dentist's fee and your plan's payment for the approved service.

* If you are enrolled for dependent coverage, a maximum family deductible may apply.

Savings from enrolling in a dental benefits plan will depend on various factors, including the cost of the plan, how often participants visit the dentist and the cost of services rendered.

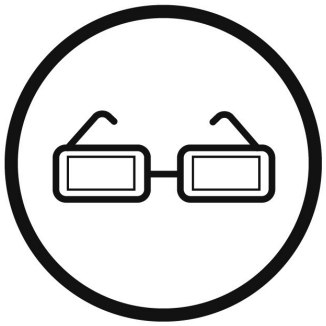
Selected Covered Services and Frequency Limitations*

Type A	
• Oral Examinations	2 in 1 year.
• Cleanings	2 in 1 year.
• Fluoride	Children to age 19 / 2 in 12 months.
• Bitewing X-rays	Adult - 1 in 12 months / Children - 1 in 12 months.
• Full Mouth X-rays	1 in 60 months.
• Space Maintainers	For dependent children to age 14. Limited to 1 per lifetime per area.
• Sealants (1st & 2nd permanent molars)	1 per tooth in 3 years of a dependent child up to 19th birthday.
Type B	
• Periodontal Maintenance	4 in 1 year less the number of teeth cleanings.
• Emergency Palliative Treatment	
• Periodontal Root Planing & Scaling	1 per quadrant in any 24 months period.
• Periodontal Surgery	1 in 36 months.
• Amalgam & Composite Fillings	1 per surface in 24 months.
• Simple Extractions	
• Root Canal	One per tooth per Lifetime.
• Surgical Extractions	
• Repairs (Crowns)	1 in 12 months.
Type C	
• Crowns	1 in 60 months.
• Dentures	1 in 60 months.
• Bridges	1 in 60 months.
• Implants	1 in 60 months.
• TMJ	
Orthodontia	
• Dependent children are covered up to their 26th birthday.	
• All dental procedures performed in connection with orthodontic treatment are payable as Orthodontia. • Payments are on a repetitive basis. • 20% of the Orthodontia Lifetime Maximum will be considered at initial placement of the appliance and paid based on the plan benefit's coinsurance level for Orthodontia as defined in the Plan Summary. • Orthodontic benefits end at cancellation of coverage.	

The service categories and plan limitations shown in this document represent an overview of your plan benefits, but are not a complete description of the plan. Before making any purchase or enrollment decision you should review the certificate of insurance which is available through MetLife or your employer. In the event of a conflict between this overview and your certificate of insurance, your certificate of insurance governs. Like most group dental insurance policies, MetLife group policies contain certain exclusions, limitations and waiting periods and terms for keeping them in force. The certificate of insurance sets forth all plan terms and provisions, including all exclusions and limitations.

***Alternate Benefits:** Your dental plan provides that if there are two or more professionally acceptable dental treatment alternatives for a dental condition, your plan bases reimbursement, and the associated procedure charge, on the least costly treatment alternative. If you and your dentist have agreed on a treatment that is more costly than the treatment upon which the plan benefit is based, you will be responsible for any additional payment responsibility. To avoid any misunderstandings, we suggest you discuss treatment options with your dentist before services are rendered, and obtain a pretreatment estimate of benefits prior to receiving certain high cost services such as crowns, bridges or dentures. You and your dentist will each receive an Explanation of Benefits (EOB) outlining the services provided, your plan's reimbursement for those services, and your out-of-pocket expense. Actual

EyeMed Vision



Our vision plan is provided by EyeMed Vision and accesses the Select network. Plan highlights include:

- $10 eye exam copayment
- $150 allowance toward the purchase of your frames
- $150 allowance toward the purchase of your contacts
- Plan is accepted at University Health Services, but also at major retailers, like LensCrafters, Target Optical and Pearle Vision
- You can use your plan to purchase glasses and contacts in the same 12 months
- Extra $20 off contacts & free shipping at ContactsDirect.com and any frame, any price for $0 out-of-pocket at Target Optical

Important to Note

Plan Year: Vision benefits renew on a *point of service basis*: you are eligible for a particular benefit 12 months after the last time you used that benefit.

Network: Our plan has a nationwide network. You can see a provider while away from home. Just use an in-network provider to minimize your costs. If the provider is out-of-network, you will need to submit your receipt and an out-of-network claim form directly to EyeMed.

UAW/UMass Hw-Post Doc Unit Group #9878760

Additional discounts

40% OFF
Complete pair of prescription eyeglasses

20% OFF
Non-prescription sunglasses

20% OFF
Remaining balance beyond plan coverage

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

Take a sneak peek before enrolling

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

SUMMARY OF BENEFITS

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

Benefits are not provided from services or materials arising from: Orthopic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses, medical and/or surgical treatment of the eye, eyes or supporting structures; Any Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; safety eyewear; Services provided as a result of any workers' compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; Plano (non-prescription) lenses; Non-prescription sunglasses; Two pair of glasses in lieu of bifocals; Services or materials provided by any other group benefit plan providing vision care; Services rendered after the date an insured person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the insured Person are within 31 days from the date of such order. Lost or broken lenses, frames, glasses or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available. Benefits may not be combined with any discount, promotional offering, or other group benefit plans. Standard/Premium Progressive lens not covered – fund as a Bifocal lens. Standard Progressive lens covered – fund Premium Progressive as a Standard. Benefit allowance provides no remaining balance for future use within the same benefits year. Fees charged for a non-insured benefit must be paid in full to the Provider. Such fees or materials are not covered. [Δ]Premium progressives and premium anti-reflective designations are subject to annual review by EyeMed's Medical Director and are subject to change based on market conditions. Fixed pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels. Not available in all states. Some provisions, benefits, exclusions or limitations listed herein may vary.

What's in it for me?

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

Benefits Snapshot

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

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

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

85% SAVINGS with us*

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

Download the EyeMed Members App

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

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

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

Childcare Reimbursement

The Trust Fund distributes an annual pool of approximately $51,000 across eligible postdoc families to help defray the cost of on or off-campus childcare.

Eligibility requirements

To be eligible, you must be a UMass postdoctoral employee working at least 50% time and paying out-of-pocket for licensed childcare. Eligible childcare must be state-licensed (or equivalent), including infant, toddler, pre-school, and after-school or summer camp care for a school-aged dependent. There is a $6,000 per child annual cap on the amount a family can be reimbursed.

How we distribute funds

Eligible applicants are sorted by family size and income according to the MA EEC Financial Assistance Parent Co-Payment Table (see following pages). Your family will be assigned a "fee level" according to the chart. Our priority is to reimburse applicants in levels 1-11 at the highest percentage possible.

For those above level 11, we adjust your total reported costs by an "expected parent copayment," calculated according to a flat fee schedule available at https://www.uawumasstrustfund.org/geo-childcare. Your reported costs are then reduced by this amount, and any remaining costs are eligible for possible reimbursement. After we reimburse families in levels 1-11, we move up the income levels, reimbursing the highest percentage of costs our funds allow.

Any applicant's total reported costs will also be reduced by a GSS award, CCAMPIS grant or GEO childcare reimbursement received by the household *for the same period.*

What you'll need to apply

In addition to basic personal information, you'll need:

1. Just the page of your most recent federal tax return showing your adjusted gross income (AGI) for you and your spouse/partner. Please redact SSNs.
2. Receipts from your childcare provider.
3. If your child isn't listed on your tax return, we'll need proof of dependency.

How to apply

The childcare reimbursement application is part of our regular online benefits application: http://www.uawumasstrustfund.org If you ve already applied for dental and vision, log in to your existing application and follow the prompts for the childcare application. If you re new to the online system, start a new application. Reimbursements are typically made within 8 weeks of the application deadline and funds are distributed by check emailed to the address we have on file for you, by PayPal, or to your Amazon.com account, per your election.

*We can't guarantee reimbursement due to the # of application variables, but we can tell you what similar families have received in the past. During summer 2019, reimbursements were at the following %s: 100% for levels 1-11, 70% for levels 12-18, 35% for levels 19 and above.

Deadlines

We reimburse childcare costs 3 times per year:

June 1-15: previous spring's childcare receipts are due
Sept 1-15: previous summer's childcare receipts are due
Jan 1-15: previous fall's childcare receipts are due

SHERRI KILLINS
COMMISSIONER

Commonwealth of Massachusetts

Department of Early Education and Care (EEC)

EEC FINANCIAL ASSISTANCE

PARENT CO-PAYMENT TABLE

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

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

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

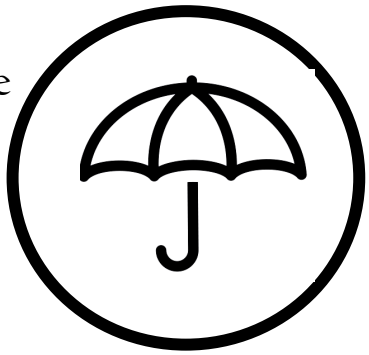
GROSS MONTHLY INCOME								PARENT CO-PAYMENT				FEE LEVEL
Family of Two	Family of Three	Family of Four	Family of Five	Family of Six	Family of Seven	Family of Eight	Family of Nine	Daily Fee	Weekly Fee	Daily Fee SACC Blended	Weekly Fee SACC Blended	
$ 0-971	$ 0-1180	$ 0-1421	$ 0-1663	$ 0-1905	$ 0-2146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

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

Life Insurance

Postdocs working at least 30 hours/week are eligible to purchase supplementary life insurance at affordable rates through MetLife. This benefit is *100% employee paid*. Highlights of the policy include:

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



How to apply

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

Forms 1 & 2 are available at http://www.uawumasstrustfund.org

Note: email uawdental@external.umass.edu right away when you leave employment to receive timely information on porting your life insurance.

UMass Post Doctoral Unit Plan Benefits

To request coverage:

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

Employee & Spouse Coverage	Employee Age Monthly Premium For:										
	< 30 -	**30 - 34**	**35 - 39**	**40 - 44**	**45 - 49**	**50 - 54**	**55 - 59**	**60 - 64**	**65 - 69**	**70 - 74**	**75 +**
$5,000	$0.45	$0.47	$0.55	$0.79	$1.20	$1.85	$2.86	$4.24	$7.37	$11.80	$11.80
$10,000	$0.89	$0.93	$1.10	$1.58	$2.39	$3.70	$5.71	$8.48	$14.74	$23.59	$23.59
$15,000	$1.34	$1.40	$1.65	$2.37	$3.59	$5.55	$8.56	$12.72	$22.11	$35.38	$35.38
$20,000	$1.78	$1.86	$2.20	$3.16	$4.78	$7.40	$11.42	$16.96	$29.48	$47.18	$47.18
$25,000	$2.23	$2.33	$2.75	$3.95	$5.97	$9.25	$14.28	$21.20	$36.85	$58.98	$58.98
$30,000	$2.67	$2.79	$3.30	$4.74	$7.17	$11.10	$17.13	$25.44	$44.22	$70.77	$70.77
$40,000	$3.56	$3.72	$4.40	$6.32	$9.56	$14.80	$22.84	$33.92	$58.96	$94.36	$94.36
$50,000	$4.45	$4.65	$5.50	$7.90	$11.95	$18.50	$28.55	$42.40	$73.70	$117.95	$117.95
$60,000	$5.34	$5.58	$6.60	$9.48	$14.34	$22.20	$34.26	$50.88	$88.44	$141.54	$141.54
$70,000	$6.23	$6.51	$7.70	$11.06	$16.73	$25.90	$39.97	$59.36	$103.18	$165.13	$165.13
$75,000	$6.67	$6.97	$8.25	$11.85	$17.93	$27.75	$42.83	$63.60	$110.55	$176.93	$176.93
$100,000	$8.90	$9.30	$11.00	$15.80	$23.90	$37.00	$57.10	$84.80	$147.40	$235.90	$235.90
$150,000	$13.35	$13.95	$16.50	$23.70	$35.85	$55.50	$85.65	$127.20	$221.10	$353.85	$353.85
$200,000	$17.80	$18.60	$22.00	$31.60	$47.80	$74.00	$114.20	$169.60	$294.80	$471.80	$471.80
$250,000	$22.25	$23.25	$27.50	$39.50	$59.75	$92.50	$142.75	$212.00	$368.50	$589.75	$589.75
$300,000	$26.70	$27.90	$33.00	$47.40	$71.70	$111.00	$171.30	$254.40	$442.20	$707.70	$707.70
$350,000	$31.15	$32.55	$38.50	$55.30	$83.65	$129.50	$199.85	$296.80	$515.90	$825.65	$825.65
$400,000	$35.60	$37.20	$44.00	$63.20	$95.60	$148.00	$228.40	$339.20	$589.60	$943.60	$943.60
$450,000	$40.05	$41.85	$49.50	$71.10	$107.55	$166.50	$256.95	$381.60	$663.30	$1,061.55	$1,061.55
$500,000	$44.50	$46.50	$55.00	$79.00	$119.50	$185.00	$285.50	$424.00	$737.00	$1,179.50	$1,179.50

Dependent Child Coverage[3] - Monthly Premium For:				
$1,000	**$2,000**	**$4,000**	**$5,000**	**$10,000**
$0.29	$0.58	$1.16	$1.46	$2.91

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

Hyatt Legal Plan

Eligible Postdocs can elect to enroll in the *optional, 100% employee paid Hyatt Group Legal Plan*, MetLaw. The employee premium to participate in MetLaw is $216/year and the minimum enrollment period is 12 months. MetLaw can save employees hundreds of dollars in attorney fees for common legal services like these:

—Estate planning documents, including Wills and Trusts

—Real estate matters

—Identity theft defense

—Financial matters, such as debt-collection defense

—Traffic offenses

—Document review

—Family Law, including adoption and name change

—Advice and consultation on personal legal matters

How to apply

Postdocs use the same online application to apply for this benefit, available at

http://www.uawumasstrustfund.org

MetLaw® Benefit Definitions & Reimbursements

The Hyatt prepaid legal plan is a voluntary employee paid benefit and costs $216/year with a minimum commitment of 12 months. You get access to an attorney, by telephone or in-person, for advice on an unlimited number of personal legal matters, and representation for a wide variety of legal services.

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

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

MetLaw® Benefit Definitions & Reimbursements

	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

MetLaw® Benefit Definitions & Reimbursements

	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

MetLaw® Benefit Definitions & Reimbursements

	Network	
PERSONAL INJURY	**IN**	**OUT-OF**
Personal Injury (25% Network Maximum) Subject to applicable law and court rules, plan attorneys will handle personal injury matters (where the participant is the plaintiff) at a maximum fee of 25% of the gross award. It is the participant's responsibility to pay this fee and all costs.		
PROBATE	**IN**	**OUT-OF**
Probate (10% Network Reduced Fee) Subject to applicable law and court rules, plan attorneys will handle probate matters at a fee of 10% less than the plan attorney's normal fee. It is the participant's responsibility to pay this reduced fee and all costs.		
REAL ESTATE MATTERS	**IN**	**OUT-OF**
Boundary or Title Disputes This service covers negotiations and litigation arising from boundary or real property title disputes involving a participant's primary residence, where coverage is not available under the participant's homeowner or title insurance policies. The service includes filing to remove a mechanic's lien.		
• Negotiation and Settlement	Fully Covered	$500
• Trial	Fully Covered	$1,500
• Plus Trial Supplement for Out-of-Network Service*		$100,000
Eviction and Tenant Problems This service covers the participant as a tenant for matters involving leases, security deposits or disputes with a residential landlord. The service includes eviction defense, up to and including trial. This service covers matters involving the participant's primary residence only. It does not include representation in disputes with other tenants or as a plaintiff in a lawsuit against the landlord, including an action for return of a security deposit.		
• Correspondence and Negotiations	Fully Covered	$280
• Eviction Trial Defense	Fully Covered	$840
• Plus Trial Supplement for Out-of-Network Service*		$100,000
Security Deposit Assistance This service covers counseling the participant as a tenant in recovering a security deposit from the participant's residential landlord for the participant's primary residence; reviewing the lease and other relevant documents; and preparing a demand letter to the landlord for the return of the deposit. It also covers assisting the participant in prosecuting a small claims action; helping prepare documents; advising on evidence, documentation and witness; and preparing the participant for the small claims trial. The service does not include the plan attorney's attendance or representation at the small claims trial, collection activities after a judgment or any services relating to post-judgment actions.		
• Demand Letter/Negotiations	Fully Covered	$250
• Counseling on Preparing Small Claims Complaint and Trial Preparation	Fully Covered	$150
Home Equity Loan for Primary Residence, or Second or Vacation Home This service covers the review or preparation of a home equity loan on the participant's primary residence, or second or vacation home.	Fully Covered	$350
Property Tax Assessments This service covers the participant for review and advice on a property tax assessment on the participant's primary residence. It also includes filing the paperwork, gathering the evidence, negotiating a settlement, and attending the hearing necessary to seek a reduction of the assessment.		
• Negotiation and Settlement	Fully Covered	$270
• File Request for Hearing with Attendance at Hearing	Fully Covered	$620
• Plus Trial Supplement for Out-of-Network Service*		$100,000

	Network	
REAL ESTATE MATTERS (continued)	**IN**	**OUT-OF**
Refinancing of Home (Primary Residence) This service covers the review or preparation, by an attorney representing the participant, of all relevant documents (including the refinance agreement, mortgage and deed, and documents pertaining to title, insurance, recordation and taxation), which are involved in the refinancing of or obtaining a home equity loan on a participant's primary residence. The benefit also includes attendance of an attorney at closing. This benefit includes obtaining a permanent mortgage on a newly constructed home. It does not include services provided by any attorney representing a lending institution or title company. The benefit does not include the refinancing of a second home, vacation property or property that is held for any rental, business, investment or income purpose.	Fully Covered	$350
Refinancing of Home (Second or Vacation Home) This service covers the review or preparation, by an attorney representing the participant, of all relevant documents (including the refinance agreement, mortgage and deed, and documents pertaining to title, insurance, recordation and taxation), which are involved in the refinancing of or obtaining a home equity loan on a participant's second home or vacation home. The benefit also includes attendance of an attorney at closing. This benefit includes obtaining a permanent mortgage on a newly constructed home. It does not include services provided by any attorney representing a lending institution or title company. The benefit does not include the refinancing of a second home, vacation property or property that is held for any rental, business, investment or income purpose.	Fully Covered	$350
Sale or Purchase of Home (Primary Residence) This service covers the review or preparation, by an attorney representing the participant, of all relevant documents (including the construction documents for a new home, the purchase agreement, mortgage and deed, and documents pertaining to title, insurance, recordation and taxation) which are involved in the purchase or sale of a participant's primary residence or a vacant property to be used for building a primary residence.The benefit also includes attendance of the attorney at closing. It does not include services provided by any attorney representing a lending institution or title company. The benefit does not include the sale or purchase of a second home, vacation property, rental property, property held for business or investment or leases with an option to buy.	Fully Covered	$500
Sale or Purchase of Home (Secondary or Vacation Home) This service covers the review or preparation, by an attorney representing the participant, of all relevant documents (including the construction documents for a new second home or vacation home, the purchase agreement, mortgage and deed, and documents pertaining to title, insurance, recordation and taxation), which are involved in the purchase or sale of a participant's second home, vacation home or of a vacant property to be used for building a second home or vacation home. The benefit also includes attendance of an attorney at closing. It does not include services provided by any attorney representing a lending institution or title company. The benefit does not include the sale or purchase of a second home or vacation home held for rental purpose, business, investment or income or leases with an option to buy.	Fully Covered	$500
Zoning Applications This service provides the participant with the services of a lawyer to help get a zoning change or variance for the participant's primary residence. Services include reviewing the law, reviewing the surveys, advising the participant, preparing applications, and preparing for and attending the hearing to change zoning.		
• Preparation of Documentation	Fully Covered	$250
• Documentation/Attending Hearing	Fully Covered	$500
TRAFFIC OFFENSES	**IN**	**OUT-OF**
Restoration of Driving Privileges This service covers the participant with representation in proceedings to restore the participant's driving license.	Fully Covered	$385
Traffic Ticket Defense (No DUI) This service covers representation of the participant in defense of any traffic ticket including traffic misdemeanor offenses, except driving under influence or vehicular homicide, including court hearings, negotiation with the prosecutor and trial.		
• Plea or Trial at Court	Fully Covered	$250
• Plea or Trial at Court for serious moving violations resulting in jail time or license suspension	Fully Covered	$500
• Plus Trial Supplement for Out-of-Network Service*		$100,000

* Trial Supplement - In addition to fees indicated, we will pay the attorney's fees for representation in trial beyond the second day of trial up to a maximumof $800 per day up to $100,000 total trial supplement maximum.

Exclusions: No service, including advice and consultations, will be provided for (1) employment-related matters, including Company or statutory benefits; (2) matters involving the Company, MetLife® and affiliates, or Plan Attorneys; (3) matters in which there is a conflict of interest between the Employee and spouse or dependents in which case services are excluded for the spouse and dependents, (4) appeals and class actions; (5) farm, business or investment matters, and matters involving property held for investment or rental or issues when the Participant is the landlord; (6) patent, trademark and copyright matters; (7) costs or fines; (8) frivolous or unethical matters and (9) matters for which an attorney-client relationship exists prior to the Participant becoming eligible for Plan benefits. L0514376171[exp0715][All States][DC,PR]

Smart. Simple. Affordable.®

Hyatt Legal Plans

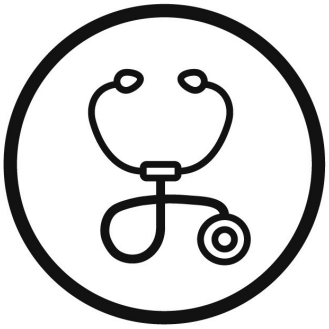
A MetLife Company

Other Benefits

Calm Meditation & Relaxation App

The Trust Fund provides free access to Calm, the world''s #1 meditation, sleep and relaxation app to eligible Postdocs starting 1/1/20. Check your online account with us for an access code and instructions to get started.

UMass Health Insurance



The Trust Fund *does not manage your health insurance plan*, but we've included relevant information here. For the most complete & up to date information, please go to https://www.umass.edu/humres/health-insurance

How to enroll

The postdoc health plan is provided by Blue Cross/Blue Shield of MA (Blue Care Elect). You can enroll when you complete your new hire paperwork at the Employee Service Center, 325 Whitmore Bldg. Postdocs contribute employee paid premiums through biweekly payroll deduction on two pay periods per month. Plan overview and premiums amounts are updated at https://www.umass.edu/humres/health-insurance **What follows is a summary from UMass's site--check there for up-to-date & complete coverage info!**

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, see bluecrossma.com/coverage-info.
For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at bluecrossma.com/sbcglossary or call **1-800-588-5508** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$250** member / **$500** family in-network; **$250** member / **$500** family out-of-network.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. In-network preventive and prenatal care, most office visits, mental health visits, therapy visits, prescription drugs; emergency room.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**$1,000** member / **$3,000** family in-network; **$3,500** member / **$7,000** family out-of-network.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See bluecrossma.com/findadoctor or call the Member Service number on your ID card for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 / visit	20% coinsurance	Deductible applies first for out-of-network
	Specialist visit	$10 / visit; $10 / chiropractor visit	20% coinsurance; 20% coinsurance / chiropractor visit	Deductible applies first for out-of-network
	Preventive care/screening/immunization	No charge	20% coinsurance	Deductible applies first for out-of-network; limited to age-based schedule and / or frequency. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	20% coinsurance	Deductible applies first; pre-authorization may be required
	Imaging (CT/PET scans, MRIs)	No charge	20% coinsurance	Deductible applies first; pre-authorization may be required
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at bluecrossma.com/medications	Generic drugs	$5 / retail supply or $10 / mail service supply	Not covered	Up to 30-day retail (90-day mail service) supply; cost share may be waived for certain covered drugs and supplies; pre-authorization required for certain drugs
	Preferred brand drugs	$15 / retail supply or $30 / mail service supply	Not covered	
	Non-preferred brand drugs	$25 / retail supply or $50 / mail service supply	Not covered	
	Specialty drugs	Applicable cost share (generic, preferred, non-preferred)	Not covered	When obtained from a designated specialty pharmacy; pre-authorization required for certain drugs
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	20% coinsurance	Deductible applies first
	Physician/surgeon fees	No charge	20% coinsurance	Deductible applies first

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you need immediate medical attention	Emergency room care	$50 / visit	$50 / visit	Copayment waived if admitted or for observation stay
	Emergency medical transportation	No charge	No charge	In-network deductible applies first for in-network and out-of-network services
	Urgent care	$10 / visit	20% coinsurance	Deductible applies first for out-of-network
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% coinsurance	Deductible applies first; pre-authorization required
	Physician/surgeon fees	No charge	20% coinsurance	Deductible applies first; pre-authorization required
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$10 / visit	20% coinsurance	Deductible applies first for out-of-network; pre-authorization required for certain services
	Inpatient services	No charge	20% coinsurance	Deductible applies first; pre-authorization required for certain services
If you are pregnant	Office visits	No charge	20% coinsurance	Deductible applies first except for in-network prenatal care; cost sharing does not apply for in-network preventive services; maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound)
	Childbirth/delivery professional services	No charge	20% coinsurance	
	Childbirth/delivery facility services	No charge	20% coinsurance	

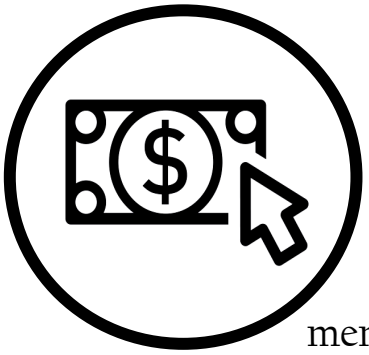
Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network (You will pay the least)	Out-of-Network (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance	Deductible applies first; pre-authorization required
	Rehabilitation services	$10 / visit	20% coinsurance	Deductible applies first for out-of-network; limited to 100 visits per calendar year (other than for autism, home health care, and speech therapy)
	Habilitation services	$10 / visit	20% coinsurance	Deductible applies first for out-of-network; rehabilitation therapy coverage limits apply; cost share and coverage limits waived for early intervention services for eligible children
	Skilled nursing care	No charge	20% coinsurance	Deductible applies first; limited to 100 days per calendar year; pre-authorization required
	Durable medical equipment	20% coinsurance	40% coinsurance	Deductible applies first; in-network cost share waived for one breast pump per birth (20% coinsurance for out-of-network)
	Hospice services	No charge	20% coinsurance	Deductible applies first; pre-authorization required for certain services
If your child needs dental or eye care	Children's eye exam	No charge	20% coinsurance	Deductible applies first for out-of-network; limited to one exam every 24 months
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	No charge for members with a cleft palate / cleft lip condition	20% coinsurance for members with a cleft palate / cleft lip condition	Limited to members under age 18; deductible applies first for out-of-network

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Acupuncture	• Cosmetic surgery	• Long-term care
• Children's glasses	• Dental care (Adult)	• Private-duty nursing

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric surgery	• Infertility treatment	• Routine foot care (only for patients with systemic circulatory disease)
• Chiropractic care	• Non-emergency care when traveling outside the U.S.	• Weight loss programs (three months in qualified program(s) per contract per calendar year)
• Hearing aids ($2,000 per ear every 36 months for members age 21 or younger)	• Routine eye care - adult (one exam every 24 months)	

BCBS Fitness Reimbursement



The Postdoc Blue Cross Blue Shield health plan includes a Fitness Benefit toward membership at a health club or for fitness classes.

The reimbursement is for membership fees for up to 3 consecutive months of one annual family or individual membership at a health club or 10 fitness classes, per individual or family per calendar year. BCBS also offers a reimbursement for up to three months of participation in a qualified weight-loss program.

To apply, submit your receipts and Reimbursement Form (see following pages and available at https://www.bluecrossma.com), to Blue Cross Blue Shield of Massachusetts Local Claims Department PO Box 986030 Boston, MA 02298.

Contact Blue Cross Blue Shield

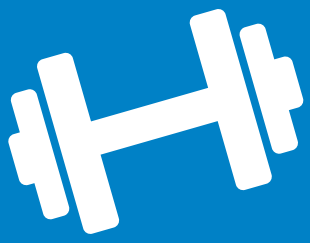
Web: https://www.bluecrossma.com

Phone: (800) 588-550

Find a Doctor: https://myblue.bluecrossma.com/health-plan/find-doctor-provider-dentist

MASSACHUSETTS

Fitness Benefit



Your Blue Cross Blue Shield of Massachusetts health plan can save you money annually in qualified health club membership fees or up to 10 fitness classes taken at a qualified health club.

3 Easy Steps to Getting Reimbursed[1]

1. 

Choose

Start by picking a qualified health club.

2. 

Complete

Once you pay for the program, fill out the attached form.

3. 

Mail

Send the completed form to the address listed at the bottom.

Important Information

- The reimbursement is for each individual (or family) health plan and can only be submitted once each calendar year.
- Keep copies of all your paperwork and proof of payment in case you are denied reimbursement.
  Proof of payment includes the following:
  - Itemized, dated, paid receipts from your health club
  - Bank or credit card statements
  - Paycheck stubs if your club fees are automatically deducted from that account
- Receipts or statements should include the name of the family member enrolled and the individual charges for a full reimbursement of health club fees or fitness classes.
- The dollar amount you receive may be considered taxable income. Consult your tax advisor about how to treat this reimbursement on your taxes.

What's covered:[2]

Your benefit will reimburse you for three consecutive months of membership fees from a qualified health club or for up to 10 fitness classes taken at a qualified health club.

A qualified health club is:

A full-service health club with a variety of exercise equipment, including:

- Cardiovascular equipment like treadmills and bikes
- Strength-training equipment like free weights and weight machines

To receive the fitness reimbursement for a qualified pay-as-you-go health club, get paid receipts from the club for your records.

What doesn't qualify?

You can't receive the fitness reimbursement for expenses for personal training, lessons, coaching, equipment, clothing, or any of the clubs below:

- Martial arts or yoga centers
- Gymnastics, tennis, aerobic, or pool-only facilities
- Country clubs or social clubs
- Sports teams or leagues

Be sure to talk with your doctor before starting an exercise program.

1. Before starting, check to see if your plan includes the Fitness Benefit.
2. Most plans offer a reimbursement for three months of membership or up to 10 fitness classes, but your employer may have offered a different benefit. Please refer to your benefits information to confirm.

Fitness Reimbursement Form[3]

To verify this reimbursement is within your plan, log in to Member Central at **www.bluecrossma.com/membercentral** or call Member Service at the number on your ID card. Submit this form once per calendar year, no later than March 31 of the following year.

PLEASE PRINT ALL INFORMATION CLEARLY

Subscriber Information (Policyholder)

Identification Number (including first 3 letters) | Subscriber's Last Name | First Name | Middle Initial

Address—Number and Street | City | State | Zip Code

Employer's Name

Member and Claim Information

Member's Last Name | First Name | Middle Initial | Date of Birth: Mo. Day Yr.

Mailing Address—Number and Street (if different from subscriber's) | City | State | Zip Code

Gender
- ☐ Male
- ☐ Female

Claim is for (check one):
- ☐ Subscriber (policyholder)
- ☐ Spouse (of policyholder)
- ☐ Ex-Spouse
- ☐ Dependent (up to age 26)
- ☐ Other (specify) _____

Name, Address, and Phone Number of Qualified Health Club

I am due $_____ for the following reimbursement (check one):

☐ Membership at a qualified health club. My monthly fee is $_____.

☐ Fitness classes at a qualified health club.
My fee per class is $_____.

Health Plan Year

Certification and Authorization (This form must be signed and dated below.)

I authorize the release of any information to Blue Cross Blue Shield of Massachusetts about my health club membership. I certify that the information provided in support of this submission is complete and correct and that I have not previously submitted for these services. I understand that Blue Cross may require additional evidence of health club membership and proof of payment for my membership before reimbursement is provided.

Subscriber's or
Member's Signature: _____ Date: _____

Questions?

To verify this reimbursement is within your plan or for further information, please log in to the Member Central website at **www.bluecrossma.com/membercentral** or call Member Service at the number on the front of your ID card.

Please complete and mail this form to:

Blue Cross Blue Shield of Massachusetts
Local Claims Department
PO Box 986030
Boston, MA 02298

3. Blue Cross will make a reimbursement decision within 30 calendar days of receiving a completed request for coverage or payment.

147581M
55-0821 (4/15)

MASSACHUSETTS

MASSACHUSETTS

Weight Loss Benefit

Your Blue Cross Blue Shield of Massachusetts health plan can save you money annually in qualified Weight Watchers®′ and hospital-based weight-loss programs.

3 Easy Steps to Getting Reimbursed[1]

1. 

Choose

Start by picking a qualified weight-loss program.

2. 

Complete

Once you pay for the program, fill out the attached form.

3. 

Mail

Send the completed form and proof of payment to the address listed at the bottom.

Important Information

- The reimbursement is for each individual (or family) health plan and can only be submitted once each calendar year.
- Keep copies of all your paperwork and proof of payment in case you are denied reimbursement. Proof of payment includes the following:
  - Paid receipts from qualified program
  - Weight Watchers Membership Book
- Receipts, statements, or Weight Watchers Membership Book should include the name of the family member enrolled in the program, the amount paid per session(s), and date(s) paid.
- The dollar amount you receive may be considered taxable income. Consult your tax advisor about how to treat this reimbursement on your taxes.

Be sure to check with your doctor before starting any weight-loss program.

What's covered:[2]

Your benefit will reimburse you for up to three months of participation in a qualified weight-loss program.

A qualified weight-loss program is:

- Weight Watchers meetings
- Weight Watchers At Work
- A hospital-based weight-loss program

What doesn't qualify?

- Weight Watchers Online
- Weight Watchers At Home
- Fees paid for individual nutrition-counseling sessions, food, books, videos, or scales

1. Before starting, check to see if your plan includes the Weight Loss Benefit.
2. Most plans offer a three-month reimbursement, but your employer may have offered a different benefit. Please refer to your benefits information to confirm.

Weight-Loss Reimbursement Form[3]

To verify this reimbursement is within your plan, log in to Member Central at **www.bluecrossma.com/membercentral** or call Member Service at the number on your ID card. Submit this form when you have paid receipts from a qualified weight-loss program, once per calendar year, no later than March 31 of the following year.

PLEASE PRINT ALL INFORMATION CLEARLY

Subscriber Information (Policyholder)

Identification Number (including first 3 letters) | Subscriber's Last Name | First Name | Middle Initial

Address—Number and Street | City | State | Zip Code

Employer's Name

Member and Claim Information

Member's Last Name | First Name | Middle Initial | Date of Birth: Mo. Day Yr.

Mailing Address—Number and Street (if different from subscriber's) | City | State | Zip Code

Gender
- ☐ Male
- ☐ Female

Claim is for (check one):
- ☐ Subscriber (policyholder)
- ☐ Spouse (of policyholder)
- ☐ Ex-Spouse
- ☐ Dependent (up to age 26)
- ☐ Other (specify) _____

Class or Program Information Required:

Attach 8.5" x 11" photocopies of paid receipts from your qualified weight-loss program. Receipts must show Blue Cross Blue Shield of Massachusetts member's name, name or logo of program, amount paid per session(s), and date(s) paid. For qualified Weight Watchers programs, a photocopy of your program Membership Book showing this information is required.

Name and Address of Class or Program

Health Plan Year

Total Amount Submitted: $ _____

Certification and Authorization (This form must be signed and dated below.)

I authorize the release of any information to Blue Cross and Blue Shield of Massachusetts about my weight-loss program. I certify that the information provided in support of this submission is complete and correct and that I have not previously submitted for these services.

Subscriber's or
Member's Signature: _____ Date: _____

Questions?

To verify this reimbursement is within your plan or for further information, please log in to the Member Central website at **www.bluecrossma.com/membercentral** or call Member Service at the number on the front of your ID card.

Please complete and mail this form (including copies of paid receipts) to:

Blue Cross Blue Shield of Massachusetts
Local Claims Department
PO Box 986030
Boston, MA 02298

3. Blue Cross will make a reimbursement decision within 30 calendar days of receiving a completed request for coverage or payment.

147582M 55-0822

MASSACHUSETTS

Providers

MetLife

The fastest and most reliable way to find a participating PDP Plus dentist is to visit www.metlife.com or you can call 1-800-275-4638. Here's a sample list of local MetLife dentists.

⇒ 1st Advantage Dental, Amherst (413) 253-9505, Greenfield (413) 773-3850, Northampton (413) 585-5425
⇒ Amherst Dental Group, Amherst (413) 253-9582
⇒ Connecticut Valley Oral Surgery, Amherst (413) 549-5100
⇒ Rigali and Walder Orthodontics, Amherst (413) 253-0001
⇒ Aaron Demaio, Amherst, Northampton & Greenfield (413) 548-882255
⇒ New Market Dentistry, Amherst (413) 549-3608
⇒ Baystate Dental, Belchertown (413) 323-7654
⇒ Chicopee Health Center, Chicopee (413) 420-2222
⇒ Schwartz Orthodontics, Florence (413) 586-1008
⇒ Greenfield Dental Assoc., Greenfield (413) 774-2871
⇒ River Valley Dental, Hadley (413) 584-6557
⇒ The Valley Dentists, South Hadley, (413) 584-6275
⇒ Big Wide Smiles, South Hadley (413) 540-9500(4
⇒ Cortland Dental Group, Holyoke (413) 319-1078
⇒ Holyoke Health Center, Holyoke (413) 420-2210
⇒ Northampton Pediatric Dentistry, Northampton (413) 835-0310
⇒ Rebecca Cochrane, Northampton (413) 584-1301
⇒ Marie Tremblay, Northampton (413) 584-7773
⇒ Crestal Health Periodontics, Northampton (413) 584-2229

Note: It is your responsibility to confirm with the dental office that they participate in the MetLife PDP Plus network.

Providers

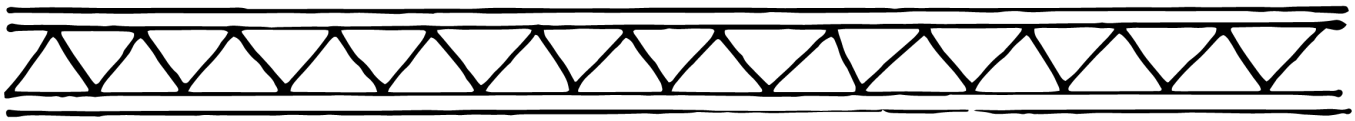
EyeMed

The fastest and most reliable way to find a vision provider is to visit www.eyemedvisioncare.com and use the provider locator on the right. Our network is "Select." Here's a sample list of local EyeMed providers.

⇒ To use your in-network benefits online:
www.contactsdirect.com and www.glasses.com You can also utilize your benefits online at www.lenscrafters.com, www.targetoptical.com and www.ray-ban.com. To locate laser vision correction providers, please visit www.eyemedlasik.com

⇒ Valley Medical Group, Amherst (413) 256-2020
⇒ University Health Services, UMass campus (413) 577-5383
⇒ MYEYEDR, Amherst (413) 549-9400
⇒ Belchertown Eye Care, Belchertown (413) 323-1196
⇒ Great Specs, Northampton (413) 586-8608
⇒ Florence Opticians, Florence (413) 584-8212
⇒ Eric David Dostal, OD, Easthampton (413) 527-9284
⇒ Dr. Vonnahme & Assoc., Easthampton (413) 650-5755
⇒ Thoren Optical, Chicopee (413) 592-1199
⇒ Super Target Optical, Holyoke Mall (413) 534-9000
⇒ Lenscrafters, Holyoke Mall (413) 532-9279
⇒ Pioneer Valley Ophthalmic, Greenfield (413) 775-9900
⇒ Eye & Lasik Center, Greenfield (413) 774-7016

Note: It is your responsibility to confirm with the provider's office that they participate in the EyeMed Select network.



FAQ

If I transition from being an enrolled UMass GEO member to a UMass Postdoc member, how will my benefits transition?

Your GEO benefits will end the day before your Postdoc employment start date and your Postdoc benefits will begin on your start date. There will be no gap; you will be covered seamlessly from one plan to the next.

Can I enroll outside of an open enrollment period?

Yes; but, MetLife has the right to impose waiting periods for employees who enroll late.

I need ID cards—how can I get them?

We email you printable ID cards when we confirm your enrollment. You can also print IDs from the dashboard of our enrollment site. You can print an ID by registering at https://mybenefits.metlife.com/ Our group name is UMass Post Doctoral Unit. Once registered, you can download a virtual ID card to your smartphone. Search "MetLife" at the iTunes App Store or Google Play to download the app. Then use your MyBenefits log in information to access these features and your ID card can be downloaded. You can print an EyeMed ID by registering at www.eyemedvisioncare.com Finally, you don't actually need ID cards to access your benefits. You can see a provider using just our group numbers (5993054 for dental and 9878760 for vision) and your SSN.

Is there an income cap on the childcare reimbursement? Is there a limit to the amount a family can be reimbursed per year?

There is no income cap. However, there is a $6,000 (per child receipts are submitted for) annual cap on the amount a family can be reimbursed.

More questions? Contact the Director of Benefit Programs at (413) 345-2156 or uawdental@external.umass.edu

Notices & Resources

Your COBRA Continuation Rights

Postdoc employees are eligible for benefits provided by the Trust Fund while they are employed and for 30 days after their employment ends. After 30 days, postdocs are eligible to apply for COBRA continuation coverage. COBRA allows you to maintain dental and/or vision coverage for up to 18 months by paying the premiums yourself. Please share this information with all qualified beneficiaries in your household, as they may have COBRA rights under the law. Find out more about COBRA and the monthly premium rates at http://www.uawumasstrustfund.org
Current rates through 6/30/20:

MetLife Dental:
Single: $40.36/month
Single+ 1: $82.45/month
Family $140.48/month

EyeMed Vision:
Single: $6.60/month
Single+1: $12.54/month
Family $18.36/month

Summary Plan Description (SPD), Summary of Material Modifications (SMM), our HIPAA Policy and the Gramm-Leach-Bliley Privacy Notice are available at https://www.uawumasstrustfund.org/pd-forms-and-documents

Contact Info

MetLife: 1-800-275-4638 https://mybenefits.metlife.com/

EyeMed: 1-866-723-0514 www.eyemedvisioncare.com

PRO/UAW Local 2322 (your Union): (413) 534-7600
https://uaw2322.org/pro/

UMass Human Resources, Beth Ives, (Health Insurance Specialist):
(413) 545-6115 bives@admin.umass.edu

About the Trust Fund

The Health & Welfare Trust Fund was negotiated as part of the union contract between GEO/UAW Local 2322 and the University of Massachusetts Amherst. The Trust Fund has grown since its inception to maintain two distinct benefit plans: the GEO Unit Health & Welfare Plan and the Postdoctoral Health & Welfare Plan. The University makes contributions per employee into the Trust Fund, which is then used to purchase health and welfare benefits for eligible employees.

The Trust Fund has provided employees with benefits since 2000, increasing and improving the benefits offered each year. The Postdoctoral Unit Health & Welfare Plan provides the following benefits for eligible postdocs:

⇒ High quality Dental Insurance with subsidized coverage for spouses, partners and children.

⇒ High quality Vision Insurance with free coverage for spouses, partners and children.

⇒ Childcare Reimbursements

⇒ Affordable Life Insurance

⇒ Group Prepaid Legal Plan

Contact Us

Phone: (413) 345-2156

Email: uawdental@external.umass.edu

Web: uawumasstrustfund.org

Skype: healthwelfaretrustfund

Social Media

UAWUMassHWTF

UAW_UMass_HWTF

uaw_umass_hwtf